Public Dollars for Religious Doctrine

America’s “Faith-Based” Health Care Initiative Threatens Patients’ Rights

LOIS UTTLEY

Across the United States, more and more patients are encountering an insidious new form of health care “gatekeeper.” Instead of denying care for cost reasons, as HMO gatekeepers do, these religious gatekeepers are using fundamentalist doctrine to decide whether the health care a patient needs will conform to strict moral codes.

They are doing so with the express permission, and even encouragement, of a Congress and White House eager to please the Religious Right. Consider:

• A rape victim arrives at a hospital emergency room. “What if I become pregnant from the rape? Is there something I can do to prevent it?” she asks. “I’m sorry,” the ER doctor says, “but we aren’t allowed to give you emergency contraception. It’s against the religious doctrine of our hospital.”

• A mother of two is about to deliver her third child. “My doctor says my high blood pressure is so dangerous that I shouldn’t have any more children. I’m planning to have my tubes tied right after I give birth,” she tells the administrator who is helping her fill out paperwork for admission to the hospital. “Do you realize that your managed care plan won’t pay for that?” the administrator asks. “It’s a religiously-sponsored plan and sterilization is against their beliefs.”

• A patient is hospitalized with a terminal illness. His wife hands his advance directive to his nurse, telling her “I want to make sure you know that he doesn’t want feeding tubes attached to him. He doesn’t want to be kept alive in that state.” The nurse replies, “I’m not sure that will be allowed here. Our Bishop thinks it’s euthanasia.”

Hospitals, HMOs, clinics, medical office buildings and even pharmacies are becoming battlegrounds that pit patients against an array of administrators, nurses, doctors and pharmacists pledged to uphold religious doctrine, even when it conflicts with sound medical practice. Individual practitioners are also claiming “conscience” rights to deny care they view as immoral, organizing themselves into groups like Pharmacists for Life.

This stealth threat to patients’ rights is growing as religiously-sponsored health systems increase in size and political influence and as religious authorities demand more and more legislated exemptions or “refusal clauses” that allow them to refuse to provide medical care if it conflicts with doctrine. They are supported by a White House busy funneling government funds to “faith-based” providers.

Religious Health Care System

The United States is fertile ground for religious health care fundamentalism because so much of the country’s health care delivery system is privately owned, including a significant and powerful sector operated by religious entities. While some hospitals founded by religious groups have become essentially nonsectarian in nature, reflecting the modern-day diversity of their patients and staffs, others use the doctrine of one faith to determine the health care choices of entire communities. The most prominent of these avowedly sectarian hospitals are those affiliated with the Catholic Church, Seventh-Day Adventists and Baptists.

Nearly one in every five hospital beds in the United States is in a religiously-controlled hospital and religious entities own four of the country’s 10 largest health systems, according to two recent studies. The largest religious system, Catholic-sponsored Ascension Health, is also the nation’s largest non-profit health system.

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which owns 75 hospitals in 21 states and $11 billion in assets.

Some religious hospitals and systems are merging with or acquiring nonsectarian hospitals and clinics, as well as medical office buildings and physicians’ practices. More than 150 nonsectarian hospitals have merged with or been acquired by religious health systems for financial reasons, often adopting religiously-based restrictions and banning certain services. Another trend has seen public “safety net” hospitals and health districts signing management contracts with religious health systems that restrict care.

Religious groups are also creating sectarian managed care plans that refuse to cover services they deem immoral. There are 52 Catholic managed care plans, including New York’s Fidelis Care, a Medicaid managed care plan into which low-income women are being unwittingly enrolled without realizing that the plan refuses to cover contraception, sterilization or abortion. The Latter Day Saints operate a managed care plan that excludes coverage for contraception, in vitro fertilization, organ transplants, marriage and family counseling, and abortions except in cases of rape, incest or when the life of the mother is endangered.

**Medicine vs. Doctrine**

While religious restrictions are in place at a variety of sectarian hospitals — Baptist and Seventh-Day Adventist hospitals, for example, often ban “elective” abortions and recommend prevention of HIV/AIDS by abstaining from sex outside of marriage — most of the controversy over religious gatekeepers has been focused on Catholic systems, because of their size and the extent of their religious restrictions. The nearly 600 Catholic hospitals in the United States are governed by the *Ethical and Religious Directives for Catholic Healthcare Services,* a set of 72 rules issued by the US Conference of Catholic Bishops. Catholic health care services, “must adopt these Directives as policy, and require adherence to them within the institution as a condition for medical privileges and employment.”

These *Directives* state that abortion and sterilization are prohibited as “intrinsically immoral,” that contraception may not be promoted or condoned, and that artificial insemination and in vitro fertilization are banned because they “separate procreation from the marriage act.” Prenatal testing is not permitted if the woman might choose to end a pregnancy involving serious fetal defects. Treatment of ectopic pregnancy must avoid becoming “a direct abortion,” leading some hospitals to bar use of the drug methotrexate and instead favor more invasive surgical interventions that are viewed as indirectly ending the pregnancy.

The *Directives* also limit end-of-life choices, instructing that a hospital not honor a patient’s advance directive or a surrogate’s decision “that is contrary to Catholic teaching.” Pope John Paul II recently declared that artificial nutrition and hydration for patients in persistent vegetative states is “morally obligatory.”

Most severely affected by these religious restrictions are those patients who have few viable alternative sources of health care, such as residents of rural areas and poor, medically underserved urban neighborhoods. In South Dakota, for example, many Native American women seeking reproductive health care have the choice of the Indian Health Service or one of the 40 percent of the state’s hospitals that are Catholic—both of which ban abortions and emergency contraception.

**“Faith-Based” Health Care Initiative**

Instead of rallying to protect patients’ rights to the health care they need and want, politicians in Washington and in a number of state capitals are busy ensuring that religious health care providers can deny care based on moral grounds—and use billions of taxpayer dollars while they do it.

Religiously-sponsored hospitals bill government Medicaid and Medicare programs more than $45 billion a year, and rely on public funds for about half of their operating revenues. The other half comes from insurance reimbursements. There is little or no church money supporting the day-to-day operations of these hospitals. Religious health providers also received some of the more than $568 million in grants the US Department of Health and Human Services gave to faith-based organizations in 2003.

While accepting billions in public money, religious health care institutions are campaigning for new exemptions from laws mandating care to which they have moral objections. Government exemptions known as “conscience clauses” or “refusal clauses,” already permit these health care institutions to refuse to provide sterilizations and abortions, while remaining eligible for public funding. These facilities are also permitted to refuse to honor patients’ end-of-life wishes and advance directives, as long as hospitals disclose these restrictions.

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In 2004, bills were introduced at both the state and national level that would allow providers to refuse to provide any health service to which they objected without any protections for patients' health or life. These proposals deem it an illegal form of "discrimination" to subject a health provider to professional sanctions, dismissal or civil liability in cases where a refusal to treat resulted in a patient's death, serious injury or impairment. In 2004, such an expansive bill became law in Mississippi. Similar bills received serious consideration in Kansas, Wisconsin and Michigan.

Congress is considering a measure that would cut off all federal funding to states or local governments that "discriminate" against hospitals, health insurers or health professionals who refuse to provide, pay for, or refer for abortion. Once again, the proposal contains no exceptions to protect a woman's health or life. Congress has also refused to act on a bill requiring all hospitals to provide emergency contraception to rape victims because it does not exempt hospitals that have religious objections.

Faith-based concepts about health care are also being introduced into policies and programs through the appointment of religious fundamentalists to key government regulatory bodies (such as Dr. David Hager's appointment to an advisory board of the Food and Drug Administration), the censoring of government health publications and websites (such as elimination of discussion of condom use to prevent the spread of HIV/AIDS) and through such actions as the rejection of over-the-counter availability of emergency contraception, despite the positive recommendation from two FDA scientific and medical committees.

**Fighting Back**

Women's health organizations, long accustomed to battling religious authorities over reproductive rights, have been leading a nationwide effort to spotlight and weaken health care policies, the proliferation of religious "refusal clauses," and the introduction of religious values into government programs.

Work at the community level is being led by the MergerWatch Project, which was started at Family Planning Advocates of NYS in 1996 after a nonsectarian hospital in Troy, NY, merged with a nearby Catholic facility and was forced by religious authoriti-
Alaska and Access

Our Health, Our Choice

CINDY SMITH

Alaska, the 49th state, is a big place. While it shares no border with the continental United States, it comprises over two-thirds of the coastline of the US and 570 thousand square miles of land, making it one-fifth the size of the continental United States. Its economy is largely based on resource extraction, and its small population tends to be young and transient. Its Native population is about 17% of the total of 630,000 people. Over two-thirds of the communities in Alaska are not connected by road. The smallest communities have no doctors, nurses, or health clinics.

When the last abortion provider for Southeast Alaska, with over 600 miles of coastline communities unconnected by road, left the state, we had to ask: in an environment like this, what does access to reproductive health care mean? How can it be delivered?

The Juneau Pro-Choice Coalition (JPCC) formed in 1992 in the wake of decisions by the Supreme Court which gave state legislatures greater authority to regulate women's access to reproductive health care. As a grassroots community organization, JPCC has worked on a range of projects and activities designed to increase women's access to basic reproductive health care, to birth control and abortions, and to create a strong pro-choice presence in our community and in the state.

In confronting the challenge of access, we have focused on several strategies we believe are essential to making progress toward better and equitable reproductive health care for Alaska's women. They are:

1. Increase Access to Information: our culture encourages its citizens to cede responsibility for their health care to what is increasingly a corporate, centralized model of medical service delivery. JPCC, through surveys and discussions, found that many women and even their doctors had no idea where to turn for abortion services, how to access emergency contraceptives, or other, similar needs. The first, most basic need, was information.

In 2001, JPCC published The Book of Choices, a statewide referral guide to providers of reproductive health care, emergency contraception, and abortion services in Alaska, and in neighboring areas of Canada, Washington and Oregon. Collaborating with groups like the Alaska Pro-Choice Coalition, Planned Parenthood of Alaska, and the Alaska Native Health Board, we distributed the guide at no cost to doctors, nurses, domestic violence shelters and to regional Native health and nonprofit providers. To date, over 2,500 copies of the guide (which was updated in 2003) have been distributed; the guide is also posted on the web (www.Juneauchoice.com) and can be downloaded and printed at any time. Other examples of this strategy included providing information regarding local access to emergency contraception, and to low-cost or no-cost health care in the community.

2. Increase Economic Access: as elsewhere in the United States, health care access is increasingly becoming the privilege of people with money. In Alaska, a woman living outside the Anchorage area faces not only the medical costs, but in the case of abortions, the cost of airfare and hotel, as the only providers until recently were in Anchorage. JPCC focuses on some specific strategies to deal with this: we try to move it closer, make it cheaper, require insurance coverage.

In doing these things, we've collaborated with local doctors and nurses, with Planned Parenthood of Alaska, which is taking a leading role in opening clinics in unserved areas of the state. We also used our own voice and membership to protect low-income women's access to all reproductive health needs, including abortion, through state matching funds and waivers within Medicaid. Recognizing the urgent need for affordable health care for low-income women, JPCC has strongly supported the presence of public health clinics in local communities, and has also testified in support of insurance equity for women whose companies often choose to cover childbirth but not birth control or abortions. The Book of Choices also lists sources of financial aid for women seeking an abortion. Finally, JPCC has raised almost $50,000 in local contributions for a Planned Parenthood Clinic in our community and region, which we hope to open in Juneau next year.

3. Change the Culture: In a country and a state increasingly driven by the agenda of the political right, JPCC recognizes that what happens in our city assembly, our state legislature, in other states, and at the federal level has implications for the lives of women in Alaska that can potentially undo anything we might be able to accomplish. Because of this, it is essential to organize a strong political base, and to collaborate with many groups to have an impact on state and national decisions.

With the help of the former Pro-Choice Resource Center in New York, JPCC founded a political action committee, which surveys local candidates for local and statewide office as well as candidates for national office. It surveys voters to identify pro-choice voters, and provides candidate endorsements to them at every election. JPCC supports Planned Parenthood of Alaska and the Alaska Civil Liberties Union in lawsuits upholding women's rights to abortion. JPCC-PAC also maintains an action alert email list regarding issues of concern at the state level, and is currently working with Planned Parenthood of Alaska to create a statewide action alert system.

Cindy Smith is the director of the Juneau Pro-Choice Coalition, a grassroots volunteer-run organization which received a grant from RESIST this year. For more information, contact JPCC, PO Box 22860, Juneau, Alaska 99802; juneauchoice@juneauchoice.com.
**Fighting for Home-Based Care**

**ADAPT Organizes to End Medicaid’s Institutional Bias**

**BABS JOHNSON**

Today, a major area of struggle among people with disabilities is for the right to live at home using community-based services, rather than being incarcerated in nursing homes. The Medicaid industry refuses to respect the fundamental human and civil rights of people with disabilities of all ages to live and receive services where they choose. People with disabilities have been used as a commodity for the nursing home industry.

ADAPT is demanding an end to the institutional bias system that forces people into institutions and nursing homes. A grassroots organization, we use direct action and non-violent civil disobedience to empower people with disabilities to integrate with full equal right into all parts of society. For 21 years, ADAPT has organized to bring about systematic change leading to a more just society.

In the campaign to combat the industry’s bias toward institutionalization, we are organizing on two levels. At the federal level, ADAPT is mobilizing in support for legislation called MiCASSA—Medicaid Community Attendant Service and Supports Act (Senate Bill 971 and House Bill 2032). At the same time, we are working to require states to offer community-based services to their constituents.

**Working for Federal Rights**

Nursing homes are the most expensive and least desirable form of long-term care. According to the Health Care Finance Administration figures, the federal government spends six times as much on nursing homes as on attendant services. States must have nursing home services in order to receive Medicaid funds, but there is no requirement for community-based services.

If enacted, MiCASSA would establish a national program of community-based attendant services and supports for people with disabilities, regardless of age or disability. Under the legislation, which ADAPT proposed, any individual who is entitled to nursing home care or other institutional services would be able to choose where and how they would receive services and supports. The two million Americans currently residing in nursing homes and other long-term care institutions would finally have a real choice.

More than 700 national, state, and local organizations have signed on as supporters of MiCASSA, which has been introduced in the House of Representatives and the Senate four times, and it has over 130 co-sponsors. Since the legislation first was introduced in 1997, ADAPT members have traveled to San Francisco, Baltimore, Houston, Orlando, Las Vegas, Columbus, Memphis, Chicago, Nashville, and Lansing—and many times to Washington, DC.

The bill has not yet passed, but we have seen some improvements. For example, when ADAPT began its campaign, Medicaid was spending $34.5 billion annually on long-term care, of which 86% was on institutional services. Now the United States spends 65% on institutional services and 35% on home and community-based services. This translates into $7.2 billion dollars more toward home and community services each year. As a result, more people can get community-based care and stay out of nursing homes or other institutions.

Not only that, ADAPT has persuaded both the Clinton and Bush administrations to allocate millions of dollars to states for System Change Grants that fund the creation and implementation of services that enable people with disabilities to live in the community. Only a year after the President said he would do so, we convinced the Bush Administration to introduce and push for a policy of “Money Follows the Person.” This is a method that allows a person to choose where he or she wants to receive services, instead of having funding streams and institutional bias determine where someone gets services. Money Follows the Person is not a bloc grant to a state, but it is a significant piece of MiCASSA.

We have also succeeded in getting the Bush Administration to allocate $6 million for housing vouchers for people with disabilities and people transitioning out of institutions. (Unfortunately, in June, the federal government announced plans to cut 250,000 people off of Section 8 by 2005.)

“Free Our People” Takes Work, Risk

None of these victories have come easily. Our action days—when hundreds of people with disabilities march many miles, occupy government office buildings, and demand their rights—are long and grueling, and they require tremendous fund raising and organizing. Often, these actions require wheelchair technicians and attendant services for long periods of time. Arrests, even though there have been hundreds, are never taken lightly.

ADAPT celebrated our 20th anniversary last year, and one lesson we have learned is that things worth fighting for are not won in a single battle. For our anniversary, we felt we had to do something that had never been done before. For the “Free Our People March,” which focused attention on MiCASSA, 200 ADAPT members walked and rolled 144 miles, from the Liberty Bell in Philadelphia to the US Capitol in Washington, DC. For 14 days, from September 4-18, we camped out in open fields, police headquarters, church parking lots, and even one ice rink! Every night, it was a city of tents with wheelchair-accessible “streets,” a generator that charged over 80 motorized wheelchairs, and portable toilets, a portable kitchen, and a portable media station. The support from the public was overwhelming. E-mails and phone calls from across the nation sent support for the march and MiCASSA.

The culmination was our arrival at the continued on page six
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Washington, DC, train station, where 300 Freedom Train Riders and hundreds of others joined us for the last few blocks to the rally site. On September 18, as we entered the Upper Senate Park, we saw the thousands there to greet us.

Still, our challenge was to continue to push—to push for hearings on MiCASSA by March 2004. But when March 23, 2004 came and no hearing was scheduled, ADAPT members (500 strong) converged on the Senate Finance Committee Room. We filled the hearing room to capacity and ADAPT convened a “People’s Hearing on MiCASSA” because Senator Charles Grassley (chair of the Senate Finance Committee) had failed to act. Powerful chants disrupted the entire floor of the Dirksen Building.

Driven by years of frustration and lie after lie, ADAPT members saturated the hearing room and halls outside. Senator Grassley’s staff soon appeared and offered to hold a hearing, but negotiations fell apart when they refused to put the offer in writing. Tired of too many broken promises and being ignored, ADAPT would cooperate no longer. Twelve hours later, the police finished arresting and processing 135 of us. We would rather go to jail than die in a nursing home. The hearing did take place one week after the arrests.

State Struggles

At the state level, disability activists across the nation face some of the greatest opposition in over a decade, and experts forecast that it will get worse. State legislatures dealing with several financial crises and buffeted by powerful anti-tax lobbies are looking for any way to slash services. As one of the biggest and fastest growing cost issues for states, Medicaid has a big impact. The legislature dropped the cuts to 5% but wanted to cap the Medicaid waiver for in-home services and tighten the eligibility criteria. We said we would not leave until there were “No caps, no cuts, and no changes.” So we set up camp at the front door of the Medicaid Building—the only door they used to go in and out! We camped there day and night for two weeks. At the end, the state Medicaid director came out for a press conference to announce that there would be no cuts or caps, and we agreed upon the eligibility changes.

Locally and nationally ADAPT has joined forces with many groups, including Disability Rights Action Coalition for Housing (DRACH), ACORN, the National Low Income Housing Coalition, homeless coalitions, National Council of Independent Living (NCIL), and protection and advocacy groups. Throughout it all, our collective goal is to empower people with disabilities with full and equal rights, including affordable housing and attendant health care. Our battle cry is The People United Will Never Be Defeated.

Babs Johnson is an organizer of Colorado-ADAPT, which received a grant from RESIST last year. For more information, contact Colorado-ADAPT, 201 S. Cherokee St., Denver, CO 80223; www.adapt.org.
Stacy Malkan

In these dark days of the Bush Administration and ever-increasing corporate control, it's heartening to remember the power of grassroots community activism. From the inner city of North St. Louis to the Gila River Indian Community Reservation in Arizona, a string of recent victories over toxic waste incinerators show that when communities get loud, organized and active, they can trump the corporate interests—sometimes more quickly than anyone expects.

"You can win against all odds, even when you fight a powerful corporate polluter that is backed by government agencies and officials," says Bradley Angel, executive director of Greenaction, who has helped close down more than 100 incinerators in the past two decades.

The stories of St. Louis and Gila River reveal a typical pattern: polluting industries—such as hazardous incinerators operated by medical waste giant Stericycle—locate in low-income communities of color and operate under the radar with little oversight or public disclosure. But the stories also show that when these tight-knit communities find out the truth about what's going on, existing networks enable them to organize quite rapidly and effectively.

"It shows the arrogance of companies like Stericycle that they think they can get away with putting toxic incinerators in low-income communities," says Monica Buckhorn of Health Care Without Harm, a coalition of health professionals and public health activists working to close incinerators around the world.

"Companies really underestimate the tremendous sense of community in low-income neighborhoods. When people find out about what's happening, it doesn't take long for them to rise up, get organized and shut these things down."
Stericycle announced two weeks later they would stop incinerating in the area for good. Within a month of the incinerator closure, Kitty Meziere died of cancer. "We try to remember her whenever we think of this victory," Logan Smith says.

Native American Tribes Organize
At the same time, in the Gila River Indian Community Reservation in Arizona, a similar story of corporate negligence and community organizing power was unfolding.

For years, a toxic waste incinerator had been operating with impunity on tribal land. "It was a typical pattern of exploiting tribal sovereignty to avoid regulation," says Bradley Angel. The incinerator was operating without a permit and without ever having had an EPA environmental impact report or public hearings.

Angel's group Greenaction exposed the truth about the incinerator to tribal members: that Stericycle was polluting the reservation by burning medical and non-medical waste from several states.

Armed with the facts and led by tribal councilmember Brenda Robertson, the tribal members and supporters, including Health Care Without Harm and the Indigenous Environmental Network, targeted Stericycle for polluting tribal lands and for giving the tribe inaccurate information about incinerator operations. They also targeted EPA for their failure to involve and inform tribal members in permit processes for the incinerator.

Faced with growing community opposition, Stericycle abruptly announced the closure of the Gila River incinerator, barely a week after the company agreed to close down its embattled North St. Louis incinerator.

In both cases, community awareness, strategic alliances, direct action protest and involvement in government processes combined to win what at first seemed to be impossible fights.

"One of the favorite chants during our many protests against incinerators is, 'If the government won't, the people will, close the incinerators!'" Angel says. "It is the people's struggle and determination that win these victories."

The victories have had ripple effects, inspiring the community groups to take their fight for justice to the next level.

In Gila River, tribal members are now taking on the Romic hazardous waste treatment plant that has been operating improperly and illegally. The tribe attended a recent meeting organized by the Indigenous Environmental Network to share their success story with tribal groups from Colorado, and the groups plan to work together to address the systemic roots of the problem of polluting industries locating on tribal land.

In St. Louis, the former MWIG has renamed itself Health and Environmental Justice (HEJ) and is taking on the problem of lead poisoning in children, which they acknowledge will be more difficult than the incinerator fight because the villain and solution are much less clear.

HEJ is made up mostly of people over 50 who live in the North St. Louis area, and the group brings something different to the table than other groups working on the lead poisoning issue. As Logan Smith put it, "they think they are much too, basically, 'respectable' to tackle this issue in the guerilla fashion we do. We name names. We ask questions people don't want us to ask. We're about to turn up the heat on that now."

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