

Voices for Health Care:

Engaging the public to advance significant health care reform

Project Report: Spring 2009



Project Sponsor: W.K. Kellogg Foundation

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The Public's Learning Curve on Health Care Reform

It has been fifteen years since the last serious effort at national health care reform. But recent polls show that public opinion has not moved much from where it was in 1994 when the Clinton plan foundered. As they did fifteen years ago, people want to expand health coverage and reduce costs but have not come to terms with the tradeoffs required to make this happen. Why are people still stuck? How can they get unstuck? Where do they come out when they finally reach judgment?

This report lays out the results of a yearlong series of intensive dialogues Viewpoint Learning conducted with ordinary Americans. They show that while the general public is still at an early stage of considering what should be done about health care, they are open to significant change once they work through the tradeoffs.

Why is the public stuck in the same place it was 15 years ago? Two major obstacles have kept the public from reaching sound judgment on how best to reform the health care system. The main reason is that the two goals of reform – ensuring coverage for the millions who now lack it and bending the cost curve – involve different strategies and priorities. The public is confused about their relative importance and how to achieve both goals without having their own personal coverage suffer. The other reason is that most Americans are satisfied with their own coverage and don't realize the many indirect ways they are paying for our current health care system.

How can they get unstuck? There were two lessons to be learned from the failure of the Clinton health care plan in the 1990s: to succeed you have to (1) engage the Congress and the interest groups, and

(2) engage the public. The findings from our dialogues with the public (reported below) show that health care reform is important to the public both for personal reasons and also for reasons of fairness to other Americans. People are passionately interested in engaging with the subject; and that engagement is the key to getting unstuck.

This research gives leaders crucial insight into how to engage the public on a broader scale. They reveal the steps Americans take to work through the issues surrounding health care reform, what information they require, how they process it and how to sequence the conversation so it keeps pace with the public's learning process. Once they realize that they are paying indirectly through higher taxes, lower wages, increased cost of goods and services, insurance premiums and so forth, they come to understand that they are

already paying dearly for an unsustainable and broken system. With this realization they begin to move toward firm and stable judgment.

What form does the public’s judgment take, once it is successfully engaged? As people work through the various tradeoffs involved in expanding coverage and bending the cost curve, they come to a number of judgments described in this report. These include:

- Support for a two-tier system, in which every citizen has publicly funded basic coverage that individuals can choose to top up with private coverage (purchased individually or through their employer).
- People taking far more personal responsibility for their own health and wellbeing, and in curbing end-of-life “heroic medicine.”
- More effective use of limited resources through evidence-based practice and through eventually changing the fee-for-service incentive system
- More emphasis on wellness and prevention
- Having more routine care provided by nurses and other non-MDs, along with more incentives to increase the number of primary providers.
- More stringent regulation of the widely mistrusted insurance industry
- Greater willingness to pay for a more effective system.

Polls and the public learning curve:

Public opinion on complex issues like health reform evolves in stages. From an initial stage of highly unstable “raw opinion” the public moves through a series of steps in which they confront tradeoffs and reconcile choices with their deeply held values. Only when the public

understands and accepts responsibility for the full consequences of their views can we say that this “learning curve” is complete.

What this process will look like for health reform was vividly shown in nine full day Choice-Dialogues conducted by Viewpoint Learning. In these sessions randomly selected, representative samples of the public worked through the kind of health care system they wanted to see in the future, and the difficult choices and tradeoffs they would be willing to support to realize that future.

Unlike polls, which give a snapshot of people’s opinions, the dialogue method engages people in reviewing scenarios for reform and the pros and cons of each. Dialogue participants moved far beyond where the general public is today over the course of the day, envisioning how to create a more sustainable health care system – as well as the tradeoffs they were willing to support to get there. The conclusions they reached were consistent across different regions and across lines of age, income, and political affiliation.

Where participants ended up is not where the general public is today. The current state of public opinion on health care reform is reminiscent of the situation at the beginning of the Clinton administration’s unsuccessful effort to revamp health care. Polls taken in 1993 also showed that the goals of expanding health care to all Americans and limiting increases in health care costs were widely favored then, even more so than today.¹

Then as now, the public’s support for health care reform was fragile, easily challenged and readily nudged into resistance. In 1993, the Clinton health plan started with a 57% majority level of support, but ended with only 37% a few months later. Today the public is still at the stage of raw opinion and has yet to work through their concerns. Until they do, it will be easy for opponents to raise public

doubts and fears.

There are three strong indicators of the instability of the current level of popular support for health care reform:

1. Recent polling shows that the general public is wary of the consequences of reform and its effects on their own health care.
 - *4 out of 5 Americans are satisfied with the quality of their health care and a majority fears that extending health care would harm the quality of their own care. More than half believe health care reform will require people who now have coverage to make changes, whether they want to or not. And while most think that health care reform would benefit the nation, less than 40% believe it would benefit them personally.*²
2. One way of gauging the firmness of public opinion is to see if small shifts in question wording produce different results or whether opinions are so stable that there is a consistent response to the questions however they are worded.
 - *For instance, the public has not yet arrived at a firm conclusion about whether it is more important to control health care costs or expand coverage. This question was raised in four recent polls. In two of these polls, a substantial majority put a higher value on improving access over controlling costs; a third showed a majority for controlling costs; a fourth showed an almost equal division of opinion.*³
3. The general public’s support for specific health care reforms is easily challenged because the public has not yet considered the pros and cons of each policy.
 - *For example, clear majorities of Americans say they support the*

1. Pew Research Center 1993

2. CBS/New York Times Poll; ABC/News/Washington Post Poll; Kaiser Family Foundation (all June 2009)

3. CBS/New York Times Poll; Pew Research Center; Diageo/Hotline; NBC News/Wall Street Journal Poll (all June 2009)

option of a public plan. But when pros and cons of such an approach are presented, support drops away. In another poll, 62% of respondents said they supported a public plan, but only 37% said they would support it if it would put some insurers out of business.⁴

Moving along the learning curve:

Dialogue participants were able to work through these concerns, especially: (1) ambivalence about the government's role in health care; (2) concerns about the loss of, or any restrictions on, the good coverage they now enjoy and (3) the issue of costs and how to pay for the health care system they want. As they worked through the tradeoffs, and defined the health care reforms that made sense to them, they became more realistic and responsible, and more willing to pay for the reforms they want. For example:

- Role of government: by the end of a day of dialogue, participants from across the political spectrum agreed that an expanded role for government would be required in any reform – many were not enthusiastic about this idea but saw it as better than the alternatives. This agreement was broadly shared by all participants, including those who were satisfied with their current coverage.
 - Several plans currently being discussed present a public option as an alternative to private insurance. Participants in these dialogues supported the idea of blending public and private but envisioned it differently: most suggested a two tier system in which every citizen has publicly funded baseline coverage, which individuals could choose to top-up with private coverage.

- Limits on care: People recognized that no health care system can provide everything for everyone. The real issue was how to allocate care fairly – something they felt the current system fails to do. Most supported some kind of evidence-based medicine that focuses health care dollars on treatments most likely to be effective. Many also noted that the current emphasis on heroic end of life care is extremely costly in terms of dollars and suffering and they wanted this to change. They did not want government or insurers deciding about people's end of life care, but they did want people to have better information & support in making those decisions for themselves and their families.
- Paying for a system that works. As people learned more about how costs are distributed in the current system — through higher taxes, lower wages, increased cost of goods and services, insurance premiums and so forth — they came to a key realization. *They were all already paying dearly for an unsustainable and broken system.* Participants differed on whether a reformed system would cost less or more than the one they had now, but all agreed that they did not want to keep pouring dollars into a system that doesn't work. And they were willing to pay for a system that does, even if it meant they had to pay more.

The dialogues reveal how regular Americans move along the learning curve: the steps that they need to take to work through the issues, what information they require, how they process it and what needs to be done to bridge the gap between public and expert opinion. The dialogue research reported here also suggests a number of areas of common ground that represent promising starting points — “low hanging fruit” — where

leaders can begin building firmer support for change. These areas include:

- Improving wellness and prevention – instead of focusing on treating illness and trauma, do more to keep people healthy in the first place;
- Encouraging people to take greater personal responsibility for their own health and wellbeing. This means not only offering incentives, but also making sure that people have the education, information and tools they need;
- Ensuring that all children have access to good care;
- Stronger regulation of the private insurance industry, which is widely mistrusted;
- Reforming health care delivery to make it more coordinated and patient centered, including:
 - Using new technology like medical ID cards to improve quality and continuity of care and help make the system more efficient
 - Changing incentives and payment systems to focus on outcomes
 - Having more routine care delivered by nurses and other non-MDs
 - Designing incentives to increase the number of primary providers, including nurse practitioners and family medicine specialists.

Starting the discussion of reform with issues like these, on which there is widespread public agreement, can help build momentum for change and open the door to pursuing other issues that are more difficult. Equipped with a roadmap of where the public can go, leaders have the opportunity to help them get there.

— Daniel Yankelovich
July 2009

4. NBC News/Wall Street Journal Poll; ABC/Washington Post Poll (June 2009)



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Across the nation, Americans agree: our health care system is in big trouble. Skyrocketing costs, rapidly growing numbers of uninsured and under-insured, and deteriorating health outcomes have pushed the issue of health care reform onto the front burner. The pressures brought on by a reeling economy — including job losses and shrinking state budgets — have magnified these concerns even further. Major reform efforts are being set in motion at both state and federal levels, and public support for some kind of significant change is strong. But what kind of change? Polls and focus groups clearly show that the public is dissatisfied with the status quo and urgent about the need for reform; but they provide little insight into what specific sorts of solutions the public might be willing to support and the conditions for that support.

To succeed, major health care reform must meet at least three tests:

1. It must be technically feasible;
2. There must be political will to carry it out;
3. It must reflect citizens' underlying values and be able to win public support.

As a society we have good ways of harnessing expertise and devising reforms that will work from a technical point of view. The political will to find a way forward through the thickets of interest groups and partisan maneuvering also seems to be coalescing at both the state and national levels. But the public is still something of a question mark. Understanding what the public would be willing to support once they have a chance to work through the consequences — and the conditions for that support — is a crucial piece of the puzzle.

Proponents of health care reform are making efforts to solicit the views of the public and to make the reform process more open. But more is required. Leaders

need to know not only where the public stands today, but also where they are likely to go as they connect the dots and begin to understand the consequences of suggested reforms. Building public support for significant health care reform depends on a deeper understanding of the public's values on the issue and the ability to anticipate how they will resolve tough tradeoffs as they move along the learning curve.

This research project was designed to provide some of these insights — and to help develop a roadmap that leaders can use to engage the public in a broader learning process to advance significant health care reform.

Project design and methodology

Funded by a grant from the W.K. Kellogg Foundation, the *Voices for Health Care* project engaged first leaders and then the public in three very different states (Ohio, Mississippi and Kansas) in working through alternatives for health care reform.

The work was conducted by Viewpoint Learning, working in partnership with state health care advocacy groups and non-partisan policy institutes. In all three states, the focus from the beginning was on building momentum, with each activity building on the one before.¹

In each state the sequence was:

1. A **Strategic Dialogue**, in which health care, political, civic and business leaders worked together to create several scenarios for reform to test with the public in *Choice-Dialogues*.
2. Three day-long **Choice-Dialogues** (in different locations around the state) in which randomly selected, representative samples of the public worked through what sort of health care system they wanted to see in the future, and the difficult choices and tradeoffs they would be willing to support to realize that future.²

3. An **Interactive Briefing** with leaders, including many who had participated in the Strategic Dialogue as well as others from business, government, health care and other sectors.
4. A series of structured 2½ hour **Community Conversations** with citizens, conducted by leaders, advocates and others using a specially designed “Meeting-in-a-Box” kit based on the Choice-Dialogue findings.
5. An **Online Dialogue** that included participants from each of the target states and across the country.
6. Outreach through local **communications** and media activities to heighten public awareness of these efforts and create “buzz” around the need for reform and the specific approaches identified by the public and leaders.

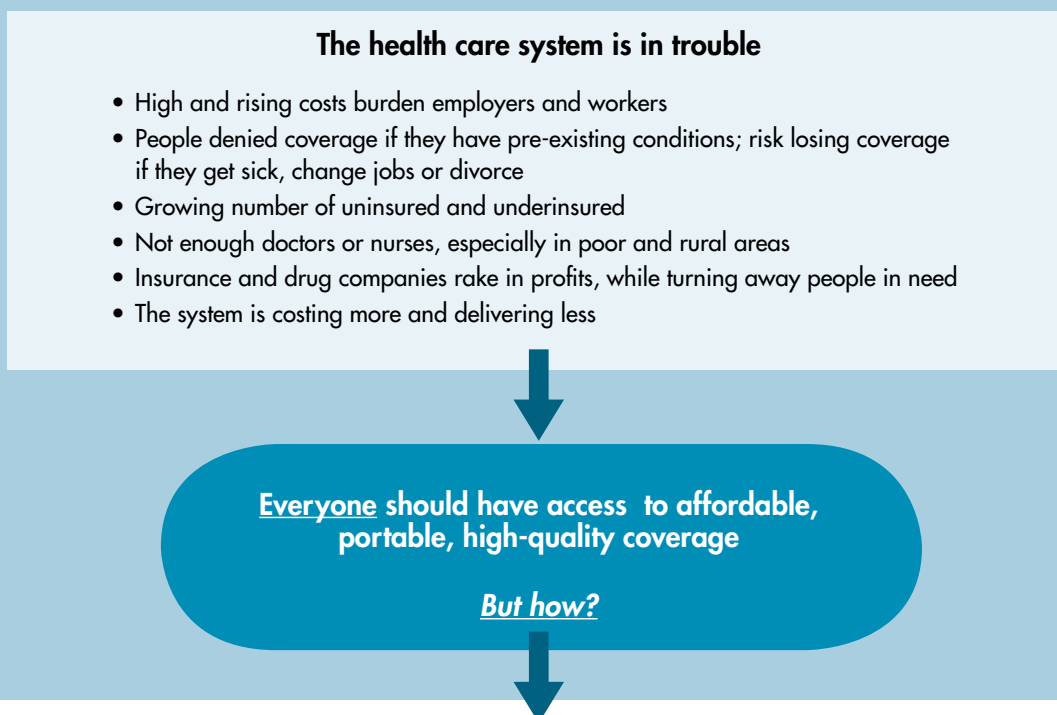
7. An **invitation-only conference**, held in Washington D.C., that reviewed project research, distilled key lessons about the role and potential of civic engagement in reform efforts and identified possible next steps.

Findings

Using the scenarios for health care reform developed by leaders in the Strategic Dialogues as a starting point, representative random samples of the public took part in day-long Choice-Dialogues. In nine dialogues across three very different states, participants followed a similar path as they moved along the learning curve, and they reached a strikingly consistent set of conclusions.

That path and those conclusions are summarized in the following chart.

VOICES FOR HEALTH CARE: HOW CITIZENS WORKED THROUGH THE CHOICES



1. A list of dates and locations of all project activities can be found in Appendix A.

2. A description of Choice-Dialogue methodology can be found in Appendix B.

Build on the current system? "Shared Responsibility"

Pros

- Employer-based system works well for many of us
- Offers choice and competition

BUT

- Can't realistically cover everyone
- Cost
- Burden on business
- Dollars still go to profit, marketing, administration
- Complexity

This approach is not likely to give us the kind of system we want

Can the state do better?

Pros

- Covers everyone regardless of circumstance
- Reduces burden on business
- Dollars go to health care, not profit or marketing
- Simple & easy to understand

BUT
We have major concerns!

- *Restrictions on choice*
- *People with good coverage could end up with something worse*
- *People who don't work, illegal immigrants, "freeloaders"*
- *Cost*
- *Big government running health care*

We need to think about this....



Working through concerns



Restrictions on choice of provider or treatment?

→ People must be able to choose primary provider. Choice of treatments may be limited to those that are scientifically proven effective (evidence-based medicine) as long as patients and doctors can appeal those decisions.

How to protect people with good coverage?

→ Consider a 2-tier system, where the state provides basic care for all and employers or individuals can buy up.

People who don't work, illegal immigrants, "freeloaders"?

→ Most uninsured people do work. Uninsured people cost the system more because they put off needed treatment. And people with communicable diseases must be treated or everyone suffers. If the system is set up so everyone pays in then everyone should be covered.

cont'd



Working through concerns (cont'd)



Cost? → We are already paying for the uninsured. A state system may cost less overall because of greater buying power and less spent on marketing, overhead and profit.

Big government running health care? → Government is the only entity that can realistically cover everyone regardless of circumstance. Dollars will go to treatment, not profit, marketing and overhead. A state-run system may be inefficient, but it will be better than what we have now.

At the end of the day, 80% support switching to a publicly run health insurance program paid for by taxes.

Includes strong majorities of conservatives as well as liberals, plus all age and income groups

Covering everyone is not enough: We need a system that will make people healthier

- Improve preventive care, disease management
- Comprehensive care for children
- Encourage personal responsibility and healthy behavior through education, incentives and reducing barriers
- Use other health providers (e.g. nurse practitioners) to handle routine care
- Use medical ID cards & electronic record-keeping to improve efficiency/quality/continuity of care and prevent abuse of system
- Improve coordination of care (e.g. "medical home" approach)

How to pay for it?

**We're paying now for a system that doesn't meet our needs;
let's pay for one that does**

Everyone benefits, so everyone needs to pay:

- **Employers** pay tax on profits and may offer supplemental coverage
- **Individuals** pay sales & income taxes, plus co-pays/deductibles scaled to income

Will accept tax increases ONLY IF earmarked for health care and there is stronger accountability and transparency about how money is spent

These conclusions were further tested in a series of community conversations in each state and in an online dialogue. Except where otherwise noted, the findings described in this report represent common ground across all dialogues.

What was perhaps most surprising in this research was the amount of common ground participants reached across lines of age, income and political orientation.

Conclusions: Implications for leaders

To build broad-based public support for change will require engaging the public on its own terms. **This involves understanding how people process information, the steps they take as they work through the issues, and how to sequence the conversation in a way that keeps pace with the public's learning process.** The *Voices for Health Care* research suggests a number of steps — and a sequence of steps — that leaders and others can take to build public trust and support for significant health care reform:

1. Begin with common ground

These dialogues identified wide areas of common ground among the public and leaders in three very different states. Our work in other states has found similar results. These were areas of agreement that people reached fairly quickly. They represent promising starting points — “low hanging fruit” — where leaders can begin building broad-based public support for change:

- **Improve wellness, prevention and personal responsibility.** Participants overwhelmingly supported improving access to preventive care like screenings, vaccinations, and disease management, as well as other measures aimed at keeping people healthy in the first place. There is also very strong support for



giving people better health education and other resources and encouraging them to take more responsibility for their own health and wellbeing.

- **Make sure all children have access to good care.** Participants emphasized that good care is especially important for children — it will pay off in improved health throughout the child's life. Support for improving health care for children cuts across virtually all demographic and political categories.
- **Improve health care delivery** by relying on providers like nurse practitioners to provide routine care and finding ways to better coordinate care delivery. Most felt that today's system focused more on treating disease than treating the whole person; they believed a more cooperative, patient-centered approach among medical professionals would improve patient care.
- **Provide incentives to increase the number of providers** and attract more young people into health care professions.
- **Adopt medical ID cards and electronic record-keeping**, on condition that strong privacy measures are in place. Most believed that this would improve quality and continuity of care, help make the system simpler and more efficient,

reduce mistakes and prevent people from abusing the system. They agreed that privacy must be protected, but even those most concerned about privacy concluded that the benefits of medical ID cards and electronic record keeping outweighed their drawbacks.

- **Stronger regulation of the private insurance industry**, for example by requiring that insurers cover everyone regardless of health status or pre-existing conditions. It is important not to underestimate the intensity of public anger where insurers and drug companies are involved. While many people recognize the political difficulty of doing so, there is a great deal of public support for taking a strong hand with insurance companies, even to the extent of capping their profits to help ensure that more dollars go toward health care.

Starting with a discussion of reforms like these, where there is already strong public support, can build momentum for change and open the door to a discussion of other issues that are more difficult. Building on common ground is a way to increase trust and move toward sustainable solutions, while building on wedge issues tends to reinforce polarization and gridlock.



2. Use the public's language/ framework

Citizens and experts often approach issues with different assumptions, frameworks and terminology — and when two parties use the same words to mean different things, misunderstanding and mistrust can result. In the course of the dialogues we noted some examples of terms where the public's assumptions and definitions differ from those of experts:

- **“Basic” coverage.** In general, most Choice-Dialogue participants took “basic” coverage to mean something that experts would describe as fairly comprehensive, including preventive care, dental, vision, and mental health, as well as procedures necessary to preserve life and health. More restricted plans (like high deductible plans or those that cover only preventive care and catastrophic illness or injury) did not fit this definition of basic — participants saw them as too limited. When talking about basic coverage or care, it is important to define these terms clearly — each audience may be making very different assumptions about what the term means.
- **Choice.** Experts sometimes interpret the public's stated desire to “maintain patient choice” as an unrealistic expectation that

everyone have access to every provider and treatment on demand. However, our participants took a more balanced view. Rather than asking for unlimited services, most wanted a more general assurance that they would always have a say in important decisions about their own care. If they disagreed with a provider about treatment, they should be able to seek a second opinion; if they disliked a particular doctor — especially a primary provider — they should be able to find another one.

- **Universal coverage.** The term “universal coverage” was a roadblock for some participants at first. While they wanted everyone to be covered, many assumed that a “universal” system was of necessity a single payer public system and they were not yet prepared to take that step. To avoid confusion, it is best to focus on the point that everyone should have affordable health coverage. Whether or not that coverage should be publicly provided is a separate and subsequent conversation.

3. Sequence the conversation

The public follows a pattern as they think through health care reform and how to create the kind of system that would better meet their needs. In the dialogues, certain

issues came up repeatedly, and people worked through them in consistent ways. What we saw in all of the dialogues is that people need to work through certain questions before they are ready to consider others — each step prepares them to take the next. Advancing reform measures before the public is ready to accept or even consider them is likely to backfire, even if the proposal is one the public might have ultimately supported given time and effective leadership. Instead, this research suggests a sequence of questions that leaders and others can use to structure the conversation in a way that advances the public's learning process:

• **Is it important to cover everyone?**

Most people begin to think about health care reform by focusing on their own situation. Giving people the opportunity to hear a wide variety of other experiences allows them to see their individual problems as part of a larger picture. It also encourages them to shift from a consumer to a community perspective.

Understanding that we are already paying to provide care for the uninsured was a major “aha” moment for participants in almost every dialogue. This provided a very practical, economic rationale for extending coverage to all and allowed participants to see this as something that could benefit all Americans (rather than something that helps some people at others' expense). Helping the public understand how the costs of health care are distributed in the current system will be a key part of any discussion of extending coverage.

- **Can we fix or build on the current system?** Once people conclude that it is important to cover everyone, the next question is how to create a system that gives everyone access to high-quality, portable and affordable coverage. Most people's first preference is to do this by building on the current system, which

works well for many Americans and offers competition and choice.

As people in the dialogues worked through what might be possible, including variations on the “shared responsibility” approach currently being implemented in Massachusetts and considered by other states, they gradually concluded that this would not do enough to fix the problems of the current system. Several factors came into play as they worked this through. Most did not believe that “shared responsibility” approaches would realistically make coverage affordable for everyone, and they worried about the impact on business. More fundamentally, they were concerned that these approaches did not do enough to control costs. Many were troubled that a private insurance system diverts health care dollars to marketing, overhead and profit. And while many hoped to maintain a central role for the private insurance system, they were dismayed at how complex and cumbersome those approaches would be. Across the dialogues, we saw a growing sense that adapting the current system would not be enough to provide the kind of coverage people wanted — something different would be needed.

• **What role should government play?**

Approaches that build on the current employer-based system usually also include a stronger role for government. Most participants, for example, strongly supported stricter regulation of insurers and state incentives to increase the number of providers. As they worked through the limits of fixing health care by building on the current system, however, participants began to examine the benefits of moving further toward a publicly run health insurance system. What initially appealed to them about a public system is that it could do a better job of covering everyone regardless

of circumstance, and it would not be driven by profit. It would ensure that coverage could not be taken away and was completely portable, and it would have greater bargaining power with drug companies, doctors and hospitals. In addition (and perhaps most important) many liked its simplicity — not only would it have lower administrative and overhead costs, it was simply easier to understand.

At the same time most participants had major concerns about a single-payer system. Much of the remainder of the dialogue focused on working through each of these concerns. The following concerns and conclusions were consistent across all dialogues:

- *Concern: A public health insurance system would limit people's choice of providers and treatments.* One key insight for participants was that ALL health insurance systems limit people's choice in some way. The real issue was how to establish limitations that mesh with people's fundamental values: e.g. that people must have a say in key decisions that affect their lives and wellbeing; that decisions about treatment should be based on what is likely to produce good outcomes, not on cost; that people should be encouraged to take responsibility for themselves. So, for example, participants in all dialogues concluded that it was essential that people be able to choose their primary provider. And on the question of choice of treatments, they supported evidence-based medicine, but only on condition that they and their doctor could appeal decisions of a medical review board.
- *Concern: A public health insurance system would mean the loss of good private coverage that some now enjoy.* Many participants were initially concerned that a public

system would force people who currently have good coverage to give that up for an inferior public plan — something that all agreed was unfair. Participants in all states concluded that a two-tier health insurance system was a potentially promising way of addressing this problem — in such a system the state would provide basic coverage to everyone while employers could offer supplemental coverage to employees (or individuals could purchase it themselves). In their view, such a system would reward hard work, preserve choice and provide some assurance that those currently enjoying good benefits would not end up with something worse. In addition, it would encourage employers to stay in the game and compete for employees by offering supplemental benefits.

- *Concern: A public system would cover people who don't work, illegal immigrants, and other “freeloaders.”* Some people felt it was a moral imperative to cover everyone. Others, however, did not like the idea of covering “undeserving” people who might take advantage of the system. As they worked through this point, many were surprised to learn that most of the uninsured are working





or in working families, and this fact led them to reconsider some of their assumptions about who is uninsured and why. In addition, they began to consider the cost of not covering everyone, and most concluded that it was to their advantage to cover everyone and keep overall health care costs lower. Most ultimately concluded that if the system was set up so that everyone living in the state pays in (e.g., through a sales tax dedicated to health care), then they would support all state residents (citizens or not) getting the benefit.

- *Concern: A public system would cost too much.* Understanding how costs are distributed in the current system — through higher taxes, lower wages, increased cost of goods and services, insurance premiums, the cost of care and so forth — was key to working through this point. Participants began to realize that they are already paying dearly for a system that is failing to meet their needs. Some believed that overall costs would be lower in a single-payer system; others were not convinced that they themselves would pay less, but they concluded that they would rather pay more if it meant they would get a system that works.

- *Concern: A public system would dramatically expand government's role in running health care.* As they considered this point, many participants believed that a state system might be inefficient and bureaucratic, but they had too many stories of the inefficiency (and sometimes cruelty) of the current system for this concern to gain much traction. They also concluded that government is the only entity big enough to provide coverage to everyone regardless of income or circumstances. In the end most were prepared to have government take on this role, on condition that there would be strong oversight and accountability about how funds are spent and to protect against waste and abuse.

As people worked through these concerns with each other, in each dialogue we saw growing support for a publicly run single-payer health insurance system, and widespread openness to seeing this put in place on a national level. (The Choice-Dialogue conversations focused on state-level reforms, but every group noted that health care reform would ultimately have to be dealt with at a national level.) This support was realistic and thoughtful: most expected some inefficiency and higher costs, but they felt a public system was the most practical way of getting the kind of health care system they wanted to see. By the end of the dialogue support for moving to a publicly run health insurance system was strong across all demographic groups — including majorities of conservatives as well as liberals, plus all age, education and income groups, as well as people with and without insurance.

It is important to note that these findings do not indicate where the general public is today. Rather they show where people

are likely to go in the future given the time to connect the dots and work through the implications of proposed reforms — as the representative random samples of the public who participated in these dialogues were able to do. The pattern described here was consistent in each dialogue, and it is also very similar to patterns we have seen in health care dialogues in other states. As people work through the realities and limitations of building on the current system, interest in and openness to a public health insurance system increases.

Even if a single payer public health insurance system is off the table at present politically, it likely will come onto the table as the public moves along the learning curve. Already polls indicate that the public is growing more open to the idea (in a February 2009 poll, 59% of respondents favored a system where the federal government provides health insurance for all Americans).³ However, this support is probably fragile, as many (perhaps most) Americans have not yet fully worked through the concerns outlined above.

The Obama Administration has suggested that Americans should have the option of signing up for a public plan similar to that offered to government workers and members of Congress. If this option is made available, there is likely to be considerable public interest.

- *How should we pay for it?* In the course of the dialogues, participants came to understand that they themselves pay for the health care system in many different ways — through taxes, wages, the cost of goods and services, insurance premiums, the cost of care and so forth. As this came into clearer focus, many began to question why they were paying so much for a system that did not meet their needs or the needs of their community. Instead of continuing to pay

3. CBS News/New York Times Poll. Jan. 11–15, 2009.

for such a flawed system, they said, they were willing to pay more to get a system that worked better. Most also agreed that everyone in the state has a stake in a better health care system and everyone should make a contribution to paying for it.

We found that once people have a chance to work through the issues and tradeoffs, and to define the health care reforms that make sense to them, they become more realistic and responsible and more willing to pay for those reforms. In general we have found that the stereotype of a public that wants it all but doesn't want to pay for it only applies to a public that has not had a chance to work through the choices and their consequences.

In this project Choice-Dialogue participants were not asked to indicate exactly how much more they would be willing to pay. If that amount is insufficient to provide the kind of system they outlined, it is not clear how they would resolve the tradeoff: by paying more for more generous coverage or by scaling back what is offered? In other projects (conducted in Arizona and California) where we were able to give participants more detailed cost information, we found that participants balanced what they wanted the state to provide with what they would be willing to pay, but that balance was different in each state. More research is needed to fully understand which way Americans would go on this question.

4. Reforming health care and building trust in a down economy

The economic turmoil of the last year has also been reflected in this project. While the Choice-Dialogues took place before the worst of last fall's financial meltdown, participants were already expressing concerns about job losses, falling home



prices and a weakening economy. As the extent of the economic downturn became clear last fall it had a powerful effect on attitudes, and by the time of our Capstone Conference, it was central to the conversation. We have noticed generally that the scope of the financial crisis and economic downturn seems to be pushing the public past wishful thinking to some degree, making them more willing to consider hard choices and rethink expectations. At the same time, the abuses of public trust uncovered by the financial collapse have added to public skepticism and cynicism. Building public support for significant health care reform will also depend on rebuilding public trust. This will require transparency and a two-way conversation:

- **Transparency.** The public does not expect leaders to provide all the answers — in fact they are increasingly suspicious of easy answers. Instead they want leaders to provide an honest, straightforward assessment of the challenges and tradeoffs. And they want to be assured that their interests are being represented.

Early steps by the Obama administration to create a more open reform process and to engage the public around these issues are a promising start in this direction.

Thus far these efforts have focused mainly on raising public awareness and developing a sense of urgency about reform. But it cannot stop there: the public must be included and engaged in the search for solutions. The next step is to help the public to work through the difficult choices and tradeoffs involved, along the lines of what we saw in these dialogues.

- **A two-way conversation.** Americans want to go beyond simply ratifying a health care proposal and paying the bill. Instead, they want opportunities to pitch in, make themselves heard and help shape the system they will live in. They expect leaders to give people the chance to wrestle with tough choices and take citizens' viewpoints seriously. Leaders who work to provide those opportunities and actively solicit public input will find a public ready and willing to make serious choices.

The importance of engaging the public

Serious effort to engage the public is not required for every policy issue — but there are certain circumstances where it is indispensable:

- **When an issue is important to people's lives.** This is certainly the case for health care reform. Since many Americans are still generally satisfied with their own health coverage, many may prefer to stick with the devil they know. Without engagement and the chance to work through the reasons for change and the consequences of the alternatives, they are likely to resist change on such an important matter.
- **When sacrifice is required.** Public deliberation is essential when proposed reforms call upon people to accept sacrifices and trade-offs that cost money, cause inconvenience, require changes in behavior, or compromise important values. If people do not have a say in reforms that require sacrifice, they will oppose them. This was part of what led to the downfall of the Clinton health care reform.
- **When special interests oppose reform.** Special interests exert their greatest power when the public is indifferent or fearful of change; it takes a strong shove from the public to give political leaders the courage to stand up to wealthy and powerful special interests capable of mobilizing their constituencies overnight and pouring resources into defeating leaders who oppose them.

Health care reform meets all three of these criteria. Engaging the public is essential for these reasons and more generally to bridge the disconnect between leaders and the public that has undermined past reform efforts. This was one of the crucial lessons to be drawn from the failure of the Clinton health care plan in 1994; we can ill afford to make such a mistake again.

Leaders have many ways of engaging the public — for example through the media, face-to-face, and through local organizations and other intermediaries. In

this project, after the Choice-Dialogues, we experimented with two approaches for engaging the public more widely: Community Conversations and Online Dialogue.

- The *Community Conversations* demonstrated that members of the public can have a thoughtful conversation — a structured dialogue — about health care reform in a much briefer time than is required for the day-long Choice-Dialogues, and also how convening such community dialogues can provide a range of benefits to civic, advocacy and other organizations.
- The *Online Dialogue* showed again the value of that medium for raising awareness and for allowing those who do not have time to participate in face-to-face events to become involved. And it demonstrated how a dialogue could be structured to work online. But it also underlined the need to bring together a wider range of viewpoints, and to do more to help people work through tradeoffs and find common ground across political lines in an online environment.

Advancing the dialogue

One consistent finding in these and other dialogues is the importance of moving beyond the like-minded and the usual suspects to engage a wider cross-section of the public. Too often conversations about public issues take place only among those who already agree in most essentials. These narrower conversations tend to reinforce polarization between different groups, increase the stereotyping of “others” — those who hold different views and make different assumptions — and limit learning.

We have found that in a dialogue (unlike a negotiation) the more diverse the perspectives of the participants,



the richer the learning and the more productive the outcome. On issue after issue, we have seen that when citizens are given an opportunity to engage in real dialogue with others from very different backgrounds and perspectives, they think and act more like citizens and less like consumers. They find surprising amounts of common ground and develop a shared community perspective, and they are ready to make and support big changes to advance the common good.

The *Voices for Health Care* project has demonstrated in microcosm that it is possible to engage the public in a more thoughtful conversation about significant health care reform, and that it is desirable — indeed essential — to do so. And it has demonstrated that the public is open to real change in their health care system once they have worked through the implications and consequences. However it will require a sustained effort to continue to engage the public, move them along the learning curve, and foster broad-based consideration of the hard choices and tradeoffs necessary to bring about a better future for health care. This research provides leaders with insight and tools they can use to lead this essential process and engage the public more broadly to advance significant health care reform.



Across the nation, Americans agree: our health care system is in big trouble. Skyrocketing costs, rapidly growing numbers of uninsured and under-insured, and deteriorating health outcomes have pushed the issue of health care reform onto the front burner. The pressures brought on by a reeling economy — including job losses and shrinking state budgets — have magnified these concerns even further. Major reform efforts are being set in motion at both state and federal levels, and public support for some kind of significant change is strong. But what kind of change? Polls and focus groups clearly show that the public is dissatisfied with the status quo and has a sense of urgency about the need for reform. However, these measures provide little insight into what specific sorts of solutions the public might be willing to support and the conditions for that support.

To be successful, significant health care reform must meet at least three tests:

1. It must be technically feasible;
2. There must be political will to carry it out;
3. It must reflect citizens' underlying values and be able to win public support.

As a society we have good ways of harnessing expertise and devising reforms that will work from a technical point of view. The political will to find a way forward through the thickets of interest groups and partisan maneuvering also seems to be coalescing at both the state and national levels. But the public is still something of a question mark. Understanding what the public would be willing to support once they have a chance to work through the consequences — and the conditions for that support — is a crucial piece of the puzzle.

The last effort at major health care reform at the national level — the '94 Clinton plan — provides a cautionary tale. In that case, polls showed strong

majority support at the outset, which emboldened the Administration to move forward. But that support dropped to barely a third of the public in a few months. What happened? The answer runs far deeper than the now-infamous “Harry and Louise” ads. Instead, the roots of the failure lie in the profound disconnect that existed between the public and its leaders — the conversation that took place among political leaders, experts and special interests did not extend to include the public. And because the public was given little opportunity to understand and work through the implications of the proposed reforms, they had not reached a firm judgment by the time the plan was unveiled. The initial polls were measuring only first impressions (raw opinion), which can shift dramatically; because the public had not yet moved from raw opinion to stable judgment, it was easy for opponents to raise public doubts and fears.¹

Current health care reform efforts seem to have learned some of these lessons, and

1. See Daniel Yankelevich, “The Debate that Wasn’t: The Public and the Clinton Plan.” *Health Affairs* (Spring, 1995).

greater efforts are being made to solicit the views of the public and to make the reform process more open. But more is required. We cannot afford to leave the public behind again. Leaders need to know not only where the public stands today, but also where they are likely to go as they connect the dots and begin to understand the consequences of suggested reforms. Building public support for significant health care reform depends on a deeper understanding of the public's values on the issue and the ability to anticipate how they will resolve tough tradeoffs as they move along the learning curve.

This research project was designed to help provide these insights — and to help develop a roadmap that leaders can use to engage the public in a broader learning process to advance significant health care reform.

Project design and methodology

Funded by a grant from the W.K. Kellogg Foundation, the *Voices for Health Care* project engaged first leaders and then the public in three very different states (Ohio, Mississippi and Kansas) in working through alternatives for health care reform. Its objectives included:

- Identifying health care reforms to lower costs and improve access that both leaders and the public will support;
- Defining the roles of employers, the public sector and individuals in such a system;
- Revealing potential roadblocks and conditions for support;
- Creating a roadmap that leaders and others can use to move these health care reforms forward;
- Developing a growing culture and capacity for dialogue and civic engagement in each state where this work is conducted.

VOICES FOR HEALTH CARE PROJECT PARTNERS

The Kansas Health Consumer Coalition (KHCC)



KHCC is a statewide health advocacy organization whose mission is to advocate for affordable, accessible, and quality health care in Kansas. Launched in 2004, KHCC has substantial relationships with the Kansas Health Policy Authority (KHPA), which was created to provide recommendations to the Legislature and

the Governor related to health policy. Through its participation on several KHPA advisory councils KHCC has provided substantive policy recommendations to KHPA. KHCC has also forged strong collaborative relationships with key stakeholder groups throughout the state and has been instrumental in creating and strengthening several partner coalitions, including the Kansas Faith Alliance for Health Reform, Alliance of Health Advocates, and Kansans for Better Health.

www.kshealthconsumer.com

The Mississippi Health Advocacy Program (MHAP)



MHAP strives to be a strong, effective voice for improved health care for all throughout the state of Mississippi, especially those whose health is threatened by poverty, racism, malnutrition and violence. MHAP will work with communities to identify health needs and formulate strategies for change, and will research, analyze, propose and promote policies that will enhance the health status of every person, regardless of financial status.

www.mhap.org

Universal Health Care Action Network of Ohio (UHCAN Ohio)



UHCAN Ohio is a statewide consumer advocacy organization promoting access to high quality, affordable, accessible health care for all Ohioans, through public education, consumer engagement, coalition building, and public policy. As one of twelve grantees of the Robert Wood Johnson Foundation "Consumer Voices for Coverage" initiative, we are building Ohio Consumers for Health Coverage, a united consumer voice with the goal of achieving health care

for all that is effective, efficient, safe, timely, patient-centered and equitable. UHCAN Ohio also provides leadership in state and local efforts involving hospital charity care accountability, expansion of primary care, medical homes, special needs plans for people with disabilities, promotion of safe, effective, affordable prescription drugs, and other initiatives to improve quality and cost effectiveness of health care to improve outcomes.

www.uhcanohio.org

In all of these efforts, we have worked closely with state health care advocacy groups as local partners, and in two states these groups in turn brought in non-partisan policy institutes as co-conveners. (Brief descriptions of our partner organizations can be found in a sidebar on page 16.) In deciding where to conduct this effort we opted for states with strong research and advocacy groups and well developed local networks that could be tapped to engage communities. In addition, we looked for states where health care reform was on leaders' radar. In this way, we aimed to maximize the impact of this effort and make it as sustainable as possible, developing local capacity and building on reform efforts already underway.

In all three states, the focus from the beginning was on building momentum, with each activity leading naturally to the next.² In each state the sequence was:

1. A **Strategic Dialogue**, in which health care, political, civic and business leaders worked together to create several scenarios for reform to test with the public in *Choice-Dialogues*. These sessions built ownership for the subsequent phases of the project and began to build momentum around broadening the engagement efforts.
2. Three daylong **Choice-Dialogues** (in different locations around the state) in which randomly selected, representative samples of the public worked through what sort of health care system they wanted to see in the future, grappling with the difficult choices and tradeoffs involved. Participants identified what sort of reforms they would be willing to support, and under what conditions, to improve health care in their state.³
3. An **Interactive Briefing** with leaders in each state, including many who had participated in the Strategic Dialogue as well as others from

business, government, health care and other sectors. The discussion in these sessions focused not only on the substance of the findings but also on ways to build on the results, reach out to other leaders, and continue to engage the public.

The remaining elements focused on “scaling up” the dialogue to engage a broader cross section of the public. These efforts encouraged people to grapple with the difficult choices involved using a variety of structured face-to-face and electronic methods. Just as important, these and other activities offered leaders in each state the opportunity to develop and deepen local institutional capacity for dialogue and public engagement — around health care as well as other challenges facing their state.

4. Based on the Choice-Dialogue findings, we developed a “**Meeting-in-a-Box**” kit that enables leaders, advocates and others to conduct 2½ hour, highly structured **Community Conversations** around health care reform. The kit includes feedback mechanisms that can be used to measure results and build a list of interested citizens who can continue to be engaged on the issue over time. Our local partners recruited local facilitators who we trained in



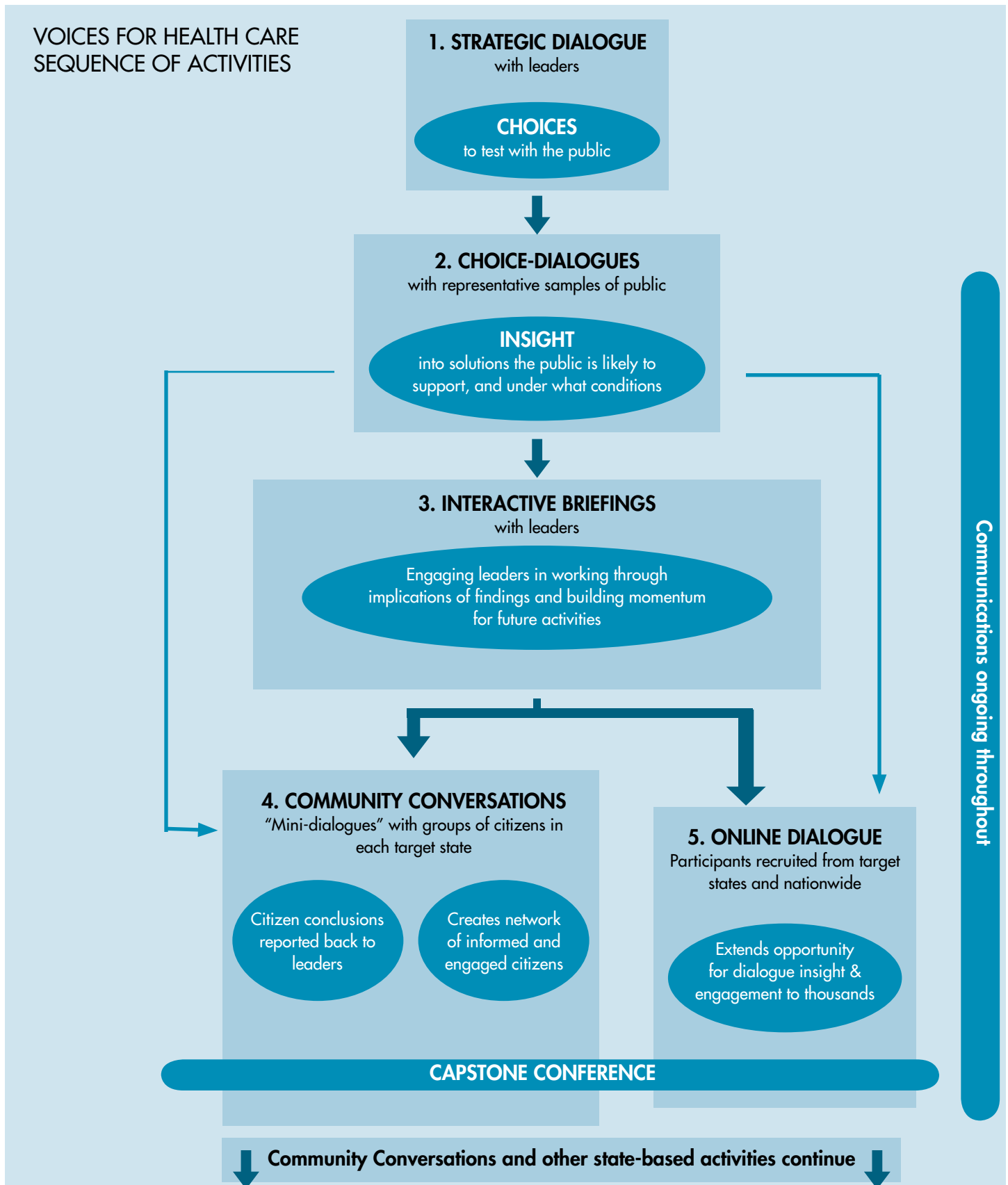
the use of the Meeting-in-a-Box kit; hundreds of people have participated in community conversations so far, and they are ongoing in each state.

5. **Online Dialogue.** We also conducted an Online Dialogue, which included hundreds of participants from each of the target states and across the country. Through Online Dialogue more citizens have had an opportunity to engage in a dialogue on health care reform online and to contribute their views, further developing awareness of and interest in possible reforms.
6. Outreach through local **communications** and media activities that heighten public awareness of these efforts and create “buzz” around the need for reform and the specific approaches identified by the public and leaders. There has been TV, print, radio and online coverage in numerous markets including Kansas, Ohio, Mississippi, South Carolina and California. In addition, we have been visible and active on social networking sites like Facebook. This has driven web traffic to the *Voices for Health Care* website, and a Facebook application we designed linking people to the Online Dialogue has been downloaded thousands of times.
7. **Invitation-only conference** held in Washington D.C., in December 2008. The conference reviewed project research, compared results across the states, and discussed the implications for national health care reform. It identified obstacles and success factors in building public support for sustainable health care reform. And it distilled key lessons about the role and potential of civic engagement in state- and national-level policy reform efforts and identified possible next steps.

The relationship among these steps is illustrated in the following chart.

2. A list of dates and locations of all project activities can be found in Appendix A.

3. A description of Choice-Dialogue methodology can be found in Appendix B.



Focus on state-level reform

Voices for Health Care focused its efforts at the state level. In recent years, many states have taken the lead on health care reform, as they have on so many other important issues, from labor laws to climate change. Now that health care reform is center stage on the national agenda, these state efforts can provide valuable insights for the national conversation and help establish possible areas of common ground and a foundation for action on the national scale.

Building institutional capacity for dialogue and civic engagement in each of the target states has been a crucial aspect of this project. The project was designed to enable local partners in each state to:

- Strengthen and broaden their links with both leaders and the public to advance reform efforts;
- Use the Community Conversations as a tangible tool to reach out to a wide range of local organizations and the broader public;
- Build a more extensive database of people who want to be part of an ongoing dialogue on this issue;
- Position their organizations as leaders in creating a more thoughtful conversation around issues of health care reform;
- Create and test a model that they and others can apply to a range of important issues beyond the life of this project.



Project results

Step 1: Strategic dialogues

In November 2007 and January 2008, Viewpoint Learning conducted Strategic Dialogues in each of the target states (Kansas, Mississippi and Ohio). Each Strategic Dialogue brought together a mix of 20-40 leaders representing health care, government, business, universities and civic and faith organizations. Participants compared notes on the changes and trends that have shaped the current health care situation in their state and developed a range of choices or scenarios for reform they would be prepared to support and would like to see tested with the public in the next step of this project.

Strategic Dialogue participants in all states arrived at surprisingly similar conclusions about the roots of the problem and the range of possible solutions that would be required to address it. In each session, participants drew a picture of an increasingly fragile health care system and identified a common set of key problems:

- Rising costs;
- Growing fragmentation and inefficiency;
- Growing number of uninsured and underinsured;
- Shrinking access to care;
- Poor lifestyle choices;
- A medical system focused far more on treating illness than promoting health;
- A growing — and alarming — gap between the haves and have-nots.

Across the board, these leaders indicated a shared desire for real change moving beyond incremental reform. Many talked about framing the issue not just as “health care” reform — focused primarily on the issues of access, cost and coverage — but instead thinking more broadly about true “health reform,” and

"I think it's important how we frame this as we move forward — if we continue to focus [just] on the acute care/medical care system we are defeating ourselves. We have to start changing people's perception about what the health care system is all about — to ... get off our typical stuck in the mud [idea] that there's only one way to do things. There are lots of ways to do things."

Strategic Dialogue participant (Ohio)

how to take bold steps to create a healthier public. While a wide variety of ideas and perspectives were raised, a number of important common themes were repeated at all three sessions:

- **Universal or near-universal coverage.** All dialogues established as a goal providing universal or near-universal health coverage in the state. This was something all participants believed was extremely important, although there were differing thoughts on how to accomplish it, what ought to be covered and what the proper roles were for the public and private sectors. But across all groups, leaders envisioned a system in which every person in the state gets some form of coverage and care regardless of age, income, employment, or health status.
- **Encouraging and rewarding personal responsibility.** Participants in all

three Strategic Dialogues said that improving the health care system should incorporate a significant role for individual responsibility. They agreed that the system must place more emphasis on prevention and disease management, as well as encouraging healthier behavior through education and rewards for those who make healthy life style choices. Many were also interested in exploring some version of an individual mandate, provided that the mandated coverage is widely affordable, even for those with lower incomes.

- **Dealing with rising costs.** Participants also considered how to address the high cost of coverage and care, though they differed in their focus. Kansas and Ohio participants focused on ways of easing the burden on businesses. In Mississippi — where the employer-based system covers far less of the population — participants focused more on ways to reduce costs, in particular by adopting evidence-based medicine protocols that would give priority to treatments most likely to have good outcomes.

Once these basic themes had been surfaced, the Strategic Dialogue participants pulled them together into

"This is a state that values personal responsibility, but I think we all define personal responsibility in a different way.... The thing that we should keep in mind is that there are large regional differences [in this state]. Rural versus urban, and many more.

Strategic Dialogue participant (Kansas)

a number of specific ideas for reform that they felt should be developed into scenarios and tested with the public. We expected that the three target states, facing such different circumstances, would arrive at different sets of choices. To our surprise, however, all three Strategic Dialogues arrived at very similar conclusions. These ideas formed the basis for four values-based scenarios that citizen participants considered in the subsequent Choice-Dialogues:

1. **Shared responsibility**
2. **Increasing personal responsibility**
3. **Public health insurance for all**
4. **A coordinated wellness system**

(The complete text of the Choice-DIALOGUE scenarios appears on page 21.)

Leaders participating in the Strategic Dialogues were impressed by the wide range of perspectives at the table, the shared sense of urgency among people from different sectors, and the variety of expertise and experience represented. They appreciated the opportunity to move beyond short-term and incremental fixes to consider a long-term coordinated vision for health care reform. Most were especially struck by the level of agreement about the need for significant reform and the core values all parties shared: they had not expected they would find so much

"I was surprised by the commonality in the responses.... There is a huge disconnect between public opinion and public policy, especially in Mississippi. But the more we continue these kind of dialogues, the better we will be able to bridge that disconnect."

Strategic Dialogue participant (Mississippi)

common ground on what needed to be and what could be done. Participants ended the day with a growing sense of what might be possible, interest in what the Choice-DIALOGUES would reveal about the public's attitude toward the reforms they had just discussed, and greater commitment to the project and its prospects.



Step 2: Choice-Dialogues

In March and April 2008 Viewpoint Learning conducted nine day-long Choice-Dialogues on health care reform in Kansas, Mississippi and Ohio (three in different locations across each state — see Appendix A for dates and locations). These dialogues were designed to explore public views on health care reform in a way that goes beyond polls and focus groups — exploring the tradeoffs the public is (and is not) willing to make to achieve a better system once they have a chance to work through the choices and their consequences. Each session was conducted with a randomly selected representative sample of 30–40 residents of the area. The total sample of nearly 300 people was extremely diverse, including participants from a wide range of backgrounds, incomes, education levels and political orientations.

As a starting point for discussion, participants used a special workbook, constructed around four distinct approaches (or scenarios) for health care reform in their state. These scenarios were based on leaders' conclusions in the Strategic Dialogues (see above), translated into the language of citizens and designed to highlight the key values and trade-offs. These scenarios provided a *starting point only* — participants were free to adapt and combine them as they saw fit. As they worked through the scenarios, participants were asked to consider health care reform in light of three key questions: 1) how people should get their insurance, 2) how to make people healthier, and 3) who pays and how.

In all nine Choice-Dialogues, across three states and a wide range of specific local circumstances, participants followed very similar steps and reached a strikingly consistent set of conclusions. The following findings represent common ground across all nine dialogues.⁴

FOUR SCENARIOS

1. SHARED RESPONSIBILITY

This approach requires employers, the government, insurers and health care providers to share responsibility for fixing holes in the current employer-based insurance system. Employers will have to provide health insurance for their employees or else pay a tax to help fund coverage for those who do not have employer-provided insurance. Insurance companies will have limits placed on their profits; and doctors and hospitals will pay new fees to subsidize coverage. People who do not get insurance through their employers will be able to get health coverage at group rates from a statewide “insurance clearinghouse.” Government-funded health care will be expanded to cover more of the lowest income children and families. Together these reforms will build on the current system to significantly reduce the number of uninsured in [State].

2. INCREASING PERSONAL RESPONSIBILITY

In this choice, every [State resident] will be required by law to have at a minimum a high-deductible health insurance plan — a plan that covers both extraordinary medical expenses that cause financial hardship and basic preventive care. If people don't get health insurance from their employers, they will have to buy it themselves. The state will require that all insurers offer at least one low-cost high-deductible plan. For low-income people who can't afford insurance and whose employers don't provide it, the state will contribute to the cost. To pay for this, people who have the most generous employer provided benefits will pay income tax on their benefits. How much people pay for health insurance will depend on whether they are avoiding unhealthy habits and taking steps to stay healthy. The state will provide more information to help people choose hospitals and doctors and will develop new health education programs for all [State residents].

3. PUBLIC HEALTH INSURANCE FOR ALL

In this approach, all [State residents] will get comprehensive insurance through a statewide agency that acts as a single insurance company for all [State residents] under 65. The plan will cover basic preventive care, all medically necessary doctor visits, drugs, hospital stays and tests. All current health care providers in the state will be included in the new system, but they will not be employed by the state and people will be able to choose which providers they use. The new state agency will establish uniform standards for quality care, and an independent commission of doctors will make decisions about what treatments are most effective and will be covered. Employers and individuals will no longer pay health insurance premiums; instead, this coverage will be funded by an income tax on individuals and companies that is used only for health care. Individuals and employers will be able to purchase supplemental coverage for any services not included in the comprehensive plan

4. A COORDINATED WELLNESS SYSTEM

As in scenario #3, all [State residents] will get their insurance through a statewide agency. But in this choice, [State residents] will get all of their health care in a more coordinated way that emphasizes wellness and prevention. Instead of seeing a doctor only when sick, everyone will either choose or be assigned a “medical home” — a primary health care provider who is part of a larger network of providers and specialists. The primary provider (either a doctor or a nurse-practitioner) will provide basic medical care, preventive care and health counseling, decide when a specialist's care is needed and arrange that care. All [State residents] will also have a medical ID card that carries their medical history so that both primary care providers and specialists will have instant access to a patient's medical history. This will allow them to make better decisions about care and avoid duplication and mistakes.

4. A brief flowchart illustrating participants' working through process can be found in Appendix C. Complete quantitative data from the Choice-Dialogues appears in Appendix D.

Where they started:

Participants entered the dialogues deeply troubled about the state of health care system — and many were acutely and personally affected by it. Top concerns included:

- **High — and rising — costs** for coverage, care, and prescription drugs. 63% of participants said they were “very concerned” about health care costs they were facing now or in the future.
- **Number of uninsured and underinsured.**
- **Growing insecurity.** Even those who had insurance did not feel secure. Many participants worried that they would lose their coverage if they lost or changed jobs, or if they became seriously ill.

"I have no insurance — and I have tried and tried. I have been turned down by everybody because I have a bad back. Last year I had four mini strokes. I went to the hospital the first time and I just cried when I got that bill. I went over there and begged and pleaded with them until they brought it down enough that I could borrow the money and pay it. The next three strokes, I didn't go to the hospital."

**Choice-Dialogue
participant⁵**

- **Anger at excess profits** being reaped by insurance companies, drug companies and hospitals, and at insurers' willingness to turn away people in need.
- **A shortage of doctors.** This was felt especially intensely in poorer and more rural areas. Some people simply couldn't find a provider when they got sick.

Many people felt frustrated and powerless in the face of a system that is costing more and delivering less. **93% said the US health care system is either in a state of crisis or has major problems.** And they strongly agreed that something has to change.

The health care crisis affects everyone

At the outset, many participants focused on their individual struggles with finding and affording quality care. People described outrageous bills they had received from doctors or hospitals; uninsured people described their struggles to get and pay for much-needed care; business owners described rising premiums preventing them from hiring or forcing them to stop offering coverage altogether; doctors and nurses described the challenges of trying to provide uncompensated care. As they heard these diverse stories, everyone — insured and uninsured alike — began to see their individual problems as part of a much larger picture, and they zeroed in on several top priorities that they agreed should be fixed at once.

- **Pre-existing conditions.** Participants overwhelmingly agreed that it is wrong for people to be denied coverage or care because of a pre-existing condition, or be dropped from coverage when they get sick. Fixing this was a top priority for any reform — 98% said it was “absolutely essential” or “very important” that any new health care system provide coverage that cannot be taken away.

"I don't want to have to pick a job because of the health insurance it's going to provide me. I don't want to work somewhere that I hate and say well, the health insurance is good.... It comes back to choice – choosing your own health care provider, choosing your own job, choosing your own life."

- **Portability.** Several people described being stuck in bad jobs because they could not risk losing their health benefits, and a few told of remaining in abusive marriages for the same reason. 95% said that it is “absolutely essential” or “very important” to have coverage that people can take with them when they change jobs or their circumstances change.
- **Universal coverage.** As they learned more from each other about how the health care system works, participants realized that they were all already paying dearly for the cost of caring for the uninsured. Fixing that was a matter of economics as well as justice. At the end of the day, 89% agreed that covering everyone in the state was “absolutely essential” or “very important.”

Can we build on the current system?

How to create a system that could give everyone in the state access to high-quality, portable and affordable coverage? Many participants who had good employer-provided coverage were wary of changing it, and many others valued the choice and competition offered by a private employer-based system. Better,

5. In this section, Choice-Dialogue participant comments illustrating key points are taken from all three states.

they said, to find a way to adjust and build on the current system rather than risk throwing the baby out with the bathwater.

Participants considered several possible approaches for expanding coverage by building on the current system, including an individual mandate and a pay-or-play employer mandate. But as they examined these proposals further, they came up against several serious concerns.

Many felt that too many people would still fall through the cracks — especially the unemployed, part time workers and the self-employed. In addition, they realized that these approaches do not address the problem of rising costs. Even if people receive subsidies to help make insurance more affordable, most participants felt that this would still not realistically bring coverage within the reach of low and middle-income families. Many also worried about the effect of an employer mandate on businesses, especially as the cost of coverage continues to go up — 57% felt that companies in their state would be more competitive if they didn't have to fund health care costs. More fundamentally, many were concerned that no matter what, a private insurance system diverts health care dollars to marketing, overhead and profit.

As they worked it through, most concluded that adjusting the current system would result in a system that was too complex and too costly — and that would not go far enough towards fixing the problems they were facing.

Can the state do better?

Participants then considered whether the state could do better at addressing some of the problems facing the current system. They agreed quickly that the state was better equipped to do some things. In particular they supported:

- ***Stricter regulation of insurers.***
Participants in all states supported a stronger state role in regulating insurers — capping profits and requiring insurers to cover all applicants even if they get sick or have a pre-existing condition. They rejected the counter-argument that insurers would leave the state if such regulations were imposed. 86% of participants supported capping insurer profits, and more than half (59%) supported it strongly.
- ***State incentives to increase the number of providers*** — including hiring incentives as well as scholarships to attract more students into the pipeline. This was especially important to participants in rural and medically underserved areas, where many participants felt the provider shortage very acutely.

Working through concerns about a state-run health care system.

Going beyond this, many participants began to see some advantages to a state-run health care system. It could cover everyone regardless of circumstance, and it would not be driven by profit. It would ensure that coverage was non-revocable and completely portable, and it would have greater bargaining power with drug companies, doctors and hospitals. In addition many liked the simplicity of such a system — not only would it have lower administrative and overhead costs, it was easier to understand.

But many participants had to work through major concerns. In particular:

- ***A public system could limit people's choice of choice of providers and treatments***
- ***People with good coverage today might end up with something worse***

"For the very lowest income people, I think publicly funded insurance is necessary. But I don't want it to be publicly funded for me because I want to determine what's best for my family."

- ***It might cover people who don't work, illegal immigrants, and other "freeloaders"***
- ***It might cost too much***
- ***It would dramatically expand government's role in running health care***

Participants spent much of the remainder of the dialogue working through each of these concerns. The following logic and conclusions were consistent across all dialogues:

- ***What about restrictions on choice?***
Participants were extremely suspicious of a public system at first because they feared it would result in significant restrictions on choice. Many envisioned a system where all decisions about their care — from provider to medication — would be made by faceless bureaucrats (“Like going to the doctor at the DMV”





said one participant). But as they thought about it further they soon realized that no system provides unlimited choice for everyone — it would be impractical and hugely expensive. The question was what kinds of limitations they were willing to accept and how to ensure they would be reasonable and fair.

- **Choice of provider?** Allowing people to choose their primary provider was non-negotiable for most participants, especially in Ohio and Kansas. People did not want to hand over such a personal relationship to a state bureaucracy. Participants in these states concluded that any public system would have to allow people to choose their own provider and allow for second opinions. Mississippi participants were less concerned about provider choice: so much of the state was medically underserved that Mississippians' top priority was simply to make sure people could get to a doctor at all. Even here, though, participants said that if they did not like one doctor they should be able to choose another. As one participant put it, “you cannot be healed by someone you don't like.”
- **Choice of treatment?** Most agreed that decisions about what will be covered should be made by doctors

and scientists based on what is likely to lead to good health outcomes, rather than by insurance companies focusing on the bottom line. 57% supported some kind of “evidence based medicine” protocol that would cover only treatments that have been proven effective.

But as they considered what this would mean for them personally, a serious trust issue surfaced — if care had to be limited, they wanted to make sure someone they trust and who knows them imposed these limits. While most indicated they would accept their doctors' decision about appropriate treatment, they were not so willing to accept decisions made by a faceless medical review board. Three out of four (77%) felt that the doctor's judgment should prevail in decisions about treatment. To balance these two priorities, participants agreed that any evidence-based protocol must provide a means for patients and their doctors to appeal decisions about what the system would cover and get second opinions.

"The doctor knows his or her patient. Something may be an accepted protocol, but the doctor may know ... it's not going to work on this particular patient. Medicine is still an art. Accepted protocols — sure, they can be very good, but I don't think they should be followed just because that's the rule."

- **How to protect people who have good insurance today?** Many participants were initially concerned that a public system would force people who currently have good coverage to give that up for an inferior public plan — something that all agreed was unfair, and that many felt would diminish people's incentive to work hard. Participants in all states concluded that a two-tier health insurance system was a potentially promising way of addressing this problem — in such a system the state would provide basic coverage to everyone while employers could offer supplemental coverage to employees (or individuals could purchase it themselves). Proponents said that such a system would reward hard work, preserve choice and provide some assurance that those currently enjoying good benefits would not end up with something worse. In addition, it would encourage employers to stay in the game and compete for employees by offering supplemental benefits.

However, participants differed about what exactly “basic” coverage should include. Most wanted a fairly comprehensive package of benefits like those found in an HMO or managed care plan; these participants emphasized that no one should have to go without treatment because they are unable to pay. Others were concerned that an overly generous “basic” package would cost too much and could erode people's incentive to take responsibility for their wellbeing. These participants preferred a stripped down version that would include preventive medicine and protection against catastrophic illness or injury. More research will be needed to see how people balance the belief that health care should be available based on need, not ability to pay, with the desire to control costs and encourage personal responsibility.

• **What about paying for people who don't work or for illegal immigrants?** This was a concern for some, especially at first. Many objected to paying to cover “freeloaders” and wanted to make sure that people have a strong incentive to work. But as they considered it further, they concluded that leaving people out of the system was penny-wise but pound foolish. They realized that when people are left out of the system they still get sick, and the cost of treating them is passed on to everyone else. In addition, having large numbers of uninsured people in the system increases costs in the long run, since people without coverage tend to delay treatment until minor ailments are serious and more costly to treat (something many participants confirmed from personal experience). Several also noted that they did not want uninsured people delaying treatment of communicable diseases that could harm public health. Most ultimately concluded that if the system was set up in such a way that everyone living in the state pays in, then they would support all state residents (citizens or not) getting the benefit.

"I think one of the reasons to have everybody covered is to improve everybody's health. We're all in this boat [together] so to speak, and the overall health of the community affects me. If somebody has TB and it's not treated — whether they're illegal or legal or from outer space, if I get it from them, I'm going to be unhappy."

• **What about cost?** Many participants worried that a public health insurance system that covers everyone would be prohibitively expensive. But as they learned more about how costs are distributed in the current system — through higher taxes, lower wages, increased cost of goods and services, insurance premiums, the cost of care and so forth — they began to realize that they are already paying dearly for a system that is failing to meet their needs. Some maintained that a public system would cost less than the current one. They pointed to the greater bargaining power of the state and the savings that would result from reduced costs for overhead, marketing and administration, as well as from a healthier population. These participants also hoped that if employers were relieved of the burden of providing health benefits directly they would pass some of the savings on to their employees and customers in higher wages and lower prices for goods. Other participants were skeptical that a universal public system would actually cost them less in the long run. But all agreed that they did not want to keep pouring money into a broken system — instead, they said, we should pay for one that works.



• **What about big government running health care?** Interestingly, half of participants (50%) agreed that a state-run system would be bureaucratic and inefficient — but they did not see this as sufficient cause to reject a public system. They had too many stories of the inefficiency (and sometimes cruelty) of the current system for this argument to gain much traction. **At the end of the day, 80% of participants supported switching to a publicly run health insurance program paid for by taxes; only 18% supported staying with an employer-based system. This included majorities of conservatives as well as liberals, plus all age, education and income groups, and both insured and uninsured.**

"When I came here today, I was very cynical because I didn't think many people believed in the concept of universal health care. I thought that was one of those catchphrases that frightened people: that's communism and stuff. I'm kind of surprised that so many people seem to share the idea that it's a very important concept for our state and our country."



"I think education is at the base of this. And not just educating our children. We need to be re-educated too. Because a lot of us have forgotten, or are just not up on it, or haven't had good health care for so long that we don't even know what [healthy behavior] is."

Making people healthier.

Participants in all dialogues and all states agreed that expanding access to health care was not enough by itself — they wanted a system that would make people healthier. They strongly supported a number of steps to that end:

- **Improve preventive care.** Participants overwhelmingly supported improving access to preventive care like screenings, vaccinations, and disease management. 97% of participants supported putting more resources into preventive care, and 70% supported it strongly. This was the first and most important step to making people healthier.
- **Comprehensive care for children.** Participants emphasized that good care is especially important for children — it will pay off in improved health throughout the child's entire life. Participants agreed that all children must receive comprehensive care, even if the state-provided baseline for adults is something less. This was consistently one of participants' top priorities: 76% rated it as "absolutely essential."
- **Better health education.** Participants in all dialogues wanted to make sure that both children and adults have the tools and knowledge they need to

make healthier choices. They strongly supported improving health education in schools and through the media.

- **Encourage healthy behavior.** 90% of participants supported encouraging healthy behaviors like quitting smoking, exercising, and getting screenings (64% strongly support). They agreed that while education is a key first step it is not enough in itself. It is also crucial to address systemic obstacles that make it more difficult for people to engage in healthy behaviors (high cost of fresh produce, lack of safe places to walk or bicycle). Most groups also supported sin taxes to discourage unhealthy behaviors like smoking, drinking and gambling. This idea was especially popular in Mississippi, where many said the state's tobacco tax should be raised. Not only would this bring in revenue, they said, it would also lower the smoking rate.

Participants struggled, however, with how stringently people should be held accountable for their own health choices by the health care system itself. Some people (for example smokers) said that since they chose to engage in an unhealthy activity they should be asked to pay a higher premium or fee for that choice. However, many others were uncomfortable with this idea; they

wondered who would sit in judgment and were concerned that people would too easily be scapegoated for things that were not truly under their control. As a rule, participants preferred offering incentives for "good" behavior to penalizing people for "bad."

- **Get employers involved.** Participants suggested requiring employers to give employees time off for medical checkups, as well as incentives for employers to provide wellness programs for their workers.

Participants also agreed that the system could make people healthier if some concrete steps were taken to improve how care is delivered:

- **Medical ID cards.** Participants in all states supported medical ID cards (cards that give providers access to a patient's medical history). They believed that these cards would improve quality and continuity of care, would help make the system simpler and more efficient and would prevent people from abusing the system. They agreed that privacy must be protected, but even those most

"We think that the ID cards are a very good idea.... Our only concern would be invasion of privacy, security breaches, and things like that. Though I think the ID card actually is trying to prevent a lot of problems with that. And [the cards would help] avoid the paperwork, red tape and inefficiency in health care."

concerned about privacy concluded that the benefits of medical ID cards outweighed their drawbacks. Some noted that privacy concerns would diminish dramatically in a universal system: if insurers have to cover everyone regardless of health status, one main drawback of having one's medical history more accessible simply vanishes. At the end of the day, an overwhelming 97% of participants supported using medical IDs and similar technology to improve record-keeping and coordinate care, with two thirds (66%) strongly supporting.

- **Use other health care providers like nurse practitioners to handle routine care.** 83% of participants felt that these professionals could handle most minor complaints as well as an M.D. Some supported this idea out of desire to reduce costs, others (especially in rural areas) supported it as a way of increasing access in places with few providers.
- **Better coordination of care.** Participants, especially in Kansas and Ohio, supported the idea of a “medical home” in which each state resident would have a primary provider who is part of a larger network of providers and specialists. This primary provider would provide basic medical care, preventive care and health counseling, decide when a specialist's care is needed and arrange for that care. Most participants supported this idea only on condition that people would be able to choose their primary provider and appeal decisions about care. Many felt that today's system focused more on treating disease than treating the person: a more cooperative, patient-centered approach among medical professionals would improve patient care. Mississippi participants supported this idea as well, though as already noted, the need for care was

so great in many parts of the state that reorganizing a non-existent system was not an especially high priority.

Everyone pays

Participants then turned to the question of who should pay for a better health care system, and how. They recognized that they themselves ultimately pay no matter what — through taxes, wages, the cost of goods and services, insurance premiums, the cost of care and so forth — and that they were already paying for a system that did not meet their needs. Most agreed that some additional revenue would probably be needed, and that everyone in the state has a stake in a better health care system and should make a contribution to paying for it.

- **Employers.** Participants supported a tax on corporate profits; they also hoped employers would offer supplemental coverage to employees.
- **Individuals pay co-pays/deductibles scaled to income.** Participants agreed that individuals have to bear some of the cost of their own care, for example through co-pays or deductibles. However, it was important that these payments be scaled to income: most participants (63%) felt that high out-of-pocket costs discourage people from

"Sooner or later the taxpayer's going to have to pay. We can say okay, let's have a sin tax, casinos, tobacco, alcohol - [but] we all are going have to put in. We are all in this together... So why can't we all get together and pay taxes and get everybody covered. And everybody help pay."

getting needed care, and they wanted to make sure that care is not out of the reach of the poor.

- **Taxes.** Most participants supported some combination of income taxes and sales taxes so that the wealthy pay their fair share, but everyone pays something. As noted above, they also wanted employers to pay a role in paying for coverage through a tax on corporate profits. Participants also suggested a role for “sin taxes” on tobacco, alcohol and gambling. However, they would only pay more taxes if the money was earmarked for health care and the



system provides a clear and transparent accounting of how dollars are being spent.

- **Accountability.** Participants were clear that they would accept tax increases only if the money is earmarked for health care and the system provides a clear and transparent accounting of how dollars are being spent.

By the end of the day, 79% of participants said they would be willing to pay higher taxes so that everyone can have health insurance.

"We're willing to pay a little more, whether it be premiums or sales tax or sin tax.... We'll pay taxes, because we think we'll get a better system that's going to deliver a better product than what we have today."

Differences between states

The conclusions outlined above were consistent across the three states involved in this project. However, there were some differences in priorities and intensity of responses in the different states. The sample sizes for each individual state were small, so comparisons must be treated with some caution; however, these differences are suggestive and merit further investigation.

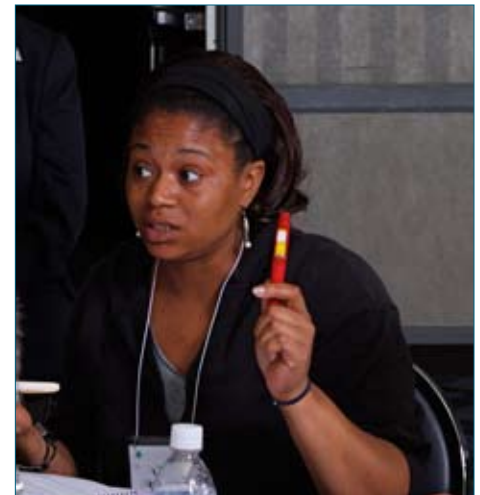
Kansas

- **Greater satisfaction with the status quo.** Compared to people in other states Kansas participants felt less urgency at first about the need to cover the uninsured. In part this was because

fewer dialogue participants were without insurance themselves (11% of Kansans were uninsured in 2007, vs. 14% nationwide). Kansas participants also reported greater than average satisfaction with their health care (75% said the quality of care in their community was excellent or good, compared with 64% in the aggregate). But as they began to work through the issues and learned more about how the health care system works they realized that the problem of uninsured and underinsured Kansans affects everyone in the state. By the end of the day, 88% of Kansans agreed that covering everyone in the state was “absolutely essential” or “very important” — the same as the aggregate.

Mississippi:

- **More pessimism about the current system.** The Mississippi Choice-Dialogues were shaped by participants' acute awareness that Mississippi is “first of the worst” — last in percent of employers offering insurance, last in providers per capita, last in health outcomes and preventable deaths, and with some of the worst smoking and obesity rates in the nation. They were much more pessimistic about the care available than people in other states: 46% of Mississippians rated the quality of health care in their community as “not so good” or “poor,” compared to 36% in the aggregate. Even those with insurance were less satisfied with their coverage than participants in other states: 40% of Mississippi participants were “extremely” or “very” satisfied with their current coverage, compared to 50% in the aggregate.
- **Access more pressing concern than choice.** Almost one in 5 Mississippians was uninsured in 2007 (19%, compared with 14% nationwide), and many more are underinsured or live in underserved areas. For many people in these



dialogues, choosing a doctor was beside the point — they just wanted people to be able to get the care they need.

- **A different path to supporting a universal public system.** While Mississippi participants ended up supporting universal public coverage by similar margins to people in other states, they reached this conclusion by a somewhat different path. Participants' primary concern was NOT worry about restrictions on consumer choice. Instead, people were concerned about encouraging a culture of dependency — many felt people who work hard and pay their taxes should not have to pay for people who don't (or won't). Mississippians were more concerned than people in other states that giving people a “free ride” would encourage abuse: 43% felt that if people don't pay for health care they will overuse the system (only 34% of people in the aggregate agreed).

But participants soon realized that many of the uninsured are hard-working taxpayers, and they also began to understand how a high uninsurance rate affects costs throughout the system. Participants wrestled with this tradeoff: they did not want to encourage “freeloaders” but they also wanted

to keep everyone's costs low — and that meant making sure that everyone has insurance. Ultimately, practicality won out: most felt that keeping costs lower by covering everyone through a public system was more important than penalizing the shiftless. (At the end of the day, participants' conclusions aligned with those in other states: 81% supported a publicly run system; 16% supported staying with the current employer-based system)

Ohio

- **More generous definition of “basic” coverage.** While participants in all states defined “basic” care fairly generously compared to how health care experts use the term, Ohioans were especially expansive in their definition. They wanted “basic” coverage to include preventive care, disease management, mental health services, drug/alcohol treatment, and prescription drug coverage. As they saw it supplemental coverage would cover “extras” like private rooms, treatments that fall outside evidence based medicine protocols, or shorter waits for non-emergency procedures. Ohioans were also more concerned than respondents in other states that the health system not have big inequities based on ability to

pay: 82% of Ohioans said that “everyone is entitled to the same level of health care” while 15% said that people who can pay more should be able to get something better. (In the aggregate these figures were 75% and 23% respectively.)

Step 3: Interactive Briefings

A few weeks after the conclusion of each set of Choice-Dialogues, Viewpoint Learning conducted **Interactive Briefings** for leaders in that state. Many of the leaders at the Interactive Briefing had participated in the Strategic Dialogues; others were new to the project, including many from sectors other than health care. These larger more diverse sessions began with an overview of the Choice-Dialogue findings and what they revealed about public priorities for health care reform.

Leaders were encouraged by the amount of common ground identified by Choice-Dialogue participants, their thoughtfulness and their willingness to confront difficult choices. In particular they were surprised at citizens' openness to a public system, their strong support for preventive care, their support for electronic record keeping, and their broad-based willingness to pay for a system that provides everyone with access to care.

Leaders recognized that serious obstacles remain — including lack of resources and significant legislative and political barriers to change. Still, the fact that such diverse groups had reached strong conclusions led even the skeptics to conclude that they had more leeway than they had previously thought to engage their constituencies, colleagues and organizations in a tough-minded conversation about potential reform. The broad range of leaders present at the Interactive Briefings underscored this point for many: engaging with leaders from other sectors who unexpectedly shared their urgency and commitment to the issue added to many participants' sense of momentum and possibility at the end of the session.

The Interactive Briefings also helped broaden interest in the Community Conversations that were soon to get underway (see next section). Leaders were given an overview of the Community Conversation effort and were invited to convene conversations through their organizations. In addition, several signed up to be trained to lead these conversations themselves.

Step 4: Community Conversations

Shortly after the Interactive Briefing, local project partners, working with Viewpoint Learning, launched a series of Community Conversations on health care in their state. These conversations are still ongoing in all three states. Using Viewpoint Learning's “**Meeting-in-a-Box**” kit (including background materials, worksheets, leader's guide, and a feedback mechanism), Community Conversations allow leaders, their representatives and a range of local organizations at all levels to conduct a highly structured 2-3 hour dialogue session in which people engage with key issues and begin to work through the choices themselves. Participants'



conclusions are collected and the results reported to leaders.

These mini-dialogues replace top-down models of “informing and educating the public” with two-way dialogue in which citizens become partners in solving problems. They can also help advocacy groups engage the public and other stakeholders in a dialogue-based conversation — one that is more likely to lead to real learning and to common ground.

The *Voices for Health Care* Community Conversation kit draws on the materials and conclusions of the Choice-Dialogues. The materials are simplified and streamlined to fit the shorter time frame, and also to distill the key insights and the points that resonated most powerfully in that state's Choice-Dialogues.

All these materials are tested and then further refined based on feedback from test dialogue participants and from local partners in each state. The resulting materials are targeted as directly as possible to the specific needs and conditions of each state. In each state, conversation participants are asked to consider two key questions:

1. How can we improve health outcomes?
2. Given our answer to the first question, how can we control costs?

Viewpoint Learning conducted a training session in each state for people interested in leading or convening Community Conversations. Participants were recruited by local partners and included leaders from the Strategic Dialogues and Interactive Briefings, along with other health care advocates, academics, community leaders, health care providers and faith leaders. Participants were taken through the Community Conversation process and worked through how to use the kit and lead dialogues

COMMUNITY CONVERSATIONS: ONE STATE'S EXPERIENCE

Kansas Health Care Coalition report on Community Conversation outcomes

- KHCC staff was able to easily recruit 23 facilitators from around the state; the ease with which KHCC staff located these individuals is a direct result of KHCC's existing, strong relationships with organizations and individuals working on a variety of health-related issues.
- The Community Conversations provided an invaluable conduit for KHCC staff to engage health consumers throughout the state in unprecedented discussions about important health reform issues.
- Allowed KHCC to increase its knowledge of existing organizations and networks dedicated to similar health reform issues.
- Increased public awareness about KHCC's mission and work.
- Helped KHCC further establish solid working relationships with diverse organizations throughout the state.
- The Community Conversations resulted in an increase in KHCC membership.
- These new KHCC members have since expressed a vivid interest in other KHCC activities and have become involved with KHCC, including writing letters to the editor on important health issues to their local newspapers and providing input related to KHCC's advocacy priorities.
- Since the Community Conversations began, KHCC has been contacted by numerous organizations and individuals throughout Kansas requesting presentations from KHCC related to health policy and the 2008 legislative session.
- KHCC staff now feels confident that they have connected with a strong and dedicated network of Kansans personally invested in health reform issues and eager to become involved in addressing policy issues as the 2009 Legislative Session approaches.
- KHCC's grassroots outreach has been strengthened.



themselves. To date, we have trained more than 60 people as Community Conversation leaders, and additional training sessions are being planned.⁶

Thus far, hundreds of people have participated in Community Conversations, which are continuing in all three states. Our local partners report other tangible benefits, including wider awareness of their organizations and increased visibility and credibility as a state leader on health reform. The Community Conversations have allowed them to connect with affinity groups (service organizations, faith-based groups, unions, etc.) that do not have health care as a primary focus. This allows our partners to tap into and develop a growing network of energized citizens who are interested and engaged in the question of health care reform. In addition, some of our local partners (notably MHAP in Mississippi) have started applying dialogue techniques and lessons learned from the Community Conversations in some of their other projects.

"Real health care reform cannot happen without effective consumer engagement involving diverse consumers. For many years, consumer advocates have sought ways to reach out beyond our ranks of committed activists and engage ordinary people in shaping health care reform. The Voices for Health Care project has given us a set of tools — including the 'community conversations' — that involve participants in dialogue (not debate) on values and trade-offs and encourage people with diverse viewpoints and experiences to find common ground — and enable us to share diverse consumer views with decision-makers."

Cathy Levine, Executive Director, UHCAN Ohio



Step 5: Online Dialogue

In November 2008, *Voices for Health Care* launched an interactive website (voicesforhealthcare.org) that invited individuals to engage the issue of health care reform online. In addition to extending the dialogue to a larger group of Americans, this portion of the project aimed to provide further insight into the potential and limitations of online dialogue as a means of civic engagement, especially when compared to face to face dialogues.

Overview

Special effort was made to recruit participants from the target states, through each state's local partners and building on the lists of participants from previous elements of the project. In addition, people were invited to attend using advertising and outreach through websites, affinity groups, health care blogs and social networking sites like Facebook. More than 550 people participated in the different phases of the Online Dialogue: slightly more than half from the target states and the rest from 40 other states across the U.S.⁷ These participants represented a wide range of ages, incomes and political leanings.

Online Dialogue produces different kinds of insight compared to those reached through Choice-Dialogue. As a self-selected group, online dialogue participants cannot be considered a representative sample, and they are more likely to have some pre-existing interest in and familiarity with the issue. This was true of *Voices for Health Care* participants, who were disproportionately female (75%), liberal (60%), were more likely to work in health care fields and had higher levels of education than found in the general population. However, their conclusions are an important reflection of

6. In some cases, setting up Community Conversations proved more challenging for local partners than they initially expected. The length of the sessions (2 ½ hours) struck some prospective leaders and participants as too long, and it was occasionally difficult to get people to agree to host a meeting and to sign up to take part. We are currently working with our local partners to develop an additional Community Conversation format that will allow the option of conducting shorter and more focused dialogues where this better meets community needs.

7. Only Alabama, Delaware, Maine, the Dakotas, Vermont and Wyoming were unrepresented.

a subset of Americans who are especially engaged in the question of health care reform. Not only are these people who are likely to show up and weigh in during public forums, they are also people in a position to help make change happen in their communities.

Visitors to the *Voices for Health Care* website were presented with two steps: a “Choice-Book” that explored possible approaches for health care reform, followed by the option to take part in a moderated small-group online dialogue.

1. “Choice-Book”

The first phase of the dialogue asked participants to complete an online “Choice-Book” that drew on material from our Choice-Dialogues. The Choice-Book was designed to:

- Allow participants to learn about the current state of health care and the need for reform;
- Describe several alternative possible approaches to health care reform so that participants could carefully consider various aspects of each approach;
- Allow people to make choices and tradeoffs based on what is important to them.

The Choice-Book took about 30 minutes to complete, and could be completed either all at once or in several sittings. Four possible approaches to health care reform were outlined in the Choice-Book, each based on one of the Choice-Dialogue scenarios (see sidebar above). As in the Choice-Dialogues, participants were asked to rate each one on a scale of 1-10 (10 being best) first at the beginning of the Choice-Book and then again once they had received more information about the choice and some of the key tradeoffs involved. (See chart on page 33.)

CHOICE-BOOK SCENARIOS

1. **SHARED RESPONSIBILITY:** Employers, the government, insurers and health care providers will all share responsibility for strengthening the current employer-based insurance system.
2. **MORE PERSONAL RESPONSIBILITY:** Everyone in the state will be required by law to have health insurance: at a minimum, a high-deductible plan that covers basic preventive care plus the kind of extraordinary medical expenses that cause financial hardship.
3. **PUBLIC HEALTH INSURANCE FOR ALL:** Everyone will get health insurance through a state agency that acts as a single insurance company for all under 65.
4. **COORDINATION AND PREVENTION:** How people get health care in the state will be reorganized to create a coordinated, well-managed system of care.

Online Dialogue participants were similar to Choice-Dialogue participants in their respective ranking of the four scenarios — as we saw in the earlier Choice-Dialogues, public health insurance for all was consistently ranked at the top (or tied for first), with coordination and prevention a close second. Many of respondents' top priorities at the end of the Choice-Book process also tracked those of Choice-Dialogue participants. In particular they supported:

- Coverage that cannot be cancelled because of illness or pre-existing conditions;
- Protecting people from being financially ruined by medical bills;
- Comprehensive care for all children;
- Spending more on preventive care;
- Electronic record-keeping;
- Encouraging and rewarding healthy lifestyles;
- Placing limits on the profits of health care insurance companies.

It is not surprising that Choice-Book respondents supported these ideas — these are points that Choice-Dialogue participants agreed to with little controversy and polls indicate that the general public widely supports them as

well. They may be best considered “low-hanging fruit” for health care reform. (And in fact the Obama administration has included many of them on their list of priorities for health care reform moving forward.)

There were several important distinctions between the Choice-Book conclusions and those reached in the Choice-Dialogues:

- While there was general agreement on the priorities listed above, there was less consensus among Choice-Book respondents when it came to the more difficult conclusions reached by Choice-Dialogue participants, such as evidence-based medicine and requiring everyone to pay something for their own care. These were points that required considerable working through in the Choice-Dialogues. The Choice-Book respondents did not have the same opportunity to work through and did not get to the same level of common ground.
- Choice-Book respondents tended to rate all approaches *lower* after they learned more about them. By contrast Choice-Dialogue participants typically rated scenarios higher at the end of the day. In part this is likely due to the much shorter time Choice-Book respondents had to consider these questions (it took about 30 minutes to complete a Choice-Book

PARTICIPANTS' EVALUATION OF SCENARIOS					
Choice-Dialogues			Online Choice-Book		
	Initial mean	Final mean		Initial mean	Final mean
Shared responsibility	5.4	6.1	Shared responsibility	5.2	4.3
Increasing personal responsibility	4.4	5.6	More personal responsibility	4.0	3.7
Public health insurance for all	6.5	7.6	Public health insurance for all	6.5	6.1
A coordinated wellness system	6.2	7.3	Coordination and prevention	6.6	6.1

Participants were asked to rate each scenario independently on a scale of 1-10, 10 being totally positive and 1 being totally negative. The initial mean for each scenario indicates participants' average rating of the choice at the start of the Choice-Dialogue or Choice-Book; the final mean represents participants' average rating of the same scenario at the end.

vs. 8 hours to participate in a Choice-Dialogue). This meant that Choice-Book respondents had enough time to take in the downsides of each approach, but not enough time to come to terms with those downsides. Even more important, unlike participants in the face-to-face dialogues, Choice-Book respondents were not able to set conditions, mix and match elements of the different approaches or engage in dialogue about them. This suggests that the public may be more open to a proposal once they have had an opportunity to make changes and establish conditions than if they have to give a straight up or down vote on an entire package. Not only does this make the specifics of a given proposal more responsive to public priorities, it also may allow the public to feel a greater sense of ownership for the approach and greater willingness to accept its implications.

- Choice-Book respondents remained polarized along political lines. Over the course of the Choice-Dialogues, participants of all political beliefs found significant common ground. For instance, at the end of the day

more than two-thirds of conservative Choice-Dialogue participants (68%) supported changing to a publicly run health insurance system — a change in perspective that many of these participants themselves found surprising. No such shift occurred in the Choice-Book process — at the end conservative respondents rejected all four scenarios, while liberal respondents strongly supported the two involving a public system.

Future online engagement efforts will need to explore ways to balance the ease and wide accessibility of a shorter “referendum” format with giving people the time to work through tradeoffs, establish conditions and look for common ground.

2. Dialogue Groups

Participants who completed the Choice-Book were also offered the opportunity to participate in a week-long moderated small group dialogue. These participants worked in small groups to identify and discuss the issues they felt should be part of health care reform and search for

common ground. The process employed the DialogueCircles.com® platform, which is designed to facilitate online dialogue and deliberation. Participants could post and read comments in their group any time day or night; they also used daily summaries from their group's moderator to keep track of what was being discussed. Participants could visit the other groups and observe their discussion (but not post). Throughout the dialogue a number of participants reported that they had visited other groups and brought back ideas and comments they had observed there.

More than 150 people took part in this phase of the online dialogue. They were placed into 6 small moderated groups, which were randomized so that they were as diverse as possible in terms of gender, age and income. Each group dealt with three main questions:

1. How can we get more people health care coverage?
2. How can we make health care more affordable?
3. Who should pay for health care and how?

The groups were asked to discuss each of these issues and identify as many areas of common ground as possible. They were also free to address any other issues that they felt were important to the topic of reforming health care. Across the six groups, several common themes emerged:

- Public health care for all;
- Restrict — or do away with — private insurers;
- Expand care and protect individuals' ability to choose treatments;
- Emphasize healthy living and prevention;
- Everyone pays.⁸

While these conclusions echoed many of those that emerged during the Choice-Dialogues, the tone of the online conversations was quite different. Participants spent relatively little time working through the tradeoffs and downsides involved in a publicly run system. Many began the dialogue already supporting a public system and found their support strengthened by the process. Those who objected to a public system were a smaller minority than in the Choice-Dialogues, and they had only a limited impact on the conclusions reached by the others.

There appear to be two factors at work here, which both raise interesting implications for online dialogue as a mode of public engagement.

As noted earlier, online dialogue participants were not a representative sample: participants were on average more affluent, more liberal and more likely to work in a health-care profession than the representative samples who took part in the Choice-Dialogues. With a narrower range of voices at the table, participants were less likely to hear perspectives that were new or challenging and more likely to have their existing opinions confirmed. One important challenge for online

dialogue is to find better ways to bring a wider range of participants and viewpoints into the conversation.

The less intense format of online discussion did not allow participants to come to terms with and work through tradeoffs to the same degree. Conversations that unfold over the course of several days with people dropping in and out lose some of the urgency and rich back and forth that occurs in the intense few hours of a Choice-Dialogue. And the relatively narrow bandwidth of text-based communication, which is still predominant online, cannot convey the non-verbal cues and emotional layers that occur in face-to-face communication. This makes it easier for people to avoid hard choices or unpleasant tradeoffs. As the bandwidth of online communication increases in coming years it may become possible to reduce this limitation, and finding ways to do that will be another important challenge for the further development of online dialogue.

The *Voices for Health Care* online dialogue suggests that an online format has some strengths and drawbacks as a means for public engagement. Participants overwhelmingly described the online dialogue as a positive experience, saying they appreciated the opportunity, had learned a great deal and that they would like to take part in similar conversations in the future. It is an extremely effective tool for raising awareness, and it allows people who do not have time to participate in face-to-face events to become more involved. At the same time we need to find better ways to bring together a wider range of viewpoints, and to help people work through tradeoffs and find common ground across political lines while working in an online medium.

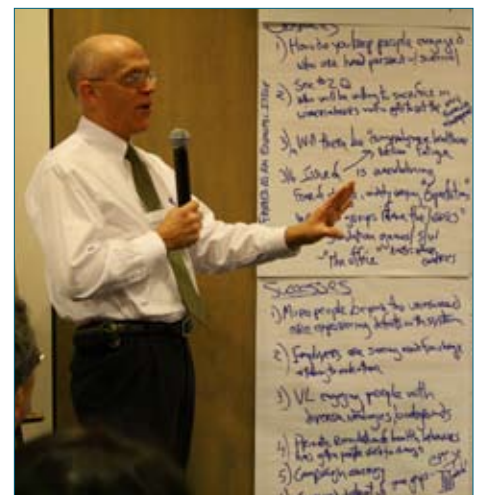
Capstone Conference

On December 8th and 9th 2008, an invited group of about 30 state and national health care leaders and policy experts, advocates, media representatives, civic engagement experts and foundation officers met in Washington D.C.. Conference participants began by reviewing the results of *Voices for Health Care* and went on to identify the most important obstacles and success factors involved in building public support for significant, sustainable health care reform.

The conference took place at an especially turbulent juncture, only six weeks before the inauguration of Barack Obama and just as the enormous scale of the U.S. economic crisis was becoming more fully apparent. Participants were simultaneously hopeful that the new administration would be able to make use of the lessons they had learned about better ways to engage the public to advance major health care reform, but also questioning whether nation's financial situation would help or hinder the push for such reforms.

Identifying obstacles and success factors

In light of the findings of the *Voices for Health Care* project and their own experiences, participants began by



8. Two reports provide a more detailed discussion of the Online Dialogue findings, including complete quantitative results. See "Voices for Health Care Online Dialogue - Choicebook Summary Report" and "Voices for Health Care - Online Dialogue Summary Report." Both are available at voicesforhealthcare.org and www.viewpointlearning.com/publications/reports.shtml

identifying what they saw as the most important obstacles and success factors for engaging the public and building support for significant health care reform.

Key Obstacles

- Complexity of the issue;
- Fairness (different views of what is fair, what constitutes equitable access, etc.);
- Scale: how to expand this dialogue, connect it to others and reach a scale that can have impact;
- Integrating this work into the policy process;
- Getting past the special interests and creating a place for the unorganized public in policy deliberations.

Key Success Factors

- Bringing many different stakeholders to the table;
- Reducing confrontation;
- Encouraging collaboration of groups across (former) silos;
- Recognizing that the issue has consequences across all sectors;
- Organized consumer health advocacy groups able to connect with policymakers combined with independent credible voices (like Health Policy Institute of Ohio, Kansas Health Institute, etc.);
- Public feeling that they have a voice and that their voice makes a difference, combined with policy makers who want to hear the public/consumer voice and see that it adds value to policy making;
- Better public education — including using new media and technologies — that covers both the complexity of the issue and process of reform.



Defining strategic goals/initiatives

Much of the remainder of the conference focused on defining a set of strategic goals or initiatives that would do the most to build public support for significant, sustainable health care reform at a national as well as state level. Each goal centered on using civic engagement to break through gridlock, and participants worked in small groups to develop preliminary action plans to achieve those goals.

The conference began by brainstorming what should be kept, or dropped or created in how we currently engage the public and build public support for health care reform. Next participants were each asked to come up with a strategic goal or initiative they thought would do the most to engage the public and advance significant reform. Participants then compared notes with each other in a series of paired conversations. After that the conference worked together to group and prioritize those ideas into a set of broader strategic goals. The result was three strategic goals, each of which combined a number of the ideas participants had suggested:

Goal 1: Cool tools — information people can use

- Create a credible intergovernmental health care information resource that is searchable, interactive and widely accessible through schools and local libraries.
- Establish a “consumer union” providing information on evidence-based medicine both in print and online.
- Set up a national social index for health with state dashboards listing status on broad range of health-related indicators (including social determinants of health) and regular reporting of these indicators.

Goal 2: Build awareness and a sense of urgency for personal action

- Campaigns to encourage people to adopt healthier behaviors and to take actions that improve personal or community health. Include use of media and community-based activities.
- Long-term mass media project (including print, billboards, radio, TV, on-line). This effort would raise awareness of barriers to health care, bust stereotypes about the uninsured and the chronically

ill, and help people connect the dots about how we're all paying for health care for the uninsured and the underinsured.

- Entertaining and educational TV programs about the messy process of health care reform.
- An interactive experiential process like a video game that allows people to learn what it is like to be uninsured and have to make tough health care choices.
- A “Health Care Day” (modeled after Earth Day) to bring health care issues to life on a local level, using a specialized curriculum and giving people the opportunity to learn by sharing their stories.

Goal 3: Working through on a national scale to uncover common ground

- A national dialogue supported by a broad coalition of leaders and experts in which tens of thousands of Americans participate in a deliberative experience that allows them to work through choices and tradeoffs. These deliberations would be focused on overall health, the social determinants of health and their impact on outcomes and would help connect the dots between health care and other important policy

areas. The results of these dialogues would inform the national strategy for reform.

- In conjunction with the national dialogue, bi-partisan groups of leaders and congressional delegates conduct a nationwide “listening tour.” Include sessions that bring decision makers together with members of the public who had participated in the dialogues to work through strategic choices and their implications.
- A 3-5 year campaign to scale up the dialogue by fostering and institutionalizing two-way communication between leaders and the public on how to fix the health care system. This would involve both the media and many different levels of leadership. In addition, the institutions and practices developed in this process might be applied to engaging the public and working through other issues in future — building a stronger ongoing capacity for civic engagement and improving governance.

In the process of developing these strategic goals, three overarching themes emerged, all of which would be necessary to advance health care reform and would be part of any successful initiative:

- Setting an explicit national goal for health care reform as a foundation for public engagement similar to the goals of the space program in sending a man to the moon.
- Connecting health care reform with economic recovery in the minds of the public and local, state and national leaders.
- Developing a coordinated system of leadership entities working across goals.

Once the conference had defined these strategic goals, participants went on to develop preliminary action plans to realize each goal.

At the end of the conference, participants agreed on a set of next steps:

- Establish a forum at the *Voices for Health Care* website where participants can continue the work begun at the conference. This includes posting materials including presentation tools participants can use for briefings and discussions as well as more detailed information on other deliberation and dialogue efforts around health care reform.
- Capstone conference participants were invited to write and submit articles on their experiences for publication in the *National Civic Review*.
- The Kansas Health Consumer Coalition, UHCAN Ohio and the Mississippi Health Advocacy Program are pursuing opportunities to promote and build on these efforts in their own states, working with some of the other participants at the Capstone Conference.

These organizations are also working to bring together a number of state policy groups from around the country to look at common work that needs to be done. KHI has already published a detailed article on their web site.⁹



9. The article, “Kansans Ready for Real Reform, Project Shows,” can be found at <http://www.khi.org/s/index.cfm?aid=1828>

- Provide the results of the *Voices for Health Care* project to the Obama administration to help in their efforts to engage the public to advance significant health care reform.

Additional Next Steps

The formal activities of *Voices for Health Care* will continue through the first half of 2009. In addition to the steps arising out of the Capstone Conference, remaining work on the project will include:

- A Stakeholder Dialogue (bringing together leaders with some citizens from the Choice-Dialogues) is planned for Kansas in April 2009. Stakeholder Dialogue participants take the citizens' conclusions from the Choice-Dialogues as their starting point and work to build on them, find common ground, and further develop a set of practical steps and action plans.
- Community Conversation are continuing in all three states. In particular:
 - Alternative Community Conversation materials are being designed. These materials will give local partners the option of conducting shorter and more focused dialogues where this better meets community needs.
 - Additional training sessions are being planned for Community Conversation facilitators in Ohio.
- Additional communications and outreach activities are being planned especially in Mississippi.



Conclusions: Implications for Leaders

There appears to be significant momentum for health care reform at both the state and national levels, but to be sustainable any reforms will need to reflect public values and be able to win public support. And while there are great hopes for what might be accomplished this year, this year is unlikely to be the end of the story. There will be an ongoing need to take the next steps in reform and to build and maintain public support for change over time. This research holds important lessons for leaders who want to build public support for significant health care reform both this year and beyond.

As the Obama administration pushes forward with its reform agenda, and states continue their health care reform efforts, these findings help illuminate where the general public can be prepared to go, given effective leadership and time to connect the dots and work through the implications of proposed reforms. Just as important, this research suggests how leaders can help advance and accelerate this learning process, and build broad-based public support for change.

Understanding the public's learning curve

More than 50 years of research, led by Viewpoint Learning Chairman Daniel Yankelovich, has demonstrated that public opinion on complex issues evolves in stages. From an initial stage of highly unstable “raw opinion” the public moves through a series of steps in which they confront tradeoffs, establish priorities and reconcile choices with their deeply held values. This process can take anywhere from days to decades. Only when the public understands and accepts responsibility for the consequences of their views can we say that this “learning curve” is complete.

In general, the public moves through three stages as it moves along the learning curve.

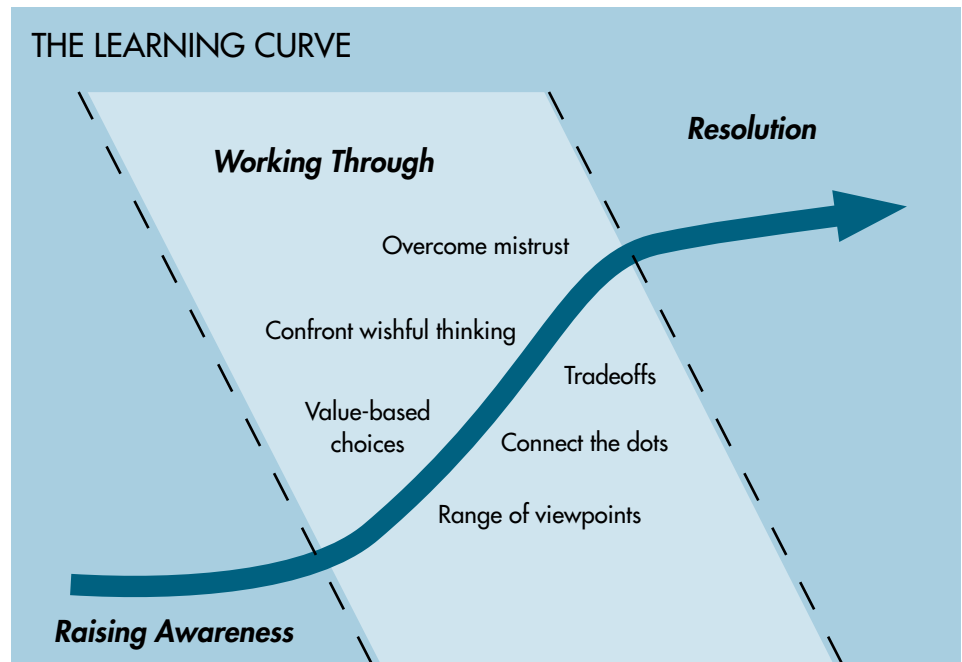
1. **Building Awareness.** The public becomes aware of an issue, begins to take it seriously and to develop a sense of urgency about addressing it.
2. **Working Through.** The public begins to confront hard choices, considers the pros and cons of proposed actions, and struggles with tradeoffs. This is the stage where issues can bog down as people struggle to reconcile their positions on issues with their fundamental values and wrestle with

denial and wishful thinking. The public can move through this process more quickly if they are able to consider specific choices and if they have access to a range of viewpoints and perspectives.

3. **Resolution.** The public reaches a considered judgment. They choose a course of action and are prepared to accept its likely consequences.

Americans' understanding of the issues surrounding health care reform has been advancing along this learning curve over the last several years. Public awareness and concern has grown as health care costs continue to rise, the number of uninsured leaps upwards, bankruptcies due to medical expenses become more commonplace, and Americans (even those with good coverage) grow more anxious about the reliability and affordability of their coverage. More and more Americans have been personally affected by the growing crisis in our health care system, if not themselves then through family or friends. And these concerns have been further magnified in recent months by mass layoffs and an unraveling economy, and by the growing political debate about the need for significant health care reform. The press of events over the last few years means that the first phase of the learning curve — raising awareness and building a sense of urgency — is essentially complete. More and more Americans are now beginning to move into the second phase of the learning curve, coming to grips with and working through the tradeoffs involved in any course of action.¹⁰

Certainly not every individual and group is at the same stage on every aspect of the issue. But these dialogues indicate that Americans are impressively consistent on a range of conclusions.



Leading a public learning process

To advance and accelerate this learning process and build broad-based public support for change will require engaging the public on its own terms. **This involves understanding how people process information, the steps they take as they work through the issues, and how to sequence the conversation in a way that keeps pace with the public's learning process.**

The *Voices for Health Care* research suggests a number of steps — and a sequence of steps — that leaders and others can take to build public trust and support for significant health care reform:

1. Begin with common ground

These dialogues identified wide areas of common ground among the public and leaders in three very different states. Our work in other states has found similar results. These were areas of agreement that people reached fairly quickly. They represent promising starting points — “low hanging fruit” — where leaders can begin building broad-based public support for change:

- **Improve wellness, prevention and personal responsibility.** Participants overwhelmingly supported improving access to preventive care like screenings, vaccinations, and disease management, as well as other measures aimed at keeping people healthy in the first place. There is also very strong support for giving people better health education and other resources and encouraging them to take more responsibility for their own health and wellbeing.
- **Make sure all children have access to good care.** Participants emphasized that good care is especially important for children — it will pay off in improved health throughout the child's life. Support for improving health care for children cuts across virtually all demographic and political categories.
- **Improve health care delivery** by relying on providers like nurse practitioners to provide routine care and finding ways to better coordinate care delivery. Most felt that today's system focused more on treating disease than treating the whole person; they believed a more cooperative, patient-centered approach

¹⁰ We have observed this shift in several of our own projects, and recent polls indicate that Americans are increasingly aware of the complexity of the issue and the hard choices involved. See for instance Kaiser Family Foundation/Harvard School of Public Health Poll, January 2009: “The Public's Health Care Agenda for the New President and Congress.”

among medical professionals would improve patient care.

- **Provide incentives to increase the number of providers** and attract more young people into health care professions.
- **Adopt medical ID cards and electronic record-keeping**, on condition that strong privacy measures are in place. Most believed that this would improve quality and continuity of care, help make the system simpler and more efficient, reduce mistakes and prevent people from abusing the system. They agreed that privacy must be protected, but even those most concerned about privacy concluded that the benefits of medical ID cards and electronic record keeping outweighed their drawbacks.
- **Stronger regulation of the private insurance industry**, for example by requiring that insurers cover everyone regardless of health status or pre-existing conditions. It is important not to underestimate the intensity of public anger where insurers and drug companies are involved. While many people recognize the political difficulty of doing so, there is a great deal of public support for taking a strong hand with insurance companies, even to the extent of capping their profits to help ensure that more dollars go toward health care.

Starting with a discussion of reforms like these, where there is already strong public support, can build momentum for change and open the door to a discussion of other issues that are more difficult. Building on common ground is a way to increase trust and move toward sustainable solutions, while building on wedge issues tends to reinforce polarization and gridlock.

2. Use the public's language/ framework

Citizens and experts often approach issues with different assumptions, frameworks and terminology — and when two parties use the same words to mean different things, misunderstanding and mistrust can result. In the course of the dialogues we noted some examples of terms where the public's assumptions and definitions differ from those of experts:

- **“Basic” coverage.** In general, most Choice-Dialogue participants took “basic” coverage to mean something that experts would describe as fairly comprehensive, including preventive care, dental, vision, and mental health, as well as procedures necessary to preserve life and health. More restricted plans (like high deductible plans or those that cover only preventive care and catastrophic illness or injury) did not fit this definition of basic — participants saw them as too limited. When talking about basic coverage or care, it is important to define these terms clearly — each audience may be making very different assumptions about what the term means.
- **Choice.** Experts sometimes interpret the public's stated desire to “maintain patient choice” as an unrealistic expectation that everyone have access to every provider

and treatment on demand. However, our participants took a more balanced view. Rather than asking for unlimited services, most wanted a more general assurance that they would always have a say in important decisions about their own care. If they disagreed with a provider about treatment, they should be able to seek a second opinion; if they disliked a particular doctor — especially a primary provider — they should be able to find another one.

- **Universal coverage.** The term “universal coverage” was a roadblock for some participants at first. While they wanted everyone to be covered, many assumed that a “universal” system was of necessity a single payer public system and they were not yet prepared to take that step. To avoid confusion, it is best to focus on the point that everyone should have affordable health coverage. Whether or not that coverage should be publicly provided is a separate and subsequent conversation.

3. Sequence the conversation

The public follows a pattern as they think through health care reform and how to create the kind of system that would better meet their needs. Certain issues came up repeatedly, and people worked through them in consistent ways. What we saw in



all of the dialogues is that people need to work through certain questions before they are ready to consider others — each step prepares them to take the next. Advancing reform measures before the public is ready to accept or even consider them is likely to backfire, even if the proposal is one the public might have ultimately supported given time and effective leadership. Instead, this research suggests a sequence of questions that leaders and others can use to structure the conversation in a way that advances the public's learning process:

• ***Is it important to cover everyone?***

Most people begin to think about health care reform by focusing on their own situation. Giving people the opportunity to hear a wide variety of other experiences allows them to see their individual problems as part of a larger picture. It also encourages them to shift from a consumer to a community perspective.

Understanding that we are already paying to provide care for the uninsured was a major “aha” moment for participants in almost every dialogue. This provided a very practical, economic rationale for extending coverage to all and allowed participants to see this as something that that could benefit all Americans (rather than something that helps some people at others' expense). Helping the public understand how the costs of health care are distributed in the current system will be a key part of any discussion of extending coverage.

• ***Can we fix or build on the current system?*** Once people conclude that it is important to cover everyone, the next question is how to create a system that gives everyone access to high-quality, portable and affordable coverage. Most people's first preference is to do this by building on the current system, which works well for many Americans and offers competition and choice.

As people in the dialogues worked through what might be possible, including variations on the “shared responsibility” approach currently being implemented in Massachusetts and considered by other states, they gradually concluded that this would not do enough to fix the problems of the current system. Several factors came into play as they worked this through. Most did not believe that “shared responsibility” approaches would realistically make coverage affordable for everyone, and they worried about the impact on business. More fundamentally, they were concerned that these approaches did not do enough to control costs. Many were troubled that a private insurance system diverts health care dollars to marketing, overhead and profit. And while many hoped to maintain a central role for the private insurance system, they were dismayed at how complex and cumbersome those approaches would be. Across the dialogues, we saw a growing sense that adapting the current system would not be enough to provide the kind of coverage people wanted — something different would be needed.

• ***What role should government play?***

Approaches that build on the current employer-based system usually also include a stronger role for government.



Most participants, for example, strongly supported stricter regulation of insurers and state incentives to increase the number of providers. As they worked through the limits of fixing health care by building on the current system, however, participants began to examine the benefits of moving further toward a publicly run health insurance system. What initially appealed to them about a public system is that it could do a better job of covering everyone regardless of circumstance, and it would not be driven by profit. It would ensure that coverage could not be taken away and was completely portable, and it would have greater bargaining power with drug companies, doctors and hospitals. In addition (and perhaps most important) many liked its simplicity — not only would it have lower administrative and overhead costs, it was simply easier to understand.

At the same time most participants had major concerns about a single-payer system. Much of the remainder of the dialogue focused on working through each of these concerns. The following concerns and conclusions were consistent across all dialogues:

○ ***Concern: A public health insurance system would limit people's choice of providers and treatments.*** One key insight for participants was that ALL health insurance systems limit people's choice in some way. The real issue was how to establish limitations that mesh with people's fundamental values: e.g. that people must have a say in key decisions that affect their lives and wellbeing; that decisions about treatment should be based on what is likely to produce good outcomes, not on cost; that people should be encouraged to take responsibility for themselves. So, for example, participants in all dialogues concluded that it was essential that

people be able to choose their primary provider. And on the question of choice of treatments, they supported evidence-based medicine, but only on condition that they and their doctor could appeal decisions of a medical review board.

- *Concern: A public health insurance system would mean the loss of good private coverage that some now enjoy.* Many participants were initially concerned that a public system would force people who currently have good coverage to give that up for an inferior public plan — something that all agreed was unfair. Participants in all states concluded that a two-tier health insurance system was a potentially promising way of addressing this problem — in such a system the state would provide basic coverage to everyone while employers could offer supplemental coverage to employees (or individuals could purchase it themselves). In their view, such a system would reward hard work, preserve choice and provide some assurance that those currently enjoying good benefits would not end up with something worse. In addition, it would encourage employers to stay in the game and compete for employees by offering supplemental benefits.
- *Concern: A public system would cover people who don't work, illegal immigrants, and other "freeloaders."* Some people felt it was a moral imperative to cover everyone. Others, however, did not like the idea of covering "undeserving" people who might take advantage of the system. As they worked through this point, many were surprised to learn that most of the uninsured are working or in working families, and this fact led them to reconsider some of their assumptions about who is uninsured and why. In addition, they began to



consider the cost of not covering everyone, and most concluded that it was to their advantage to cover everyone and keep overall health care costs lower. Most ultimately concluded that if the system was set up so that everyone living in the state pays in (e.g., through a sales tax dedicated to health care), then they would support all state residents (citizens or not) getting the benefit.

- *Concern: A public system would cost too much.* Understanding how costs are distributed in the current system — through higher taxes, lower wages, increased cost of goods and services, insurance premiums, the cost of care and so forth — was key to working through this point. Participants began to realize that they are already paying dearly for a system that is failing to meet their needs. Some believed that overall costs would be lower in a single-payer system; others were not convinced that they themselves would pay less, but they concluded that they would rather pay more if it meant they would get a system that works.
- *Concern: A public system would dramatically expand government's role in running health care.* As they considered this point, many participants believed that a state

system might be inefficient and bureaucratic, but they had too many stories of the inefficiency (and sometimes cruelty) of the current system for this concern to gain much traction. They also concluded that government is the only entity big enough to provide coverage to everyone regardless of income or circumstances. In the end most were prepared to have government take on this role, on condition that there would be strong oversight and accountability about how funds are spent and to protect against waste and abuse.

As people worked through these concerns with each other, in each dialogue we saw growing support for a publicly run single-payer health insurance system, and widespread openness to seeing this put in place on a national level. (The Choice-Dialogue conversations focused on state-level reforms, but every group noted that health care reform would ultimately have to be dealt with at a national level.) This support was realistic and thoughtful: most expected some inefficiency and higher costs, but they felt a public system was the most practical way of getting the kind of health care system they wanted to see. By the end of

the dialogue support for moving to a publicly run health insurance system was strong across all demographic groups — including majorities of conservatives as well as liberals, plus all age, education and income groups, as well as people with and without insurance.

It is important to note that these findings do not indicate where the general public is today. Rather they show where people are likely to go in the future given the time to connect the dots and work through the implications of proposed reforms — as the representative random samples of the public who participated in these dialogues were able to do. The pattern described here was consistent in each dialogue, and it is also very similar to patterns we have seen in health care dialogues in other states. As people work through the realities and limitations of building on the current system, interest in and openness to a public health insurance system increases.

Even if a single payer public health insurance system is off the table at present politically, it likely will come onto the table as the public moves along the learning curve. Already polls indicate that the public is growing more open to the idea (in a February 2009 poll, 59% of respondents favored a system where the federal government provides health

insurance for all Americans).¹¹ However, this support is probably fragile, as many (perhaps most) Americans have not yet fully worked through the concerns outlined above.

The Obama Administration has suggested that Americans should have the option of signing up for a public plan similar to that offered to government workers and members of Congress. If this option is made available, there is likely to be considerable public interest.

• **How should we pay for it?** In the course of the dialogues, participants came to understand that they themselves pay for the health care system in many different ways— through taxes, wages, the cost of goods and services, insurance premiums, the cost of care and so forth. As this came into clearer focus, many began to question why they were paying so much for a system that did not meet their needs or the needs of their community. Instead of continuing to pay for such a flawed system, they said, they were willing to pay more to get a system that worked better. Most also agreed that everyone in the state has a stake in a better health care system and everyone should make a contribution to paying for it.

We found that once people have a chance to work through the issues and tradeoffs, and to define the health care

reforms that make sense to them, they become more realistic and responsible and more willing to pay for those reforms. In general we have found that the stereotype of a public that wants it all but doesn't want to pay for it only applies to a public that has not had a chance to work through the choices and their consequences.

In this project Choice-Dialogue participants were not asked to indicate exactly how much more they would be willing to pay. If that amount is insufficient to provide the kind of system they outlined, it is not clear how they would resolve the tradeoff: by paying more for more generous coverage or by scaling back what is offered? In other projects (conducted in Arizona and California) where we were able to give participants more detailed cost information, we found that participants balanced what they wanted the state to provide with what they would be willing to pay, but that balance was different in each state. More research is needed to fully understand which way Americans would go on this question.

4. Reforming health care and building trust in a down economy

The economic turmoil of the last year has also been reflected in this project. While the Choice-Dialogues took place before the worst of last fall's financial meltdown, participants were already expressing concerns about job losses, falling home prices and a weakening economy. As the extent of the economic downturn became clear last fall it had a powerful effect on attitudes, and by the time of our Capstone Conference, it was central to the conversation. We have noticed generally that the scope of the financial crisis and economic downturn seems to be pushing the public past wishful thinking to



11. CBS News/New York Times Poll. January 11–15, 2009.

some degree, making them more willing to consider hard choices and rethink expectations. At the same time, the abuses of public trust uncovered by the financial collapse have added to public skepticism and cynicism. Building public support for significant health care reform will also depend on rebuilding public trust. This will require transparency and a two-way conversation:

- *Transparency.* The public does not expect leaders to provide all the answers — in fact they are increasingly suspicious of easy answers. Instead they want leaders to provide an honest, straightforward assessment of the challenges and tradeoffs. And they want to be assured that their interests are being represented.

Early steps by the Obama administration to create a more open reform process and to engage the public around these issues are a promising start in this direction. Thus far, however, these efforts have focused mainly on raising public awareness and developing a sense of urgency about reform (the first stage of the learning curve). But it cannot stop there: the public must be included and engaged in the search for solutions. The next step is to help the public to work through the difficult choices and tradeoffs involved (stage 2 of the learning curve), along the lines of what we saw in these dialogues.

- *A two-way conversation.* Americans want to go beyond simply ratifying a health care proposal and paying the bill. Instead, they want opportunities to pitch in, make themselves heard and help shape the system they will live in. They expect leaders to give people the chance to wrestle with tough choices and take citizens' viewpoints seriously. Leaders who work to provide those opportunities and actively solicit public input will find a public ready and willing to make serious choices.

The importance of engaging the public

Serious effort to engage the public is not required for every policy issue — but there are certain circumstances where it is indispensable:

- *When an issue is important to people's lives.* This is certainly the case for health care reform. Since many Americans are still generally satisfied with their own health coverage, many may prefer to stick with the devil they know. Without engagement and the chance to work through the reasons for change and the consequences of the alternatives, they are likely to resist change on such an important matter.
- *When sacrifice is required.* Public deliberation is essential when proposed reforms call upon people to accept sacrifices and trade-offs that cost money, cause inconvenience, require changes in behavior, or compromise important values. If people do not have a say in reforms that require sacrifice, they will oppose them. This was part of what led to the downfall the Clinton health care reform.
- *When special interests oppose reform.* Special interests exert their greatest power when the public is indifferent or fearful of change; it takes a strong shove from the public to give political leaders the courage to stand up to wealthy and powerful special interests capable of mobilizing their constituencies overnight and pouring resources into defeating leaders who oppose them.

Health care reform meets all three of these criteria. Engaging the public is essential for these reasons and more generally to bridge the disconnect between leaders and the public that has undermined past reform efforts. This was one of the crucial lessons to be drawn from the



failure of the Clinton health care plan in 1994; we can ill afford to make such a mistake again.

Leaders have many ways of engaging the public — for example through the media, face-to-face, and through local organizations and other intermediaries. In this project, after the Choice-Dialogues, we experimented with two approaches for engaging the public more widely: community conversations and online dialogue.

- The *Community Conversations* demonstrated that members of the public can have a thoughtful conversation — a structured dialogue — about health care reform in a much briefer time than is required for the daylong Choice-Dialogues, and also how convening such community dialogues can provide a range of benefits to civic, advocacy and other organizations.
- The *Online Dialogue* showed again the value of that medium for raising awareness and for allowing those who do not have time to participate in face-to-face events to become involved. And it demonstrated how a dialogue could be structured to work online. But it also underlined the need to bring together a wider range of viewpoints,

and to do more to help people work through tradeoffs and find common ground across political lines in an online environment.

Advancing the dialogue

One consistent finding in these and other dialogues is the importance of moving beyond the like-minded and the usual suspects to engage a wider cross-section of the public. Too often conversations about public issues take place only among those who already agree. These narrower conversations tend to reinforce polarization between different groups, increase the stereotyping of “others” — those who hold different views and make different assumptions — and limit learning.

We have found that in a dialogue (unlike a negotiation) the more diverse the perspectives of the participants, the richer the learning and the more productive the outcome. On issue after issue, we have seen that when citizens are given an opportunity to engage in real dialogue with others from very different backgrounds and perspectives, they think

and act more like citizens and less like consumers. They find surprising amounts of common ground and develop a shared community perspective, and they are ready to make and support big changes to advance the common good.

The *Voices for Health Care* project has demonstrated in microcosm that it is possible to engage the public in a more thoughtful conversation about significant health care reform, and that it is desirable — indeed essential — to do so. And it has demonstrated that the public is open to real change in their health care system once they have worked through the implications and consequences. However it will require a sustained effort to continue to engage the public, move them along the learning curve, and foster broad-based consideration of the hard choices and tradeoffs necessary to bring about a better future for health care. This research provides leaders with insight and tools they can use to lead this essential process and engage the public more broadly to advance significant health care reform.



DATES AND LOCATIONS OF PROJECT ACTIVITIES

Strategic Dialogues

November 8, 2007: Columbus, OH

November 15, 2007: Topeka, KS

January 11, 2008: Jackson, MS

Choice-Dialogues

March 1, 2008: Overland Park, KS

March 15, 2008: Pittsburg, KS

March 15, 2008: Cincinnati, OH

March 29, 2008: Garden City, KS

March 29, 2008: Tupelo, MS

April 5, 2008: Biloxi, MS

April 5, 2008: Greenville, MS

April 19, 2008: Akron, OH

April 26, 2008: Columbus, OH

Interactive Briefings

May 13, 2008: Jackson, MS

June 5, 2008: Columbus, OH

June 6, 2008: Topeka, KS

Community Conversation Training Sessions

June 4, 2008: Topeka, KS

June 7, 2008: Columbus, OH

October 17, 2008: Jackson, MS

Community Conversations are ongoing in all three states

Online Dialogue

November–December 2008

Stakeholder Dialogue

April 3, 2009: Topeka, KS

CHOICE-DIALOGUE: THE METHODOLOGY

Choice-Dialogue methodology differs from polls and focus groups in its purpose, advance preparation, and depth of inquiry.

PURPOSE

Choice-Dialogues are designed to do what polls and focus groups cannot do and were never developed to do. While polls and focus groups provide an accurate snapshot of people's current thinking, Choice-Dialogues are designed to predict the future direction of people's views on important issues where they have not completely up their minds, or where changed circumstances create new challenges that need to be recognized and addressed. Under these conditions (which apply to most major issues), people's top-of-mind opinions are highly unstable, and polls and focus groups can be very misleading. Choice-Dialogues enable people to develop their own fully worked-through views on such issues (in dialogue with their peers) even if they previously have not given it much thought. By engaging representative samples of the population in this way, Choice-Dialogues provide unique insight into how people's views change as they learn, and can be used to identify areas of potential public support where leaders can successfully implement policies consonant with people's core values.

ADVANCE PREPARATION

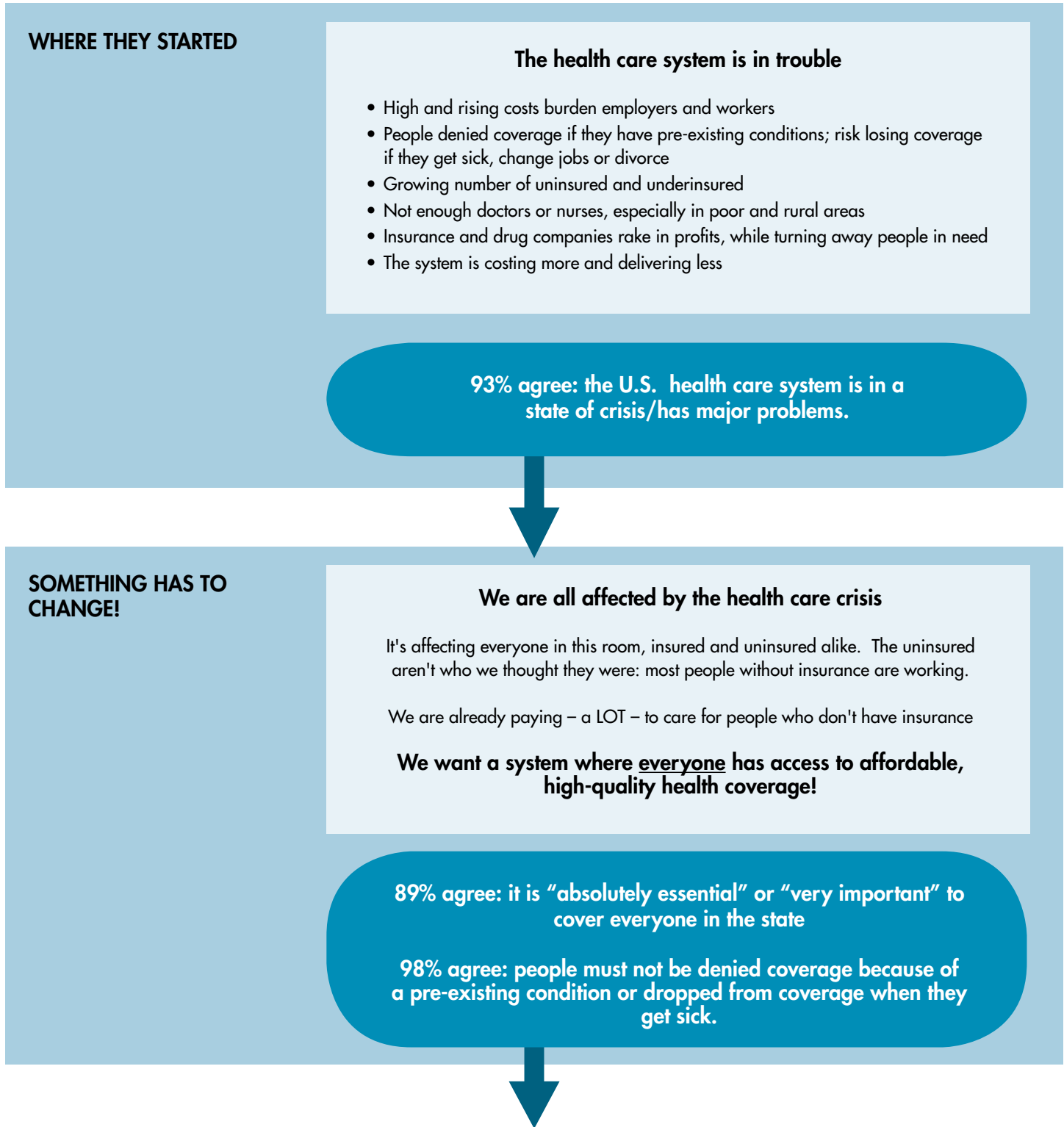
Choice-Dialogues require highly trained facilitators and (above all) the preparation of special workbooks that brief people on the issues. These workbooks formulate a manageable number of research-based scenarios, which are presented as a series of values-based choices, and they lay out the pros and cons of each scenario in a manner that allows participants to work through how they really think and feel about each one. This tested workbook format enables people to absorb and apply complex information quickly.

DEPTH OF INQUIRY

Polls and focus groups avoid changing people's minds, while Choice-Dialogues are designed to explore how and why people's minds change as they learn. While little or no learning on the part of the participants occurs in the course of conducting a poll or focus group, Choice-Dialogues are characterized by a huge amount of learning. Choice-Dialogues are day-long, highly structured dialogues — 24 times as long as the average poll and 4 times as long as the average focus group. Typically, participants spend the morning familiarizing themselves with the scenarios and their pros and cons and developing (in dialogue with each other) their vision of what they would like to have happen in the future. They spend the afternoons testing their preferences against the hard and often painful tradeoffs they would need to make to realize their values. To encourage learning, the Choice-Dialogue methodology is based on dialogue rather than debate — this is how public opinion really forms, by people talking with friends, neighbors and co-workers. These 8-hour sessions allow intense social learning, and both quantitative and qualitative measures are used to determine how and why people's views change as they learn.

CHOICE-DIALOGUES - WORKING THROUGH THE CHOICES

Choice-Dialogue participants followed a similar path as they wrestled with the options for health care reform, and across the board they reached a strikingly consistent set of conclusions. That path and those conclusions are summarized in the following chart.



HOW CAN WE GET THIS KIND OF SYSTEM?

Build on the employer-based system? ("Shared Responsibility")

Pros

- It works for a lot of us - we don't want to change it and end up with something worse
- Offers choice and competition

BUT

- Doesn't cover everyone (e.g. part time workers, the self-employed)
- Fewer employers can afford to offer coverage; fewer employees can afford to pay their part.
- Companies would be more competitive if they didn't have to fund health care cost
- The system is already too complicated

CAN THE STATE DO BETTER?

Pros

- Covers everyone regardless of circumstance
- Reduces burden on business
- Dollars go to health care, not profit or marketing
- Simple & easy to understand

BUT

We have major concerns!

- *Restrictions on choice*
- *People with good coverage could end up with something worse*
- *People who don't work, illegal immigrants, "freeloaders"*
- *Cost*
- *Big government running health care*

A STATE-RUN SYSTEM? THINKING THROUGH THE CONCERNS

What about restrictions on choice of providers or treatments?



Unlimited choice for everyone would be impractical and costly.
What kind of limits on treatments and providers can we accept?

→ *Choice of providers?*

People **MUST** be able to choose their own primary care provider

→ *Evidence-based medicine?*

- Want to focus on treatments that work - doctors and scientists should decide what's covered, not insurance companies

Evidence-based medicine OK **only if** patients and their doctors can appeal decisions and get second opinions

cont'd

**A STATE-RUN SYSTEM?
THINKING THROUGH THE
CONCERNS (cont'd)**



What about people who have good coverage now?

→ *Allow buy-up with a two-tier system?*

State provides basic coverage; employers offer supplemental (or people buy it themselves)

- Protects people with good benefits from ending up with something worse
- Rewards hard work
- Preserves choice
- Encourages employers to stay in the game and compete for employees
- How do we define "basic"?
 - No one should go without treatment because they can't pay
 - BUT we can't provide everything for everyone – people have to take some responsibility

More research needed to clarify how people balance these two values



What about people who don't work or illegal immigrants?

No "freeloaders" - people need an incentive to work

But does it really make sense to leave people out?

- Most uninsured people do work
- Uninsured people cost the system more because they put off needed treatment
- People with communicable diseases must be treated or everyone suffers
- If everyone living in the state pays in, then all (citizens or not) should get the benefit

It's more important to cover everyone and keep costs down than to penalize the "undeserving"



What about cost?

- We're already paying for the uninsured as it is
- A state system may cost less overall because of its greater bargaining power, and because less money is spent on marketing, overhead and profit

cont'd

**A STATE-RUN SYSTEM?
THINKING THROUGH THE
CONCERNS (cont'd)**



What about big government running health care?

Can the state do better than what we have now?

- Government is the only entity that can realistically cover everyone regardless of circumstance
- Health care dollars go to treatment, not profit

A state-run system may be inefficient, but it's better than what we have now - as long as there is strong oversight and watchdogs to protect against inefficiency and waste

80% support switching to a publicly run health insurance program paid for by taxes; only 18% support staying with the current employer-based system.

Includes strong majorities of conservatives as well as liberals, plus all age and income groups



**COVERING EVERYONE
ISN'T ENOUGH - WE NEED
A SYSTEM THAT MAKES
PEOPLE HEALTHIER**

Steps to improve wellness

- Improve preventive care
- Comprehensive care for children
- Encourage healthy behavior
 - Start with health education
 - Address systemic barriers to healthy behavior (high cost of fresh produce, lack of safe places to walk or bicycle)
 - Should we penalize unhealthy behaviors?

It's better to offer incentives for "good" behavior than to punish people for "bad."

- Get employers involved: e.g. require employers to give time off for medical checkups, give them incentives to offer wellness programs etc.

cont'd

**COVERING EVERYONE
ISN'T ENOUGH - WE NEED
A SYSTEM THAT MAKES
PEOPLE HEALTHIER (cont'd)**

Steps to improve how care is delivered

- Medical ID cards. Must include measures to protect privacy – but advantages (better quality and continuity of care, efficiency, prevent abuse of system) outweigh privacy concerns.
- Use other health care providers like nurse practitioners to handle routine care.
- Better coordination of care. Interest in the idea of a “medical home,” IF people can choose their primary provider and appeal decisions about care.
- State incentives to increase the number of providers



HOW DO WE PAY FOR IT?

**We're paying now for a system that doesn't meet our needs;
let's pay for one that does**

More money will likely be needed beyond what we are paying now - everyone must do their part to pay for a system that works

Employers

- Tax corporate profits
- May offer supplemental coverage to employees

Individuals

- Co-pays/deductibles scaled to income
- Taxes. The wealthy pay their share, but everyone pays something
 - Income taxes
 - Sales taxes
 - “Sin taxes” on tobacco, alcohol and gambling

Will accept tax increases **ONLY** if the money is earmarked for health care and the system provides a clear and transparent accounting of how dollars are being spent.

QUANTITATIVE FINDINGS - CHOICE-DIALOGUES

Ratings of the four scenarios:

In each Choice-Dialogue, participants were surveyed twice, once at the beginning of the day and again at the end. They were asked to rate their response to each scenario independently on a scale of 1 to 10, 1 being totally negative and 10 being totally positive. The initial mean for each scenario indicates participants' average rating of the choice in the morning; the final mean represents participants' average rating of the same scenario at the end of the dialogue.

	initial mean	final mean
Shared responsibility	5.4	6.1
Increasing personal responsibility	4.4	5.6
Public health insurance for all	6.5	7.6
A coordinated wellness system	6.2	7.3

ADDITIONAL QUESTIONS

5. Today we have been discussing alternative health care systems. How important is each of the following elements to you in a health care system for KS/OH/MS?

5a. Universal coverage: all legal residents of KS/OH/MS covered

	%
absolutely essential	54
very important	35
somewhat important	7
not very important	3

5b. No charge for preventive care like check-ups, shots, mammograms

	%
absolutely essential	40
very important	36
somewhat important	19
not very important	5

5c. Coverage protects people against being financially ruined as a result of medical problems

	%
absolutely essential	61
very important	31
somewhat important	7
not very important	1

5d. Cost of prescription drugs covered

	%
absolutely essential	54
very important	37
somewhat important	7
not very important	2

5e. Can go to any doctor and hospital you want without additional charge

	%
absolutely essential	56
very important	32
somewhat important	11
not very important	2

5f. Medical records coordinated by primary provider

	%
absolutely essential	39
very important	42
somewhat important	16
not very important	3

5g. Coverage cannot ever be cancelled because of illness or pre-existing conditions

	%
absolutely essential	76
very important	22
somewhat important	2
not very important	1

5h. All children receive comprehensive health care

	%
absolutely essential	76
very important	21
somewhat important	1
not very important	1

5i. Lower costs for people who have a healthy lifestyle (non-smokers, not overweight, etc)

	%
absolutely essential	34
very important	38
somewhat important	20
not very important	8

5j. Everybody has their own primary care provider

	%
absolutely essential	34
very important	43
somewhat important	17
not very important	5

5k. People with chronic conditions get help managing their conditions

	%
absolutely essential	48
very important	43
somewhat important	8
not very important	1

5l. Everyone contributes something to the cost of their own health care

	%
absolutely essential	51
very important	38
somewhat important	9
not very important	2

5m. Coverage that you can take with you even if you change jobs

	%
absolutely essential	60
very important	35
somewhat important	4
not very important	0

6. Which of these statements do you think best describes the U.S. health care system?

	%
state of crisis	45
major problems	48
minor problems	5
does not have any problems	0

7. Each of the following has been suggested as a way to reduce health care costs. How strongly do you support or oppose each choice?

7a. Putting more resources into preventive care

	%
strongly support	70
somewhat support	27
somewhat oppose	1
strongly oppose	1

7b. Using technology to improve medical record-keeping and better coordinate care

	%
strongly support	66
somewhat support	31
somewhat oppose	2
strongly oppose	1

<p>7c. Requiring all employers to provide health insurance to their employees or pay a tax to fund coverage for the uninsured</p> <p style="text-align: right;">%</p> <p>strongly support 43</p> <p>somewhat support 34</p> <p>somewhat oppose 15</p> <p>strongly oppose 7</p>	<p>7i. Changing to a publicly run health system which would have the bargaining power of a single insurer with drug companies, doctors and hospitals</p> <p style="text-align: right;">%</p> <p>strongly support 46</p> <p>somewhat support 33</p> <p>somewhat oppose 12</p> <p>strongly oppose 9</p>	<p>13. Which comes <u>closer</u> to your point of view?</p> <p style="text-align: right;">%</p> <p>Everyone should have basic health insurance that covers preventive care and protects against financial ruin 43</p> <p>Everyone should have comprehensive health insurance that covers all needed doctor visits, preventive care, tests, hospitalization and other treatments 54</p>
<p>7d. Limiting the profits of health insurance companies</p> <p>strongly support 59</p> <p>somewhat support 27</p> <p>somewhat oppose 9</p> <p>strongly oppose 4</p>	<p>8. Which do you think would be better for KS/OH/MS?</p> <p>A publicly run health insurance program like Medicare that is paid for by taxpayers 80</p> <p>The current system where many people get their insurance from private employers and some have no insurance 18</p>	<p>14. Please indicate the extent to which you agree or disagree with each of the following statements.</p> <p>14a. It's just too expensive to provide comprehensive health coverage for all KS/OH/MS</p> <p>agree strongly 13</p> <p>agree somewhat 32</p> <p>disagree somewhat 28</p> <p>disagree strongly 26</p> <p>14b. Insurance company profits add considerably to the cost of health care</p> <p>agree strongly 54</p> <p>agree somewhat 35</p> <p>disagree somewhat 7</p> <p>disagree strongly 3</p> <p>14c. It's not fair that some people get generous benefits from their employers while others have to pay a lot for insurance on their own</p> <p>agree strongly 39</p> <p>agree somewhat 35</p> <p>disagree somewhat 18</p> <p>disagree strongly 8</p> <p>14e. A state-run health system will be bureaucratic and inefficient</p> <p>agree strongly 19</p> <p>agree somewhat 31</p> <p>disagree somewhat 34</p> <p>disagree strongly 14</p>
<p>7e. Only covering medical tests and treatments that have been proven to be effective</p> <p>strongly support 22</p> <p>somewhat support 35</p> <p>somewhat oppose 28</p> <p>strongly oppose 13</p>	<p>9. Which comes <u>closer</u> to your point of view?</p> <p>Everybody is entitled to the same level of health care 75</p> <p>Medical care is like anything else you buy - those who can pay more should be able to get something better 23</p>	
<p>7f. Putting limits on extreme measures in end-of-life care</p> <p>strongly support 22</p> <p>somewhat support 35</p> <p>somewhat oppose 26</p> <p>strongly oppose 17</p>	<p>10. Which comes <u>closer</u> to your point of view?</p> <p>People have the responsibility to be prepared for the high cost of serious illness or injury 12</p> <p>No one should be forced into financial ruin because of high medical expenses 87</p>	
<p>7g. Encouraging and rewarding healthy behaviors and lifestyles</p> <p>strongly support 64</p> <p>somewhat support 26</p> <p>somewhat oppose 6</p> <p>strongly oppose 3</p>	<p>11. Which comes <u>closer</u> to your point of view?</p> <p>If people don't have to pay for their health care, they will run to the doctor for every little ache 34</p> <p>If people have to pay for every medical visit and treatment, they will delay getting health care when they need it 63</p>	
<p>7h. Requiring everyone to have some form of health insurance</p> <p>strongly support 53</p> <p>somewhat support 27</p> <p>somewhat oppose 11</p> <p>strongly oppose 8</p>	<p>12. Which comes <u>closer</u> to your point of view?</p> <p>Only treatments that have been proven effective should be covered by health plans 21</p> <p>Health plans should cover any treatment that is recommended by your doctor, not rely on outside judgments of how effective it is 77</p>	

14f. KS/OH/MS companies will be able to be more competitive in the global economy if they don't have to fund health care costs

	%
agree strongly	20
agree somewhat	37
disagree somewhat	27
disagree strongly	14

14g. Government-run systems in other countries provide better health care for most people than our system does

	%
agree strongly	28
agree somewhat	37
disagree somewhat	20
disagree strongly	14

14h. Nurses and other trained non-physicians can handle routine medical care and minor complaints as well as a doctor can

	%
agree strongly	40
agree somewhat	43
disagree somewhat	11
disagree strongly	6

14i. I would be willing to pay higher taxes so that everyone can have health insurance

	%
agree strongly	37
agree somewhat	42
disagree somewhat	11
disagree strongly	9

14j I would be willing to have limits placed on my choice of provider if it costs significantly less

n = 210	%
agree strongly	13
agree somewhat	30
disagree somewhat	28
disagree strongly	28

15 Overall, how would you rate the quality of health care in your community?

	%
excellent	11
good	53
not so good	26
poor	10

16 How concerned are you about the health care costs you are facing now or will face in the future?

	%
very concerned	63
somewhat concerned	28
not very concerned	6
not at all concerned	1

DEMOGRAPHIC INFORMATION

D1. Gender

	%
male	46
female	54

D2. Age

	%
18-29	18
30-49	37
50-65	30
over 65	15

D3. Do you currently have health insurance?

	%
yes	86
no	13

D4. (if insured) What is the source of your primary health insurance coverage?

n = 253	%
your employer or union	44
spouse/parent's employer or union	18
Medicare	19
Medicaid	5
a plan you bought yourself	8
other	4

D5. (if insured) Overall, how satisfied are you with your current health plan?

n = 253	%
extremely satisfied	21
very satisfied	29
somewhat satisfied	35
not too satisfied	10
not satisfied at all	4

D6. In general, would you describe your political views as:

	%
very liberal	6
liberal	17
moderate	47
conservative	22
very conservative	4

D7. Annual household income from all sources before taxes:

	%
under \$20,000	18
\$20,000 - \$29,999	16
\$30,000 - \$49,999	27
\$50,000 - \$74,999	21
\$75,000 - \$99,999	7
\$100,000 or more	8

D8. The highest level of schooling you have completed:

	%
less than high school graduate	5
high school graduate	20
some college	31
college degree	28
graduate study/degree	15

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