

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

On November 15, 2007, business, political, health care, civic and academic leaders participated in a strategic dialogue of the future of health care in Kansas. The meeting, convened by the Kansas Health Consumer Coalition and the Kansas Health Institute and sponsored by the W.K. Kellogg Foundation, was the first step in a multi-stage effort to engage Kansans and their leaders in a dialogue about the range of options and tradeoffs involved in improving the long-term future of health care in Kansas. 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 Kansans** 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 Kansans 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 Kansas** presenting the results of the ChoiceDialogues and developing the implications and possible next steps.
4. **Community Conversation:** 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 2–3 hour streamlined dialogues in which a broader range of Kansans can consider the same choices. The results will be shared with decision-makers and media.
5. **On-line Dialogue:** A national Internet-based dialogue which will allow Kansans to work in small groups with Americans from other states to grapple with the choices and tradeoffs involved in health care reform.

In the Strategic Dialogue, over 40 leaders met to share their expertise and begin a process of identifying possible solutions to Kansas’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 climate in Kansas. Participants drew a picture of an increasingly fragile health care system – marked by rising costs, growing fragmentation, poor lifestyle choices and a persistent decrease in access to care.

All the participants saw uninsured Kansans 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:

- **Demographic trends:** Three significant demographic trends were cited as playing a major role in health care, and in particular cost and access:
  - The aging of the population as people live longer (and an unwillingness to deal responsibly with end-of life issues)
  - The widening gap between the haves and the have-nots
  - The every-growing flight of residents, and more critically health care providers, from rural Kansas. Access to care was seen as a particularly troubling problem in Kansas.
- **Advances in treatment and rising expectations:** The assembled leaders cited 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, they also have reshaped patients' expectations of what constitutes "good" medical care. Consumer demand for specific treatments, the proliferation of information, both good and bad, available on the Internet, and an increasing assumption that there will be a drug to cure any ill have changed the way patients participate in their own care. Some participants felt this was related to the phenomenon of people's reduced sense of responsibility for taking care of their own health.
- **Lifestyle changes and a decrease in personal responsibility:** Participants noted a decrease in personal responsibility for staying healthy coupled with rising expectation for exceptional 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 it for them. And they did not see the lack of responsibility as limited to unhealthy behaviors. Many participants also indicated they'd seen a shift in people's willingness to pay for their own care, and the expectation that someone else, either the government or their employer, should shoulder the cost.

- Health care industry costs and compensation structure: Participants spoke about 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. Related to this, doctors and hospitals are rewarded for the number of procedures rather than for keeping people healthy. Many also cited greed in the form of excessive profits on the part of providers, insurers and pharmaceutical companies as a key factor driving up costs.
- Economic trends: Leaders saw a major change in the social contract between businesses and their employees, and an associated decrease in coverage. In particular, participants noted the rise of small business, a shift toward lower-wage jobs, and an overall focus on the bottom line. Farmers in Kansas, with low profit margins to begin with, find themselves in a particularly precarious position when it comes to health care for their families and employees. Businesses (and particularly smaller businesses, which make up the majority of employers in Kansas) are feeling a greater pressure to cut costs. This has led many employers to reduce health care benefits (by switching to more limited plans, asking employees to pay a greater share of costs, or relying more on part-time employees) or to eliminate them altogether. The end result has made health care less affordable for employees.
- Policy trends: Participants expressed a desire to see their political leaders engage in a genuine and sustained dialogue on health reform. Several participants also noted that the health care industry has become increasingly complex, impersonal and profit driven.

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 Kansas’s future if no changes are made in the state’s current health care system, the participants’ assessment was bleak. If Kansas 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 and the rest. This, in turn, would lead to growing numbers of uninsured or underinsured Kansans.
- Too few providers: Participants believed that the number of doctors in rural Kansas would drop as a result of lower salaries, reduced compensation and more difficult working conditions. As doctors left the rural areas there would also be a depopulation of the western half of Kansas.
- A much sicker Kansas: The lack of insurance 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 more people will turning to emergency rooms for

basic health needs, the decreasing health status of the population and consequently decreased economic competitiveness

- “Wal-Mart Medicine”: Participants envisioned a radical restructuring of health care delivery, with care provided on a fee-for-service basis in retail stores like Target or Wal-mart.
- Ultimately, many participants saw a future in which access to quality health care becomes a mark of privilege – accessible only to those wealthy enough to afford it and with the skills needed to navigate an increasingly complex system.

### What to do about it? Ideas to consider

Participants shared a desire for real change instead of incremental reform. As one participant, a state representative, put it: *I just share the frustration of my constituents; we talk about health care reform and we end up tweaking.*

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 Kansas. 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 Kansans. 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 Kansan 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 “Kansas 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.
- **Ease the burden on businesses.** Participants felt that any system must do something to reduce the burden on businesses. 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 some support for exploring “shared cost/shared responsibility” approaches like those being considered in California and implemented in Massachusetts. This

included some mention of a “pay or play” system for employers, but only with built in caps and controls -- and incentives for healthy behaviors -- that would reduce the cost burden.

Over the course of the discussion, the leaders at the Topeka meeting outlined a number of specific ideas that they felt might be developed into scenarios and tested with the public. While varying in their particulars, most fell into five basic approaches described by the participants who then worked together to identify the pros and cons for each:

- **Government sponsored coverage for preventive and catastrophic care (and private for supplemental).** The government would fund limited health insurance for all Kansans. Coverage would be limited to basic preventive care and catastrophic medical expenses. This system would be paid for by some tax mechanism and might require a form of budgeting where the amount to be spent on health care is decided in advance. All providers would be required to participate in such a system and there would be a range of options for individual or employer sponsored supplemental coverage (“buying up”). Participants liked the idea of going back to a model of true “insurance” rather than a pre-paid health plan.
  - **Pros:** Acknowledges that health care (even the most basic coverage) is a basic right, but this approach forces society to define what constitutes real insurance and rethink what is necessary. In such a system, more people would have at least some coverage and rates would stabilize.
  - **Cons:** The approach does little to control costs, and is likely to increase the gap between haves and have-nots. It does not do enough to improve access to providers; people might have coverage under this scenario, but no doctors, especially in rural parts of the state, without some sort of reorganization of care focused on preventive medicine.
- **“Medicare-for-All”** Some of the scenarios laid out a single payer system in which the state government served as the primary insurer for all state residents.
  - **Pros:** A single payer system was described as equitable, efficient and simple, and participants cited patient’s satisfaction with Medicare.
  - **Cons:** Participants worried that reimbursement rates under a single payer plan would be so low as to be a disincentive for physicians to practice in Kansas. They viewed decreasing reimbursement rates as a major problem for Medicare and expected that a program that included all Kansans would have the same problem. They saw this as being unaffordable, and voiced concerns about a likely decrease in innovation in medical care and questions about accountability for funds.
- **Shared responsibility:** Several groups suggested scenarios that shared the cost and shared the responsibility for health care. These included some form of “pay or play” in which employers either had to provide coverage or pay into a system of coverage for those who do not receive coverage from employers. In addition, most suggested increasing coverage for low-income Kansans by expanding Medicaid or through some form of subsidies. Most included significant adjustments to the current system such as caps on spending or profits and other regulatory cost controls, along with

added preventive care and incentives for healthy behaviors. 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 Topeka meeting.

- **Pros:** This approach recognizes that employers have a vested interest in their employees’ health. It also avoids “throwing the baby out with the bathwater;” that is, it keeps much of what is positive about our current system while expanding coverage and reducing cost-shifting.
- **Cons:** This approach was seen as simply too expensive for most small businesses, and thus unsustainable.
- **Prioritize prevention and wellness by rewarding healthy behavior.** This approach is about re-envisioning the health care system with a focus on creating monetary incentives for staying healthy by rewarding both individuals for choosing a healthy life style (personal responsibility) along with rewarding providers for keeping patients healthy. Here transparency would be crucial in making patients aware of the true costs of service. Coverage would likely be provided through a basic plan provided by the government with the options for individual and employer supplementation. Under this scenario there would be a need for meaningful health care education, consequences for poor choices, increased transparency and an ongoing focus on health.
  - **Pros:** Many saw this approach as the best chance of making significant reductions in the cost of health care. Supporters saw this as placing responsibility where it belongs—on individual choices. 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. There was also concern that this required a level of knowledge and sophistication on the part of patients that was wildly unrealistic.
- **Reorganizing primary care.** Expands the ability of the individual to access care beyond the traditional delivery models. Ideas falling in this category included a system in which every Kansan is enrolled in a medical home, and all care is centered around that home (necessitating an investment in Electronic Medical records.) 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 saw that this approach would be difficult to implement in rural counties, and in general would fly in the face of consumer preference

(for freedom of choice) and currently accepted practice. Other drawbacks were privacy concerns raised by EMR's and the significant investment required to essentially transform the existing health care system.

## **NEXT STEPS**

These findings, in particular the possible scenarios and their associated pros and cons, will serve as a basis for the next phase of this project, day-long ChoiceDialogues with Kansans from diverse regions. Viewpoint Learning, working with the Kansas Health Consumer Coalition, the Kansas Health Policy Authority 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 the pros and cons for each scenario. Representative groups of Kansans (of about 40 people in each of three sessions around the state) will grapple with the choices. They will weigh the pros and cons and ultimately develop their own scenario for health reform in Kansas, including the conditions necessary for their support.

The ChoiceDialogues are designed to 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 a comprehensive outreach and education program designed to engage many more Kansans in serious discussion about health care.

Following the conclusion of the dialogues, Viewpoint Learning, KHCC and KHPA will once again invite leaders to participate in an interactive briefing on the results. As the Kansas Health Consumer Coalition, the Kansas Health Policy Authority and Viewpoint Learning 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 the public engagement phase, 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 Kansas, 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.