A Rural Community for Human Rights

How a Montana County Seeks to Realize the Right to Health Care

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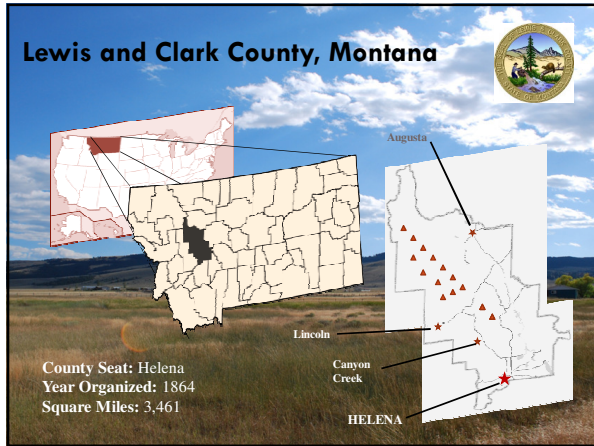**National Economic and Social Rights Initiative**
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Presenter Disclosures

Anja Rudiger

The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:

No relationships to disclose

Lewis and Clark County, Montana

Augusta

Lincoln

Canyon
Creek

HELENA

County Seat: Helena
Year Organized: 1864
Square Miles: 3,461

County Health Statistics

Population: 60,925
Density: 17.6 per square mile
Health Professional Shortage Area:
21% medically disenfranchised

- Poverty rate: 10.7% in 2008
  (Montana: 14%, poorest MT county: 22.5%)
- 28% live below 200% FPL
- Estimated uninsured people: 14% to 21%
- FQHC: number of visits by uninsured patients
  increased from 24% in 2001 to 60% in 2007
- 12% adults unable to see a doctor due to cost

HPSA Status	% population undeserved in Montana	% population undeserved in United States
Primary Care	24	12
Dental Care	20	11
Mental Health	40	20

Area	IMU Score
Augusta, Lincoln, Canyon Creek	55 - 60.6
Helena	52.0
Lowest scoring MT county: Daniels	33.8
Maximum score for medically underserved designation	62.0

Board of Health Resolution:
Everyone has a Human Right to Health Care

The Human Right To Health

Governments have an obligation
to respect, protect, and fulfill

our "right to a system of health protection which provides
equality of opportunity for people to enjoy the highest
attainable level of health."

International Covenant of Economic, Social and Cultural Rights
(legal interpretation, General Comment 14)

The Normative Human Rights Framework

- **Universality:** Everyone must have access to equal high-quality and comprehensive health care
- **Equity:** Costs and resources must be shared equitably, with everyone getting what they need and contributing what they can
- **Accountability and Public Goods:** The people oversee the provision of health care as a public good, shared by all

Human Right to Health

Human Rights and Participation

Human rights…
- arise from people's fundamental **needs**
- prioritize the needs of the most disadvantaged groups
- place **people** at the center of policy and practice
  - → Participation is a key human right
    - People have a right to active and informed participation in health related decisions that affect them. This means communities should be enabled to take part in local decisions about the development, implementation, and review of health programs and strategies.

Human Right to Health

Process and Partnerships

The City-County Board of Health
- Initiator and early champion

The Universal Health Care Task Force:
- Community-led, all-volunteer Task Force
- Two-year unfunded work program to implement a multi-phase project
  - Phase I: Community needs assessment
  - Phase II: Action plan

Supporters:
- Public Health Department (administrative coordination)
- FQHC

Partners:
- Montana Human Rights Network (advisory member on the Task Force)
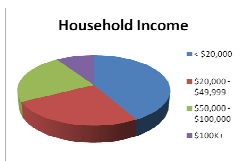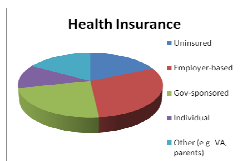- NESRI (technical assistance)

Community Health Needs Assessment

Qualitative research with community:

- Trained & supported Task Force members in focus group research
- 9 focus groups
- 56 participants (4 to10 per group)
- Locations in Helena, Augusta, Lincoln, and Canyon Creek
- Uninsured, low-income, and rural demographics prioritized

Focus Group Participants

Health Insurance

- Uninsured
- Employer-based
- Gov-sponsored
- Individual
- Other (e.g. VA, parents)

Household Income

- < $20,000
- $20,000-$49,999
- $50,000-$100,000
- $100K+

Insurance Status (Unknowns excluded)	number	percentage
Uninsured	11	21%
Employer-based	18	34%
Gov-sponsored	14	26%
Individual	7	13%
Other (e.g. VA, parents)	10	19%

NOTE: some participants had more than one source of insurance

Household Income (Unknowns excluded)	number	percentage
< $20,000	18	42%
$ 20,000-$49,999	11	26%
$50,000-$100,000	10	23%
$100K+	4	9%

Community Health Needs Assessment

Participation Objectives:

- To reach out to the community and enable engagement with Task Force
- To capacitate Task Force members to discuss health needs and rights with community members using a human rights framework
- To enable community members to discuss their health needs and rights, thereby increasing awareness
- To increase community engagement by bringing a human rights lens to health policy development

Community Health Needs Assessment

Research Objectives:

- To identify how sample populations (esp. rural, low-income, uninsured and underinsured) use health services
- To identify barriers to accessing health care
- To identify unmet health needs
- To solicit recommendations on what measures the county should take to ensure universal access
- To obtain feedback on the Board of Health's human rights resolution

Community Health Needs Assessment

Key Findings:
Community Views and Needs

Access

Human rights standard: universal, equitable, not dependent on payment

- **Cost barriers impede full access to health care and coverage**
  - Low-income and middle-income people are particularly affected
  - Both insured and uninsured people are affected
- **Coverage does not equal care**
  - High-deductible insurance plans and co-pays often preclude respondents from actually using their insurance
  - Insurers are perceived as controlling patients' care by limiting access or leaving patients with incomprehensible and unexpected bills
- **Access to health care is based on a person's ability to pay**

> *"If you don't have money, then you don't have the right to care."* (Helena 4 Focus Group)

Availability

Human rights standard: where and when needed

- **Shortage of health care providers**, particularly in very rural areas
  - Low income residents have greater difficulty finding providers
  - Some providers only take self-paying patients or those with private insurance
  - Some providers are perceived as putting their business interests over the health needs of patients and communities

> *"It used to be that if you were a dentist or a doctor you took an oath to take care of people."* (Helena Foodshare Focus Group)

- **Few local specialists**; high cost of out-of-network or need to travel
- **Dependence on personal transportation**
- **Poor navigability** and low awareness of available services

Key Findings

Quality

Human rights standard: medically appropriate, timely, continuous, patient-focused

- Providers may not be sufficiently incentivized to give appropriate and coordinated care, as the system rewards use of technology and drugs
- Quality of care experience for similar services increases with income level
- The county's only hospital (a private facility in Helena) is perceived as not providing an adequate service to community members
- Participants are satisfied with the FQHC satellite and volunteer ambulance

Key Findings

Dignity

Human rights standard: respect dignity, provide culturally appropriate care, be responsive to diverse needs

- Low-income people report that they have not always been treated with dignity and respect by providers
- Some were made to feel they had no right to demand quality care because they were not paying the full cost
- Fear of stigmatization may be reinforced through publicly displayed resentment of alleged "welfare" recipients accessing care

Key Findings

Do We Have a Human Right to Health Care?

Around two thirds of participants consider health care to be a human right.

"It's everyone's right as a human being." (Helena 4 Focus Group)

Others emphasize ethical obligations to meet health care needs, but do not feel comfortable using the term "human right."

- Poor people, Medicare and Medicaid enrollees, and students are most likely to consider health care a human right
- Self-identified middle class respondents with very low incomes express resentment of those receiving 'free' care and are less likely to consider it a human right

Key Findings

Human Rights and Public Goods

Participants link the human right to health care to
- responsibility for health (personal and collective)
- principles of equity, universality, and inclusion

"Just from my observation of equal access, it doesn't seem fair that I have access and other people don't." (Students Focus Group)

"We're human beings; it doesn't matter whether we make $7 an hour or six digits a year. We're humans and we all have something to offer. … Why can't we get good health care?" (YWCA Focus Group)

Most participants agree that we have a collective obligation, with roles for government or the community, to help everyone to be as healthy as possible

"I'd be willing to pay my share, according to my income, to have something that took care of everybody." (Lincoln 2 Focus Group)

Key Findings

Community Recommendations for Local Government

► Expand financing options to enable access for all

► Expand health services, esp. primary care and the FQHC

► Improve care-coordination

► Improve navigability and information about services

► Increase transportation

► Treat patients with respect and respond to their needs

Task Force Action Ideas

- **Increase or reallocate funding for health care**
  - Set up a county-wide universal health care zone, e.g. with an expanded FQHC as the clinical and administrative hub, offering affiliation benefits for private doctors
- **Expand delivery system, esp. primary care**
  - Develop interagency agreements to pool resources across providers
  - Expand non-insurance models of delivery, with the FQHC taking a lead role
- **Hold providers accountable to ensure universal access**
  - Create community-based partnerships with providers, particularly the hospital, to design and implement responses to the community's unmet health needs.
  - Set up a community-led oversight and regulatory commission to review health services and expenditures

Next Steps: Action Planning

Phase II: Action Planning
- Develop consensus recommendations for actions at county level
- Develop proposals for financing and implementing recommendations
- Identify potential opportunities and constraints imposed by the PPACA
- Develop reporting, dissemination and follow-up vehicles, including community involvement

Lessons Learned

Using a human rights framework:
- as a tool to raise awareness and engage people
- as a vehicle for participation and empowerment
- as a basis for conceptualizing and demanding policy change
- to tap into existing ethics of caring for neighbors, community spirit, etc.

Implementing a solidarity-based partnership approach:
- link local efforts with state and national groups
- offer unconditional support and meet any request for help
- build trust and relationships, ideally aided by a local champion
- work inclusively with all challengers