HEALTH CARE SYSTEM REFORM

Position Statement

Adopted: 10/21/91, Revised: 10/19/2004

The Montana Association of Churches supports health care system reforms at the state and national levels that will:

- Grant universal access to affordable health care benefits, including access to primary and acute health care, dental, visual and hearing care, immunization services, early diagnostic and treatment programs, prescription medicines, provider and consumer education, programs of extended care and rehabilitation, mental health and health and wellness promotion.
- Provide "a wide range of coordinated services to enable older Montanans to: Maintain an independent lifestyle, avoid unnecessary institutional care, and live in dignity." (Montana Older Americans Act, 1987 Legislature).
- Give the same rights and opportunities to persons with HIV/AIDS as to persons with other serious communicable diseases.[i]
- Reduce costs of health care through the elimination of unnecessary administrative costs and the promotion of health education and preventive care.

Recognizing that overall systemic reform may take years to accomplish, the Montana Association of Churches supports intermediate steps, such as the Children's Health Insurance Program (CHIP) and programs to reduce the cost of prescription medicine. Given our State's uniquely rural character and vast size, such intermediate steps can increase access to basic health care for many Montanans, especially for children and other vulnerable people.

Supporting Statement

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A growing number of United States citizens do not have access to affordable health care. 43 million U.S. citizens are medically uninsured, perhaps as many as 60 million at some time during one year, while all citizens in the following countries have access to health care: Canada, United Kingdom, France, Germany, Sweden, Netherlands, Australia, Japan. Compared with the above named countries, the U.S. has the highest infant mortality rate and the lowest life expectancy. $4,178 is spent per capita on health care in the U.S., while the other 8 countries with full access to health care spend $1,461-$2,312 per capita.[ii]

Private insurance covers 61% of the U.S. population, while public insurance that includes Medicare, Medicaid, the military, and Indian Health Service covers 23% of the population. Private health insurance is not available to everyone because of lack of affordability, pre-existing health conditions, and lack of availability, particularly in rural areas.[iii]

The average per person health care expenditure in 2000 in the U.S. was $3340. This average reflects two very different groups. The healthiest 60% required $700 or less per person; the sickest 20% cost $22,600 each. The sickest 10% pays $3170 out of pocket for health care. For people with incomes of less than $15,000, about 20% of their income goes to health care.[iv]

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Prescription drug costs in the U.S. have risen 3 times as fast as health costs overall, doubling between 1997 and 2001. Prices in the U.S. are as much as 10 times higher than in other countries. Patents grant drug companies monopolies that enable them to charge high prices. Governments in other countries offset patented-drug industry to protect their citizens by keeping drugs affordable. Attempts to reduce the costs of prescription drugs in 2003 in the U.S. were thwarted by 637 pharmaceutical industry lobbyists.[v]

In the U.S. as of December 2001, the cumulative number of AIDS cases reported to the Centers for Disease Control is 816,149 and the total deaths of persons with AIDS are 467,910 including 5,257 children under age 15. There are an estimated 800,000 to 900,000 people currently living with HIV in the U.S. with approximately 40,000 new HIV infections occurring every year. As of December 31, 2002, Montana reported 486 cumulative HIV tests, 230 living with AIDS. The majority of reported AIDS cases come from 10 of the 56 counties.[vi]

The 2003 Montana Household Survey identified an overall uninsured rate of 19% for all ages or 173,000 Montana citizens. The Montana survey identified that 17% of children between 0-18 are uninsured (41,500 children); the uninsured rate for ages 19-25 equals 39% (32,000 individuals); ages 26-49 have an uninsured rate of 24% (75,000); and ages 50-64 has an uninsured rate of 13% (24,000). Employer based insurance covers 58% of Montanans under 65 years of age, compared to a national average of 67%. Individual health insurance policies account for 9% of the population, compared to a national rate of 7%. Medicaid and CHIP account for 10% of the state's non-elderly health coverage.[vii]

In 2001, the number of Montana citizens not having health care was 165,000, representing 18.5% of the population. Of this group, 29% were children and 39% were non-elderly living in poverty. Over 85% of the non-insured were employed but made too much to qualify for federal medical aid and too little to pay for private health insurance.

Montana has an increasingly disproportionate number of elderly with chronic conditions living in isolated rural communities. Montana ranks first in the nation in percentage of Medicare beneficiaries residing in rural areas (75% compared to 23% nationally).[viii]

6.2% of Montana citizens are American Indians. Montana Indians have a higher incidence, frequency of complications, and a higher death rate from diabetes and cardiovascular diseases than non-Indians.[ix]

Montana has low wages. Medical expenses are a leading cause of family debt and bankruptcy across Montana. Montana has a high rate of depression and suicides. The leading cause of death for Montana children, aged 10-14, is suicide.[xxi]

In 2001, Montana's hospitals wrote off $100 million in charity care and uncollected expenses, in addition to the $400 million in discounts provided to Medicare and Medicaid programs whose beneficiaries account for about 60% of all hospital services.[xii]

A Department of Public Health and Human Services State Planning Grant allowed for interviews on health care access and insurance in Montana of key informants between March and July 2003. The August, 2003 final report stated three main themes were consistent across all interviews:

- cost is the single reason identified by all interviewees as the reason that people do not have health insurance;
- the system as it exists today is broken and can not be fixed; and
- ultimately, the only way to replace the current system is with some type of universal, single-payer approach.[xiii]

Our present system is ineffective and wasteful. One of the most effective cost containment measures is promoting wellness and preventing health problems rather than just treating them. Promoting healthy lifestyles must be a foundation of any health care program. A comprehensive health system starts with education on protection from disease, environmental safety, reducing injury and disabilities in work places, promoting communities that support health and healing, and policies that enable people to breathe clean air, drink clean water, eat wholesome food, have effective sanitation, and enjoy adequate housing.

The above statistics are symptoms of a healthcare system which is in need of fundamental reform. The Montana Association of Churches stands in solidarity with and in public witness to the suffering of those thousands of Montanans who cannot afford adequate health care for themselves or their loved ones. We believe that without access to adequate healthcare, human potential is seriously impeded, if not denied.

As Christians we believe we are God's temples and that God's Spirit dwells within us (I Corinthians 3:16). Each of us is called to be a good steward of our own health, not merely for living well, but for the broader purpose of serving God and our neighbor.

Our Christian faith tells us that every human being is made in the image of God (Gen.1:27). Every human being possesses an inherent dignity that must be respected; and each person has both the right and the responsibility to realize the fullness of that dignity. We have a responsibility as members of society to protect and promote those rights.

Our faith traditions and social justice teachings tell us that we reach our fullness as human beings only in relation to each other. God has called us to community and, as such, to be responsible for each other. Because this is so, we are especially responsible for, and stand in solidarity with those whose rights are withheld or denied. Our faith demands that social structures be arranged to promote the dignity and well being of all persons.

The capability of our health care system to meet the needs of vast numbers of Montanans (and Americans) is rapidly deteriorating. We cannot stand by and watch the human suffering and the deprivation that such a breakdown entails.

We cannot wait indefinitely for the federal government to address this pressing problem. Montana is but one state of fifty, and yet we have a long tradition of creativity, innovation, and leadership, which has affected national policy. Therefore what we do in Montana can have an impact on national policy.

Because of our rural character and vast size, Montana needs to explore and develop special strategies to offer basic health care services to small, remote populations. National and State policies must be sensitive to the special needs of rural States. While we continue to work and pray for national reforms, there is much that can be done within our State to mend the health care system and alleviate the suffering of our citizens.

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[ii] Universal Health Care Action Network, *Seeking Justice in Health Care,* December, 2003, Chapter 8, Table C.3.

[iii] Ibid. p. 4.4-4.5

[iv] Ibid. p. 3.14

[v] Ibid. p. D.1-D.2

[vi] All U.S. specific facts were from the Centers for Disease Control, www.cec.gov/hiv/stats.htm and Montana specific facts were from AIDS Action, www.aidsaction.org, September 2003.

[vii] University of Montana, Bureau of Business and Economic Research.

[viii] Montana Faith Health Cooperative, *Disparities, Inequities and Injustices in Health Care, October 2002, p.7*

[ix] Ibid. p.6

[x] Ibid. p. 7

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[xii] Ibid. p. 7

[xiii] Herling, Daphne and Seninger, Stephen, Ph.D., *Final Report: Key Informant Interviews on Health Care Access & Insurance in Montana,* submitted to the Department of Public Health and Human Services, August 2003, p.2