

THE FUTURE OF HEALTH CARE IN MISSISSIPPI STRATEGIC DIALOGUE WITH CIVIC LEADERS

On January 11, 2008, more than thirty leaders representing health care, state government, business, universities and other civic and faith organizations participated in a strategic dialogue about the future of health care in Mississippi. The meeting was convened by the Mississippi Health Advocacy Program and the Mississippi Center for Non-Profits and was sponsored by the W.K. Kellogg Foundation. It was the first step in a multi-stage effort to engage state residents and their leaders in a dialogue about the range of options and tradeoffs involved in improving the long-term future of health care in Mississippi. The meeting was designed and facilitated by Viewpoint Learning, an organization that specializes in dialogue on complex, value-laden issues.

These busy leaders indicated that they made the time for the in-depth dialogue because of their concerns about the condition of health care in Mississippi. Their initial comments centered on the following hopes for the future:

- Increasing access to quality affordable primary and preventive health care, especially for those in rural areas
- Being able to provide care for the uninsured and underinsured despite federal cutbacks, in part by increasing public demand for action at the state level
- Reaching a greater number of low income residents (including those who are eligible but not applying for Medicaid/state programs)
- Reducing income and race-related health disparities, especially for children, to create improved quality of life
- Embracing a more holistic system with an integrated view of health and coordinated delivery, and reducing the growing number of people suffering from chronic disease
- Identifying ways to contain rising costs, especially for small businesses

The group spent most of the session identifying key trends and changes that have led to the current situation and then developing a set of scenarios for reform that will inform all of the remaining elements of the project:

1. **Strategic Dialogue with community leaders:** The results of the January 11, 2008 session, described below, will help inform the choices that members of the public will be asked to consider in the ChoiceDialogue™ phase of the project.
2. **ChoiceDialogues™ with Mississippi citizens** to identify which choices the public will be willing to support and under what conditions. These daylong citizen dialogues (scheduled for late March - April 2008) will explore what sort of health care system they 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 Mississippi** presenting the results of the ChoiceDialogues and developing their 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 community dialogues in which a broader range of the Mississippi public can talk meaningfully with one another about the hard choices involved in health care reform.
5. **On-line Dialogue:** A national Internet-based dialogue in which Mississippians can work in small online groups with Americans from other states to grapple with the choices and tradeoffs involved in health care reform.

KEY FINDINGS

In the Strategic Dialogue, Mississippi leaders met to share their expertise and begin a process of identifying possible approaches that look beyond the state’s immediate health care funding crisis to long term directions for sustainable reform. 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.

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 Mississippi. Participants drew a picture of an increasingly fragile health care system focused on treating illness rather than promoting health – marked by rising costs, growing fragmentation and inefficiency, poor lifestyle choices and a persistent decrease in access to care.

Participants described a bifurcated system: “we have private insurance focusing on healthy people and public insurance focusing on poor, sick people” which is getting harder and harder to balance. Great advances in medical technology were noted but juxtaposed with the absence of basic care for so many: “the gap between what the capabilities are and what the access to it is just causing a tremendous amount of frustration among people.”

The group surfaced several interrelated factors that they saw as crucial in shaping the current situation:

“Ever-increasing” number of uninsured – This trend was discussed in the context of demographics and the relationship of poverty and poor health (with causality going both ways), plus the relationship of education and poor health. It was specifically noted that the introduction of recertification procedures has reduced the number of people in Mississippi being served by Medicaid, and that SCHIP enrollment is down too. The leaders also stressed that scores of counties in Mississippi were terribly underserved and lacked basic health care providers and facilities. Consolidation of hospitals, clinics, physicians groups and other providers was cited as a factor in that problem.

“Reactive” medical care – In addition to decreasing access to primary and preventive care due a focus on episodic care of acute illnesses, these leaders described a system that is “reacting” to (and overwhelmed by) chronic diseases rather than one that is working to prevent them. This trend is exacerbated by a litigious environment that has led to what was tagged as “defensive” medicine. Ironically, this is happening at the same time that the platform for patient safety and good record keeping appears to be eroding (as participants noted was clearly demonstrated in the aftermath of Hurricane Katrina, in which many paper records were destroyed, and many patients were discovered to have no records at all).

Change in Individual Behaviors - Some identified a trend that individuals were assuming less responsibility for their health, adopting unhealthy behaviors. Concern was raised about the increasing levels of obesity, especially among children. The discussion touched on environmental factors such as food ingredients that may be exacerbating the obesity epidemic. Increased advertising of pharmaceuticals was noted as perhaps adding to a culture that prefers taking a pill versus to making healthier lifestyle choices.

Shifting perspectives about the role of government in health care – The discussion identified what may be crosscurrents in public opinion. Some spoke to a preference for a shrinking role for government in health care coupled with enormous financial commitments to non-health related expenses such as the war in Iraq. Alternately, others were seeing some nascent hopeful signs that the public may be re-thinking the role for government (and in fact, thinking about a more central role) in “providing the climate for affordable and improved care.”

Decreasing voice from the underserved – Those without insurance and the poor of Mississippi in general were described by the leaders as becoming increasingly “hopeless”, apathetic and being less and less motivated to try and influence the situation. Some noted that the tide of public opinion might be turning in favor of providing a more robust safety net for those in poverty and that the lives of all Mississippians, not just those with means, are of value.

Changes in the insurance industry – Leaders in Mississippi noted increasing bureaucracy in how insurance companies decide to screen people and cover procedures, creating “roadblocks” to care and difficulties for consumers trying to navigate the system. These layers of administration were seen as increasing costs for everyone in the system and were related to the broader trend of “corporatization” of medicine with an emphasis on profits. Participants pointed out a factor particular to Mississippi: having relatively few insurers in the state reduces the positive effects of competition experienced elsewhere.

Rising health care costs – Many leaders noted that health care costs that have been rising faster than inflation for a long time. They saw many of the trends listed above as significant cost drivers, e.g.: changes in the insurance industry, treating increased chronic diseases, poor lifestyle choices, lack of good primary care, needing better records systems, etc. But some participants expressed a frustration that we do not have clear understanding of how much each of these, and other, factors are contributing to high and rising health care costs.

At points, the conversation touched on some of the strengths of the current health care system, such as technological advances and specific treatment successes. Yet these bright spots did not diminish participants’ agreement that the existing system in Mississippi is in need of significant reform.

The consequences of doing nothing

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

- Critical care needs would “skyrocket” and the system will not be able to respond. Vulnerable populations would see increased mortality along with an increase in infant mortality (already on the rise and at levels three/four times the state average in some regions).
- Mississippi would remain rated #51 for health outcomes, but the actual outcomes would be even worse. Obesity levels would continue to rise, especially among children.
- A reduction in the number of hospitals, especially in rural areas, was predicted. There would be fewer providers overall and more corporate involvement (thus a more intense focus on profit rather than community benefit) with those that are remaining.
- The cost of doing business in Mississippi would increase, as premiums rose to cover the higher costs for treating the uninsured and the workforce gets sicker. This would serve to drive businesses out of the state and hurt the state's overall economic development and potential. At the same time, fewer employers would be able to afford to offer insurance to their employees.
- The health care system would still be focused on treating illnesses, not working toward making people healthier.
- The gap between the health care “haves” and “have-nots” will create anger and resentment that could lead to social unrest and safety issues.

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

What to do about it? Ideas to consider:

These leaders indicated a shared desire for real change instead of incremental reform. While a wide variety of ideas and perspectives were raised, the following rose to the surface as common principles:

- **Universal or near-universal coverage.** All ideas had as a goal universal or near-universal coverage for Mississippians. This was something all participants believed was extremely important, although there were differing thoughts on how to accomplish it. Opinions on what ought to be covered varied, ranging from catastrophic to comprehensive, and proposed systems were both public and private and often a combination. But across all, these leaders envisioned a system in which every person in Mississippi gets some form of coverage and care regardless of age, income, employment or health status.
- **Encouraging and rewarding personal responsibility.** Participants concluded that individual responsibility must play a significant role and that the system must encourage

healthier behavior. In an effort 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, and flexible spending accounts, along with rewards and incentives for actions taken toward healthier lifestyles. On the education front, there was a special focus on children at the school setting (health lunches, nutrition education, mandatory exercise) and the idea of placing community clinics at schools.

- **Increasing coordination of medical care.** A key concept that surfaced was the idea of a “medical home” that would use a prevention model and serve as a gatekeeper for other care when needed. This was accompanied by an expansion of health information technology that in addition to enhancing the safety and effectiveness of care could also provide a way for providers to reach out to patients in rural locations. The idea of a centralized authority was another aspect of coordination, described as “keeping everything equal for all payers and beneficiaries in the system.”
- **Controlling costs.** Participants felt that any re-envisioned system must take comprehensive steps to control costs. Many participants believed that it made sense to adopt a system of “evidence-based medicine” to maximize impact of treatments and increase the cost effectiveness of care. The leaders discussed the need to restructure the profit motive for insurers to reduce that element of rising costs, perhaps through a cap on profits or adjusted loss ratios – and to look at containing pharmaceutical profits as well. They also expressed an interest in examining the impact of costs on hospitals and providers, perhaps asking them to pay into the system in return for lessening the burden of un-reimbursed care.

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 four general directions emerged to test with the public:

- **“Mississippi Medicare-for-All”:** Some of the scenarios laid out variations on single payer systems, in which the state government serves as the primary insurer for all state residents. All providers would be required to see patients with this type of coverage – but individuals could also choose to buy supplemental coverage if they like. Participants suggested that this approach could be funded through some sort of an employer tax along with some progressive public taxes.
 - **Pros:** A single payer system was described as equitable, efficient and simple. Businesses would benefit by limiting their involvement in and spending on health care and at the same time would gain a healthier workforce. Some also saw it as a much-needed paradigm shift in which comprehensive health care becomes a right – part of the “social contract” - rather than a commodity. They also believed a system with a single insurer would lead more quickly than any other approach to the development of a comprehensive health information system.
 - **Cons:** Participants noted powerful mistrust of government as a possible roadblock for single payer, along with fear that such a system would be driven by “politics.”

There were concerns about lack of choice and waits due to possible “rationing” and that this system would do nothing to increase personal responsibility, leaving people with healthier lifestyles paying more to help cover those without. They also raised the fear that decreased competition would inhibit creativity and innovation.

- **Prioritize Prevention and Personal Responsibility:** One group envisioned a system that provided all people in Mississippi preventive care with no deductible (“first dollar coverage”). Beyond prevention, a shared risk pool could be used to make coverage affordable to more people along with increased access to and incentives supporting the use of health savings accounts. Insurers and employers would create 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.
 - **Pros:** Many saw this approach as addressing a core issue in making significant reductions in the cost of health care. Both prevention and detecting conditions earlier reduces expenses and improves outcomes. People would enjoy higher quality of life and employers would have more productive employees. Supporters saw this as placing responsibility where it belongs – on individual choices which also provides increased personal control – while creating a system that encourages people to get regular care.
 - **Cons:** Some saw this as an overly intrusive approach, regulating personal behavior and creating a “loss of volition.” They wondered if it overstepped in trying to manage specific behaviors. They also were concerned about residents in the rural parts of the state not having enough education to be able to participate effectively. Providers were described as already being overstretched to meet current treatment needs and that new providers would be required for the prevention program.
- **Access for All: Shared Responsibility:** This approach is based on the premise of spreading out responsibility for health care and health outcomes. In this system, everyone that has an interest in a healthy Mississippi (employers, providers, individuals and insurers) would pay in to ensure that everyone is covered. There would a mandate for employers to provide health insurance or pay into a fund, accompanied by tax incentives to make it affordable. State-funded insurance would be expanded to cover more vulnerable populations such as the unemployed, disabled and elderly. The plan would have a strong prevention component as well.
 - **Pros:** This approach recognizes that everyone in Mississippi has an interest in creating a better health care system, and all bear responsibility for paying for it. Such an approach 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, including individual choice, while expanding coverage.

- **Cons:** Some saw that this would place an unreasonable burden on employers, especially small businesses who might be forced by the higher costs to lay off employees. Some employers might also choose to stop offering health insurance if the ability to pay into the central fund cost less (the “crowd-out” effect). There were also questions about how to design this so that those with healthy behaviors were not still paying for the “excess” expenses of those with less healthy lifestyles.
- **Reorganize Primary Care:** One of the approaches would require everyone in Mississippi to have a “medical home” in which a primary care provider provides regular and preventive care and coordinates other needed care. Health information technology would be an integral element, especially as a way to connect with patients in the many underserved counties with very limited access. The system would be state-funded and state-coordinated, with private payers and an expansion of public payers.
 - **Pros:** Participants cited continuity of care (“from birth to death”) as a key strength, along with more coordination of care for better outcomes. They envisioned better access for rural areas, plus the ability for providers to be able to piece together family histories. On the cost control side, the information technology and resulting patient database could help reduce fraud as well as unnecessary tests and procedures. Plus, it could be a boon to public health initiatives.
 - **Cons:** The hopes for rural access would need to withstand those who are skeptical about care without a provider in the room. The medical database raised fears about personal privacy and who would have the ability to access the data and for what purposes – coupled with a concern that providers would resist sharing “competitive” information. The medical home “gatekeeping” system limits personal choice and takes away people’s current ability to access specialists directly.

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 citizens from diverse regions in Mississippi. Viewpoint Learning, working with the Mississippi Health Advocacy Program, the Mississippi Center for Nonprofits 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 Mississippi citizens (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 Mississippi, including the conditions necessary for their support.

The ChoiceDialogues are designed to provide unique insights that go 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 a much broader cross section of the Mississippi public in serious discussion about health care.

Following the conclusion of the dialogues, Viewpoint Learning, MHAP and the Mississippi Center for Nonprofits will once again invite leaders to participate in an interactive briefing on the results. As we 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 Mississippi, 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 though 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.