

A System in Crisis
A sermon preached by the Reverend Diane D. Teichert
Paint Branch Unitarian Universalist Church
September 20, 2009

The sermon this morning is not what I announced in the September newsletter. With President Obama coming to our neighborhood on Thursday to speak at the University of Maryland about health care reform, and having advocated for health care reform, specifically a single-payer system, since the mid-seventies, I felt drawn to preach on it myself.

I am preaching this morning a sermon I first delivered on February 27, 2005 as a fundraising strategy for First Parish Unitarian Universalist in Canton, Massachusetts where I served as minister for ten years through June 2008. Shortly after its delivery, I submitted it to the UUA's Health Care Sermon Contest, hoping to win the \$1,000 first prize, which we did!

The stories I'll tell you today were told to me by members of that congregation.

A "sweet" young woman, twenty-three years old, a recent state college graduate with a degree in chemistry, was working in a chemical company when she became pregnant. Her husband was a seminary student; they got their health insurance through her job. She worked in the lab testing products using a solvent called NMP, spills of which were common. She read that skin exposure to NMP caused spontaneous abortions in rats. So, her obstetrician referred her to an occupational medicine physician for evaluation of the exposure. The physician, a member of the congregation, recommended to the company that she be moved to a different job. The company refused, but they did give her a half-face mask and latex gloves. Not wanting to lose her health insurance while pregnant, the woman stayed in the position. At around her 16th week of pregnancy, there was a major spill of NMP and she was the one to clean it up. She noted at the time that her latex gloves dissolved in the solvent, causing extensive direct skin contact to her hands, one of which had a slight cut. Within a few weeks, her baby stopped showing normal weight gain. Soon, no fetal heartbeat could be heard. Labor was induced and the baby, a boy, was stillborn.

This is sad, and it is morally wrong!

Another healthy pregnant young woman, proud to be a female working in a typically male environment, also had solvent exposure on the job. She worked in a furniture factory, in a booth spray-painting lacquer finishes. She, too, was recommended for a job transfer by the physician. The company said they were small and had nowhere else to move her. If she left her job, she'd lose her health insurance. If she didn't leave, she might lose her baby. She resigned. A few weeks later, she miscarried. Maybe she was going to miscarry, no matter what. Or, maybe she lost her baby due to the solvent exposure, or maybe due to the stress of being unemployed and without health insurance. This is sad, and it is morally wrong.

Sad, yes. Wrong, yes. But these people aren't *us*. We've been lucky, or smart enough, to choose clean jobs, right? And, we've got health insurance, right?

Well, suppose you work in an office, use a computer all day, and start developing problems with, say, your eyesight. You're not getting younger, so maybe it's just your age. But, you mention your symptoms to your ophthalmologist, and the specialist you see for the chronic disease you have; both visits covered by the very fine health plan offered by your employer. No one is too alarmed. Your eyesight gets worse. You make mistakes at work. You can't recognize your co-workers in the hall until they speak. You are referred to a neurologist, who takes one look at the list of meds you're on for the chronic disease and says, "This one is known to cause loss of sight. But going off it, may not bring back your vision."

You fear losing your job and, along with it, your health coverage, which a person with a chronic disease cannot risk losing. You are advised to do something that completely goes against your grain: sue your doctor for payment of your health insurance for the rest of your life.

This could happen to any of us. In fact, it *is* one of us. It's someone we know and love who only last year served as your president!

One of *us* is losing her eyesight and thus may lose her job and, along with it, her health coverage! This is sad, and it is morally wrong!

As Unitarian Universalists, one of our dearest-held principles, “justice, equity, and compassion in human relations” is violated each and every day by the system-in-crisis that is U.S. health care today.

But these aren't just UU principles, they are *American values*, and they are vulnerable, very vulnerable, in health care today.

Where is the justice, where is the equity, where is the *compassion*, especially the compassion, in a system that ties health coverage to jobs and forces a pregnant woman to choose between her job and her baby, or fails to tend to the symptoms of a patient to the point that she fears going blind, losing her job and, with it, her health insurance?

A system that ties health coverage to jobs violates our values. It causes havoc and discontinuity in medical care for those who change jobs frequently, which is more and more of us, the younger we are. It causes terror for anyone who fears being laid off. It causes people to stay in dangerous jobs, jobs that threaten their own and their babies' health. And, worse of all, it leaves 45 million Americans *un-insured*, most of whom have jobs but not health coverage! (Alice Dembner, “Many Workers Draw on State Free-Care Pool,” *Boston Globe*, February 2, 2005)

This is sad, and it is morally wrong! And, it is a violation of our Unitarian Universalist principles, and of our American values.

Clearly, the present system is morally wrong from the point of view of the people who need medical care. That would be most of us, some time in our lives. Whatever you want to call us—recipients, patients, clients, consumers—we are *not* being adequately served by this system which links health coverage to our jobs.

But, now I want to shift our attention to those who *provide* care. Because, as I discovered in talking with those of you here at First Parish who work in the system-in-crisis that is U.S. health care today, it's not working for you, either.

In preparation for this sermon, thirteen First Parish folks met together and/or spoke with me. They are working in speech/language pathology, case management for an insurer, internal medicine with refugees and torture survivors, occupational medicine, nursing home administration, physical therapy, hospital equipment installation, state employees health insurance, obstetrics-gynecology, psychiatric social work, and psychopharmacology.

Terrible angst permeated our conversations. These bright and caring people work every day in the midst of a crisis that asks, even demands, that they curb costs by corroding care, in violation of their own principles—*our* principles of justice, equity and compassion in human relations. One said he now “hates” his job “every single day.” Two have taken the risky road of going into business for themselves. One, a practicing Buddhist, for whom Right Livelihood is a tenet of the Eightfold Path, asks “Is my workplace, with its inherent values, congruent with my values?”

Much of what they reported was a surprise to me. Sad, too. And morally wrong.

Most of the health care practitioners in our pews report they are required to limit their time with each patient to 10 or 15 minutes, in order to see a quota of patients and to have time to complete the multiple insurance forms, which differ from carrier to carrier. They feel it

takes more than 10 or 15 minutes to create a trusting rapport and to elicit information crucial to providing quality care. Creating trust is, they feel, a prerequisite for compassionate quality care, and the system practically prohibits trust by limiting time. It's a constant, wearing tension, as they weigh in good conscience the demands of their employer and the insurers... against the needs of their patients.

Most of the health care practitioners in our pews are pressured to prescribe medications from a "preferred drug" list, regardless of research or experience that tells them a different medication would likely work better for their patient. To prescribe an alternative, they must take time—as much as an hour—to complete a form justifying their request for approval by the patient's insurance company. They long to be able to prescribe the medication that, in their educated judgment, will best suit the patient's needs, though of course, all things being equal, they would prescribe the least costly. Instead, they receive a report at the end of the year, comparing their rate of prescribing from the "preferred drug" list to the rates of their colleagues, there having been incentives for those who most comply. They feel this competition is eroding trust between colleagues.

Oh, and did I tell you that the order of appearance on the "preferred drug list" is not determined by proven effectiveness? Are you concerned, as I was, to learn that your last prescription was not necessarily written for the best drug for your needs, but for the one for which your insurer had negotiated the best deal? This erodes patient trust, as well.

Most of the practitioners in our pews are deeply troubled by the pervasive influence of the pharmaceutical industry. I learned that drug companies fly physicians and their families to expensive resorts in exotic places for quote-unquote "continuing education" presented by... drug company scientists. In fact, it is barely disguised seduction to prescribe the host company's products. Why deny your spouse and kids, who you rarely see due to your long workhours, a few days in the Caribbean?

I learned that this drug company influence appears even in community health centers, where a fine spread of favorite carry-out food will be laid out in the staff room, compliments of the pharmaceutical company whose products are at the top of the "preferred list." Why not save that peanut butter and jelly sandwich for tomorrow?

This seduction of health care providers is nothing compared to the greed at the top echelons of pharmaceutical corporations, as I read. In 2002, the combined profits for the top ten drug companies in the Fortune 500 were more than the profits for all the other 490 businesses put together. And, in 2003, while profits of the Fortune 500 drug companies dropped to 14.3 percent of sales, that was still more than three times the median for all industries for that year.

We cannot believe drug company explanations that they need those profits for research and development. The fact is that the percentage of revenues going to profits far exceeds the percentage of revenues going to R&D, in some instances by nearly two times, and most research to develop new drugs is publicly funded anyway (or was--if President Bush's new budget is passed, it's not clear *where* funding will be found). What's happening to these profits? If you own drug company stock, you're getting some nice dividends. And, the pharmaceutical company CEO's are doing quite well. For example, just one, former chairman and CEO of Bristol-Myers Squibb, Charles A. Heimbold Jr., made \$74,890,918 in 2001, not counting his more than \$76,000,000 worth of unexercised stock options. Nearly 75 million dollars in annual salary!!! How is *that* just, equitable or compassionate? (drug company facts from Marcia Angell, "The Truth About Drug Companies" in *New York Review of Books*, VOLUME 51, NUMBER 12 · JULY 15, 2004)

Among the practitioners in our pews, the pharmaceutical industry is almost universally regarded as corrupt, unethical, greed-driven, and even "evil"! Let me remind you, greed is

one of the seven deadly sins. And, it's pervasive in our health care system. The self-interest of those who so sinfully benefit from the system-in-crisis that is U.S. health care today will cause them to stand hard and fast, with well-funded lobbyists and huge contributions to election campaign coffers, against the changes necessary to rebuild that system on a foundation of justice, equity and compassion.

What *would* those changes be? What do you think? Should health insurance be tied to our jobs? Should so many of our health care dollars be spent on administration? Should practitioners be under such pressure to see so many patients in so little time, and to prescribe medications with so little regard for what might be best? Should we allow for-profit hospitals, for-profit nursing homes, and for-profit pharmaceutical companies?

I put this question to the health care practitioners among us. I asked them, if you could create the ideal system, what would it be?

Their ideal system, and mine too, is a universal (available to all) single payer system, not tied to jobs, with the same array of providers and choices we currently have. This would allow even access to medical care for all, and reduce administrative time and costs because there would be only one insurer, with only one set of forms to fill out and one set of regulations to follow. This would eliminate the wasteful duplication of multiple private health insurance companies and also remove the profit incentive at that level.

In our ideal system, our society will grapple with and come to agree on what is "basic" health care, and go about providing it equitably. It will be like public education—as fraught with disparities as it is, at least it is available to all. We accept that the wealthy would buy into more expensive private health care coverage, just like they send their children to private schools, but at least everyone's basic needs would be met continuously, without relation to job security.

As to what is "basic?" we agreed that many difficult choices must be made in our ideal system, especially with very premature births and very prolonged deaths. But, all pregnant women will receive prenatal care. And, all elders who so desire will receive services enabling them to live longer at home.

In our ideal system, Americans would take responsibility for our health, individually and collectively. The system would provide incentives for meeting, and penalties for not meeting, one's personal health goals. No longer could we expect to eat and drink foolishly, smoke and not exercise, and then expect to be saved by meds and surgery. We will take responsibility for our collective health, as well, with rigorous standards for environmental protection and workplace safety and health, for laxness in these areas has adverse health effects that increase medical costs.

And, our ideal system would deal with the pharmaceutical industry. The new single payer would negotiate for lower prices, as do the US Veterans Administration and Canadian government today. This would result in a single "preferred drug list," which was negotiated in public, with our interests in mind, in terms of both care *and* cost. These negotiations could also provide incentives for Research and Development, and for studies to assess safety and effectiveness after a drug is in use, now woefully lacking.

We can do this! We can make it happen! Wouldn't it be grand?

Let's think now of the people whose stories were told at the beginning.

Those two pregnant young women working in factories?

Imagine how different their lives would be in our new health care system. First off, no worker (male or female, pregnant or not) would be handling toxic solvents with dissolvable latex gloves!

But, just imagine: in our new health care system, each of those young women would resign their dangerous jobs, with peace of mind, knowing that they and their babies would continue to receive the exact same medical care, regardless of their future employment status.

Imagine that! This is how it ought to be, and we can make it happen! We can do this!

And, what about the patient in our pews, one of our appreciated lay leaders, the office worker with vision problems? Imagine how different *her* life would be in our new health care system! Her initial worries about her eyesight would be heard and pursued by her health care providers. They would not be under great pressure to end the appointment or be wary of taking the time to request a different medication for her. They would even confer with each other on her behalf!

Her medication would be changed promptly, the damage to her eyesight would be arrested, and she would not now fear the loss of her vision and her job. And, even if she *did* lose her job, she would continue to receive the same medical care, regardless of her future employment status. She would not need to put herself, and her doctor, through a soul-wrenching, torturous malpractice suit. They both would have peace of mind.

Imagine that! This is how it ought to be, and we can make it happen!

First we have to want it! Do we want it?

Well, then, I believe, where there is a will, there is a way! We can do this!

So may it be.

A System in Crisis – Sermon Reprise

Well, five and a half years have passed since that sermon was delivered and the number of uninsured is up to 46.3 million according to the most recent Census Bureau data. And right now the United States is closer than we have ever been to arresting the crisis that is our health care system. But, the proposals today are not nearly the "reform" my parishioners and I had envisioned back then.

After the sermon then, like today, we sang that powerful South African freedom movement song, "God give us power" but in these years we didn't build the power to achieve those aims—and I'm not blaming God!

How idealistic of us to have thought a universal, single-payer health system negotiating deals with the pharmaceutical companies was even remotely possible!

But, I believe President Obama is nearly as naïve as we were idealistic when he says, as I heard him say to the packed arena at the University of Maryland on Thursday morning, "I'm not the first president to try to reform our health care system, but I want to be the last." The reform that passes this year, whether it includes the public option or not, will not be the last reform needed.

Until we achieve a system in which health insurance is not provided as an employment benefit, so that you can leave or lose a job and not lose your medical care... Until we achieve a system that makes it feasible for medical practitioners to develop trusting, effective relationships with their patients, regardless of patient income ... Until we achieve a system in which more profits are invested in care and research and less into dividends and executive salaries... Until we achieve a system in which U.S. health indicators are as good as those of the other industrialized democracies... people will be calling for more health care reform.

But, today I feel hopeful. Most change happens slowly unless it happens violently.

So, I choose to believe that incremental changes are good enough, especially if they include a public option which will begin to make affordable care universally available even if it doesn't eliminate the administrative waste and profit margins of the private insurers.

You may well see these things differently than I do. That's fine. Because when you gave *me* the "freedom of the pulpit" in the Letter of Agreement I signed last May, *you* didn't give up your "freedom of the pew!" Or chairs, here.

This is our tradition, as Unitarian Universalists. And, please know that I am interested to hear about your experiences with health care and to understand your views about these policy matters.

Our challenge, as usual, is to draw on our Unitarian Universalist values as we take our stands and also to remember, in the words of nineteenth century Unitarian minister Edward Everett Hale, "I am only one, But I am still one. I cannot do everything, but I can still do something. And because I cannot do everything, I will not refuse to do the something that I can do."

Amen. So may it be!

HYMN #172 Facing challenges far greater than we do, seeking liberation from apartheid, the people of South Africa sang this song that they might gain the power to make changes.

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