

1 Mennonite Church USA
2 Atlanta 2003 Delegate Assembly

3 **Health Care Access Resolutions for Delegates**

4 Prepared by the Anabaptist Center for Health Care Ethics
5 April 17, 2003

6 The Anabaptist Center for Health Care Ethics has agreed on behalf of Mennonite Church USA
7 Executive Board, to facilitate the activities necessary to implement the following resolutions.
8 For this work, The Anabaptist Center for Health Care Ethics will represent the collaborative
9 efforts of the following organizations: Mennonite Health Services, Mennonite Mutual Aid,
10 Mennonite Central Committee, Mennonite Chaplains Association, Mennonite Medical
11 Association, and Mennonite Nurses Association.

12 **Resolved:**

- 13 1. That Mennonite Church USA develop a new Resolution on Health Care in the United States,
14 taking into account the current problems of access to health care along with the resolutions
15 on record from the former General Conference Mennonite Church (1992) and the Mennonite
16 Church (1993).

17 *Special instructions:* The new resolution will be disseminated in draft format to Assembly
18 Delegates of record by no later than July 2004, with the understanding that their feedback
19 will be received and integrated into a final statement for delegate action at the 2005 Delegate
20 Assembly.

- 21 2. That Mennonite Church USA authorize the Access Initiative, a project to demonstrate our
22 commitment, as a community of faith, to universal access to health care by developing
23 models that focus on helping congregations deal with problems of access to health care.
24 These models will incorporate the following principles:

- 25 • Access to health care for all persons (The starting point in this project will be
26 Anabaptist congregations and the lives they touch.)
27 • Emphasis on health promotion and prevention of illness
28 • An emphasis on healing and caring rather than focusing only on curing
29 • Recognition of our mortality and the limits required by stewardship of scarce
30 resources

31 *Special instructions:* The project team will explore the unique resources and talents of
32 Mennonite health care professionals and provider organizations. They will collect, organize,
33 and disseminate stories from providers and church members, work with key stakeholders,
34 and begin engaging congregations interested in developing an access model in their
35 communities. A progress report will be provided for delegates at the 2005 assembly.

36 The pages that follow provide additional background, rationale, and vision for this work.

37 **A Prospectus on Health Care Access**
38 for
39 **Atlanta 3003 Assembly Delegates**
40 *April 17, 2003*

41 **1. Why is access-to-care a high priority at this time? The US health care system today is a**
42 **system nearing chaos.**

43 The problems are numerous.

- 44 • ***Uninsured.*** Over 40 million persons, or nearly 20% of all persons under age 65 in our
45 country do not have health insurance. Disproportionate numbers of these persons are
46 children and heads of single parent households. A recent study showed there were 75
47 million people without health insurance at some point during the past two years. Many of
48 these persons find their work in jobs paying a subsistence wage.
- 49 • ***Affordability.*** Health insurance costs are exploding! During the past year employers
50 experienced average cost increases of 15% in their health insurance plans. Employers, in
51 an effort to manage this financial strain are passing along more of their costs to
52 employees. Persons who have insurance are finding that the cost of insurance is
53 increasing by substantial amounts even as they are subject to ever-greater restrictions in
54 the services offered under their present coverage.
- 55 • ***Insurance underwriting.*** In order to provide competitive health insurance plans, insurers
56 are forced to screen new entrants, selecting wherever possible the populations least likely
57 to require high cost medical care and excluding known illnesses from coverage for
58 extended periods of time.
- 59 • ***Consumer behavior.*** As consumers of medical care we must also own our complicity in
60 the problem. At its core, the crisis in health care involves our misguided values and
61 beliefs: our obsession with physical health, our unrealistic expectations of the medical
62 profession, our fear of death, our faith in unlimited scientific progress, and our
63 individualism. Our appetite for expensive care and our assumption that any available
64 technology is ours for the asking makes the prospect of controlling costs an unreachable
65 dream. In the interest of finding the “best price” or the lowest cost insurance we make
66 choices to support plans that discriminate against the chronically ill who are most in need
67 of care.
- 68 • ***Challenges for institutions.*** Mennonite health care organizations, senior care, behavioral
69 health, and disability service providers are trying to operate in this context. They deal
70 day-to-day with the growing challenges of the uninsured, the under-insured, and
71 declining reimbursement from state and federal sources.
- 72 • ***Where is community?*** We place unreasonable expectations on MMA by expecting them
73 to provide health insurance for high-risk groups and then select our coverage elsewhere
74 in order to reduce our insurance expenses.
- 75 • ***Stewardship of health.*** We must accept the role that our life styles contribute to the
76 consumption of medical care. It is safe in our faith community to speak of the excess
77 costs related to the consumption of alcohol or the use of tobacco and other drugs. It is
78 also time that we consider the price we are extracting from the health care system by our
79 sedentary life style and our dietary habits. We need to adopt the language of stewardship
80 when we speak of our health or physical well-being. The God who cares about how we
81 steward our time, talents and money is also concerned about how we care for our bodies.
82 How well we care for our bodies has a direct impact on our cost to the health care system.

83 **2. What have Anabaptists already said about access to health care?**

84 In 1992 – 1993 the predecessor denominations to Mennonite Church USA each adopted a
85 Resolution on Health Care. (See Exhibits 1 and 2.) The resolutions identified four
86 foundational principles that should undergird a just health care system. We said, “the church
87 is called to respond to this crisis out of its biblical concern for both healing and social
88 justice. These concerns are evident in the message of Jesus: "The Spirit of the Lord is on
89 me, because he has anointed me to preach the good news to the poor. He has sent me to
90 proclaim freedom for the prisoners and recovery of sight for the blind, to release the
91 oppressed, to proclaim the year of the Lord's favor" (Luke 4:18-19).” In response we called
92 for a system that:

- 93 • Provides access to health care for everybody everywhere in the U.S.;
- 94 • Places emphasis on health promotion and prevention of illness;
- 95 • Emphasizes the role of healing and caring rather than focusing only on curing;
- 96 • Recognizes our mortality and the limits required by stewardship of scarce resources.

97 We spoke of our concern because of our “belief in the sanctity and dignity of persons created
98 in God's image. This commitment to justice calls us to free people from social structures
99 which deny them that dignity. Our concern for stewardship calls us to use our limited
100 resources wisely and in the promotion of justice.”

101 We continue to believe all of these were and are laudable goals and believe the intervening
102 years require that those resolutions be updated and strengthened. We further believe that the
103 conditions those resolutions addressed have worsened since their approval. We confess that
104 we have not consistently sought the image of *justice* and *responsibility* these aspirations call
105 us to.

106 **3. What do we, as Anabaptists, have to offer in responding to the present access dilemma?**

107 As Anabaptists, we are called to help shape the vision for a better and more just health-care
108 system. We should be demonstrating by our actions that we are working to implement this
109 vision. We commend the following historical events as a challenge and an encouragement to
110 energize us to carry forward this agenda.

111 ***Civilian Public Service.*** Mennonite and Brethren Conscientious Objectors in the Second
112 World War and the Korean conflict were instrumental in revolutionizing the treatment of the
113 mentally ill and those in prison. We believe this story demonstrating the power of a small
114 group of dedicated persons should give us hope that our voice can carry weight beyond our
115 numbers to foster yet another social good for our society. As we spoke out for the voiceless
116 and the weak fifty years ago so should we demonstrate our care for the voiceless and
117 marginalized today. That history has demonstrated for us the power of a small group
118 speaking truth into a larger system. We have lived out our beliefs in history. By doing so
119 now we will create a new history for our country and our people.

120 ***Health Care Workers and Organizations.*** By the middle of the 19th century Mennonites
121 were already developing institutions of care – for widows, children, and the homeless.
122 Today we have a large number of Mennonite-affiliated ministries spread across the country
123 caring for the mentally ill, the frail, elderly, and those that are developmentally challenged.
124 These institutions are under stress today because of the pressures on the health care system.
125 Each such institution has the potential to become part of the solution to the problem of

126 access to care as they, being part of the faith community, seek to be faithful to their charge to
127 minister to all people.

128 In addition, we have a higher than average proportion of Mennonites in the caring
129 professions. These individuals care deeply about their work and believe that their faith
130 shapes their practice. They too struggle to know what it means to be faithful in the context
131 of a “broken” system. They have important perspectives and resources to share within the
132 community of faith as we create new ways of caring.

133 **Anabaptist Beliefs.** As Anabaptists we understand that following Jesus means a daily
134 responsibility to practice what we believe. We believe in justice and self-responsibility
135 because we are accountable for our actions.

136 We are a congregational and community people. We value relationships within our families,
137 our congregations, and the wider church. We tell our stories of support and care within the
138 congregation. We tell them for all to hear and by doing so we challenge all to be supportive
139 of each other and for the church by their actions. We respect and value the gifts each person
140 brings within our community.

141 We believe that being a good steward of our health is not just seeking treatment for our acute
142 and chronic illnesses, but attending to our spiritual, mental, emotional, and physical well-
143 being. We believe in working together to provide mutual support for each other, and to
144 support community needs beyond ourselves.

145 We believe in showing compassion to those in need in our communities. We will commit
146 ourselves as a body to identifying with those who are cast aside by the present system. We
147 will begin by caring for those in our midst who lack basic medical insurance. We will call
148 our people to sacrifice their own advantage for the purpose of enabling all who are
149 connected with the Anabaptist community to access health care.

150 **4. Organizing a response – a proposal for consideration.**

151 Mennonite Church USA will authorize and initiate a project to demonstrate our commitment,
152 as a community of faith, to universal access to health care by developing:

- 153 a. A new Resolution on Health Care in the United States, and
- 154 b. Models that focus on helping congregations deal with the problems of access to
155 health care based on the guiding principles noted above.

156 We will call on our brothers and sisters in the Anabaptist community to join in this effort –
157 the “Access Initiative.”

158 The Anabaptist Center for Health Care Ethics will be asked to facilitate the implementation
159 of this initiative. Sponsors joining in this effort will include Mennonite Health Services,
160 Mennonite Mutual Aid, Mennonite Central Committee, Mennonite Chaplains Association,
161 Mennonite Medical Association, and Mennonite Nurses Association. They will assemble a
162 panel of church and business leaders who will bring visibility to this effort as well as offer
163 guidance and energy to the initiative. They will make resources available for congregational
164 and conference leaders, including information and workshops on the subject. Together we
165 will gather with Anabaptists in all fields related to health care delivery and usage to listen to
166 their stories, concerns, and suggestions. We will encourage exploration of alternative
167 systems of medical care delivery. We will seek to be an advocate for all who are
168 marginalized, and to stimulate congregational dialogue with this issue. We will ask “*What*
169 *does being a person of faith living in community have to do with access to health care?*”

170 Through the Access Initiative
 171 we will solicit the creativity of
 172 many persons who will be able
 173 to offer counsel about the
 174 values that should be in
 175 operation for a truly just health
 176 care delivery system. Groups
 177 identified include: physicians
 178 and other health care
 179 professionals, health care
 180 administrators, pharmacists,
 181 government, insurers,
 182 employers, attorneys,
 183 denominational leaders, and
 184 consumers. We will ask these
 185 questions:

186 • *What will it look like if the*
 187 *household of faith got*
 188 *serious about providing*
 189 *universal access to health*
 190 *care?*

191 • *What will you be willing to contribute in order to provide universal access to health*
 192 *care for all Anabaptists and the lives they touch in a given geographic community?*

193 While the ultimate goal from our perspective of justice is to include all persons, everywhere
 194 in the United States, the starting point for this project will focus on interested Anabaptist
 195 congregations and their needs.

196 We will seek to publicize the failure of justice and stewardship in health care delivery in our
 197 country. We will endeavor to build this consensus first in the Anabaptist community and
 198 will find opportunities to add our influence to other groups who also seek justice and
 199 responsibility in health care delivery. In so doing, we will become a part of the grassroots
 200 initiative that will be required to bring about the changes needed in our health care system.

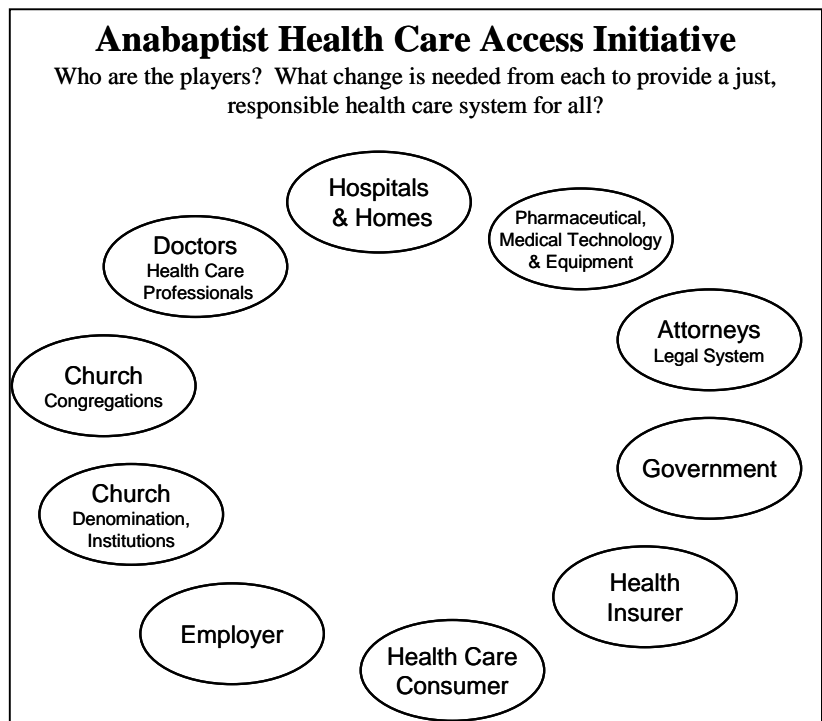
201 **5. Here is a vision for a new order**

202 We will insist that our committed church leaders not have their health care insurance
 203 jeopardized because of their health care history or by the financial hardship that health care
 204 insurance has become.

205 Each congregation will be engaged in health care advocacy and counsel for their members
 206 who desire it. Every person will have a home for health care.

207 Our potlucks will no longer look like an invitation to a heart attack.

208 We will find and publicize ways to promote the stewardship of health through various means
 209 (exercise, diet, stress reduction, etc.) leading to a greater sense of well-being. We will
 210 promote wellness of the whole person, and create healing environments which integrate
 211 treatment for the body, mind, emotions, spirit, and soul.
 212



213 We will tell stories about collaboration within the congregation for the care of those who are
214 ill or dying. We will hold these up as examples of the best values of community.

215 We will tell stories of heroes of the faith who renounced health care options with the
216 potential of prolonging life for the short term in order to find time and space to build and
217 strengthen relationships during the dying process.

218 We will hear of congregations where members have covenanted to be accountable to each
219 other in choosing degrees of health care, trying to balance the “right” for services with the
220 “expense” to the community in choices related to: infertility treatments, obesity options,
221 cosmetic surgeries, choice of prescriptions, etc.

222 We will hear of committees and reference groups within congregations that are available to
223 help other members navigate the many decisions that must be dealt with in the closing weeks
224 of life.

225 We will hear testimonies of those who have been challenged to live a life of meaning
226 because of the witness of one who died in Christ.

EXHIBIT 1

Resolution on Health Care in the United States (Mennonite Church, 1993)

Preamble

The U.S. health care system is in crisis. It has become intolerably expensive, yet fails to provide equitable access to care or achieve a better level of health. Health care now consumes nearly 14 percent of our Gross National Product, but more than 37 million people lack health insurance.

However, the crisis in health care involves more than politics and money. At its core, the crisis reflects misguided values and beliefs: our obsession with physical health, our unrealistic expectations of the medical profession, our fear of death, our faith in unlimited scientific progress, our individualism, and the pursuit of unfair profit.

Because of these difficult problems and a change in national leadership, health care reform is a priority on the national agenda. This climate has created a new opportunity for the church to be involved in reforming the system.

The church is called to respond to this crisis through its biblical concern for both healing and social justice. The connection between these concerns is evident in the message of Jesus.

The Spirit of the Lord is on me, because he has anointed me to preach the good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord's favor. (Luke 4:18-19)

The concern for justice in health care arises from our belief in the sanctity and dignity of persons created in God's image and calls us to free people from social structures which deny them that dignity. The rising cost of health care widens the gap between the rich and the poor, between those who have access to health care and those who do not.

As Mennonite Christians, we affirm the following vision of a more effective and just health care system and commit ourselves to specific actions to work toward its realization.

I. We call for a health care system that

A. provides access to basic health care for everyone, everywhere in the United States. As a social good, basic health care should be available to all regardless of ability to pay. While the system cannot provide everyone with all the services they might want or need, all people should have access to basic preventive, curative, supportive, and emergency services.

B. emphasizes health promotion and prevention of illness. The health care system should encourage individual responsibility for a healthy lifestyle and for appropriate use of the system. It should emphasize health education, wellness promotion, illness prevention, and primary care.

C. places the curing of individuals in the larger context of healing and caring for one another. We must replace our endless pursuit of curing with a broader vision of healing which stresses the overall well-being of the person and community. There can be cure without healing and healing without cure. We must always care, though we cannot always cure.

D. recognizes our mortality and the limits of our financial resources. We must acknowledge death as an inevitable part of life, and resist the temptation to fight it at all costs. We must also recognize that financial resources are limited and that excessive spending on health care reduces our ability to meet other social needs such as education, housing, and transportation.

271 **E. is guided by a national health care policy which controls cost while emphasizing**
272 **quality care.** This comprehensive policy should guide management of the health care
273 system by addressing issues of finance and administration, access to care, resource
274 allocation and planning, treatment and technology assessment, medical education and
275 research, and legal reform.

276 **II. As delegates we call on our congregations, institutions, and members to**

277 **A. reaffirm our biblical beliefs about health and illness, life and death, and our hope**
278 **in the resurrection through Jesus Christ as the basis from which we approach**
279 **health care issues.**

- 280 1. We commit ourselves to completing advance directives (e.g., living wills and
281 proxies) as an affirmation of our beliefs about life and death and as a symbol of
282 our commitment to stewardship and justice.
- 283 2. We commit ourselves to living self-controlled lifestyles, especially in the areas of
284 diet, exercise and stress reduction.

285 **B. strengthen the congregation as a health promoting and healing community.**

- 286 1. We encourage the establishment of congregational health ministries programs
287 which incorporate a theology of health promotion and healing as a vital part of
288 our ministry.
- 289 2. We will encourage people to make important health care decisions within the
290 context of their congregations.
- 291 3. We will educate ourselves on issues of healing, personal wellness, advance
292 medical directives, health care ethics, and health care alternatives.

293 **C. recognize with appreciation the ministry and accountability of health care**
294 **institutions, health care professionals, and other caregivers.**

- 295 1. We challenge them to fulfill their unique mission in a manner consistent with
296 kingdom values and priorities. We call on them to go beyond professional self-
297 interest in responding to the health care crisis.
- 298 2. We call on both our health care professionals and members to exercise greater
299 restraint and stewardship in the utilization of health care resources.

300 **D. recover a commitment to community in bearing the cost of health care.**

- 301 1. We call for the utilization of financial resources, institutions, and people to find
302 new ways of doing mutual aid in today's health care environment. We ask the
303 church and Mennonite Mutual Aid to reconsider the justice of commercial
304 underwriting practices and find alternatives which embody the biblical ideals of
305 justice and mutual aid.
- 306 2. We call for the personal and institutional sacrifices necessary to provide justice in
307 the health care system. We acknowledge that changing the health care system
308 will be painful. Those of us who have power, financial resources, and access to
309 care must be willing to pay more or do with less so that those without may have
310 access to care.

311 **E. share our vision and values with government and support efforts to develop a**
312 **comprehensive national health care policy which sets priorities and brings justice**
313 **and order to our chaotic health care system.**

314 *The Mennonite Church General Assembly adopts the "Resolution on Health Care in the United States"*
315 *and as delegates call on our congregations and institutions to give attention to the actions identified in*
316 *the resolution.*
317 Mennonite Church General Assembly
318 July 30, 1993

Exhibit 2

A Resolution on Health Care (General Conference Mennonite Church U.S. Assembly, 1992)

A Resolution on Health Care

Preamble: The American health-care system is in crisis. The system has become intolerably expensive, and fails to provide equitable access to care or achieve a better level of health. The cost of health care is rising much faster than the rate of inflation, with health care now consuming more than 11 percent of our Gross National Product. Nevertheless, fewer and fewer people are being served by the system. Over 34 million people, including 12 million children, lack health insurance which would provide them with access to care.

However, the crisis in health care involves more than just politics and money. At its core it reflects misguided values and beliefs: our obsession with physical health, our unrealistic expectations of the medical profession, our fear of death, our faith in unlimited scientific progress, our individualism and the pursuit of unfair profit.

The church is called to respond to this crisis out of its biblical concern for both healing and social justice. These concerns are evident in the message of Jesus: "The Spirit of the Lord is on me, because he has anointed me to preach the good news to the poor. He has sent me to proclaim freedom for the prisoners and recovery of sight for the blind, to release the oppressed, to proclaim the year of the Lord's favor" (Luke 4:18-19).

Historically, the healing ministry of Jesus (Matthew 4:23-25) has been carried forward by the church in efforts to restore health and wholeness to individuals and communities. One example of this mission is the founding of hospitals and medical missions throughout the world.

The concern for justice in health care arises out of the belief in the sanctity and dignity of persons created in God's image. This commitment to justice calls us to free people from social structures which deny them that dignity. Our concern for stewardship calls us to use our limited resources wisely and in the promotion of justice.

Thus, as Mennonite Christians, we are called to help shape the vision for a better and more just health-care system. We must also actively work to help bring it about. Therefore, we affirm the following vision of a health-care system and commit ourselves to specific actions to work toward its creation.

I. We call for a health-care system that

- A. provides access to basic health care to everyone, everywhere in the United States. As a social, and not strictly individual good, basic health care should be available to all regardless of ability to pay. While we cannot provide everyone with all the services they might want or need, all people should have access to basic preventive, curative, supportive and emergency services.
- B. emphasizes prevention of illness and health promotion. The health-care system should encourage individual responsibility for a healthy lifestyle and for appropriate use of the health-care system. To enable people to be responsible we should emphasize health education, wellness promotion, illness prevention and community-based primary care.
- C. places the curing of individuals in the larger context of healing and caring for one another. We need to shift from our endless pursuit of curing to a broader vision of healing which stresses the overall well-being of the person and community. There can

- 363 be cure without healing and healing without cure. We must always care, though we
364 cannot always cure.
- 365 D. recognizes our mortality and the limits of our financial resources. We must acknowledge
366 death as an inevitable part of life, and resist the temptation to fight it at all costs. We
367 must also recognize that the financial resources available for health care are limited and
368 that we cannot continue to spend without jeopardizing other social needs.
- 369 E. controls cost and spending while emphasizing quality care. While the system should
370 continue to emphasize quality of care, it should control cost and spending through more
371 simple administration, reduced malpractice litigation, increased emphasis on primary
372 care and the wise use of technology.
- 373 F. is guided by a national health-care policy. This comprehensive policy should guide
374 management of the health-care system by addressing issues of access to health care,
375 resource allocation and planning, technology assessment, medical education and
376 medical research.
- 377 II. As congregations, institutions and members we resolve to
- 378 A. reaffirm our biblical beliefs about life and death, and our hope in the resurrection.
379 Questions about what we want from a health-care system are fundamentally religious in
380 nature. These foundational beliefs should provide the basis from which we approach
381 the healthcare system.
- 382 B. promote the congregation as a healing community. We must integrate a theology of
383 healing into our worship, teaching and small group ministries, incorporating the practice
384 of prayer and anointing for healing in worship services and implementing
385 congregational health-ministry programs.
- 386 C. educate ourselves on issues of healing, personal wellness, advance medical directives,
387 health-care ethics and health-care alternatives. Through education we can help
388 congregations become health-promotion communities.
- 389 D. recognize and affirm the ministry and accountability of health-care institutions, health-
390 care professionals and other caregivers. These people and institutions possess
391 valuable skills, knowledge and abilities. We support, encourage and challenge them to
392 fulfill their unique mission in a manner consistent with kingdom values and priorities.
- 393 E. recover a commitment to community in bearing the cost of health care. We should
394 utilize our financial resources, institutions, volunteers and professionals to find new
395 ways of doing mutual aid in today's healthcare environment.
- 396 F. become advocates for a health-care system that includes fairness, accountability and
397 accessibility.
398 Advocacy is a natural outgrowth of our Christian mission in health and healing. We
399 should share our vision of a just health-care system with government and encourage
400 the development of a national health-care policy that sets priorities and brings justice
401 and order to our chaotic health-care system.
- 402 G. call on Mennonite health-related organizations (Mennonite Health Association,
403 Mennonite Health Services, Mennonite Nurses Association, Mennonite Medical
404 Association and Mennonite Mutual Aid) to lead in responding to the health care crisis.
405 We urge them to develop consultations, statements and exemplary activities which are
406 needed to move us from dialogue to action in redefining the church's mission in health
407 and healing in the '90s.

408 Health Dialogue Steering Committee: James Waltner (chair), Lawrence Greaser, Gene Yoder,
409 Anne Hershberger, Vyron Schmidt, Carl Good, James Lapp and Willard Krabill.
410 Adopted by delegates to the U.S. Assembly of the General Conference Mennonite Church, July
411 22, 1992.
