

**UNITARIAN UNIVERSALIST
COMMUNITY CHURCH**

Park Forest, Illinois

Sunday, January 9, 2005



TOO POOR TO GET SICK -

America As Third World Country

The Rev. Dr. Randolph W.B. Becker,

70 Sycamore Drive
Park Forest, IL 60466-2600

1 (708) 481-5339
minister@uucpf.org

It was a Tuesday.

The line was longer than I would have liked.

I had planned to get in and get out in a manner of minutes.

But, that was not the case.

She stood in front of me in line. I had plenty of time to see that she was well dressed, that she had an eye infection, that she was in pain.

Eventually, the pharmacist took the prescription from her, and told her that it would cost her \$10. She seemed surprised at that. She said her medical plan claimed drugs only cost \$1 co-pay. The pharmacist then sympathetically told her that, yes, it was \$1 for the most common drugs, but that other, less common drugs had co-pays of \$5, \$10, even \$20. She sighed. Then she said she would be back on Friday, payday, to pick up the prescription. She said her kids had to eat first, and she could wait.

You see, even though she had medical insurance, she was too poor to get sick.

(Let me quickly add, she did not go home that day to wait three days for her needed medicine - the discretionary funds this congregation provides me meant I could pay for that co-pay for her.)

She is not the only person in the United States who is too poor to get sick.

But, I suspect that if each of you could draw a picture of a person who is in a similar bind around medical insurance and medical care, collectively we could not draw an accurate picture of those people.

We could expect to get many pictures of people who are unemployed or homeless. Surprisingly, those people may not lack access to quality medical care. Identified as people in need (and therefore worthy of Samaritan type of care), numerous programs exist in many communities to ensure that those without employment and housing have their medical needs met. In the best cases, they will receive some of the best medical care in the world. In the worst cases, they will have to inconveniently travel to wait in long line for marginal care at best. They will get care, eventually, but the iffy-ness of it will encourage many to not seek care at all. The poor, at times, are really too poor to dare to get sick.

But whose pictures should rightfully join the ranks of the obviously poor?

How about the elderly who are covered by Medicare? Even with the provisions of last year's changes, being covered by Medicare does not mean being covered. The issue faced by the woman here at the Pharmacy faces many of the elderly, as their co-payments can quickly add up. A hospital stay of a couple of weeks followed by recuperation in an appropriate facility could easily tally thousands of dollars not covered by Medicare. And this for people who are paying between \$78 and \$450 a month in premiums. Of course, those who are able can afford supplemental insurance. But what of those who cannot? In 2001, the US Census Bureau found that 16% of our seniors live in poverty, which means that they do not have the available income for either supplemental insurance or co-payments. Our elderly are, too often, too poor to get sick.

How about the young, striving to find their way into meaningful careers? Easily covered during their years of education, they find that soon after their graduation they are cast out of parental coverage and must fend for themselves in the highest cost insurance markets at a time when they may be least likely to have sustained and supportive employment. The result, as John Kerry pointed out, is that 40% of those 18-30 are uninsured, willing to gamble their well-being in exchange for having disposable income and participate in the American experience. Our youngest, our finest, too often find themselves too poor to get sick.

How about those in-between: The women and men who are in the midst of their careers, working in their jobs, in their professions, in their callings? The press is filled with stories of this company or that company negotiating a new employee contract on which the major issue is health insurance: for every time we read or hear of an expansion or continuation of coverage, we hear or read twice of a reduction or elimination of coverage. Not to mention the changes of plans by which new employees are limited or excluded in the coverage. Being employed by a company offering health insurance does not mean coverage, and that coverage does not eliminate the costs of worker shares, co-payments, and exclusions.

But, this is too simple a picture. How many of the newest employees dare to miss work to deal with a health condition? How many of the veteran employees, worried they will be seen as too old, dare not to miss work for the same reason? How many employees, knowing that employers have access to their medical insurance claim records, dare not file claims and therefore do without? How many workers, building the great American abundance, dare not change jobs

because to do so will mean to eliminate or diminish health care coverage? Too often the well-employed are also too poor to get sick.

And what of those who are self-employed? I relate to this personally, as a Professional who, like my colleagues in other professions, must find my own health insurance. Let me tell you of the last ten years of my life in relation to health insurance, knowing that mine is, by far, not the worst case.

When I moved to my last settlement, I lost the coverage I had enjoyed through a group plan. I searched for a replacement, and the best I could find was a policy at the same rate for the same coverage, or so I thought. When the policy was delivered to me, it included two exclusions for medical conditions which were considered “pre-existing,” but which moved from the specific to the global. A year later the premiums rose by more than 40%! Thereafter, I lived through a series of three insurers who could offer coverage at the same level at slightly lower cost, but all of which used the first renewal as an opportunity to raise premiums at least 25%. Eventually, I found stability, but only at a higher rate of premium and deductible. But, what if I choose to change my position?

One of the quirks of these United States is that while we argue about a national health policy, health insurance policies are handled on a state-by-state basis. This might not seem like a big problem. But what if your Ministerial Search Committee two years ago had been told that they could only consider candidates from this state, and what if I had thought that my only choices for

a ministry were back in my former state?

The reality is that we consider ours an Association of Congregations which is at least national, if not international. We also believe in congregational polity, which cedes to each congregation, as a natural, religious right, the freedom to seek and call ministries of the congregation's choosing, without interference from bishop, or synod, or denomination, or state. You sought, I sought, we found, we are here together!

But what that meant to me as a Professional, as one who is considered self-employed, was that I needed to apply for new health insurance. The result was a premium increase of nearly 25%, a reduction of benefits available without deductible, and an increase in deductible of more than 100%. For professionals, for the self-employed, moving over state lines means drastic changes in insurance coverage. (Fortunately, for me, this congregation understood what this meant, and at last year's Annual Meeting made changes that rendered the changes infinitely less burdensome to me, and I thank you!)

The bottom line for too many is that the self-employed and professionals are too often too poor to get sick.

And the list goes on. The hourly worker who cannot afford to miss work for either illness or medical care. The seasonal or migrant worker. The people who have to cobble together a string of part-time positions, none of which reaches a threshold at which health insurance is provided.

The people who, through no fault of their own, live with physical or mental conditions which render them virtually uninsurable. The divorced person who had been covered by a partner's insurance who is now thrust into the insurance market to fend for herself or himself, often with pre-existing conditions, often at the lowest point in their adult economic situation.

Or, to get to the bottom line which is being drawn by our society as a whole, not by the individuals in it: an average household of two adults and one child, with both adults working full time at minimum wage, produces a total family income of just over \$20,000. If the average health insurance plan with any reasonable deductible for such a household costs about \$10,000 a year, where do you think you will find either an employer who will spend 50% more just for this benefit or an employee who can spend half of her or his income on health insurance?

Through the combination of less-than-living-wage income and out-of-control health care costs, the bedrock of our society is functionally too poor to get sick.

One of the easiest definitions of what it means to be a Third World country is to have a socio-economic structure in which major segments of society do not have reasonable access to the benefits of a modern society. What separates developed and developing nations is not so much the presence of advanced technology, which includes health care, but the nearly universal availability of that technology. I could begin a list of attributes of a modern, developed nation (such as universal public transportation, quality education, communication, sanitation, affordable housing) and health care would surely be there. But, it is not here. It is ironic that travelers from many of the developed nations of the world worry when they travel here, not

because of terrorism or other threats to their lives, but because if they were to get sick here, it could cost them their financial future. When it comes to health care, coming to the US is more like going to a Third World country unless you are very rich or very insurable.

But, I suspect I am preaching to the choir again. I doubt there is a single person here this morning who has not been touched by this crisis in some way. A loss of insurance with a job change. A child growing off our plans and deciding to, as they say, self-insure. A neighbor who has to sell his or her home to pay for medical bills. The problem is never very far from us – often it is line right in front of us.

Then, if the problem is so widespread and understood, where is the solution?

I am not going to pretend that I have every answer to the problems of the health care and insurance industry, but I am going to suggest that I have three simple answers that would make a difference.

Those three answers could be summarized as We, Me, and Them.

When I say “We,” I am speaking of the collective whole of our society. One of the first things we could do to make a difference would be to change our attitudes toward health care. We have been raised with an expectation of life without illness or suffering. When we are ill or suffering in some way, we want relief, and we want it now! There is nothing wrong with that when it is

expressed with understanding and moderation, but –

when hundreds of millions of dollars are spent annually on antibiotics to treat viral infections on which they have no effect,

when billions of dollars are spent on artificial sustenance of lives which are immediately terminal,

when untold dollars are spent on testing for conditions which are more annoying than either dangerous or life-threatening –

we all are responsible for much of the rise of health care costs. If we change our own expectations around health care, we have a major impact on costs!

As for “me,” I could adopt lifestyle changes which would be beneficial to the whole of our society. One estimate has attributed more than 25% of our health care costs to lifestyle choices made by Americans, made by people with enough affluence to be able to make those choices. What I eat, how much I eat, how much I exercise, how I exercise, how much I drink, if I smoke, what mode of transportation I choose, how much I take wellness and preventive care to heart – all of these are my choices to make. To the extent to which we are not active in living lives which promote our own health, we are contributors to the problem, we are the haves who are choosing to live in ways which, ultimately, make others healthcare have-nots.

And what can “they” do? They need to see that a wisely managed health care system, one that is not one based on profit motives, providing for all is better than a profit managed one which provides for only some. Such a response by the “them” of the coalition of government, the

insurance industry, and the healthcare industry, would have three essential elements.

They would create health care availability which would be national, avoiding the present system of state-defined programs and insurance. As a citizen of the United States, I should be able to expect the same level of care and support whether I live in Manhattan or West Virginia, in Vermont or in New Mexico.

They would create health care availability which would be universal, without whole segments of the population excluded by reason of economics or location or density of population or any other factor. This would mean that we would have to actively treat all of our people, no matter where they live, as true equals. What a concept!

And they would create a health care system which did not create its own companion industry. In many of the plans offered for consideration in 2004 election cycle, one feature was prominent in many of them: that eliminating insurance overhead costs would produce sufficient income to fund a truly national, universal health care plan at no more bottom line cost to society than the present piecemeal one of privilege. Eliminating the levels of advertising, underwriting, record-keeping, litigation, and so forth would transfer billions of dollars from administration to actual care.

A single-payer, socially-responsive federal plan of health care in this country, coupled with changed expectations of the people and wiser choices in personal life style, could produce a

health care system for all of us which would respect the inherent worth and dignity of every life. It is that simple, and that complicated. Until we collectively decide that our nation is rich enough to be well, we all will be too poor to get sick.