Diagnosing Washington State's Health Care Problems

A Rainier Institute Report
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Problems in our Health and Medical Care Systems

Background

The U.S. spends more than twice as much per capita on healthcare than the next closest nation, but 41 million Americans and one in seven Washingtonians have no health insurance. Meanwhile, many U.S. and Washington citizens believe they receive high quality healthcare, but population health measures in the U.S. are below those of other industrialized nations, raising a question about the quality of care as well.

The good news is that Washington citizens, as part of a larger grass-roots process such as the HumanLinks sponsored meetings and Washington Health Foundation's Community Roundtables project, already have begun discussions around the state about the problems faced by Washingtonians and possible solutions to those problems. The Rainier Institute here puts forth its expertise regarding the problems of our system and possible solutions for public discussion.

Problems of our Healthcare System

1. The System is "Fractured"

The health care system is a system in name only. In Washington, as in most of the U.S., we have an increasingly fragmented, inefficient, and confusing collection of insurance products and providers of health care. In this environment there are few examples where providers and/or insurers create healthcare systems that are integrated, communicating entities with easy entry, an understandable road map, or measurable positive outcomes.

The health insurance market is a thoroughly confusing mix of insurers, products, benefit schedules, restrictions, requirements, and costs that consume a growing part of the healthcare dollar and confuse both physicians and patients alike. A recent study showed that in Seattle there were over 755 different health plans. Whether you are insured or not, most of us have experienced difficulties with various problems including physician referrals, billing, or denials of necessary care. When a person enters the system for diagnosis or treatment, there are few guideposts through the 'wilderness' and often no one person coordinating an individual's care.

2. Public Health

The foundation for a healthy society is a strong public health infrastructure. Currently, this foundation rests on some of the state's least stable financial ground, eroding further each "no new taxes" budget cycle. The public health system oversees and sometimes provides direct services (e.g., immunizations and treatment of contagious diseases), as well as assessing,

through research and monitoring, current and future health problems and provides guidance in setting priorities for health spending and system development.

Outside of reducing poverty, nothing else a community does affects the health of its people more than assuring that contagious diseases, environmental conditions, child health, and behavioral risk factors are controlled. This has never been more evident than the catastrophes that are playing out with SARS in Asia, AIDS in Africa, and bioterrorism, antibiotic resistance, obesity, and diabetes in the United States. The local, state and national public health systems have been under-funded for years and we are now suffering the results of that neglect. The commitment to public health is a commitment to the concept of the common good.

3. Limited Access to Care

Health services and systems are lacking for many people. A recent series of reports from the Institute of Medicine document the effects of being uninsured: the uninsured are less likely to see a doctor regularly, obtain the medicines they need, and receive timely diagnosis of diseases such as cancer. Washington has an increasing number of uninsured, now about 786,000 or more at any one time. Even larger numbers of people have insufficient coverage, exemplified by the nearly 70% of Washington residents that are worried about finding affordable health insurance (Economic Opportunity Institute, February 2002). Rapidly growing costs of purchasing healthcare insurance have made it unaffordable for many, especially those with lower incomes and chronic diseases.

Meanwhile, the safety-net infrastructure that has supported many of the uninsured is eroding. Public programs that have supported many of the uninsured are declining. For example the state legislature recently decided to cap enrollment in the Basic Health Plan at 100,000. In addition many parents of low-income children now need to pay a premium for their children's Medicaid coverage (Thomas, R. "Adding up the winners and losers." The Seattle Times, June 8, 2003) Safety net institutions have lost significant financing, while fewer physicians are providing charity care (Cunningham, P., "Mounting Pressures." Report, No. 6, Center for Health Systems Change, Dec. 2002) and increasingly are unavailable due to rising malpractice insurance costs and low reimbursement rates. Decreased access for the uninsured affects everyone in the community, e.g., emergency departments that need to be available to all of us are increasingly overcrowded and "diverting" patients ("A Shared Destiny: Community Effects of Uninsurance," Institute of Medicine, 2003).

4. Costs of the Health Care System

All payers - businesses (large and small), governments, and individuals - are dealing with the growing burden of healthcare costs. Increasing technology costs (pharmaceuticals, diagnostics and treatments), administrative costs, the aging of the population, price increases, and cost-shifting all contribute to increasing costs. Meanwhile, most methods used in the U.S. for controlling costs (e.g., managed care) have either not worked or have only transiently arrested cost increases for a few years. The large segmentation of the health care system makes it more difficult to access bulk purchasing discounts and results in increased administrative costs (20% in the individual market). Worse, the segmentation of healthy people into small groups makes health insurance less affordable

for older and sicker people that need more services. The health care system also is a maze of costs shifted from one purchaser or provider to another in order to recover the costs of providing care for the uninsured.

Many employers would like to get out of the business of providing health care insurance, but currently still are compelled to do so in order to compete for talent in the workforce and because of the current tax incentives afforded to businesses sponsoring employer-provided healthcare plans. Healthcare costs per privately insured person increased 9.6% in 2002 after five years of steady increases, while employers continue to face double-digit increases in premiums (Strunk and Ginsburg. "Tracking Healthcare Costs…" Health Affairs web exclusive, June 2003.).

Individuals feel the cost burden directly. Many people (whether or not they are insured) pay an increasing amount of their expendable income on healthcare, leaving them fearful of their ability to pay health bills. A recent poll (NPR/KFF/Harvard, June 2002, www.kff.org/content/2002/20020605a/) showed that 44% of respondents reported problems "affording" their healthcare. An ethical concern is that only 1/4 of workers in the lowest income quintile are provided health insurance by their employers, compared to nearly all workers in the highest income quintile. Moreover, the uninsured pay a larger portion of medical costs out-of-pocket (Hadley and Holahan, Health Affairs, February 2003) and often are charged more by hospitals as individuals. In the State of Washington, a family of four in 2002 needed an income of about $45,000 yearly to buy food, rent housing, pay for public transportation and incidentals, and purchase health insurance (WA State Planning Grant, 2002). People below that income level, without an employer or public subsidy for health insurance, must make understandable economic trade-offs when they choose between food and housing and/or health insurance. As the average worker's income in 2001 was about $31,000, there are many families in Washington State whose fear of not being able to afford health expenses is well founded.

5. Quality

Many citizens and health professionals perceive that the U.S. has the best healthcare system in the world based on their assessment of our technological prowess. However, many recent studies describe the numerous improvements that could be made in our system in regards to preventing medical errors and improving the practice of evidence-based medicine. In addition, large geographic variation exists in the use of various medical services. U.S. health outcomes rank us at the middle or bottom of industrialized countries in the world (20^{th} to 29^{th} place depending on the measure, see Healthy People 2010 at www.healthypeople.gov). American consumers are not receiving full value for the money spent.

6. Public Expectations

Many want to have access to a full range of health services, but often are not willing to pay for it. Some of this is rational economic behavior – they need services, but cannot afford the costs. However, consumer directed advertisements, limited awareness of the cost of medical treatments, and media coverage of medical technology "breakthroughs," all contribute to these expectations, even when the benefit of those technologies have not yet been proven.

7. Systems of Care Need Improvement

We are quickly becoming a society with chronic diseases as our main health challenge. Our health system was developed on an acute care model and concentrates its resources in specialized services and impressive technologies at the expense of preventive and primary care. Developing systems that can address chronic diseases such as diabetes and asthma will take larger and more community-based teams.

All other industrialized countries base their health systems on strong primary care networks and have much smaller specialty superstructures. This is apparently more cost-effective and improves health outcomes (Starfield, B. et al, Journal of Health Economics, June 2002, www.eurekalert.org/pub_releases/2002-06/jhub-asp062402.php).

8. Status Quo

Special interests and stakeholders play a large role in the system and many have a large financial interest in maintaining the status quo (Oberlander J, "Why Bad Things Happen to Good Plans," Health Affairs, August '03). As the health sector has grown and more money has been invested, the ability to reform has decreased. For many stakeholders, the best choice is the status quo.

The Bottom Line

At the dawn of the 21st century we Americans have led the world in creating medical and health technologies that can prolong human life for a century or more, which can defeat many age old diseases that have plagued human civilizations for millennia and that can even create life artificially. In the U.S., we will spend no fewer than $1.5 trillion on public health and medical care this year, 60% of which will be government-spent dollars. In absolute terms, this exceeds by several times, the total health economy of every other country. But, our health outcomes are among the poorest in the industrial world and nearly one in three of us are uninsured or underinsured, placing us at risk for poor health outcomes and personal financial catastrophe.

We simply believe that a country as technologically advanced, economically viable and world respected as the U.S., should have the world's best health delivery system and the world's healthiest citizens.

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About the Rainier Institute

The Rainier Institute is a non-partisan progressive think tank founded by retired Governor Booth Gardner, former Congressman and Washington Department of Transportation Director Sid Morrison and former State Supreme Court Justice Phil Talmadge.

Formed in 2001 out of a desire to respond to Washington State's lack of public policy clarity and leadership, our board includes policy experts and officials from all three branches of state and local government. The Rainier Institute uses a variety of progressive and pragmatic methods to implement meaningful solutions to problems affecting Washington State residents. Current work is focused on public education, health care, tax reform, initiative reform, and children's services.

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