

The Future of Health Care in Ohio
Strategic Dialogues with Business and Civic Leaders

On November 8, 2007, business, political, health care, civic and academic leaders participated in a strategic dialogue of the future of health care in Ohio. The meeting, convened by UHCAN Ohio and the Health Policy Institute of Ohio and sponsored by the W.K. Kellogg Foundation, was the first step in a multi-stage effort to engage Ohioans and their leaders in a dialogue about the range of options and tradeoffs involved in improving the long-term future of health care in Ohio. The meeting was designed and facilitated by Viewpoint Learning, an organization that specializes in dialogue on complex, value-laden issues.

The overall project has six elements:

1. **Strategic Dialogue with community leaders** - The results of this session, described below, will help inform the choices that members of the public will be asked to consider in step 2 of the project:
2. **ChoiceDialogues™ with Ohioans** to identify which choices the public will be willing to support and under what conditions. These daylong citizen dialogues (scheduled for February - March 2008) will explore what sort of health care system Ohioans want to see in the future, what balance they want to see between the roles of individuals, employers and the public sector, what tradeoffs they are willing to accept and under what conditions. (A more extensive discussion of the ChoiceDialogue approach can be found in Appendix A.)
3. **Interactive briefings for leaders in Ohio** presenting the results of the ChoiceDialogues and developing the implications and possible next steps.
4. **Community Conversations:** Development of a specialized “Meeting in a Box” process and kit that allows leaders, their representatives and a range of local organizations at all levels to conduct a streamlined 2–3 hour dialogue in which a broader range of Ohioans can consider the choices.
5. **On-line Dialogue:** A national Internet-based dialogue in which Ohioans can work with Americans from other states in small groups to grapple with the choices and tradeoffs involved in health care reform.

In the Strategic Dialogue, Ohio leaders met to share their expertise and begin a process of identifying possible solutions to Ohio’s growing health care crisis. Participants engaged in a facilitated dialogue designed to broaden their perspective and identify common ground around a range of possible solutions to sustainable health care reforms and the conditions for support of those solutions.

KEY FINDINGS

How we got where we are today

As a starting point, participants worked together to identify changes and trends over the last twenty years that have affected the current health care situation in Ohio. Participants drew a picture of an increasingly fragile health care system focused on illness rather than health – marked by rising costs, growing fragmentation and inefficiency, poor lifestyle choices and a persistent decrease in access to care.

The leaders in Columbus saw the growing number of uninsured and underinsured Ohioans as a particularly serious problem. Many saw the state as increasingly separated between the haves and have-nots. The group stressed several interrelated factors that they saw as crucial in shaping the current situation:

- **Economic trends:** Leaders saw globalization and the perceived need for single-minded focus on the bottom line as a driver of the breakdown of the employer-based system. It was one of many factors they saw increasing the disparity between the rich and the poor. Tax breaks for the wealthy were another, along with a shifting employment base away from industrial jobs that used to provide benefits for less educated workers. Businesses (and particularly the increasing numbers of smaller businesses) are feeling a greater pressure to cut costs. This has led many employers to reduce health care benefits (by switching to more limited plans, “consumer-driven” plans, asking employees to pay a greater share of costs, or relying more on part-time employees) or to eliminate them altogether.
- **Political and policy climate:** Politics as usual were a big part of the problem according to many of the leaders. The current culture of partisan debate and a general lack of political will or leadership (at the state and federal level) to address the needs of the consumer were cited, along with poor coordination between states and the federal government. Term limits, some felt, were a hindrance to legislators developing real expertise on such a complex issue. While S-CHIP was noted as a success and a model policy, welfare reform, in the eyes of some participants, had served only to drive more Ohioans into poverty, making their health care more fragile. There was a sense, however, that political dialogue was beginning to be more prominent and possible in Ohio, which some attributed to the election of Governor Strickland, accompanied by a growing acceptance that major reform was essential. Some hoped that the perspective of the uninsured could be included in the dialogue, especially around the issue of affordability.
- **Social Inequities:** Leaders in Ohio focused on the growing disparity between the haves and the have-nots along with the increase in their non-English speaking population. They pointed out the increasing pressure on the safety net and noted that even those with insurance, in particular lower income Ohioans, could not afford the co-payments and deductibles and were becoming sicker and poorer as a result. They also stressed that entire counties in Ohio were terribly underserved and lacked basic health care providers and facilities, much less adequate coverage.

- Advances in treatment and rising expectations: Participants noted the tremendous health benefits associated with advances in pharmaceuticals, treatments and medical technologies. At the same time, they saw less positive consequences associated with these technological breakthroughs. Not only have these treatments driven up the cost of care, especially at the end of life, they also have reshaped patients' expectations of what constitutes "good" medical care. Physicians expect much higher incomes today, which has led to difficulties attracting providers to primary care and to underserved areas. And the increasing access to medical information on the Internet and through pharmaceutical advertising has helped patients become more involved in their own care, but has also, perhaps unrealistically, increased their expectations of what modern medicine can achieve.
- Cultural changes and a decrease in personal responsibility: Participants noted a decrease in personal responsibility for staying healthy coupled with rising expectation for health outcomes. Startling increases in obesity among children and adults, along with skyrocketing rates of diabetes and hypertension, along with other chronic illness and risky behaviors were seen as evidence that people are no longer taking care of themselves and are counting on "modern medicine" to do the trick. This trend has also significantly increased the cost of care and will only get worse. They noted some positive developments, like Ohio's smoking laws, and an increasing awareness of the affect health care has on our society and a growing willingness to take on tough choices.
- Health care costs and compensation: Participants noted dramatic ongoing increases in the cost of health care, often outstripping reimbursement rates. There was general agreement that financial incentives in the health care system have become increasingly skewed towards treating serious illness rather than keeping people healthy. Along with the costs associated with increasing litigation, they blamed a fee-for service/pay for performance design for discouraging consistent primary care (and medical homes,) therefore driving up costs as people lack the means to stay healthy. Physicians and hospitals "cherry pick" the patients they want. The failure of managed care to improve health outcomes, the lack of good information technology in health care and the loss of the certificate of need in Ohio were also seen as drivers of the increasing crisis in health care. And the system's fragmentation was a major concern as well,

Several participants noted the strengths of the current system – for example, excellent health care is available and there are many advances in treatment. Yet these bright spots did not diminish participants' agreement that the existing system is in need of significant reform.

Consequences of doing nothing

When asked to consider Ohio's future if no changes are made in the state's current health care system, the participants' assessment was bleak. If Ohio sticks with the status quo, participants envisioned a range of serious consequences:

- A sharp increase in the number of have-nots, and a much larger gap between the privileged few who get quality health care and the rest who do not. This, in turn, would lead to growing numbers of uninsured or underinsured Ohioans.
- Costs spiraling out of control and the gradual decline of the employer-based system, pushing more people into an overburdened Medicaid system and creating a subset of sicker people who cannot purchase insurance on the private market.
- The rise of a monopolistic insurance industry, with one or two giant insurers controlling the market. They would only take the healthiest patients, leaving fewer options for the rest.
- Dramatic shortages of providers, with tremendous shortages of primary care providers and ultimately specialists as American physicians cater to the wealthy and foreign health care providers leave the United States.
- A burgeoning “black market” for health care, with unlicensed providers treating lower income patients, and those with the means leaving the state to get treatment elsewhere, further impacting the ability of providers to work in Ohio.
- A much sicker Ohio: The lack of insurance, provider shortages and the high costs even with insurance would prevent people from getting the care they need, or from seeking preventive or follow-up care. This would lead to increasing rates of premature and unnecessary death rates, the decreasing health status of the population and consequently decreased global competitiveness.

It was a disturbing picture, and brought the tremendous urgency of the problem into very clear relief.

What to do about it? Ideas to consider

Participants shared a desire for real change instead of incremental reform. Leaders talked about framing the issue not just as “health care” reform, with a focus on the critical issues of access, cost and coverage, but in thinking more broadly about true “health reform,” and how to take bold steps to create a healthier Ohio. While a wide variety of ideas and perspectives were raised, all ideas under discussion included the following essential points:

- **Universal or near-universal coverage.** All ideas had as a goal universal or near universal coverage for Ohioans. It was something all participants believed was extremely important, although many had concerns about its practicality and cost. Participants envisioned a system in which every Ohioan gets some form of coverage and care regardless of age, income, employment or health status. The level of coverage varied, ranging from catastrophic to comprehensive, and systems were both public and private and often a combination. But all systems (save for one that offered a “starting point” of coverage for all children 18 and under) offered significant coverage expansions and in most cases, some sort of universal coverage.
- **Encouraging and rewarding personal responsibility.** Participants concluded that there was a significant role to be played at the individual level and that the system must encourage healthier behavior. People saw real personal responsibility as a true “Ohio value.” In an attempt to get back to a culture of personal responsibility and its connection to prevention and wellness, participants sought to restructure the health

care system to support these values through education, transparency and rewards for those who made healthy life style choices.

- **Sharing the cost and easing the burden on businesses.** Participants felt that any re-envisioned system must, in addition to taking steps to control costs, do something to redistribute the costs for health care. There was a strong belief that all players, business, government and individuals had to pay something play a role in paying for care and take responsibility for creating a healthier Ohio, on either an individual or systemic level. Most felt that employers should continue to play some role in insurance, for example by providing supplemental policies, but on the whole they strongly supported the idea of exploring approaches that would relieve employers of some of the burden of providing health insurance. There was strong support for exploring “shared cost/shared responsibility” approaches like those being considered in California and implemented in Massachusetts. While employers continued to pay something in many of the suggested scenarios, there was very little discussion of traditional “pay or play” approaches in which employers serve the primary providers or funders of health insurance. Although the leaders felt employers still had an important role to play in providing coverage, the employer based system changed dramatically in almost all suggested approaches.

Over the course of the discussion, participants outlined a number of specific ideas that they felt might be developed into scenarios and tested with the public. These varied in their particulars and level of specificity, but a number of key elements rose to the surface as critical to test with the public:

- **Reorganizing primary care.** There was considerably energy around the concept of a true “medical home” (or “health care home”) for every state resident. In general, participants were very positive about the health benefits of a medical home and a radically improved coordination of care. Many saw this approach as necessitating an investment in Electronic Medical records and other information technology and it would be accompanied by new levels of transparency that allowed people to make more informed choices about providers. Other suggestions included the utilization of more nurse practitioners and other providers rather than physicians for primary and preventive care. There was also some discussion about expanding possible points of access to the health care system.
 - **Pros:** Most participants strongly believed that reorganizing primary care was essential to improving outcomes, access and cost. They liked that such an approach would create a more holistic, patient centered system and most believed that moving to a system focused on wellness rather than illness was a necessary paradigm shift.
 - **Cons:** Participants were very concerned about the cost of this approach and limiting care somehow so that it would be financially sustainable. Other concerns surfaced around the privacy issues raised by EMR’s and the initial increases in cost to essentially transform the current system.

- **“Medicare-for-All”** Some of the scenarios laid out variations on single payer systems, in which the state government served as the primary insurer for all state residents. Some suggested adding incentives for providers to expand access and a greater focus on compensation based on outcomes rather than procedures.
 - **Pros:** A single payer system was described as equitable, efficient and simple. Some also saw it as a much-needed paradigm shift in which comprehensive health care becomes a right rather than a commodity and funds are more oriented to outcomes.
 - **Cons:** Participants noted the powerful mistrust of government as a possible roadblock for single payer, along with a concern that such a system would perpetuate a culture of entitlements doing nothing to increase personal responsibility or reduce costs. They also raised the fear that decreased competition would inhibit creativity and innovation.
- **Shared responsibility:** As described above, participants had a number of suggestions for systems that would spread out responsibility for health care and health outcomes. People discussed individual mandates as one way of moving to universal coverage, including a connector system between public and private insurance providers (and funders) that would ensure that health insurance is portable, but only when coupled with subsidies or tax credits. Allowing people to buy in to state and federal programs was another suggestion. Some participants brought up a form of pay or play in which employers either had to provide coverage or pay (on a sliding scale) into a system of coverage for those who do not receive coverage from employers, along with reinsurance to help smaller employers. In addition, some increased coverage for low-income Ohioans by expanding Medicaid or through some form of subsidies. These scenarios, based in part on what is currently happening in Massachusetts and California, meant that everyone has “some skin in the game” and that idea was appealing to leaders at the Columbus meeting.
 - **Pros:** This approach recognizes that every Ohioan has an interest in creating a better health care system, and all bear responsibility for paying for it, and felt politically feasible to many. It recognizes that while the financial burden on employers is difficult, employers have a vested interest in their employees’ health. It also avoids “throwing the baby out with the bathwater;” that is, shared responsibility maintains much of what is positive about the current system while expanding coverage and reducing cost-shifting.
 - **Cons:** These approaches were seen by some as expensive, highly complicated (“too many moving parts”) and unlikely to be affordable or sustainable. Without community rating and guaranteed issue, these approaches are not workable, and the approaches do not address the very real problems of access.
- **Prioritize prevention and personal responsibility.** One group re-envisioned health care system where the focus is on creating monetary incentives for staying healthy by rewarding individuals for choosing a healthy life style and participating in health risk assessments, regular screenings and other preventive behaviors.

- Here transparency would be crucial in making patients aware of the true costs of service. Under this scenario there would be a need for meaningful health care education, consequences for poor choices, and an ongoing focus on public health.
 - **Pros:** Many saw this approach as addressing a core issue in making significant reductions in the cost of health care. Supporters saw this as placing responsibility where it belongs—on individual choices, with a system that encourages people to get regular care. They believed that cultural change, although difficult, would have the best return on investment that could last generations.
 - **Cons:** Some saw this as a moralistic approach, penalizing someone’s idea of unhealthy behavior without necessarily considering the cost. They wondered who would make judgments about what constituted healthy behavior and wanted to be sure that people would not be financially penalized for getting sick (“it’s not your fault if you get cancer.”) They were concerned that people would not be able to afford coverage and such an approach would require a level of knowledge and sophistication on the part of patients that was wildly unrealistic relative to widespread medical illiteracy.

Participants mixed and matched many of these elements to create their scenarios, and underlying all were two fundamental assumptions. First, most participants believed that any major change of direction would require real insurance reform (guaranteed issue, community rating and coverage for pre-existing conditions.) Second, participants made it clear that increased transparency and an ability to both track dollars and outcomes were essential to a reformed system.

NEXT STEPS

These findings will serve as a basis for the next phase of this project, day-long ChoiceDialogues with Ohioans from diverse regions. Viewpoint Learning, working with the UHCAN Ohio, the Health Policy Institute of Ohio and other local advisors, will create a set of four values-based scenarios to test with the public. These will be presented in a detailed workbook which will include a general framing statement, important background information, scenario descriptions and accompanying values, key elements that would change and pros and cons for each scenario. Representative groups of Ohioans (of about 40 people in each of three sessions around the state) will grapple with the choices, weighing the pros and cons and ultimately developing their own scenario for health reform in Ohio and identifying the conditions necessary for their support.

These ChoiceDialogues will provide unique insight that goes far beyond polls and focus groups, exploring how people’s minds change as they learn, what sorts of solutions they are likely to support given the chance to work through the tradeoffs and again, the conditions for support. These citizen dialogues will generate a road map for leaders wishing to engage the public in a more thoughtful consideration of these difficult issues, and will serve as the basis for several follow-up efforts designed to engage many more Ohioans in serious discussion about health care.

Following the conclusion of the dialogues, Viewpoint Learning, UHCAN and HPIO will once again invite leaders to participate in an interactive briefing on the results. As the project partners embark on the next steps of this project, there will be further opportunities for Strategic Dialogue participants to be involved. We may consult further with participants as we develop the ChoiceDialogue materials, and Strategic Dialogue participants are encouraged to observe ChoiceDialogue sessions if they wish. And as the project moves from research into public engagement, leaders will have access to a range of tools to engage their colleagues, constituents, clients and organizations in an expanding dialogue on what approaches to health reform make sense for Ohio, for themselves and for their children.

Appendix A

ChoiceDialogue™: The Methodology

ChoiceDialogue methodology differs from polls and focus groups in its **purpose, advance preparation, and depth of inquiry.**

- **Purpose.** ChoiceDialogues 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, ChoiceDialogues 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. ChoiceDialogues 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, ChoiceDialogues 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.** ChoiceDialogues 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 ChoiceDialogues 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, ChoiceDialogues are characterized by a huge amount of learning. ChoiceDialogues 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 ChoiceWork 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.

Steps in a ChoiceDialogue Project

- 1) Archival analysis of polls (or conducting a special one) and other research to provide a baseline reading on what stage of development public opinion has reached;
- 2) The identification of critical choices and choice scenarios on the issue and their most important pros and cons, and the preparation of a workbook built around those scenarios in a tested format for use in the dialogues;
- 3) A series of one-day dialogue sessions with representative cross-sections of the population. Each dialogue involves about 40 participants, lasts one full day and is videotaped. A typical one-day session includes the following:
 - Initial orientation (including the purpose of the dialogue and the use to be made of the results, the nature of dialogue and ground-rules for the session, introduction of the issue and some basic facts about it);
 - Introduction of the choice scenarios on the issue, and a questionnaire to measure participants' initial views;
 - Dialogue among participants (in smaller groups and in plenary) on the likely good and bad results that would occur as a consequence of each choice if it were adopted, and constructing a vision of the future they would prefer to see;
 - A second, more intensive round of dialogue among the participants (again both in smaller groups and in plenary) working through the concrete choices and tradeoffs they would make or support to realize their vision;
 - Concluding comments from each participant on how their views have changed in the course of the day (and why), and a questionnaire designed to measure those changes.
- 4) An analysis of how people's positions evolve during the dialogues. We take before and after readings on how and to what extent people's positions have shifted on each choice as a result of the dialogue. This analysis is both quantitative and qualitative.
- 5) A briefing to leaders to make sense of the results. The briefing summarizes what matters most to people on the issue, how positions are likely to evolve as surface opinion matures into more considered judgment, the underlying assumptions and values that shape that evolution, and the opportunities for leadership this creates.