WASHINGTON UNIVERSAL HEALTH CARE WORK GROUP

Problem Statement and Root Cause Analysis (Updated 01/16/2020)

Note: This document reflects the input of work group members and their perspectives on the root causes of problems with Washington's health care system. It is not intended to be a complete or comprehensive root cause analysis. It is a living document that may be refined as the work group continues to evaluate the root causes identified.

Consolidated Problem Statement:

The following statement consolidates problem statements developed by work group members in small breakout session.

Universal health care means all Washington residents can access essential, effective, and appropriate health care services when and where they need it. Currently, however, not all Washington residents have access to effective and appropriate health services. Health outcomes for Washington residents are worse—on average—than comparative countries, and there are disparities in health outcomes between Washington residents. Rising health care costs and spending, and increasing complexity adversely impact the economy, families, employers of all sizes, and taxpayers, and undermines the sustainability of a universal health care system.

Accessing health care means:

- It is affordable
- It is accessible
- It is culturally-attuned
- It is equitable
- It is coordinated

Effective and appropriate health care services include:

- Comprehensive (including behavioral, oral health, vision, hearing, and end-of-life services)
- Preventative
- Curative
- Rehabilitative
- Palliative

Consolidated Root Cause Analysis

The following reflects root causes proposed by work group members in small group breakout sessions. The work group will continue to refine this document as they assemble evidence to support the root causes they identified in discussion.

Problem #1: Currently, not all Washington residents have access to essential, effective, and appropriate health services.

1. Access to care
    a. Limited providers within insurance networks.
        i. Insurance companies control costs by contracting with a limited number of providers.
    b. Lack of availability of appropriate providers.
        i. Reimbursement mechanisms and rates—especially under publicly-funded programs and in rural areas—discourage some providers from offering care in certain geographic areas or to specific populations.
        ii. It is difficult to attract providers to some geographic areas.
        iii. Economics of providing care in some geographic areas—such as rural communities—does not work for some providers.
            1. Low population density challenges the economic viability of providing care in some rural areas
            2. Rural areas are more expensive.
        iv. Workforce constraints.
            1. The pipeline for future health workers is inadequate.
                a. Education and training system for health providers constrains providers.
                    i. Cost of medical education can be prohibitive, leading to high debt
            2. Many providers choose to specialize over primary care.
                a. Cost of medical education can be prohibitive, leading some providers to choose to specialize
        v. Tend to use more expensive providers, even when an appropriate but less costly option exists (e.g. medical doctor rather than nurse practitioner, nurse practitioner rather than community health worker, etc.)
    c. Health care system is not designed to accommodate patient needs.
        i. Appointments with a provider often overlap with work schedules.
        ii. Transportation to/from appointments is difficult for some.
        iii. Health care system (or systems) is complex and difficult to navigate. (For more on the root causes of the complexity of the health care system, see Problem #2.)
2. Lack of health care coverage for all Washingtonians.
    a. Not everyone buys health care coverage.
        i. There is no longer an enforced mandate to purchase health care coverage.

1. State or federal action is required to restore the mandate.
2. There is a political interest to maintain free will; it is not a priority to maintain the mandate.

ii. Some make too much money to qualify for subsidies or publicly-funded programs but cannot afford health care from the Exchange.
1. Health care subsidies are underfunded.
a. WA lacks income tax.
2. Costs for health care coverage—including premiums, deductibles, and co-pays—are rising. (For more on the root causes of rising costs, see Problem #3)

b. Some Washingtonians are not eligible for subsidized health care coverage.
i. Undocumented immigrants are ineligible.
ii. Federal law does not offer subsidies or Medicaid to immigrants in the U.S. fewer than five years, and many cannot afford Exchange plans without it.
iii. "Family glitch": families are not eligible for federal subsidy if "affordable" coverage is available to them.[1]

[1] Language in the Affordable Care Act stipulates that "affordable" employer plans are ones where the employee's required contribution is less than or equal to 9.86 percent of the employee's income. Another provision in the Act defines the employee's required contribution to mean the amount that is required for *individual* coverage. As such, the law does not consider the cost of *family* coverage in calculating whether an employee's required contribution is "affordable."

Problem #2: Health outcomes for Washington residents are worse—on average—than comparative countries, and there are disparities in health outcomes between Washington residents.

1. Lack of access to affordable, quality, and timely health care.
    a. Systemic/institutional racism and other social inequities in the system.
    b. If necessary or preventative health care is unaffordable, people may delay or forgo it. (For more on the root causes of lack of affordability, see Problem #3.)
        i. People of color have less access to affordable coverage.
            1. Fewer people of color have access to employer-based coverage.
    c. Inconsistent availability and quality of service providers; differences exist geographically and throughout the health care system. (For more on the root causes of lack of access, see Problem #1.)
    d. Lack of culturally-attuned care.
        i. Systemic/institutional racism and other social inequities in the system.
        ii. System is not designed for whole population health.
        iii. There is a lack of standards among providers for providing culturally-attuned care.
            1. Culturally-attuned care is not part of provider education and training.
            2. Provider culture.
        iv. Lack of a diverse workforce.
        v. Language barrier between providers and patients.
        vi. Policies that contribute to, rather than fix the problem.
2. We underfund investments in social determinants of health (e.g. housing, education, etc.).
    a. We spend much of our available revenue on health care.
        i. There is a societal focus on medical over social.
        ii. Systemic/institutional racism and other social inequities in the system.
        iii. Washington has an inefficient tax system.
            1. Entrenched financial interests sustain an inefficient tax system.
3. The health care system is not person-centered or focused on evidence-based care.
    a. The incentives are not in the right place.
        i. The current system—including the fee-for-service model—focuses on volume over outcomes.
    b. Lack of investment in preventative and coordinated health care, behavioral health integration, and end-of-life care.
    c. Health care system (or systems) is complex and difficult to navigate.
        i. It is difficult to get the information necessary to compare providers, treatment options, prices, side effects, etc., and make informed decisions.
            1. There is a lack of transparency regarding prices and options for services. (For on the root causes of lack of transparency, see Problem #3).
        ii. Patients/health care consumers struggle to make informed choices

1. The stakes are high (life or death, health and wellbeing) and the human body is complex and precious, making it difficult to make rational decisions.
    a. Patient support is needed to make informed decisions about health care, but patients, providers, and payers do not have the right tools and support to make informed decisions about care.
    b. People are afraid to use the system because of its complexity.
    c. There is a lack of health literacy.

iii. The health care system is not one system, but many systems that are difficult to understand and navigate.
    1. People want unlimited choices.

c. Health care system is not designed to accommodate patient needs
    i. Current reimbursement system focuses on volume over outcomes.
        1. The U.S. health care non-system is designed to make money, not to serve patients: We have chosen a business model (i.e. a corporate model with investors) instead of a European-style public service model
    ii. System is centered around disease states and “over-medicalization”.
        1. It’s harder to make money off healthy people.
        2. Physicians are not independent; they are accountable to corporate management.

Problem #3: Rising health care costs and spending, and increasing complexity adversely impact the economy, families, employers of all sizes, and taxpayers, and is unsustainable.

1. Health care funding model contributes to uncontrolled spending.
    a. Financing system for health care is fragmented, and no single entity is in charge.
        i. Powerful and financially-entrenched systems are invested in maintaining the status quo and preventing meaningful change.
    b. Pricing structure is profit motivated.
        i. Providers can charge whatever they want.
        ii. There are few incentives to manage the cost of care.
    c. Funding model caters to employers, rather than consumers.
2. Costs of care are uncontrolled.
    a. Lack of transparency in pricing of health care services and products.
        i. No incentive or ability for consumer to shop around.
        ii. No incentive to disclose health care costs (incentive is to hide costs).
        iii. Because the system is fragmented, there is a lack of bargaining power amongst consumers and payers.
        iv. Lack of accountability throughout the system.
    b. Costs of prescription drugs are rising.
        i. U.S. pays for more innovation and the risk that comes with it; other countries regulate pharmaceuticals to bring prices down.
        ii. Marketing is expensive and costs more than health care research.
        iii. Care = consolidation.
    c. Costs of hospitalizations are rising.
        i. High administrative costs.
        ii. Monopolies across the state [limit competition and control of prices].
    d. There is duplication of services.
    e. Consumers want unlimited choices.
    f. Cross-subsidization of care: cost of medical care is higher to balance other system costs, such as medical education expenses and lower reimbursement rates for publicly-funded care and care for people who are uninsured.
3. Excessive administrative overhead.
    a. Administrative overhead is built into federal law.
    b. Health care losses are corrected by rate increases.