MEDICAL SOCIETY OF THE STATE OF NEW YORK

Resolution 2017 - 208

Introduced by: Bronx County Medical Society

Subject: The Right to Health and Healthcare

Referred to: Reference Committee on Reports of Officers & Administrative Matters

Whereas, article 25 of the Universal Declaration of Human Rights (UDHR) states that every person has the right to a standard of living adequate for the health and well-being of himself and of his family, including medical care; and

Whereas, the United States of America, as a Member State of the United Nations, voted in favor of the UDHR in 1948, ratifying our commitment to the ethics therein; and

Whereas, the United States is also a Member State of the World Health Organization (WHO); and

Whereas, WHO resolution WHA58.33, passed in 2005, urges all member states to contribute to meeting the needs of the population for health care; and

Whereas, the United States makes good on these promises via the Medicare and Medicaid programs which assure basic levels of medical care for all Americans who have attained the age of 65 and whose income and resources are not sufficient to meet their medical costs; and

Whereas, the Emergency Medical Treatment and Active Labor Act (EMTALA), passed in 1986, furthers these goals by assuring that our country’s infirmed always receive care at emergency rooms, regardless of insurance and economic status; and

Whereas, the philosophical root of these policies, from the UDHR onward, is the right of citizens in a free and just society to basic levels of health and healthcare; and

Whereas, the very mission statement of the AMA is to promote the art and science of medicine and the betterment of public health; and

Whereas, Chapter 11 of the AMA Code of Medical Ethics explicitly states that health care is a fundamental human good and society has an obligation to make access to an adequate level of care available to all its members, regardless of ability to pay; and

Whereas, there is an entire body of AMA policy that exists under the heading Civil and Human Rights; and

Whereas, many of these policies support the fundamental concepts of human rights; and

Whereas, all American-trained physicians and, therefore, many members of the AMA, committed themselves to those very same ethics when they took their Hippocratic or Maimonides Oath; and

Whereas, these covenants require them to care for all people without exception for social or economic status; and
Whereas, there exist insurmountable barriers to patients receiving this healthcare, be them unaffordable premiums, high deductibles, lack of competitive markets, expensive medications, or exclusions for pre-existing conditions;\textsuperscript{11,12,13,14} and

Whereas, these barriers limit the freedom of hardworking Americans to pursue the health and well-being of himself and of his family, including medical care; therefore be it

RESOLVED, That the Medical Society of the State of New York (MSSNY) advance the right to health and wellbeing of all Americans, including medical care; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) reaffirm its commitment to removing those barriers to healthcare that limit citizens in life, liberty and the pursuit of happiness; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) publicly state that basic levels of health and healthcare are human rights; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) forward to our American Medical Association (AMA) that it advance the right to health and wellbeing of all Americans, including medical care; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) forward to our American Medical Association (AMA) that it reaffirm its commitment to removing those barriers to healthcare that limit citizens in life, liberty and the pursuit of happiness; and be it further

RESOLVED, That the Medical Society of the State of New York (MSSNY) forward to our American Medical Association (AMA) that it publicly state that basic levels of health and healthcare are human rights.

References:
Declaration of Professional Responsibility H-140.900

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

1) Respect human life and the dignity of every individual.
2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
3) Treat the sick and injured with competence and compassion and without prejudice.
4) Apply our knowledge and skills when needed, though doing so may put us at risk.
5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
7) Educate the public and polity about present and future threats to the health of humanity.
8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
9) Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor. CEJA Rep. 5, I-0; Reaffirmation A-07

Professionalism and Medical Ethics H-140.951

The AMA reaffirms that the medical profession is solely responsible for establishing and maintaining standards of professional medical ethics and that the state cannot legislate ethical standards or excuse physicians from their
ethical obligations; and urges all physicians and other appropriate health professional organizations to make their views known to their state legislatures and governors. Res. 4, A-95; Reaffirmed: CEJA Rep. 2, A-05; Reaffirmation I-09

Patient Advocacy H-140.997
Our AMA believes that physicians are the primary patient advocates, are not rationers of medical care, and will continue to utilize diagnostic and therapeutic measures and facilities in the best interest of the individual patient. Res. 146, A-84; Reaffirmed: BOT Rep. I-93-25; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Rules and Cred. Cmt., I-97; Reaffirmed: CEJA Rep. 2, A-04; Reaffirmation A-05; Reaffirmed: CEJA Rep. 5, A-15

Planning and Delivery of Health Care Services H-160.975
(1) Planning agencies should utilize policies, educational programs and incentives to develop and maintain individual lifestyles that promote good health. The planning process should identify incentives for the providers and participants in the health care system to encourage the development and introduction of innovative and cost-effective health care services. Government at all levels, as a provider, purchaser and consumer of health services, should play an integral role in the planning process, including the provision of adequate funding and ensuring that government policies and/or regulations facilitate and do not unduly restrict the planning process. The authority to impose sanctions on those who take actions that are inconsistent with developed plans should be separated from the planning process. Funding for the planning process should be developed by the participants.

(2) The planning process should seek to ensure the availability and the coordination of a continuum of supportive health care services for special populations in senior citizen centers, day care and home care programs, supervised life-care centers, nursing homes, hospitals, hospices, and rehabilitation facilities.

(3) Decisions concerning the use of health care services, including the selection of a health care provider or delivery mechanism, should be made by the individual.

(4) Both the public and private sectors should be encouraged to donate resources to improve access to health care services. Where appropriate, incentives should be provided for those in the private sector who give care to those who otherwise would not have access to such care. In addition, existing short-comings in the current public system for providing access need to be addressed.

(5) Health care facilities should have or should establish review bodies (such as hospital ethics committees) to resolve conflicts over access to scarce health care technologies. In the event that a conflict over delivery of scarce health care technologies cannot be mediated satisfactorily, individuals should be able to seek redress through appropriate appeal mechanisms. BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publishing successful models. CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
   a. Health insurance coverage for all Americans
   b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
   c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
   d. Investments and incentives for quality improvement and prevention and wellness initiatives
   e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
   f. Implementation of medical liability reforms to reduce the cost of defensive medicine
   g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees’ access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
   c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
   d. Distributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
   e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
   f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.


Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Elimination of Health Care Disparities Resulting from Insurance Status 65.016MSS
AMA-MSS (1) supports the elimination of health care disparities caused by differential treatment based on insurance status of Americans; (2) encourages the Commission to End Health Care Disparities to specifically address in its mission, advocacy and actions, the contribution of differences in insurance status to health care disparities; and (3) supports efforts by the Agency for Healthcare Research and Quality to specifically investigate the impact of insurance-based segregation of Medicaid patients in different settings on racial and ethnic health care disparities and make appropriate evidence-based recommendations. MSS Sub Res 29, A-11

Reducing Barriers to Preventive Health Care Delivery and Compensation 160.022MSS
AMA-MSS will ask the AMA to (1) support both the reduction of financial barriers to the delivery of cost effective preventive health care services, and the implementation of financial incentives for cost-effective preventive medical care; and (2) conduct a study examining the effects of improvements in financial incentives for the delivery of cost-effective preventive care, and to make information from such study available through avenues including but not limited to the AMA web site to better educate physicians and the public about the benefits of preventive health care services. MSS Res 20, I-11; Reaffirmed Existing Policy in Lieu of AMA Res 107, A-12