

# Forum Report

## Whatcom Alliance for Healthcare Access

July 2007

For the Whatcom Alliance for Healthcare Access (WAHA), their June 11th 2007 Community Healthcare Forum marked a turning point in thinking about healthcare access for the entire community. It began with a summary of WAHA's four and a half years of accomplishment, and ended with a bold look at ways to fix the healthcare system. An address by former Oregon Governor John Kitzhaber, healthcare activist and physician, challenged listeners to understand the dire problems inherent in the current system and come up with better alternatives. Participants came to understand the hopeful message that together, we can be the architects of a new and healthier healthcare system in Whatcom County.

## Governor Kitzhaber's challenge

In his address, former two-term Oregon Governor John Kitzhaber challenged the group to expand their understanding of America's healthcare crisis: it's more than an insurance crisis. It is, he says, the "single most pressing domestic challenge we face as a nation and society." And it is within each community's power to address.

Fixing the healthcare system will involve exposing the contradictions and inequities of the current system, creating a shared vision of what an equitable system will look like, and stimulating meaningful discussion by creating tension between the status quo and the vision.

### His three key points were:

1. We must control costs. Healthcare costs are growing faster than any other segment of the economy and will saddle our children and grandchildren with debt.
2. We cannot control costs by defining the problem narrowly as an insurance problem. We must look at the underlying structure of the U.S. healthcare system and think differently about what it offers and how it is delivered.
3. We are not powerless.



Former Oregon Governor, John Kitzhaber, physician and healthcare activist



## WAHA: A retrospective of accomplishments

The goal of the day was to envision ways to accelerate progress toward a future where everyone in Whatcom County has access to basic healthcare, delivered safely and efficiently. However, a few minutes were devoted to acknowledging the years of steadfast work that have gone into WAHA's accomplishments.

Four and a half years ago, WAHA created an ambitious vision and a plan to help achieve consistent access to healthcare for the people of Whatcom County, 13% of whom are uninsured. To ensure inclusion of all views, the WAHA Leadership Board purposefully includes people from competing interests and differing vantage points—community and business leaders, healthcare providers, insurers, elected officials and consumers. The agreement to check competing interests at the door during WAHA meetings served the group well as they single-mindedly worked through many complex issues resulting in programs and partnerships that have extended healthcare access in Whatcom County:

- With three WAHA access counselors and a network of trained State Health Insurance Benefit Advisors (**SHIBA**) volunteers, WAHA helps connect residents with health insurance coverage and care.
- Whatcom Project Access, in partnership with the **Whatcom County Medical Society**, helps qualified low-income, uninsured people connect with specialist care.
- WAHA and the **Whatcom County Health Department** secured a federal rural health designation for Northern Whatcom County, resulting in higher payments for physicians who see Medicare & Medicaid patients.
- Working in partnership with **area school districts**, WAHA has established a model school outreach program, resulting in uninsured students receiving health insurance and greater access to care.
- Physician recruitment and retention was strengthened through a partnership between WAHA and the **WWU Small Business Development Center**.
- **Elected officials** seek practical insight from the WAHA board and see WAHA's solutions as influencing needed changes in state and federal health policy.

## US healthcare...a little history

Understanding how the current healthcare system evolved to its current state requires a little history. In his address, Governor Kitzhaber offered a thumbnail sketch.

During the World War II labor shortage, a wage and price freeze in the U.S. made attracting workers difficult. To offer a legal incentive, employers began offering (what was then) inexpensive health insurance as a benefit.

After World War II, the federal government provided veterans with healthcare through the Veterans Administration.

By the 1950s, labor unions began to negotiate health insurance as part and parcel of their

labor contracts. Today, three-quarters of Americans who have health insurance are insured through their employers.

In the mid-1960s, when most of the nation's elderly were poor, the federal government enacted Medicare, providing a basic level of government-paid healthcare for all citizens 65 and older. At the same time, it enacted Medicaid, a program targeting low income pregnant women, children and the disabled.

Today, 50 years later, the system no longer works. In the 1950s and '60s, no one could have envisioned today's highly competitive global economy where rising health insurance costs prevent American companies from competing with businesses in other countries that finance healthcare in other ways. They

could not have foreseen that the public subsidy for these programs would grow to more than \$200 billion per year, paid by all taxpayers, even the uninsured who receive no benefit for their contribution. They could not have envisioned employers grappling with health insurance premiums escalating faster than the rest of the economy, or the "Baby Boom" demographic that now means fewer workers must support 30% of the population over age 55.

Kitzhaber pointed out that no operating system lasts forever. Computer systems, for example, are updated every year or two. But changing an entrenched, 50-year-old healthcare system will take a deep understanding of what needs to change coupled with a commitment to a vision for a quality, efficient and fair system for all.

## The impact of the "system" we have

Although Kitzhaber questions whether you can call our healthcare programs a "system", it is clear that imposing this antiquated healthcare system on a modern society is exacting an unacceptable price. It focuses narrowly on cures for individuals at the expense of basic healthcare for every citizen. It threatens the country's finances, poses impossible social and ethical dilemmas, and makes it difficult to extract value (improved health) for the dollars spent.

### Financial picture

- Healthcare expenditure is the single leading driver behind the nation's \$9 trillion national debt and costs continue to escalate at two to three times the Consumer Price Index.
- Since 2003 the cost of Medicaid has exceeded the cost of primary and secondary education in many states.
- Some 18% of lifetime costs for medical care—over \$40,000—is estimated to be incurred in the last year of life.
- Ford Motor Company now pays more for health insurance than for steel. With steel, they understand exactly what they are paying for: with healthcare, they do not.

### Social and ethical fallout

- Despite expenditures in excess of \$1 trillion, nearly 50 million people—over 17% of our population—do not have health insurance.

- A 2002 report from the National Academies' Institute of Medicine concluded that Americans without health insurance are more likely to have poorer health and die prematurely than those with insurance. Uninsured people with colon or breast cancer face up to a 50% greater chance of dying.
- If your employer offers health insurance, if you are a veteran, or if you are a federal employee, you will be covered. Otherwise, government subsidized health insurance is granted only to certain categories of citizens, thus there is a coverage gap:
  - ⇒ If you are a poor, pregnant woman or a poor child, blind or disabled, you will receive care through Medicaid. If you are a poor man, you will not.

⇒ If you are 65 or older, even if you are among the country's wealthiest citizens, you will be covered by Medicare. The tax dollars that pay for Medicare come from the payroll taxes of those still working—even the working poor who are uninsured.

**"We demand a different standard for public resources. We should also demand the same in healthcare so that we know the health benefit received for the dollars spent. That benefit should be for all, not just some."** —Gov. Kitzhaber

- Eligibility for publicly funded insurance can change any time definitions change. Eligibility for private insurance can end with a job change, divorce, or simply an employer's decision to discontinue coverage. As people are "defined out" of coverage, costs shift back to the public, through Emergency Room usage.
- The inability to pay medical bills is the second leading reason for personal bankruptcy (31%), second only to job loss (33%).
- American companies cite health insurance costs as the leading factor in their inability to compete in the global marketplace. Employee health insurance, for example, adds \$1800 to the price of each Ford car. Every year, 4.5% of employers stop offering health insurance.

(Continued on page 3)

**The value proposition**

- The United States spends more on healthcare than any other industrialized nation in the world, yet according to leading indicators of health, Americans are far from the healthiest people.
- *Business Group on Health*, says 70% of care rendered is not evidence-based.
- Emphasis on payment for *procedures*, instead of payment for better patient *outcomes*, leads to inconsistent care and tremendous expense. For instance, the payment structure makes it difficult for a diabetic person to receive good, yet relatively inexpensive, preventive care. But every insurance plan will pay for a foot amputation—a devastating, expensive, and completely preventable complication of the disease.
- The Dartmouth Atlas examines how healthcare resources are allocated throughout the country. It routinely finds wide variations in, and no correlation between, spending and outcomes. In its most recent report, the Atlas discovered that *“the extra spending, resources, physician visits, hospitalizations and diagnostic tests provided in high spending states, regions and hospitals don’t buy longer life or better quality of life. In fact, those who live in high rate regions have slightly shorter life expectancies and less satisfaction with their care than those in regions with lower rates of spending. The problem is waste and over-use in high rate states, regions and hospitals — not under-use and healthcare rationing in low rate areas and institutions.”*



Governor Kitzhaber joins the discussion

## Is this the system we would choose?

The current healthcare system is a maze of 50-year-old ideas that have been added to and tinkered with, evolving haphazardly. Gov. Kitzhaber illustrated a central point: *this is not the health system we would design today*. If we were to capture the design of the current system—actually create a piece of legislation that would mandate it—it might look something like the example below.... the **fictitious** “Healthcare Equity and Empowerment Act of 2007”...a bill no one would ever draft and no one could support.

**DOES THIS MAKE SENSE?**

**The 2007 Healthcare Equity and Empowerment Act of 2007**

**Preamble**

- (1) There shall be no explicit policy objective adopted to guide the allocation of public healthcare resources.
- (2) No clear responsibility shall be assigned for financing the care of those who cannot pay for it themselves.

**Section I**

Categories shall be established to differentiate between the “deserving poor” and the “undeserving poor.”

- (1) The “deserving poor” shall include poor women who are pregnant, families with dependent children, and those who are blind or disabled. People in these categories shall be provided with publicly financed healthcare.
- (2) The “undeserving poor” shall include poor women without children who are not pregnant and poor men. People in these categories shall be denied publicly financed healthcare.

**Section II**

- (1) All those who are over 65 years old shall be entitled to publicly financed healthcare, regardless of their income.
- (2) All those who are employed and under the age of 65, regardless of whether they can afford healthcare for themselves and their families, shall be required to pay a portion of their taxes to purchase healthcare for wealthy citizens over the age of 65.

**Section III**

- (1) The public program for the elderly (Medicare) shall not provide coverage for long term care services.
- (2) The public program for the poor (Medicaid) shall provide coverage for long term care services.
- (3) The elderly in need of long term care shall be required to spend themselves into poverty in order to become eligible for Medicaid, at which point their needs will compete directly with those of poor women and children.

**Section IV**

- (1) The criteria of financial need and ability to pay shall not be used to determine eligibility for a public subsidy.
- (2) The relative effectiveness of various medical interventions in producing health shall not be considered in deciding which services will be paid for by public resources.

## We can design a better system

The alternative Kitzhaber proposes uses the public education system as a model. All American children are explicitly eligible for a free basic public education, funded by an explicit public subsidy to which everyone contributes. Those with more income can purchase more services, but a basic level is guaranteed. When the public schools encounter financial constraints, cutbacks are made to the benefit—never to basic eligibility. For example, an elective may be cut or the school year shortened, but the public school system does not stop teaching those over the age of 12 or stop offering fourth grade one year.

Could the healthcare system be made to function equitably at a higher level of quality? Most analysts agree that there are currently enough dollars in the system to fund a basic level of care for everyone and improve the quality of the care that's given.

Kitzhaber proposes that communities and states promote solutions that ask that the federal tax dollars used to fund the current system be given to the state to allocate in a way that allows every resident to receive a “core” health service benefit. Kitzhaber has promoted this idea in Oregon where S.B. 27 asks that the \$7 billion federal tax dollars used to fund the current system be allocated to the state for this purpose. In part, the plan is intended to force a debate about what comprises “basic” healthcare. It is a bold, but low-risk idea.

Kitzhaber urged the group to start by envisioning an ideal system and work toward that goal, rather than try to devise ways of fixing the existing system. While elements of the existing system can be preserved, they need to fit the vision. He stressed the urgency for change, stating that the risk of inaction is worse than the risk of trying a new idea.



Over 200 people representing a wide cross section of the community participated in the forum

## Ultimately, healthcare is local

### *Participant's comments:*

“This was a challenge to my thinking. I have always believed that progress wasn't possible in the community when the problems were created far away, at the state and federal level. It is liberating to think that we could imagine a new system and make it happen. If the old obstacles don't apply, it is possible.”

“I've always seen the healthcare problem as national. My attitude has changed. The answer has to come from here. We can create a different paradigm.”

“The emphasis on education is important. If patients have some financial stake in healthcare, their attention will be focused. It can present an opportunity for them to be more responsible for their health, most of which revolves around lifestyle.”

“The challenge will come when we have to consider the community-based benefit design. Who decides who makes the decisions about who receives what? With limited resources, tough decisions will need to be made.”

“I thought the answer to the healthcare problem was in Washington D.C. After today I see a role for this community and business leaders to be part of the change.”

— Ken Oplinger, Bellingham Chamber of Commerce

“The delivery of healthcare is local, and transforming our healthcare into the system that we want will take vision, persistence, and engagement from all parts of our community. We are not powerless, and we do not have to wait for a distant government entity to fix things for us.”

— Dave Lynch, MD

## Forum “round table” discussion groups

Forum attendees were invited to participate in small discussion groups, made up of people from across the community spectrum. Participants included clinicians, patients, hospital leaders, business and union leaders, employers, elected officials, clergy, insurance experts, state health policy analysts, educators, social workers, volunteers, mental health providers, dental professionals, and representatives from the nonprofit sector. The groups were asked to consider two questions: 1) What is your vision for the ideal healthcare system? and 2) How do we get there from here?

### QUESTION # 1

#### What is your vision for the ideal healthcare system?

If all obstacles were removed and the community was able to devise a new system from the ground up, what would it look like? Theme Table participants organized input from the discussion groups into five basic system characteristics. The ideal system would:

1. **Promote personal responsibility for health** so that people make healthy life style choices, and avail themselves of plentiful opportunities for health education that aims to reduce the over-use, under-use and misuse of medical services.
2. **Broaden the definition of healthcare services** as the basis for a more inclusive and integrated delivery system that meets medical, dental, and mental health needs.
3. **Ensure access to basic healthcare for all** through a healthcare system that is built on the principles of equity and shared responsibility, and is value driven, affordable and sustainable.
4. **Encourage patient / provider partnership** so patients are more engaged in their own healthcare and providers are fairly compensated for the time it takes.
5. **Streamline administration** so that the system is simple and non-duplicative, and costs are controlled by paying for what works.

### QUESTION # 2

#### How do we get there from here?

Forum participants had just 30 minutes in their discussion groups to begin to tackle the “how” of healthcare reform. The following summarizes major themes of this discussion and will serve as a foundation for discussing further how WAHA and other community groups can move forward over the coming months.

- **Engage a wide cross section of the community in educational events** that build understanding and commitment to healthcare reform, and system improvements.
- **Build strategic partnerships with businesses, nonprofit organizations and government agencies** that promote mutual understanding and opportunities for collaboration.
- **Advocate for health policy changes at the federal and state levels**, including reallocation of resources.
- **Develop resources** needed to support the community vision.
- **Implement local initiatives that test and improve the vision.** Ideas included federal and state waivers for creative implementation of Medicare and Medicaid, establishment of pilot projects with implications at the state and federal level and expansion into our four county region.



Participants exchange ideas about their vision for healthcare in our community and the steps we can take to get there



## Next steps...staying connected

On behalf of the staff and board of the Whatcom Alliance for Healthcare Access we want to thank everyone who participated in the Community Healthcare Forum on June 11th. It was a significant commitment of your personal time and energy and we don't take that for granted. While we are very pleased with how the day turned out, we recognize that a forum is ultimately only as good as the follow-up after the event. We are committed to making the best possible use of all the input gathered throughout the day.

The WAHA Leadership Board will be reviewing and refining the rich discussion from the community forum, and posting more detailed summaries on the WAHA web site. The forum results will serve as a foundation for updating WAHA's strategic plan, and support broader community participation in realizing a shared vision of a better healthcare system for everyone in in Whatcom County. Please stay connected, visit the WAHA web site and contact us with your ideas and interests.

Charles S. Beard, President

The "Changing Healthcare in Whatcom County" community forum was made possible by the generous support of the St. Luke's Foundation. WAHA and the St Luke's Foundation would like to thank the following:

### Event Sponsors:

Family Care Network  
Haggen  
Madrona Medical Group  
Molina Healthcare  
Sterling Life Insurance Company  
Wells Fargo Bank  
Western Washington University  
Whatcom Educational Credit Union

### Additional Event Contributors:

Community Health Plan  
Bellingham/Whatcom Economic  
Development Council  
St. Joseph Hospital

◆ ◆ ◆

Photography: Chris Coffin  
Process consultant: Rachel Lucy  
Newsletter: Naida Grunden  
Video: Think-a-Tron Media Labs



St. Luke's Foundation  
for a healthy community



## For more information or to get involved

Visit: [www.WhatcomAlliance.org](http://www.WhatcomAlliance.org)

Video of the forum (two hours): [http://www.whatcomalliance.org/videos/june\\_11\\_2007/](http://www.whatcomalliance.org/videos/june_11_2007/)

Dr. Kitzhaber's presentation: <http://whatcomalliance.org/media/documents/Whatcom-Morning.pdf>

What is WAHA? video (15 minutes): [http://www.whatcomalliance.org/videos/what\\_is\\_waha/](http://www.whatcomalliance.org/videos/what_is_waha/)

## Whatcom Alliance for Healthcare Access

800 E. Chestnut  
Lower Level / Suite 2  
Bellingham, WA 98225



Phone: 360-788-6531  
E-mail: [waha@whatcomalliance.org](mailto:waha@whatcomalliance.org)  
[www.WhatcomAlliance.org](http://www.WhatcomAlliance.org)