“Let’s Look at Me Personally”:
Mapping the Gaps Between Expert and Public
Understandings of Sustainability and Health Care

A FrameWorks Research Report

Prepared for the FrameWorks Institute
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INTRODUCTION

The research presented here was conducted by the FrameWorks Institute and sponsored by Blue Cross Blue Shield of Massachusetts, Inc. The current research represents the first stage in a multi-method exploration of how communications can improve the American public’s understanding of sustainability and health care. More specifically, the goal is to identify strategies for communication that allow the public to see the importance of planning the future of health care in a rational and systematic way rather than approaching the issue through political, emotional, and individualistic considerations. Such an endeavor is critical at this point in time, when the sustainability of the health care system is being called into question by notable studies on America’s fiscal future. The National Research Council and National Academy of Public Administration’s report, Choosing the Nation’s Fiscal Future, for example, demonstrates that three major government programs – Medicare, Medicaid, and Social Security – are largely responsible for the dramatic growth of government spending compared to revenues. The report further argues that “no reasonably foreseeable rate of economic growth would overcome this structural deficit.” With two of these three programs based in health care, there is growing recognition that dramatic changes to health care must be enacted to ensure the future viability of this system and the economy more generally. Communicating effectively with the public about these changes will be critical in building support for the reforms and thereby fashioning a quality health care system that can be sustained into our nation’s future.

This particular report lays the groundwork for this larger communications effort by comparing expert discourse on sustainability and health care with the ways that average Americans talk and think about these issues. We comparatively analyze data from interviews with members of these groups to locate gaps in understanding that can ultimately be addressed through strategic communication strategies. Future phases of the larger project will seek to fill these gaps and address other challenges to public understanding by designing and testing targeted communications tools. Such tools can be employed to effectively and efficiently promote an appreciation of the critical importance of having a viable health care system; of the specific challenges this system faces now and will face in the future; and of the necessary changes in the domains of quality, efficiency and costs that must be made to achieve this sustainability.

FrameWorks has conducted research in the past documenting Americans’ conceptions of health care, in the current project, however, we seek to gain a more strategic understanding of the models that Americans use to make sense of the future of this system. Here, our aim is to describe the ways that Americans make sense of specific aspects of the system that determine its sustainability, including how they assess the quality of health care and explain health care costs.

The research presented in this report suggests that Americans reason about the future of the health care system by evoking a layered system of highly patterned ways of talking and thinking. At the most surface level, this talking and thinking is directly about health care but at a deeper level, it extends into foundational cultural models that Americans bring to their understanding of a wide range of issues. More specifically, this layered hierarchy of thinking and talking can be parsed into the following three levels.
1. **Patterned discourse**: At the most surface level, our informants fell into two opposing patterns of talk – they either said the system was on a path to failure or they rattled off standardized statements about the system enduring because “it simply has to.” These ways of talking were of little utility in enabling deeper explanations, and when the interviewers pushed informants to explain such statements, informants ran into notable difficulty. For this reason, we describe this discourse as “thin” and “shallow.” We therefore probed deeper to understand what, at a cognitive level, was supporting these easily discernable patterns of discourse.

2. **Narrow, specific definitional models of health care**: The most frequent answer to questions about the future of the American health care system was that this system is on a path to catastrophic failure. Digging down to try to find patterns of thinking that supported this highly standardized way of talking, analysis revealed four narrow, yet robust, definitional models of health care. These models – *health care as insurance, health care as rising costs, health care as bureaucratic giant, and health care as politics as usual* – lead informants to highly deterministic ways of talking about the imminent collapse of the system, or the equally deterministic discourse of “it will all be fine because it has to be.” These four definitional models of the health care system and the determinism that they structure preclude practical thinking about concrete changes that could be made to curb the path to failure.

3. **Deep foundational models of consumerism and humanism**: The narrow models of health care described above do not structure a working understanding of the health care system that enables thinking about more complex issues. When informants were faced with the difficult cognitive task of answering questions about how the system functions, who is involved, and what makes it good, they struggled. It became clear that their specific cognitive equipment available to think about health care was insufficient and failed to structure top-of-mind answers. Faced with this difficulty, our public informants dug deep into their cultural repertoire and found cultural models that assisted them in thinking about questions of function, players and quality. Analysis revealed the presence of two foundational cultural models that informants drew on to answer these more involved questions about health care: *consumerism* and *humanism*. Employing the *consumerism* model, individuals see the world as a marketplace – individual actors pursue their own self-interest by purchasing goods and services that maximize individual benefits while minimizing individual costs. These consumers purchase the goods and services from producers who operate to maximize profit in a free market system based on competition and the rules of supply and demand. On the other hand, thinking with the *humanism* model, our informants assumed a set of unalienable, basic, human rights and affordances. This model assumes that there are certain moral obligations that must be met and that these obligations should not be subject to the rules of the consumer marketplace. In the body of this report, we will explain the coexistence of both of these models and how informants bring them to bear in answering the complex questions about health care. In so doing we will demonstrate the dominance of the *consumerism* model in structuring how our informants conceptualized “thinkable” health care solutions.

Examining the interrelations between the three levels of thinking about health care sustainability and how individuals employ these patterns is key in crafting communications that can effectively build new, more productive ways of thinking about health care. In this report we distinguish between patterns of talking and patterns of thinking. We refer to the former as *discourse* – highly standardized and patterned cultural ways of talking that do not implicitly structure deeper
thinking. In fact, discourse typically arises as the result of the shared implicit associations and understandings that members of a culture apply in patterned ways in their reasoning – what we call cultural models in mind. There are specific models that structure thinking in a particular domain, such as the definitional models of health care we discuss here. And there are foundational models – models that undergird thinking across many different domains, such as the models of consumerism and humanism. These distinctions between patterns of talking and various levels of patterns in thinking are central to understanding the findings and implications presented below.

By pushing our informants to think through the complex questions at the heart of health care sustainability – issues of cost, quality and efficiency among others – we are able to compare their discourse and cultural models with the views of experts. In the following research report, FrameWorks uses a series of interviews with issue experts to identify principles, messages and themes that characterize the expert view of health care sustainability. Our research shows clear gaps in understanding between the ways that experts and the public understand this issue. We “map these gaps” to pinpoint specific places where communications tools are needed to bridge conceptual expanses. With improved knowledge of the “gaps,” we are able to move toward the second stage of Strategic Frame Analysis™. In this second stage, FrameWorks will identify communications strategies that can build public support for sustainable reforms by closing the gaps mapped by this current research.

**SUMMARY OF FINDINGS**

**Expert Interviews**

- **Serious reform is necessary but feasible.** The experts interviewed considered the current system of health care unsustainable. They did, however, face the challenge pragmatically, offering many feasible suggestions to sustain the system into the future. Experts focused their discussion of such reforms on the need to create more “value” in the system. They defined “value” as better health outcomes for lower costs.

- **Quality of care is paramount.** Experts cited global statistics, from rates of infant mortality to life expectancies, to show that the United States’ health care system lags behind that of other countries, all of which spend less than the U.S. to achieve better outcomes. They saw numerous opportunities to improve the quality of care, which for them was focused on patient health outcomes. Furthermore, they asserted that this could be done without increasing costs.

- **Reform should increase efficiency.** Experts looked to increase the efficiency of the system. They saw cost and time inefficiencies as two of the most important areas to reform in order to increase sustainability.

- **Prevention is the best medicine.** Experts also focused on the need for a more preventative approach to health care, and they discussed patient safety as an important aspect of prevention.
Cultural Models Interviews

• The future is “hard to think.” One of the most significant findings from our interviews with members of the general public was that informants’ thinking about the future was extremely underdeveloped. When we asked people specifically about sustainability and more generally about the future of health care, we found three thin surface patterns of discourse. These ways of talking were shallow and unproductive as informants could not elaborate further on or explain these deterministic beliefs.

  o Sustainability means stasis. The public defines sustainability as maintaining a current state.
  o Path to failure. The system is on a course towards collapse.
  o Blind faith. Health care will endure, because it has to.

• Thinking about the future is structured by narrow definitional models of the health care system. To understand why Americans predominantly considered the health care system to be on a path to failure, we plumbed for the patterns of thinking that gave rise to these more surface patterns of talking. When we dug deeper, we found four specific definitional models of health care that analysis suggested were structuring the patterned discourse about the future of the system.

  o Health care = insurance. When Americans think about “health care,” they focus narrowly on the specifics of “insurance” coverage. This association proved so powerful that it crowded out other aspects of health care, such as doctors, hospitals, and other health-related issues.
  o Health care = rising costs. Thinking about the costs associated with health care often dominated discussions of the future of health care. Costs, in this case, were conceptualized from the individual’s point of view as “how much am I going to have to pay.”
  o Health care = bureaucratic giant. Informant discussion evidenced an implicit understanding in which the system is assumed to be so complex and confusing that it takes on qualities of something “out there” that belies comprehension.
  o Health care = politics. Americans assume that any discussions about health care involve national/party politics – a conceptual connection that activates all of their cultural models of government and brings them to bear in thinking about health care. Because of the assumptions following from this model, the discussions about the future of health care were often emotional, highly pessimistic and were strongly flavored by a “politics as usual” sense of futility.

• Deeper foundational cultural models are recruited when narrow models of health care are insufficient in answering more complex thinking. When we dug into Americans’ understandings of more complex issues related to health care, such as “function,” “access,” “quality,” and “affordability,” issues that require an understanding about how the system works, the four specific definitional models of health care described above proved unproductive. By this, we mean that these definitional models, which provided ways of thinking about what health care is, were unproductive in helping
people answer these process-based questions about health care. Faced with this difficulty, informants dug down to a deeper level of cognition and recruited foundational cultural models that provide ways for Americans to think about how the world works. Analysis showed clearly that when challenged with questions that their specific models of health care could not handle, informants relied on the opposing foundational models of consumerism and humanism.

- **How does health care function?** The consumerism model dominates thinking about this question, leading people to think about health care as a consumer good that individuals purchase in a marketplace governed by the laws of supply and demand.
- **Who are the major actors in health care?** Although health care was primarily associated with insurance, we pushed informants to consider other actors, such as doctors and government. Here again, people drew on models of consumerism and humanism in a way that led them to value certain actors (companies) but not others (government).
- **What makes health care good?** With respect to “quality,” the American public largely drew on the implicit understandings of quality as choice but also considered quality as cost and as technology. These assumptions are also highly consistent with the prevailing consumerism model.

- By understanding how these models constrain and enable certain ways of thinking about health care, we can better understand public speculations on what should happen with the future of health care. These “thinkable solutions” are also largely based on the consumerism model. Relying primarily on individualistic thinking, our informants espoused recommendations like “limiting CEO pay” and “behaving in healthy ways.” The research reveals that Americans on both sides of the political aisle are essentially arguing for the status quo and not engaging with any productive consideration of the changes that experts see as necessary to create a viable system.

**Overlaps in Understanding:**

Research identified the following overlaps between the ways that ordinary Americans and experts understand the issues associated with health care sustainability. These overlaps suggest ripe areas to explore in future prescriptive communications research:

- **Individual agency.** Experts and non-experts both called for increased agency for patients. They advocated for increased patient control and greater access to information.

- **Efficiency.** Experts and non-experts both saw several costly inefficiencies in the current system. Both groups concluded that the way the current system manages and uses information is inefficient. Both groups also shared a focus on time wasted in unnecessary follow-up appointments, long waiting times and bureaucratic referral procedures. Non-experts viewed this as a poor use of patient time and an annoyance, whereas experts viewed such inefficiencies as key opportunities to cut costs and create a “leaner system.”

- **Prevention.** Experts and non-experts overlapped in discussing prevention as a way for the system to save money. Both groups discussed prevention by way of avoiding unnecessary trips to the ER and by maintaining a healthier population. Experts tended to
see systemic ways to work toward a healthier population while lay informants placed responsibility on the individual. Nonetheless, we think this is a promising conceptual area for communication.

Gaps in Understanding:
Based on this research, we found several significant gaps in understanding between the ways that ordinary Americans and experts understand health care and the sustainability of this system:

- **Understandings of sustainability as a useful way to think about reform.** Non-experts had at best a rudimentary understanding of the concept of sustainability and at worst a misunderstanding of sustainability as stasis. Experts, on the other hand, had exactly the opposite understanding – a notion of sustainability as predicated on *dramatic change and reform to the existing system*.

- **The nature of rising costs.** Both experts and non-experts were concerned about skyrocketing health care costs, but they differed dramatically in their thinking about why costs were rising and in the ways that such costs could be reduced. Experts saw health care costs rising disproportionately due to inefficiencies in the system, and they envisioned practical ways to reduce costs, such as reforming financial incentives and coordinating care. Non-experts considered health care costs to be rising because, as our informants explained quite simply, “everything goes up.” Trapped in this pattern of thinking, our public informants could see no way to remedy the situation, other than by taking action against individuals, such as making sure CEOs received lower salaries and bonuses. Rising costs became a simple fact of life and a characteristic of “how the world works,” rather than a function of the way the health care system is built and managed.

- **Quality.** Our lay informants patriotically expressed their belief that health care in the United States is “the best in the world.” This belief was based primarily on the public’s models of quality – as choice, cost, and technology – and on what has been called “American exceptionalism,” or the idea that America’s unique circumstances create a set of institutions that are innately superior to any other. From this perspective, thinking about improvements is tempered by the notion that the U.S. is already “at the top.” Experts, on the other hand, saw serious concerns with quality, citing global health statistics that painted a much different reality. They focused reform considerations on outcomes, such as increased patient health and safety.

Communications Implications

The most significant implication for communications that emerges from this research is that Americans lack a fundamental understanding of how the health care system works and, perhaps more importantly for this communicating about the future of health care, that this lack of understanding prohibits members of the general public from productively engaging in discussions about the future of health care and the changes that must be made to assure the sustainability of this vital system. This inability to understand the workings of the system is reinforced at all three cognitive levels discussed: the deterministic surface talk about the future,
the specific definitional models of health care, and the deeper foundational models of consumerism and humanism.

The overarching recommendation that emerges from this research is to treat communications as knowledge building – and a major building project at that – rather than as targeting and cuing any specific existing cultural models. Communicators need big ideas – ways that the conversation can be framed that will avoid problematic models while also providing, in accessible ways, more productive understandings of how the health care system works. At the same time, they must prevent fall-back to the largely unproductive tension between consumerism and humanism. Such building strategies will be developed and tested in the next phases of FrameWorks’ research. In the meantime, the FrameWorks Institute offers the following preliminary recommendations. Some of these are broad recommendations that will set the stage for the reframing efforts. Other recommendations target more immediate refinements that have as their goal, not the foundational knowledge-building that is ultimately necessary, but the enactment of a more immediate “do no harm” strategy. This can help communications avoid falling into many of the traps in public thinking that this research has identified.

- Address the zero-sum consumerism perspective by explaining how quality and costs can simultaneously be addressed.
- Explain the power of science to improve “outcomes.”
- Use the value of “prevention” to shift perspective and focus attention on key health promotion work that is required to reduce costs and move towards system sustainability.
- Acknowledge rising costs carefully, and only with a strong dose of pragmatism.
- Focus on the system’s responsibility to provide better and more available information.

RESEARCH METHODS

I. Expert Interviews

To locate “experts” on health care sustainability, Blue Cross Blue Shield of Massachusetts compiled initial lists of both academics and key figures in the field. FrameWorks then narrowed that list down to 11 key experts for interviews. Given the wide range of professionals studying and working in this field, the final list was created with an eye for including as much variation as possible in background (disciplinary), specialization (content specialty) and professional role (academic researchers as well as those working on policy and program design and evaluation). In this way, the final list of “expert” participants represented a wide range of opinions on and approaches to the issue of health care sustainability.

A total of 11 one-on-one interviews were conducted by telephone with these experts from October 2010 through January 2011. Interviews lasted approximately one hour and, with participants’ permission, were recorded and subsequently transcribed for review and analysis.

Expert interviews consisted of a series of probing questions designed to capture interviewees’ understandings of the topic of health care sustainability as it relates to the American health care
system and the range of current and proposed reform ideas, initiatives, challenges, and the wider implications of these issues. The interviewer went through a series of prompts and hypothetical scenarios designed to challenge expert informants to explain their research, experience and perspectives, and to break down complicated relationships and simplify concepts and findings. In addition to preset questions, the interviewer probed for additional information throughout the interview. In short, the interviews were semi-structured, collaborative discussions with frequent requests from the interviewer for further clarification, elaboration and explanation.

Analysis employed a basic grounded theory approach.iii Common themes were pulled from each interview and categorized, and negative cases were incorporated into the overall findings within each category, resulting in a refined set of themes that synthesized the substance of the interview data.

II. Cultural Models Interviews
To complete the other side of the comparison, FrameWorks conducted 20 in-depth cultural models interviews with members of the American general public. Twelve of the interviews were conducted in Boston, Massachusetts, and the remaining eight were split between Philadelphia, Pennsylvania, and Hartford, Connecticut. The interviews were conducted by three FrameWorks Institute researchers in December 2010 and January 2011.

Informants were recruited by a professional marketing firm through a screening process developed and employed in past FrameWorks research. Informants were selected to represent variation along the domains of ethnicity, gender, age, educational background and political ideology (as self-reported during the screening process). Individuals working in fields related to health care were excluded from participation to avoid biasing the sample and impeding our ability to gather data about how members of the general public, as non-experts, reason about the target concepts.iv

Efforts were made to recruit a broad range of informants in terms of age, political identity and level of education. All in all, 10 women and 10 men were recruited. Nine of the 20 participants were Caucasian, six were African American, three were Hispanic, and two were Asian. Five participants self-identified as “conservative,” five as “liberal” and the remaining 10 as “middle-of-the-road.” The mean age of the sample was 41 years old, with an age range from the early 20s to the late 60s. Although the sample was constructed to include as much variation as possible, it is not meant to be statistically representative. A subsequent phase of FrameWorks’ research will quantitatively test demographic variability and representativeness via online experiments with a large sample size and rigorous statistical sampling techniques.

Informants participated in one-on-one, semi-structured “cultural models interviews.” Consistent with interview methods employed in psychological anthropology,\textsuperscript{v} cultural models interviews are designed to elicit ways of thinking and talking about issues – in this case, ideas about health care and the sustainability of the health care system. All interviews were recorded and transcribed. Quotes are provided in the report to illustrate major points, but identifying information has been excluded to ensure anonymity.
Elements of social discourse analysis, cultural models analysis and grounded theory were applied to identify shared cultural models. First, patterns of discourse, or common, standardized ways of talking, were identified across the sample using a basic grounded theory approach to thematic analysis. These discourses were then analyzed to reveal tacit organizational assumptions, relationships, propositions and connections that were commonly made but taken for granted throughout an individual’s transcript and across the sample. In short, our analysis looked at patterns both in what was said (how things were related, explained and understood) as well as what was not said (shared, but taken-for-granted assumptions). More detailed information about the specific methodology and format of these interviews can be found in Appendix 1.

FINDINGS

I. Expert Interviews

Responses from the expert interviews point to a single expert view of health care sustainability that was highly consistent across all experts.

A. Sustainability as a Useful Concept, but an Empty Term

Experts, for the most part, were interested in the concept of sustainability but not the term. When we asked about sustainability, several experts pointed out that they preferred not to use the term.

**Expert:** The first thing I would say is that that is not a term or a concept that I think is widely being thought about. So the issues are more about affordability, about access, and I guess quality. So, to me, when you talk about “sustainability,” the question is, is the health care system of the future going to be different than it is today in terms of will it be as high quality even though people don’t realize that it’s not as high quality as they may think it is. Is it going to be as affordable and will they be able to get equivalent access to the doctors, hospital services that they have today?

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**Expert:** [Sustainability] is not a term that I use very frequently in anything I speak about.

**Interviewer:** So what term would you usually use?

**Expert:** How about an effective and efficient system?

Despite the experts’ discomfort with the term, they agreed on a definition of the concept that was based on the idea of costs.

**Expert:** I would define sustainability as a health care system that we can afford, where we, as Americans, can afford to provide the best possible care to everyone. And for our children.
Experts explained that in order to increase sustainability, the system itself would have to be significantly reformed. Consequently, all the changes discussed by experts were intended to make the system more sustainable, but the term itself was not seen to hold any special analytic power in thinking about the long-term viability of the system.

**B. The Current State of Affairs Is Not Sustainable**

The experts we interviewed agreed that the current rate of health care spending is not sustainable. When asked to explain this “impossible future,” experts focused on the costs and quality of the system.

**1. Health Care Costs**

The staggering growth of health care costs as a percentage of GDP was a consistent concern articulated by experts. That these costs were growing faster for health care than for any other sector of spending with a growth rate so high that, as one expert put it, it is “cannibalizing the economy” was a major preoccupation across this set of expert interviews.

**Expert:** These costs are just not sustainable. It’s not sustainable for federal or state government’s health care costs, consuming an increasing amount of federal and state dollars that then can’t go to other things that we all like, like education, and police, and fire, and infrastructure.

**2. Quality**

Experts were adamant that the quality of care in the current system is poorer than it should be. Despite the oft-invoked statement by politicians that America has the “best health care system in the world,” experts were unanimous in arguing that, when measured by outcomes across the system, the United States does not provide consistently high-quality care. Experts cited global statistics of various types, from infant mortality rates to life expectancies, to show that the U.S. system lags behind other countries, all of which spend less than the U.S. to achieve better outcomes. One expert said:

**Expert:** Despite spending more, we have substantially worse health by every measure. We don’t live as long, we have higher infant mortality rates, and we have more lives lost for conditions that are preventable. And I don’t think the American public understands that we’re throwing money at something in the name of buying health, but we’re not getting health in return.

Experts often pointed out patient safety as a critical area in need of quality improvement. Experts cited hospital infections as a major threat to patient safety and to cost efficiency.

**Expert:** There are some hospitals in the country where your chance of a hospital-acquired infection is essentially zero now and others where your chances are substantial.
In sum, experts were concerned about the current state of affairs being unsustainable primarily because of skyrocketing costs. They also decried the current state of affairs by focusing on the fact that quality and safety were not as good as they could or should be.

C. Reforms Are Required to Make the System More Sustainable

Experts saw concrete reforms that could be made in order to make the system more sustainable for the long run, and they spoke of such changes in a largely pragmatic tone. The two main areas on which they focused in their discussion of reforms were quality and efficiency:

1. Quality

- **Quality can be improved without rising costs.** Experts frequently made the argument that quality could be improved while at the same time reducing costs. They explicitly argued against the idea that “rationing” was the only way to cut costs.

- **Quality is about improving patient health outcomes.** Experts consistently measured the quality of care in terms of patient outcomes, and argued that methods for improving outcomes have been identified and should be implemented. They include:

  a. **Changing doctor incentives:** Experts all pointed out that doctor compensation is completely divorced from outcome and that this disjuncture needs to change. This is discussed in more detail below, as this was a primary reform stressed by experts in addressing issues of the system’s efficiency.

  b. **Enhancing patient agency through education:** Experts called for more education and support for patients to augment their agency in the health care decision-making process. Experts explained that this enhanced agency would include the capacity to: (1) query and understand, rather than blindly follow, doctors’ recommendations; (2) be aware of treatment costs so that patients can help conserve health care resources; and (3) be more informed in making key health decisions, such as those affecting end of life care.

  c. **Relying more on evidence-based medicine:** Experts consistently explained that increasing the system’s reliance on evidence would improve efficiency – improving both health outcomes and making the system more cost effective. Many pointed out that medicine is currently treated as “an art rather than a science,” and that gathering reliable data about treatment outcomes, costs, and other factors is anywhere from challenging to next to impossible. All experts stressed the necessity of building an integrated, electronically accessible evidence base for American health care practice as a critical element in addressing the overall system’s viability.

  d. **Improving safety:** Experts stressed the importance of patient safety, both in terms of outcomes and cost savings. By way of example, several experts cited the risks of infection that accompany admittance to many hospitals in the country, a safety hazard deemed both fiscally wasteful and eminently preventable.
2. Efficiency

- **Care must be coordinated by a primary doctor.** Experts stressed that care must be centrally coordinated in order to reduce wasted time and money. Many argued that efficiently coordinated systems of care are in place in some places, but that there are many parts of the system that do not employ such structures of coordinated care (Medicare, for example). Another example of poorly coordinated care is the frequent use of expensive and inefficient ER services in place of primary care services. Experts stressed that having a “medical home” in the form of a primary care provider was an essential component of developing system-wide coordination of care.

- **Care can happen outside traditional sites.** Experts suggested several ways that care can be managed outside of the hospital and outside of doctors’ offices. They stressed that chronic illnesses can be managed in the home, and they proposed that some follow-ups with doctors can be made by telephone or email rather than via an unnecessary in-person office visit. Experts focused on the time wasted by these visits for both the patients and the doctors, and stressed the financial imposition of such inefficiencies. They also noted, however, that there are no financial incentives for this kind of follow-up practice and that reforms need to be made to incentivize such changes. The net result of these changes would therefore be improved outcomes for patients at a lower cost to the system – the quintessence of experts’ concept of efficiency.

- **The government is a necessary player in improving efficiency.** Experts stressed that increased efficiency and quality improvements will only be possible with increased government involvement in health care. Some experts called for more government involvement in centralizing patient information as well as coordinating results from evidence-based medicine studies across the country. Other experts called for more government involvement in evaluating providers (a “Consumer Reports” of health care), in order to arm patients with the information they need to make informed choices. Some experts expressed the caveat that these changes did not necessarily have to be implemented by the federal government; they explained that many of these services could be applied at the state or local level.

- **Prevention is critical for efficiency.** Experts uniformly discussed the importance of prevention as a means of both increasing quality outcomes and keeping costs down. Prevention was discussed in relation to wellness initiatives and as a means of avoiding costly ER visits. Experts mentioned the unhealthy population of the United States and the costs to the system due to preventable chronic illnesses.

- **Incentives must reward quality over quantity.** One of the most critical areas for reform (mentioned above as it also deals with the issue of quality) is the way financial incentives are structured. Experts emphasized that the “fee for service” model needs to change. Experts cited this current model through which doctors are compensated as one of the primary reasons that the U.S. has such a costly system. Experts also stressed the
disproportionate incentives for doctors to go into specializations and for hospitals to cater to technological innovations for financial reasons rather than outcomes.

Figure 1: The Expert View of Health Care Sustainability

With this summation of expert thinking in mind, we now turn to the results of the cultural models interviews that were conducted with members of the American general public who lack specific expertise in this topic.

II. Cultural Models Interviews

We set out to examine how Americans think about the future of the health care system and to determine how well they understand the concept of sustainability applied to the domain of health care. We gathered data that allowed us to answer these questions through a set of cultural models interviews. What we found suggests that Americans have considerable difficulty in productively considering how specific reforms to this system would promote or impede the future viability of health care in this country. At the most surface level, our informants fell into two opposing patterns of talk – they thought the system was either on a path to failure or they blindly thought,
“Everything will be OK because it has to.” In order to explain how Americans come to talk in these patterned ways and have difficulty explaining such views, we dug deeper to look at the patterns of thinking that could be seen to support these deterministic discourses.

First, we found that the public’s thinking is constrained by four highly specific and narrow definitional models of health care that structure the deterministic patterns of thinking (see Section B below). Second, our interviews suggest that these definitional models fail to provide Americans with productive ways of thinking more deeply about issues related to how this system works. Faced with this difficulty, they dig even deeper and recruit foundational models in order to think through more complex issues such as how the system works, how its parts and parties are related, and what quality means in health care. Below we address each of these three levels in turn, working from the most surface level of largely empty patterns in talk, down through specific definitional models of health care and finally to the foundational cultural models that were brought to bear in making sense of health care when the more specific models proved insufficient.

A. Patterned Discourse: Sustainability and the Future of Health Care

Analyzing the data from questions in which we asked informants to think and talk about the future and sustainability of the health care system, FrameWorks researchers found the three patterns of discourse listed immediately below. It is essential to realize that these discourses operated at the level of talk rather than as deeper patterns of thinking and reasoning. Informants rattled them off in standardized ways, but they were largely unproductive in helping them think through more detailed answers regarding the future of the system. This was evidenced by the frequent inability of informants to go deeper and explain why they, for example, thought that the health care system was “on a path to failure” or what could be done to right this sinking ship.

1. Sustainability Means Stasis
2. Path to Failure
3. Blind Faith

1. Sustainability Means Stasis

We asked our informants if they had ever heard the term “sustainability” as related to health care and what it meant in that particular context. If they had not heard the term “sustainability” used in relation to health care, we asked them what the term generally meant and then asked them to speculate on what it might mean in the domain of health care.

Responses to this line of questioning revealed an implicit understanding in which sustainability was assumed to mean “stasis.” This was true when the term was considered from within the context of health care and also when it was defined more generally. For these informants, sustainability was not an adaptive or dynamic process, but rather one that was fundamentally about “maintaining” a current state.
Informant: [Sustainability means] to try to sustain and remain and not go up or down. Just to maintain what you’ve got.

Informant: Sustainability means that they hold the course. Sustainability means you’re getting the job done. You’ve got to maintain, got to have sustainability with what you already have...maintaining.

Informant: I would think sustainability would be focused around overall citizen health. But I could also see it being referred to in the light of sustainability of the system in general and whether or not the foundation can be strong enough to withhold kind of the pressures it’s faced now.

In sum, our informants did not see sustainability as implying adaptation. Instead, they envisioned sustainability as maintenance of the status quo in a way that assures steadiness and stability. But this is not to say that our informants couldn’t think about the future of health care. In fact, they had two highly patterned understandings that they employed in thinking about the future of the system.

Below we examine the two patterns of discourse that informants invoked when thinking about the future of health care.

2. Path to Failure

The most dominant way that informants talked about the future of health care was that it is on a course toward imminent failure. Informants suggested that the health care system as we know it could not endure, and that if nothing changed, the system would collapse. From this perceptual vantage point, informants explained that when the system does collapse – an event that they explained was inevitable – the general health of the American population will decline.

Informant: I think that there's going to be a lot of decline in how long people are living. Instead of saying we're going to live up to 70, we're going to be living up to 50 or 60. I think we're going to have a lot more deaths.

Informant: If the health care system stayed the same, I could see a collapse of the whole system. In terms of those people who can't afford it, I could see them not being treated at all. Just dying.

In our interviews, we pushed informants to explain more about what they had little difficulty describing as an imminent failure. We asked questions about what specifically would cause the system to collapse or what could be done to avoid such an implosion. Informants’ answers to these questions made it clear that these truly were patterns in talk rather than rich structures of thinking with inferential potential and implicit associations.
Our analysis in Section B will show how the *path to failure* discourse arises out of four specific cultural definitional models of health care that lead informants in deterministic directions in thinking about the future of this system.

3. Blind Faith

In addition to the *path to failure* discourse, informants’ discussion across the sample evidenced a *blind faith* discourse. Talking in this way, informants reported that the health care system will endure because it “has to.” While informants demonstrated faith that the nation would find a way to solve the problems attendant in the system, their faith was “blind” and lacked any clear understanding of how this would be accomplished. Informants frequently toggled between this understanding and the *path to failure* discourse. It was clear that, for our informants, these patterns of discourse coexisted without any apparent contradiction – although health care was currently on a path to failure, there was blind faith that the problems would somehow be resolved.

*Informant*: *This is America and you encourage creativity and innovation. I can't imagine not having a doctor to go see or a hospital to go to. I mean, they've been around forever; there's no reason to think they wouldn't stay around forever.*

Just as with the *path to failure* discourse, when we pressed our informants to explain more about how the system would endure, they stumbled, stammered and ran into palpable difficulty, employing a simple rhetorical strategy in which the system would persist because it “has to.”

**Implications of Sustainability and the Future of Health Care Discourse**

- **Discourse about the future is heavily deterministic and therefore presents problems for communicating about solutions.** Informants were alternatively committed to the notions that the system is either destined to fail or that “success is the only option.” Both of these assumptions are problematic in their determinism, which results in disengagement from the issue. What’s the point of learning more about the issues or working for change if the result has already been determined? Furthermore, the *path to failure* model may appear promising on the surface, as it echoes some of the experts’ caution about the calamities that lie ahead if we do not address existing problems in the system. However, the problem with this rhetoric is that while it allows people to parrot the existence of “major problems,” it inhibits thinking about the ways that the system can be fixed. That is, the determinism inherent in this dominant pattern in discourse impedes solutions-thinking.

- **Thinness of the discourse presents mixed implications.** On one hand, because informants talk and think about the future of the system at the surface level only, communications about this issue will not be fighting against deeper well-developed but counterproductive models. On the other hand, because they are so shallow, these patterns of discourse are not productive cognitive structures on which to build. As such, this research suggests that reframing the issue of the future of the health care system is a task
that will be more about knowledge building rather than shifting from more to less problematic existing models.

- **Sustainability as stasis is fundamentally problematic.** The common misunderstanding of sustainability as stasis is highly problematic for communications that aim to use this term as a frame for promoting reform. Our research shows clearly that when models of sustainability become operative as a way to think about the health care system and its future, Americans will focus on maintaining current practices and will find change threatening and “hard to think.”

### B. Specific Models of Health Care

As described in the section above, our informants were only able to talk about the future of the health care system at the surface level and were largely incapable of explaining their answers. This is a classic symptom of the difference between patterns in talk (discourse) and patterns in thinking (cultural models). Of the two patterned ways of talking about the future, the path to failure dominated discussions. Therefore, the pressing analytic task for us was to provide a cognitive explanation for why informants so consistently came to the conclusion that the system is on a path to failure.

We hypothesized that this dominant pattern in talking about the future of health care could only be understood by digging down to a deeper level – looking specifically at the cultural models that inform thinking about health care in general, not just the future of this system. We found four basic models of health care that indeed explain how Americans come to the dominant view about the inevitability of the failure of this system.

The four basic models of health care are:

1. Health care = insurance
2. Health care = rising costs
3. Health care = bureaucratic giant
4. Health care = politics

Together, these models lead to a view of the health care system as an insurance-based bureaucratic nightmare with costs spiraling out of control that exists in the realm of politics and is without solution. This view contributes to Americans’ disengagement with the issue; they are dissuaded from learning more about the specifics of the system and unwilling to take action to work towards improvement. In this section, we present these four basic models of health care and show how these models structure and support the specific path to failure view of the system.

#### 1. Health Care = Insurance

All FrameWorks interviews included the general question: “what comes to mind when you hear the term health care?” There are many ways that our informants might have answered that
question. They might have thought about the birth of a child or a friend who got sick from infection during a routine hospital visit. They might have thought about an elderly parent’s daily medications or the latest episode of “Grey’s Anatomy.” But the overwhelming answer to this and subsequent questions about health care – even where questions were directly aimed at “health” and “medicine” – was insurance. In short, when Americans think about health care, their thinking is dominated by one part of this system – the insurance industry.

Informant: [I]t’s weird because I have a mindset, like an American mindset, where I think health care, I think insurance bills, and I think about policies that make health care not work.

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Informant: I think about coverage. When I think health care, I think of having insurance provided by somebody.

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Interviewer: When you hear the word or the term "health care," what do you think about?

Informant: Just the medical insurance that I get through my job.

In addition, in each of our 20 interviews, this model continued to structure informant thinking over the course of the next two hours, to the point where much of what informants talked about was health insurance. This is strong evidence of a truly powerful implicit association – a highly dominant cultural model of health care. This focus on insurance persisted despite multiple questions and probes that tried to redirect informants to non-insurance aspects of the system. For example, with several questions, we tried to get people to talk about the medical care aspect of health care or where people “access” health care, or about health as an outcome of the system; we wanted to get their understandings of hospitals, doctors’ offices, clinics, etc. Instead, we found informants, at an implicit level, clung tenaciously to the association that health care is about the system of insurance. In the following example, an informant is asked about where he accesses health care. He responds with the following:

Informant: I access it online. I mean, I [also] know that there's pamphlets when you're employed at a new job; there's pamphlets and information that's given to you.

One additional way we pushed informants to check the strength of this fundamental assumption was in asking them to think about the health care “system.” We expected that priming them with the word “system” might elicit bigger-picture thinking about the various parts and parties that make up health care. Instead, our informants continued to boil it down to one part of the system.

Informant: The health care system? I guess a health care system could be one company’s different types of coverages. Like Aetna...who else is another big provider? Blue Cross and Blue Shield. You know they have their large insurance companies that
provide health insurance. In my opinion, a system would be, Aetna would have a different health care system, a means of developing insurance plans and marketing them.

Because Americans so strongly and narrowly think of health care as health insurance, when they try to think about the future of health care, they are similarly focused on insurance. This trains their attention on what they know about insurance, mainly the costs that it imposes and the headaches that it creates in their lives. These notions of cost and inconvenience can be seen to give rise to the path to failure discourse described above.

2. Health Care = Rising Costs

If the model of health care as insurance explains what Americans are thinking about when they think about the sustainability of health care, the implicit association informants made between insurance and skyrocketing costs explains the primary reason why they think health care is on a path to failure.

Informant: Cost control is becoming out of hand, and I think that's the major issue – money.

Interviewer: What comes to mind for you when you hear the term “health care,” when you hear those two words?

Informant: Honestly, when, probably I don’t know what most people would think – maybe of being taken care of – but I think of cost.

This preoccupation with cost has been noted by previous FrameWorks research. In a Message Memo summarizing health care research conducted from 2002-2004 in Arizona, California, and New Hampshire, FrameWorks researchers concluded that:

For citizens/voters across the three states, health care was largely considered to be “about” cost. The first words used by focus group participants to describe health care related to cost: expensive, money, uncontrollable, etc. Left to their own devices, they defaulted to a health care conversation that was almost entirely focused on cost. People also worried that their own access to health insurance would be constrained by escalating costs and thus, the entire solution to access problems was making the product (health care) more affordable.

Because health care is modeled as insurance, informants often asserted or assumed that insurance company greed was responsible for the rising costs.

Interviewer: What’s responsible for the costs that continue to go up and up? How come?

Informant: I think there’s a lot of greed out there. I think that, again you’re paying eight hundred to a million dollars maybe for a director of a hospital and then all the
equipment costs continue to rise I’m sure. I don’t know how much negotiating goes on. I just think sometimes people take it for granted that there’s free money there and they just aren’t as careful and they get into financial problems.

It is critical to note that this model, though generative in thinking about the problems with health care (or rather the problems with insurance), was not useful in understanding how money actually flows through various parts of the health care system. Instead, it was informed by what appears to be a more foundational assumption that costs for everything are rising:

**Informant:** Everything goes up. I don’t know why. It just seems like nothing goes down. And in a good economy, things still go up.

This model of health care as rising costs supports and explains the more surface *path to failure* belief, as seen in the following quotes.

**Informant:** I think that the cost, the premiums are going to continue to rise, and I think they’re going to rise to a point that employers aren’t going to be able to afford them anymore.

**Informant:** People will not be able to afford it. There’ll just be a broken system.

This naturalistic way of thinking – that “everything goes up” – is emblematic of the ways that the American public misunderstands costs as part of a broader, planned system. Instead of a productive discussion about incentives, for example, Americans conceptualize rising costs as natural, and therefore inevitable.

### 3. Health Care = Bureaucratic Giant

Adding further support for the *path to failure* stance were informants’ conceptions of the health care system as a bureaucratic giant.

**Informant:** It's so complicated. You don't know what you're covered for. You get sick, you don't know if it's covered. I don't go to the doctor that often. But I don't necessarily want to go and get something checked out if I might get sick in three months and I've already used my one check-up a year. And I have to pay $300 or $400 because it's out of policy.

**Informant:** There are loopholes and there are hoops that you have to jump through to get everything. If he could have just gone in, then again, if they see the guy and get it taken care of, then it wouldn't be a problem. But right now there are a lot of hoops you have to jump through to get the right things done.
Informant: *Take any bill that you get. They give you a 100-page booklet on the services that we provide you. You get a booklet of all these things, people get lost in it, and they don’t understand what’s being provided. Also, you get bills, and you’re like, I have absolutely no idea what this is, and you can get the same exact service two different times, but it’d be two different prices.*

Informants were so overwhelmed in trying to grasp the complexity of the insurance bureaucracy (*health care = insurance*), that they had difficulty thinking about specific reforms.

Interviewer: *What would you think are the major challenges facing our health care system today?*

Informant: *I just think there are just too many layers, upon layers, upon layers, upon layers to get through. I just think it’s way too complicated and I don’t know that they’ll ever be able to whittle it down to something that can work for everybody. I think it’s kind of gotten out of control. You know, “too many cooks spoil the soup” type of deal.*

This frustration with the perceived complexity of the system led to a metaphorical understanding of the system as a giant:

Interviewer: *When I say “health care,” what comes to mind for you?*

Informant: *A big jolly green giant. A big monster that controls a lot of what goes on in the health care industries, how doctors practice, how people take care of themselves, and how people see health care. It’s a big giant. I see it as a big giant.*

Interviewer: *All right, so it’s a “jolly green giant”?*

Informant: *Well, not so jolly. It’s really mean.*

Considering these three models (health care as insurance, rising costs, and bureaucratic giant), it’s easy to see how Americans consider the system to be on a path to failure. They metaphorically envision a lumbering, mean giant that is bloated by rising insurance costs and burdened by bureaucracy and complexity. The task of addressing this massive lumbering monster proved too daunting for informants to address. This pattern of disengagement and the lack of agency that was apparent across all our interviews are further explained by the fourth model of health care.

4. Health Care = Politics

When informants thought about the future of health care and reforms to improve the system’s viability, they were constrained by a fourth model of health care, *health care as politics.* Informants found it difficult to separate health care from politics and assumed an intertwined and symbiotic relationship between these domains. This trend was almost certainly accentuated by the timing of these interviews, as they occurred during the immediate aftermath of the lengthy and contentious debate surrounding the signing of the Patient Protection and Affordable Care
Act in March 2010. When first asked about health care, many immediately registered the topic as one that was inseparable and inherently embroiled in politics.

**Interviewer:** When I say “health care,” what comes to mind for you?

**Informant:** Controversy!

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**Interviewer:** All right, so we’ll start off talking about “health care.” What comes to your mind when you hear the term “health care”?

**Informant:** [SIGH] I think about Obama and the health care reform act that he pushed through. And I think what that ultimately means to me, and what I think about is, I end up spending more money, and I see it every day as my premiums go up and now having a new family, means I’m spending more.

The emotions generated by the topic were strong – people used words and phrases like “anger,” “frustration,” and “pisses me off.” But when asked for specifics of the reform package, not one of our informants could even make a guess as to one of the plan’s specific reforms.

**Informant:** I’m not even going to bullshit you. I don’t really know. I don’t know specifics. But I don’t believe everyone’s happy.

While people could not name specifics, they did generally believe that there would be two consequences from the changes: a) more people would be covered; and b) costs would go up.

**Informant:** I feel like it’s just going to raise our premiums…cause, listen, insurance companies aren’t going to provide stuff for free. So, you know, providing more free stuff to people who can’t afford it means that the people who can afford it are going to pay more.

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**Informant:** I get so disgusted with it at this point; I just kind of tuned it out. There was so much and it’s not going to personally affect my life one way or another. You know, we aren’t the family that needs the help. The only way it's going to affect me is we'll probably end up paying more in premiums. And more taxes.

Also encroaching on people’s understanding of this issue were American cultural models of “politics” and “government” more generally. FrameWorks has observed this model applied in several different cognitive domains. In a 2006 Message Memo on Government, FrameWorks explained that

Among the most damaging misperceptions of government is a chronically available “default frame” that equates government with elected officials, the current Administration and politics-as-usual, and suffers from parallel associations with corruption, partisanship, and elitism. When government is “about” people in
power, this easily available mental short-cut effectively concretizes and personifies government, literally shutting down deeper thinking. People reach quick judgments about government based on their attitudes to politics in general or the specific party in power. As long as government is seen as being about electoral politics, the focus is on people and those people most likely to come to mind are elected officials, not those who are responsible for implementing the ongoing business of the country nor the governmental structures we have in place to ensure that the country runs smoothly.

With regards to the recent political debates about health care, informants expressed pessimism that the political process could result in productive changes of health care because of both the nature of the political process and the politicians themselves.

**Informant:** A Democrat will say, I'll sign this if you sign this – something that has nothing to do with the health care bill. And the Republican will do the same. It doesn't matter if you're red or blue. I'll do you a favor, if you do a favor for me. How do warplanes have anything to do with our health care system? Yet, it's somehow tucked in [the bill]. Nothing is just taken for the issue at hand.

**Informant:** These politicians are not in politics to make a statement. They're in it for a career. This country was based on politics being a statement. It's no longer a statement; it's a career.

Americans thus assume that any discussions about health care involve national politics – a conceptual connection that activates all of their cultural models of government and applies them to health care. This patterned connection between domains further explains the determinism and resulting disengagement of both the path to failure and blind faith discourse.

**Implications for Specific Models of Health Care**

- **Specific models of health care lead to determinism.** All four of these models of health care lead people to disengage from thinking about health care reform and from productively considering the need for change in order to create a more viable system.

- **Health care as insurance is highly problematic.** When Americans conceptualize health care narrowly as insurance, the many other important parts of the system – such as health outcomes, medical care and medicine – drop out of mind. This precludes productive thinking about how the system works.

- **Skyrocketing costs as a symptom of modernity feeds determinism.** The model through which Americans understand all costs, on everything, to be skyrocketing actually distorts what experts saw as an important point – that health care costs are rising disproportionately. This illustrates one of the gaps between the American public and the experts (discussed in greater detail in “Gaps” section below). Furthermore, while experts saw rising health care costs as a symptom of the system’s problems and inefficiencies,
the American public appears to assume these cost increases to be a natural association with progress and modernity. This exacerbates the disengagement that people feel; if rising costs are a byproduct of progress, there is nothing specific or productive to be done.

- **Politics as usual is dangerous in this domain.** Communications about health care reform must be extremely careful to avoid triggering the cynical models of politics and government that make up thinking on health care as these models have a well-documented effect in discouraging people from thinking productively about solutions to social problems.

C. Consumerism vs. Humanism: Recruiting foundational cultural models to fill the cognitive “holes”

As described above, the public draws upon four specific definitional models of health care that structure the dominant view that the system is on a *path to failure*. These definitional models constrained thinking about the system in highly specific ways. But there were more fundamental questions regarding the health care system that these models were too shallow to even address. This failure became apparent when our questioning shifted to issues of the system’s function, structure and quality. In response to our questions about such issues, informants were initially stumped, as the four definitional models failed to provide a way for them to think productively about these questions. Nonetheless, after initially fumbling to address these questions, informants were able to find *something* that helped them think about these more challenging questions. Our analysis shows that in such situations, informants dug deep into their cultural repertoire and found foundational cultural models that helped them to think about questions of function, players and quality.

Analysis revealed that in highly patterned ways, informants cognitively recruited two deeper foundational cultural models to answer more involved questions about health care. We refer to these models as *consumerism* and *humanism*. Employing the *consumerism* model, individuals saw the world as a marketplace – individual actors pursue their own self-interest by purchasing goods and services that maximize individual benefits while minimizing individual costs. These consumers purchase the goods and services from producers who operate to maximize profit in a free market system based on competition and the rules of supply and demand. On the other hand, thinking from the *humanism* model, our informants assumed a set of unalienable, basic, human rights and affordances. This model assumes that there are certain moral obligations that must be met and that these obligations should not be subject to the rules of the consumer marketplace.

In the sections below, we will explain the coexistence of both of these deep foundational models in answering these complex questions about health care:

1. How does it work?
2. Who is involved?
3. What makes it good?
Following this, we will demonstrate the dominance of the consumerism model in structuring how our informants conceptualized “thinkable” health care solutions (Section D).

1. How does it work?

When we asked informants about the function of health care – basically about their understanding of how the system works – they heavily recruited the two dueling foundational models described above.

Employing the consumerism model, informants conceived of health care as working quite simply, as the informant below explained, like a business. In this way, there is a tension, or balance, between individual consumers who seek to get the most benefit from their coverage, and producers who try to provide services at the maximum costs that the market will tolerate.

Informant: I get it. It’s not a charity; it’s a business!

Informant: So, I think they provide some level of security, but at the end of the day, too, they want to make as much money as they possibly can and so, I think that’s their number one goal – to make money.

Informant: I think health care in this country is a moneymaking business, I think that their goal is to make money. And I don't agree with this but I hear people say that they could have cured cancer a long time ago if it wasn't for the fact that they're making so much money.

The consumerism model also structured the way that informants thought about who gets access to health care. When reasoning through this model, access to the health care system is a “good” that you earn or buy, either because you work for a company that provides coverage, or because you are able to purchase this benefit with your own “hard earned money.”

Informant: For as much as we pay in, I don’t see any benefits, truly, coming back out. You know, and maybe this is selfish of me...I see illegal immigrants coming to this country, and I see low-income people who are getting “free” service, when I’m saying, well how is that fair? I’m a legal citizen. I pay my taxes, but I have to pay a lot of money towards health care? That bothers me.

Informant: I hate to say this and it's going to sound awful, but I don't want to see a fourth generation welfare teenage mother weighing in at 400 pounds and shocked that she has diabetes and I need to foot the bill.

Even as the public applies a dominant consumerism model to its thinking about how the health care system functions, research revealed the presence of the humanism model – an alternative assumption about how the health care system should work. According to this model, health care
is a basic human right that everyone deserves. This alternative to consumerism was used specifically as a way of critiquing the consumerism line of reasoning. Informants employed the humanism model to argue that unfettered consumerism might not be right for health care; that people should be protected and cared for; that health care is a social service, not an optional consumer good; and that all people should have health care as a basic human right.

**Informant:** It's more of a business rather than a right under the Constitution like it should be. Everybody should be able to get health care. I understand we're a democracy and things are business and all that, but what's morally right to do?

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**Informant:** [Health care] is a need in your life, not a want, though most people have to treat it as a want. And, could you imagine if you don't have it for your child? There are people who don't go [to the doctor]. Their kids don't go to the doctor; they don't get the things that they need. So I don't know...I think they made it more convoluted and I don't know why – if it's a self-serving thing or a business thing. “I'm the insurance company and I'm going to make more money cause that's what I do.” Rather than [treating] health care as a human issue.

The humanism model also informed ideas about who should get “access” to health care. As robust as the consumerism model of access was for informants, there was also a strong sense in which health care was assumed to be a basic human right for everyone, not just those who could afford it. In short, according to the humanism model, a person who is ill and suffering should never be denied care, and all of those in need should have access to the care they require.

While the consumerism model was clearly dominant as a way of understanding how the system works, all informants were able to occasionally toggle to the humanism perspective as well. They used this model to talk about how the system should work. These two models mapped neatly onto a cognitive distinction that FrameWorks has found to be powerful in the way that Americans understand other social issues – what we refer to as ideal versus real modeling. This ideal versus real modeling is widespread in how Americans think about issues like government, budgets and taxes, and public safety. According to this organizing mental framework, there is a glaring separation between the way that things should be and the way that they are in real life. In thinking about how the health care system works, the consumerism model gets associated with the real and the humanism model becomes associated with the ideal. It is important to note that the critiques of consumerism are thus considered unrealistic and the only realistic way to think about the future of health care is through the consumerism model.

**Informant:** [I]t came down to one person had insurance, one person didn’t; one person’s wealthy, one person isn’t. What made that person so much more valuable that he gets an extra five years, seven years, 10 years? And I don’t think as human beings we were meant to make that decision. I think everybody has a right to go ahead and survive as long as they can, and I don’t think that happens.

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Informant: I want everybody to be treated equally. I was going to say different, but it’s equally. Everybody should be treated equally no matter what, of their age, what type of disease they have, what type of problems they may have, and any sickness. They should be treated equal, not looked down to. Because they do treat you different when you go into an emergency room and you’re – let’s say you’re looking a little raggedy versus somebody who has high-class clothes…jewelry and everything else because they do treat you different. And that’s everywhere, too. They take more time to explain to you certain things than somebody who doesn’t look as professional.

Interviewer: What would you say is the purpose of health care? The goal?

Informant: To provide everyone means to get to see a doctor, have surgery, and to get prescription drugs…therapy, etcetera, etcetera. That everybody would be eligible. You know, nobody’s without coverage. That’s the way it should be. I don’t think it ever will be.

2. Who is involved?

As discussed in Section B above, when our informants thought about health care, they were primarily thinking about insurance, using the narrow model health care as insurance. However, in our interviews, FrameWorks researchers pushed them to think about other players in the health care system. If they didn’t specifically mention doctors or government, we asked them directly. We wanted to see how they thought about these different groups of actors who play a central role in the expert view of health care sustainability. We found that when our informants answered questions about the major groups who participate and interact in health care, their thinking was again structured by the consumerism and humanism models. These models structured informant thinking about three groups that they could see as being involved in the system: large, for-profit companies; doctors; and government.

a. Companies

Recall that in the public’s way of thinking, insurance represents the entirety of the health care system. That said, in discussing major players, informants did occasionally alight on another type of company that they saw as involved in health care – pharmaceutical companies. In their discussion of both insurance and drug companies, two opinions consistently emerged – that companies are integral parts of the consumer marketplace and that companies are guilty of greed and abuse. These specific views were clearly shaped by the more foundational understandings of consumerism and humanism. The consumerism model led informants to see these companies and their seemingly unbridled pursuit of profit as key components of a proper functioning system; the humanism model enabled viewing such motivation as an immoral threat to basic human rights and dignities.

When informants thought and talked about how insurance and pharmaceutical companies operate, they drew primarily on the consumerism cultural model. Through this model, informants asserted that health care companies are businesses just like any other business. Their modus
operandi is, as it should be in a free market, the blind maximization of profit. Profit-seeking is the sole goal of such companies and, from this fundamental vantage point about how the world works, such motivations are valid and even laudable.

Informant: Well, I mean, it's certainly become more, it's more of a business, as opposed to being about helping people.

Informant: Health insurance companies are for-profit businesses. They're not non-profit. And they keep telling you that they're going bankrupt yet, you know, they inevitably clear...

Informant: But they're a business and the goal of a business is to be profitable so that's the role they play. How do we minimize our expenses or costs and maximize our profits and most cases for their shareholders, cause most of them are publically traded?

Informant: It's basically like a war to keep market share, grow-gain market share and reach your goals, reach your, you know, your benchmarks that you've set forth for yourself that your shareholders use to measure the health of your company.

At the same time, informants frequently toggled back to the humanism assumption about how the world should work. In so doing the same informants who described a profit-maximization motivation as “good” in one breath, in the next became critical of such motivations as threats to humanity. They did not argue against the marketplace model so much as argue that the maximization of profit has gotten out of control and that insurance companies’ profits should be reigned in. Profits without caps were considered to hurt the goal of the system which, according to the humanism model, was that all Americans should have access to affordable health care.

Informant: So I'm not saying that they shouldn't be able to make money, but if they've got all that money laying around, then why can't it be spread, or maybe a dividend?

Informant: It's about the greed. Because once again, if Aetna, as an insurance company, and let's just say their CEO is making, in my imagination, probably like 43 million, with bonuses, dollars a year, with stock options and stuff like that. So let's just say they're making that, okay? Now we have to bring that back to a more reasonable point. So you can't work for an insurance company and make that amount of money, okay? You just can't do that. Because the effect, what's happening is they're laying off people to make more money. No pure capitalism works.

Informant: [T]hey give you such a run around that you just say, “Forget it; I'm fed up and I won't deal with it anymore.” But they're a business and when you put profits in front of health, you know, making someone healthier, that's a scary thing.
b. Doctors

In their talk about doctors, informants across our sample consistently articulated two views – doctors as caring individuals (a view which was structured by the foundational humanism model) and doctors as corrupt (a patterned discourse undergirded by the consumerism model).

The most frequently voiced view about doctors was the ideal Rockwellian picture of the “caring doctor.” Interestingly, when voicing this opinion of doctors, and operating in humanism mode, discussions were void of consumerism ideas. Some informants even explained that doctors need to operate outside of the constraints of the free market system.

Informant: I want [doctors] to spend as much time as they need to, knowing that their pay is not affected by how long they’re in a room with me.

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Informant: If you work a twenty to thirty-six hour shift and you have three patients, you’re not getting paid for three patients; you’re getting paid for that thirty-six hours.

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Informant: Well when they get hired, they get a salary. I’m sure they get a salary and then the hospitals um – I think it’s a salary.

However, the familiar toggle back and forth between the humanism model and the consumerism perspective also surfaced in discussions of doctors. Informants frequently switched from the ideal notion of doctors as caring individuals to an extant but less pervasive opinion of doctors as greedy participants on the shady side of capitalism where they are corrupted by profit motives and “kickbacks” from drug representatives, medical supply companies, or even other doctors.

Interviewer: How much difference do you think there is between doctors in terms of what they recommend as treatments for the same condition?

Informant: Oh, there’s a lot of difference. A lot of the salespeople for pharmaceutical companies go around to the doctors saying “use our drugs,” and they get their little kickbacks. So yeah, I think doctors may tend to write more prescriptions for something like that as opposed to something else.

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Informant: I would think that a doctor, and I know doctors take advantage of the system, their job is to get you in and get you out and get you healthy. And what I see is they’re making you come back for visits, and this and that, and maybe some of those visits are unnecessary and they’re bleeding the system.

Interestingly, although insurance companies and other businesses were expected to operate by the rules of consumerism, doctors were primarily expected to be motivated by “caring” rather than the bottom line. Charges of doctor greed were reserved for rare and unseemly corruption
and kickbacks. Importantly, informant discussions of such cases were void of any awareness of the system by which doctors are currently incentivized.

c. Government

In what has now become a clear and discernable pattern, our analysis also revealed the presence of consumerism and humanism models in how informants talked about the role of government. Analysis of the way informants discussed government revealed two patterned discourses: government as protector and government as a threat to consumerism. The cultural model of humanism lay behind the former while consumerism clearly was the driving force behind the latter. This is consistent with FrameWorks’ earlier research on how Americans think about government more generally.¹

In light of the propensity for companies to serve the interests of their bottom line over the needs of public health and welfare, informants talked about government as a necessary check on corporate excesses, and as a hoped-for guarantor of the interests and “basic rights” of the American people.

**Informant:** I think government’s role is to kind of oversee the industry and the businesses involved. To make sure that they're operating within the legal constraints that currently exist.

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**Informant:** Well, the government would have to regulate prices of the health care. They should. If they don’t, they should. They should regulate prices and then don’t let anybody gouge somebody. Keep it under control, so to speak. Try to keep it honest, no escalated costs.

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**Informant:** Government’s role is making sure that the people who are in charge up there aren't abusing the system, I guess, or taking advantage, or finding ways to make loopholes and having people jump through hoops.

This notion of government as protector illustrates the skepticism of consumerism – that capitalist enterprises cannot be trusted to serve the public interest. Nonetheless, informants clearly saw a limited role for government as protector, and were quick in such conversations to resort back to consumerism mode whereby they explained that too much government interference denigrates the purity and elegance of the American capitalist system. Put another way, when humanism was applied in understanding the role of government, it very quickly was seen as a threat to the more dominant consumerism understanding of how the world really works. Such interference limits competition and difference, thereby increasing uniformity and limiting choice, all of which conflict with the notion of “quality” constructed by the consumerism model (Section 3 below).

**Informant:** I think right now the system is definitely in the free market. So I think that's the part that they're threatening. You know, if we uniform that and say you can only charge this for your doctor’s visit or your prescriptions, I think that becomes an issue.
**Informant:** If you change [such] that the only option is to bring the government in and make it uniform, you remove what we stand for in terms of coming to America to live in a free market and earn a living. I can see why they're really struggling with it. It's a very difficult decision to make. Cause where do you stop? I mean do we come right down to a local bakery, and the government says you can only sell these muffins for “x.” I mean how far will it go?

A further opposition to government interference in the operations of the marketplace was articulated relative to the subsidization of health care services. According to this way of thinking, the government becomes too involved in health care when it uses taxpayer dollars to give away health care to the poor through a “welfare” system, which is a direct violation of the basic tenets of the consumerism model.

**Informant:** If you could ask middle- to upper-class people they would say, “I don’t want my taxes going towards subsidizing health care for people who are either illegal immigrants, or children who are born here illegally, or even for the poor.” You know, there’s some element of social welfare that I think ultimately we all think we need to do. But to subsidize it for the entire country is an unfair burden. I think that’s where you’d see the perception – that’s where I see it, because you know, a pretty substantial part of my check goes to health care and taxes, so if I’m giving up almost 45% of my check...at what point do they say, well I want 60% of it?

Once informants started down the road of imagining more government involvement in health care, they recognized such trending as a slippery slope where the American way of life would soon be threatened.

3. What makes it good?

In the same way that they employed the foundational models of humanism and consumerism in thinking through questions of how the system works and how various parties are involved, informants drew on these same models in thinking about the quality of the system. Our interviews with members of the American public revealed three patterned responses to questions of health care quality, all of which are supported by an underlying consumerism model. It is interesting to note that on issues of quality, the humanism model was not brought to bear, and consumerism was unilaterally the operative cognitive structure that informants employed.

a. Quality is choice

The most frequent answer to questions about the quality of health care was choice. Informants explained that high-quality health care was that which gave the individual consumer a plethora of options and plans from which to choose. It is notable that this view is structured from the perspective of the patient as a consumer of a service – clearly an articulation of the consumerism cultural model. In this modeling, health care services are a commodity in a marketplace, one with multiple options just like a marketplace for any other consumer goods.
**Informant:** I think we have more choices, more abilities, more privileges...more choices of what you can choose for a doctor and what hospital you use. You can get second opinions.

**Interviewer:** What does the term “quality health care” mean to you?

**Informant:** That you could go to any doctor, clinic, or hospital that you want to go to. That you can see the best doctor for you. I want to see this doctor so, that’s quality health care.

When informants were asked to envision the future of health care in this country, what they most feared was a reduction in choice and options.

**Informant:** In using this health maintenance organization, you do give up a little bit of your freedom because they do have lists of preferred providers and preferred places that you need to go to be considered part of the network that they will cover you under. And if you wish to see someone who’s not one of those providers, some will give you a choice to do that, but they charge you more, and then others say, “No, you can’t do that, and if you do, you’re on your own.”

**Informant:** But then you're really sort of restricted based on the insurance company that you get if you have the money. Because they're still putting limitations on the doctors to make decisions about your health care.

**Informant:** If you've got a certain insurance, you've got to go to a certain doctor. HMOs were the buzzword in the 90s, but I don't really think they're as bad as people made them out to be. But a PPO is almost as bad. You have to pick a guy, and you go to that guy. And he bills whatever he bills. But if you try to go somewhere else, they might not necessarily cover it. And that can be hard when you change doctors or if you move. You've got to file all this paperwork.

### b. Quality is cost

The public’s model of health care quality is derived from the more general, cultural understanding that this system works like a capitalistic marketplace. In addition to the choice model of quality, informants related quality and cost in a direct and linear way – the more you pay, the better quality you get. In other words, the consumerism model structures an understanding of quality as “you get what you pay for.”

**Interviewer:** What if I said “quality health care”? What would you imagine that meant?
Informant: It costs a lot more. And not that I think my health care now is not quality because I couldn't afford the higher tier. I have to now do more things cause I could only afford the lower tier. I have to just be more active in it. I have to pay more attention.

Informant: The degree of your health care and the quality of your health care is determined by how much you can pay for your health care. If you are a private payer, or if your employer pays a significant cost of your health care, you're going to have top-level coverage. If you are receiving state-paid benefits or government-paid benefits, you're going to receive a substandard quality of care.

Informant: Well, if I have the resources, I can access the best of the best.

Informant: And then when you can afford the health care, then I think you really probably get what you pay for.

c. Quality is technology

Our interviews with members of the general public also revealed a pervasive view that technological sophistication and innovation were evidence of quality.

Interviewer: How would you rate the quality of health care in this country?

Informant: Overall, not so good. I mean certain states don’t have the quality, the technology that others do.

Interviewer: Would you say the quality of health care has been improving over the last couple of decades, or getting worse?

Informant: Oh no, it’s definitely better. The technology is constantly improving. So I would say it’s better.

This line of explanation was clearly related to the consumerism model; free markets and “pure” capitalism were seen as the engines of technological innovation and the producers of “cutting-edge” advancements. Pollution or dilution of such principles was seen as the bane of such innovation.

Implications of Models Used to Fill Cognitive Holes on Health Care:

- Consumerism obscures collective benefits and costs. Values associated with consumerism – individualism, choice, competition, commodities supplied and demanded – are dominant in how Americans think about health care. Communications must be aware of this pattern of thinking as a dominant lens through which Americans reason...
about how the health care system works, who is involved, the quality of this system and more specifically about the future of health care. This model of **consumerism** obscures the idea that creating a health care system that is viable in the future affects the collective rather than just the individuals who buy and consume this “product.” In short, from the vantage point of **consumerism**, it is hard to see and appreciate the ways that reforming or not reforming the system will affect the common good and how specific reforms will have far-reaching impacts across the public systems that Americans share.

- **Ideal versus real dichotomy explains the dominance of consumerism.** When Americans think about the function of health care, they resort to extremes – health care is either an entirely free market capitalist venture or it is one entirely about moral compassion and “basic human rights.” This leads to a contrast between the “ideal” – in this case, clearly conceptualized through the **humanism** model – and the “real” – which is seen through the lens of **consumerism**. The “ideal” is compelling but is modeled as the opposite of the real, which goes far in explaining the relative dominance of the **consumerism** model in people’s thinking about how the system works practically and optimally.

- **Models of government suggest caution in communications.** When the public thinks about the role of government in health care, there are positive and negative models in use. On one hand, the government is seen as a protector. On the other hand, it is seen as interfering with **consumerism**. Additionally, government is associated with ineffective bureaucracy that stands in the way of innovation. As such, communications should tread carefully when suggesting an expanded role for government. Our research suggests that specific attention needs to be paid to clearly articulating the ways in which regulation can have positive effects for the system and the health of Americans.

- **Missing health “outcomes” are problematic for communicating about reforms and the future of the system.** The American public models quality as choice, technology, and consumer good without actually considering health outcomes as part of the equation. This allows people to continue to believe that the U.S. quality of care is the highest in the world, when outcome measures suggest otherwise. Effective communication about health care reform will need to find a way to make health outcomes “thinkable” as part of the discussion about the quality of health care.

- **Don’t mess with “choice.”** The most dominant way of talking about quality in health care is “choice.” This suggests that communications about reforms should steer clear of discussions of the necessity of reduced choice as part of moving towards health care viability. This is especially true at the top of communications, before a more productive tone is set. Even if some reforms involve paying for choices that were previously included in a plan, the emphasis should be on the fact that choices are being maintained. Framing reforms in terms of a reduction in choice is likely to be a non-starter given the consumerist conception in which **quality is choice**.
• “You get what you pay for” thinking is problematic in communicating about “value.” Because the public associates paying more with higher quality (just like with other consumer goods), discussions of “value” in health care will face serious challenges. This “you get what you pay for” perspective associates less costly procedures with lower quality, which will stand in direct opposition to many of the reforms necessary to create a viable system in the future.

• The technology focus has mixed implications. The public places high value on technology and innovation as important aspects of health care quality. This could potentially offer an effective frame for thinking about how to discuss the issue of the system’s efficiency. Thus, FrameWorks plans to test the utility of this value in upcoming prescriptive reframing research. However, our research suggests that the public considers technological advancements in and of themselves as the mark of quality health care. This focus may structure the notion that we all need access to the newest and best (i.e., more expensive) technological diagnostics and treatment procedures rather than those that achieve the most appropriate balance between high-quality outcomes and costs. In this way, the consumerism model “eats” the innovation value, transforming the discussion into one in which more technology equals better health care.

D. Thinkable Solutions: Continuity or Reform?

Having accounted for consumerism and humanism models and the various views they structure (how the system works, who is involved and what is quality), we can come full circle to consider how these deep foundational models shape thinking about where the system is heading and what it would take to sustain its viability into the future. Below we examine how the cultural models described in the previous sections of this report lead inexorably to specific ways that our informants thought about changing this system. In short, these are ways of thinking about reforming the health care system that are “easy to think” given the deep foundational models that Americans recruit to conceptualize this system.

By looking across the solutions most available to the public’s thinking, one of the most important findings from this research comes into clear relief. The solutions that the public finds most thinkable are not the practical, systemic reforms advocated by the experts, nor do they indicate an understanding of “tough choices.” Instead, they are calls for the maintenance of the status quo – suggestions that actually change very little and that support the basic tenets of the current, unsustainable system. It is important that those framing sustainability recognize how adopting these particular solutions reinforces consumerism and individualism, leading Americans away from an appreciation of the system’s long-term viability.

1. Doctors’ autonomy must be maintained. Individual doctors are highly revered and are seen as the key to good quality treatments. Americans believe doctors make decisions based on each individual patient, by going with their “gut” and “thinking outside the box.” Just as in the television show “House,” Americans want their doctors to be brilliant and unconventional – to treat each illness as a unique puzzle. They do not want doctors’ decisions limited by insurance
companies or by hospitals. Such views are clearly structured by the application of the humanism model to think about doctors and their work, with important implications for the implementation of industry standards or guidelines from evidence-based medicine.

Informant: You cannot tie doctors’ hands. You cannot.

Informant: Standardized treatment never has seemed like it worked very good for anything.

Informant: You're a doctor and you have a gut feeling. There's a certain amount of guts that go into the job. If you're a doctor and you've been there for a few years, you should have some sort of consistency with your job and hopefully be trusted by your peers.

When asked about standards or guidelines that doctors could follow in practicing medicine, informants reacted strongly against this idea. They believed that doctors should not be asked to follow guidelines because their success in treating each patient was contingent upon their ability to “do what they think is right” in treating each patient as a unique individual.

Informant: As a consumer, I would say I wanted to be tested first before you gave me anything. I don't want to be treated like the masses. Let's look at me personally. So maybe the consumer needs to stand up and say this is what we need to do.

Informant: I mean, this “one size fits all” doesn’t work. It’s never going to work. I think having different opinions just makes us, you know, human.

Informant: I think you want doctors to think outside of the box and treat each person individually. Even cholesterol or high blood pressure within two different people could react differently to the medicine that they're provided with. So since everybody’s unique and individual, health care needs are unique, I think that requires a doctor to decipher that and not be so uniform.

2. Limit CEO pay. When the public thinks about ways to improve the system, one evident solution is cutting the “bonuses that CEOs give themselves.” This solution was based solidly in the individualistic perspective facilitated by the consumerism model.

Informant: And you would have to put a cap on pay. You can't have people making a hundred million dollars a year at the expense of the individual. This country was not built on spiting the masses for the individual.

Interviewer: Who’s making the money?
Informant: The CEO, I don’t know. The CEO is making the money. There’s a lot of that out there.

3. Each and every person must adopt more healthy behavior. Another prominent, and highly individualized, suggestion for improving the viability of the system was that each person should take greater responsibility for maintaining their own health. In discussing such changes, informants emphasized how important it is that we also hold others accountable for maintaining their own health through diet, exercise, and prudent behavior. Again, we can see strong undertones of the individual responsibility aspects of consumerism in this solution.

Informant: You have to take care of yourself unless there's an underlying medical condition. Obesity is huge in this country. And it's self-controlled. And it's about being responsible for your own actions. If you choose to smoke, if you choose to eat five Big Macs, you shouldn't be allowed free health care.

Informant: I believe you're in charge of your own health to a certain degree, preventative measure-wise. What you eat, what you do. Do you drink? Do you do drugs? Do you smoke? I think a lot of people don't want to take responsibility for their own actions and themselves and when they wind up sick, they point the finger at everybody, which makes me a little crazy.

4. Individuals must educate themselves. In line with the consumerism model, informants identified more information as one way of navigating what they saw as a confusing and hostile system. By availing themselves of more information, informants explained, individuals could become better consumers of health care – finding the right doctor, the right plan, and the right treatment.

Informant: I think people are more aware. There are so many information channels out there now. Sometimes I think it's bad, sometimes I think it's really good. You can go on WebMD; you can go onto all these health sites.

Informant: I Google everything and say my leg is cramping, back of my calf. I'll put in specifics and then it'll come up what could be the problem – what medications are out there.

Informant: [I]t seems like it's always changing all the time. So I think as a parent and as an individual, to be responsible, you need to do the research and find out what you're comfortable with. And look for side effects. Just doing your own legwork. And I think a lot of people have a hard time doing that. Whether they're busy working or just don't know. I think of not knowing as an excuse because there's so much information at your fingertips. Even if you don't have the Internet, you can go into any doctor's office. There are pamphlets, there's information out there. So, I think being able to get informed is key.
5. Patients must be their own advocates. Informants also asserted that the system could be improved if patients took a more active role as advocates for their own rights as consumers. They asserted that when patients put their money into the system, they should be responsible for making sure they get the right treatments. In the eyes of our informants, the system would improve dramatically if each individual patient were to do a better job fighting for their interests relative to a large, depersonalized, cumbersome health care “giant” that is not designed to serve their unique, personal needs.

**Informant:** I think people have to pay more attention. They also have to be more proactive – making their decisions about what they need to do, and fighting for what they want if it's something that they should have. Not just accept it.

**Informant:** Just starting from the basics, health care is taking care of your own health. Being responsible for one's self – getting well visits, preventative medicine, making sure you have decent doctors and dentists and whoever you need.

6. “Prevention” can improve health and save the system money. Informants also cited early detection, prevention, and the maintenance of good health as ways of improving health care. They spoke of prevention most consistently at the individual level, which is in line with the suggestion of improved personal responsibility described above. But they also explained that preventative measures can actually benefit everyone by saving money and resources to the system overall. It is in the latter sense that we find prevention a potentially promising component of a reframe for sustainability.

**Informant:** First of all, if we have a healthy country, you could end up saving millions and millions of dollars.

**Informant:** If you're able to catch a disease at its early stages, I believe that you will spend less money caring for that person. Or for a poor person. So I think that if we were able to provide universal health care and everybody was entitled to it, well then you spend less money. If they were able to catch it early and I was able to beat that disease in the long run, it would save my insurance company and even the public.

**Informant:** It's been a proven fact over and over again that someone with health care that goes to take care of themselves is actually less of a burden on the health care system than someone who waits until the last minute and then finds out something. And then, now the state has to pay for their health care. So that's a big proven fact. I mean, it's been proven over and over again. The insurance companies don't want you to know that. But it's been a proven fact that people with insurance are actually less cost, it's more cost effective, because they take care of themselves better.
Implications of the Thinkable Solutions

- **Be careful with standards and guidelines.** The public will be wary of standards and guidelines, whether they come from evidence-based medicine or not (in fact, they think our medicine is already evidence-based). They will expect that the standards are hard and fast rules that will take away the individuality of the patient and the individual decision-making capacity of the doctor. Therefore, communications should be careful not to position such measures as overt threats to individual choice or individual treatments.

- **Individualist thinking shapes visible solutions.** When the public thinks about saving money to the system of health care, they go right to executive pay of insurance companies. And when they think about improving health, they call for individuals to make more responsible decisions. This thinking will constrain the public’s ability to imagine reforms that do not neatly fall into these consumerist or individualist categories.

- **Prevention can be productive.** Although the informants largely considered prevention to be an individual’s responsibility, they were able to think about preventative measures as having system-wide effects. This understanding illustrates promising integration of individual action with system-wide effects. As such, this particular topic offers a concrete example of a potentially successful way to communicate about health care and sustainability. That being said, the public still largely attributes responsibility for prevention to the individual rather than to the system, indicating that considerable work is still required to refine the way prevention is presented.

GAPS AND OVERLAPS IN UNDERSTANDING

The goals of this analysis have been to: 1) document the way experts talk about and explain the issue of health care sustainability; 2) establish the way that the American public understands this and related issues; and 3) compare and “map” these explanations and understandings to reveal the overlaps and gaps between these two groups. We now turn to this third task.

Overlaps in understanding:

Comparative analysis suggests that there are key areas of overlap between expert and public understandings. Some of these overlaps represent features of the cognitive landscape that communications can strategically leverage, activate and build on. In so doing, communication should be able to improve the accessibility of expert information and facilitate more engaged and active consideration of what needs to happen to create a viable health care system. FrameWorks will be empirically testing the effect of leveraging some of these overlaps in upcoming prescriptive reframing research.

1. **Individual agency.** Experts and non-experts both called for increased agency for patients. They shared an emphasis on the need for increased availability of information. However, the two groups differed in how they attributed responsibility for increasing information accessibility. Experts placed responsibility on the system to provide such
information while the public placed the responsibility on their own individual shoulders and reasoned that they, as consumers, must actively seek out such information. We believe that this shared emphasis on the importance of information availability could be productive in framing efforts if other communications elements are able to shift responsibility towards the systems perspective.

2. **Information integration for efficiency.** Experts and non-experts saw the obvious inefficiencies in the way that information is not integrated across various parts of the health care system. This overlap may be productive in framing communications so that the public can see that inefficiency goes beyond personal annoyance and actually causes harm to the system at large.

3. **Time and inefficiency.** Our lay informants decried the time they wasted going for follow-up appointments that were unnecessary – waiting hours for appointments, having to schedule a special visit just to get a referral, etc. Experts also saw this as a huge problem. In fact, experts focused on ways that such inefficiencies could be reduced – by exchanging emails with doctors or talking with them on the phone, by managing care at home, or by effectively utilizing nurse practitioners. In short, the public’s emphasis on wasted time may be a ripe area into which to introduce reforms designed more broadly to improve the efficiency of the system and its resources.

4. **Prevention.** Perhaps the most obvious and, from a communications perspective, the most important overlap was that both experts and members of the public saw prevention as an important strategy in improving the health care system. Experts tended to adopt a more systems-thinking view of prevention while lay informants discussed prevention in terms of individual actions and health choices. Nonetheless, that both groups saw prevention as a method to improve the system suggests a promising area to explore in subsequent communications research.

**Gaps in understanding:**

In addition to the promising overlaps discussed above, our map-the-gaps comparative analysis also revealed a key set of gaps between the ways that experts and Americans thought about health care and sustainability. Below, we take each one of the gaps and discuss its communications implications with greater specificity.

1. **Sustainability: stasis versus reform.** Our discussions with members of the general public revealed an understanding of sustainability as *stasis*. Experts, on the other hand, understood exactly the opposite – that for health care to be sustainable it has to change. This suggests the term “sustainability” is counterproductive as an element of reframing efforts.

2. **The future: determinism versus pragmatism.** Our lay informants discussed the future of health care in largely deterministic terms – it was either on an unavoidable *path to*
failure or was regarded with blind faith. Experts, on the other hand, were clear about the
danger ahead of us if the current system persisted, but also employed a decidedly
pragmatic tone in their view that changes could be made to put the system on a viable
trajectory. Getting the public to exchange their determinism for pragmatism will be a tall
task.

3. **Explanations for rising costs: inevitable casualty of modernity versus fixable inefficiency.** Non-experts were quite preoccupied with the rising costs of health care; however, they conceptualized these rising costs as inevitable. Furthermore, they equated health care increases with a general trend that “everything goes up.” Experts referenced statistics to emphasize that health care costs are neither inevitable nor keeping pace with other cost increases. This difference in perspective about rising costs presents a serious challenge to communication; the public’s view establishes a perception in which the problems created by rising costs cannot be fully appreciated and the solutions cannot be envisioned.

4. **Levers of change: patients and CEOs versus providers.** In discussing the future of health care, our lay informants clearly viewed individual patient consumers and their behaviors as the impetus of change, emphasizing the importance of healthier choices and behaviors. These informants also pointed to CEOs and their “astronomical” salaries as something that needed to change. Meanwhile, experts focused squarely on providers and the set-up of the system as the levers that needed pulling to create a viable system. This gap points to the need to give the public better ways to think about the system – how it works, how its parts are related and what makes for good quality health care.

5. **Quality: choice versus outcomes.** Ordinary Americans were overconfident about the quality of health care in this country, largely because of the way that they understood the concept of “quality health care.” They consistently rated it the best in the world, citing “choice” and the availability of state-of-the-art technology as evidence of this view. Experts, on the other hand, employed a different perspective on quality that focused on outcomes – a focus which generates a dramatically different picture of the quality of the U.S. system of health care. This difference in perspective on one of the most key aspects of thinking about the future of the system – both in terms of its need for reform and with respect to the specific changes that are required – represents one of the most fundamental gaps in understanding that emerged from this research.

6. **Financial compensation: salary versus incentives.** When asked to think about how doctors get paid, it became evident that our lay informants had either never thought of this before or had assumed vaguely that these practitioners get paid a fixed salary to care for patients. Experts, on the other hand, noted that financial incentives towards quantity rather than quality actually reward inefficiencies. This constitutes a major gap in the way that these groups understand how the system works and how they assess possibilities for reform.

7. **The role of government: butt out versus a necessary player:** Our lay informants, working from the consumerism perspective, saw government as a dangerous and inept
interference in America’s capitalistic system. Experts, on the other hand, saw more possibilities for local government interventions and accord government a critical role in regulating across insurance providers and across places. This impasse in thinking about a role for government in the future of the health care system poses a serious obstacle to any communications about the regulation of health care.

CONCLUSIONS

The research presented here should inspire a deep appreciation for the challenges inherent in communicating about the future of the health care system to the American public. To use our working analogy, this report has plotted the cognitive landscape that Americans travel when faced with information on health care and the future of this system. In our view, better-connected and more traversable routes of perception and understanding cannot be created without first assessing the lay of this land.

Health care experts and advocates face an uphill battle in communicating publicly their perspectives on the system and its need for reform. The most significant implication for communication that emerges from this research is that Americans lack fundamental understandings about health care as a system; the absence of such understandings will make it difficult for them to consider the arguments that experts make about systemic costs, quality and efficiency. This lack of understanding, or in some cases what can be more appropriately thought of as a misunderstanding, is the result of patterns in talking and thinking at three levels: the deterministic surface talk about the future, the specific definitional models of health care, and the deeper foundational cultural models of consumerism and humanism.

These dominant discourses and cultural models will create considerable difficulty for communications that seek to create a productive public dialogue about the changes that need to be made to create a sustainable health care system. Therefore, the overarching recommendation that emerges from this research is to treat such communications as knowledge building rather than as targeting any specific recessive models. Communicators need conversation frames that will create foundational understandings of how the system works; the frames should be accessible and meaningful to the public, while avoiding problematic cultural models. These frames will be developed and tested in the next phases of FrameWorks’ research.

In the meantime, the FrameWorks Institute offers the following preliminary recommendations. Some of these are broad recommendations that will set the stage for the reframing efforts. Other recommendations target more immediate refinements that have as their goal, not the foundational knowledge-building that is ultimately necessary, but the enactment of a more immediate “do no harm” strategy. This can help communications avoid falling into many of the traps in public thinking that this research has identified.

1. **Provide an alternative to the zero-sum consumerism perspective by explaining how quality and costs can simultaneously be addressed.** Our lay informants believed that they, as consumers, will bear the brunt of any reform to the health care system and that this brunt will be borne in the form of higher costs. Americans already feel tapped out, and they do not want to hear about more sacrifice required of them; this is a surefire way
to halt productive engagement with this issue. Instead, communications should focus on how experts describe costs and quality – that costs to the system can be reduced at the same time that health care outcomes are improved.

2. **Explain the power of science to improve “outcomes.”** The American public wants their health care to be state of the art. Communications would be wise to employ this inherent focus on innovation and emphasize the role of science as a means through which to study and improve results. In short, communications should stress that using science and evidence can make America a modern, healthier nation.

3. **Use “prevention” to link individual to systemic issues.** One of the biggest challenges emerging from this research is the difficulty in moving the American public beyond thinking about individual interests in the health care system to thinking about the system and the nation more generally. One area where informants were able to link individual and more systems perspectives was in thinking about prevention. We suspect there is value to be derived from activating a prevention lens insofar as this can be leveraged as a systemic solution.

4. **Acknowledge rising costs carefully, and only with a strong dose of pragmatism.** The American public is preoccupied with what they see as skyrocketing costs to their health care. Experts show that such concerns are valid on a system-wide level as well. But the public conversations about cost run the risk of being derailed by the health care = rising costs model and the foundational consumerism model. Once more knowledge about the system has been built, communications may acknowledge these rising costs but only with constant reference to what can practically be done to fix the systemic inefficiencies.

5. **Focus on the system’s responsibility to provide better and more available information.** Individuals want to understand what is going on with the health care system. We suggest that communications capitalize on this call for improved transparency by focusing on how changes in the system can empower individuals through improved information accessibility and clarity.
APPENDIX 1: RESEARCH METHODS

We were careful to recruit a sample of civically engaged persons for this project in order to increase the likelihood that our informants could speak to the issues at hand with some degree of knowledge and opinion. Because cultural models interviews rely on our ability to see patterns of thinking – the expression of models in mind – through talk, it is important to recruit informants who are more likely to actually talk about the issues in question, but who are not experts or practitioners in the field. Moreover, to help ensure that participants were likely to have ready opinions about these issues without having to be primed by asking them directly about the target issue\textsuperscript{xiv} – in this case, health care sustainability – the screening procedure was designed to select informants who reported a strong interest in news and current events, and an active involvement in their communities through participation in community and civic engagements.

Cultural models interviews require gathering what one researcher has referred to as a “big scoop of language.”\textsuperscript{xv} Thus, a sufficiently large amount of talk, taken from each informant, allows us to capture the broad sets of assumptions that informants use to make sense of information. These sets of common assumptions and understandings are referred to as “cultural models.” Recruiting a wide range of people allows us to ensure that the cultural models we identify represent shared, or “cultural,” patterns of thinking about a given topic.

As the goal of these interviews was to examine the cultural models Americans use to make sense of and understand issues of the sustainability of health care, a key to this methodology was giving informants the freedom to follow topics in the directions they deemed relevant and not in directions the interviewer believed most germane. Therefore, the interviewers approached each interview with a set of topics to be covered and questions to ask but left the interview open enough to thoroughly follow each informant’s train of thought.

Informants were first asked to respond to a general issue (“What do you think about X?”) and were then asked follow-up questions – or “probes” – designed to elicit explanation of their responses (“You said X, why do you think X is this way?” or “You said X, tell me a little bit more about what you meant when you said X,” or “You were just talking about X, but before you were talking about Y, do you think X is connected to Y? How?”). This pattern of probing leads to long conversations that stray (as is the intention) from the original question. The purpose is to see where and what connections the informant draws from the original topic. Informants were then asked about various valences or instantiations of the issue at hand and were probed for explanations of these differences (“You said that X is different than Y in this way, why do you think this is?”). In this way, the pattern of questioning began very generally and moved gradually to differentiations and more specific topics.

Informants were first asked a series of open-ended questions about health care that provided them the opportunity to speak to whatever associations came to mind – about the meaning of the term “health care”: who is involved with health care; what is the purpose of it; where do people access it; and what the function or goal is. A similar line of questioning then asked about the health care “system” in order to see if the addition of that term would enable people to move
beyond their individualist thinking to a more systems thinking. Informants were then asked detailed questions about the organization of health care, the financial aspects of the system, and the different ways they might evaluate the quality of the system in the United States compared to other countries. Informants were then asked in greater depth about a series of topics—“sustainability,” “quality,” “affordability,” “access,” “evidence-based medicine,” and current health care debates.

As every interview has to begin somewhere, we started from the position that the order of questions was likely to have some biasing effect on the responses offered. For example, we suspected that discussions of sustainability would bias those of quality and lead to more frequent connections between the two concepts that would not otherwise have been made. However, this biasing effect was mitigated by asking about a wide range of questions quickly at the start of the interview. Then the rest of the interview probed those topics deeper. As such, interviews provided some information about all of the eventual topics to be considered before going in depth about any one of the topics and perhaps biasing answers with an ordering effect. In addition, because the concept of sustainability was the primary focus, it was always the first specific topic to be covered. As it turned out, even given this advantage, links between sustainability and other specific topics were rare. Despite our opportunistic harnessing of the biasing effect, there is no easy or absolutely “clean” solution to this effect in interviews. That said, consideration of these effects was built into the analysis and in this case they were found to have negligible priming or biasing effects. Furthermore, some of the biases associated with question-ordering can be overcome by the fact that the object of analysis in cultural models work is implicit and tacit assumptions, rather than explicit views. Additionally, an advantage of the multi-method, iterative design of Strategic Frame Analysis™ is that subsequent research, using both other qualitative methods and quantitative experiments, will allow FrameWorks to triangulate results, examining possible biasing effects and verifying the results presented here.
APPENDIX 2: THEORETICAL FOUNDATIONS

The following are well-accepted characteristics of cognition and features of cultural models that figure prominently into the results presented in this report and in FrameWorks’ research more generally.

1. **Top-down nature of cognition**
   Individuals rely on a relatively small set of broad, general cultural models to organize and make sense of information about an incredibly wide range of specific issues and information. Put another way, members of a cultural group share a set of common, general models that form the lens through which they think and make sense of information pertaining to many different issues. Or as Bradd Shore notes, “Culture doesn’t determine reality for people. It provides a stock of conventional models that have a powerful effect on what is easily cognized and readily communicated in a community. Cultural codes socially legitimate certain ways of thinking and acting. They also affect the cognitive salience of certain experiences.”

This feature of cognition explains why FrameWorks’ research has revealed many of the same cultural models being used to think about seemingly unconnected and unrelated issues – from education to health to child development. For example, FrameWorks’ research has found that people use the mentalist model to think about child development and food and fitness – seemingly unrelated issue areas. For this reason, we say that cognition is a “top-down” phenomenon. Specific information gets fitted into general categories that people share and carry around with them in their heads. Or, again as Shore notes, “You could reason from the part to the whole.”

2. **Cultural models come in many flavors but the basic ingredients are the same**
   At FrameWorks, we often get asked about the extent to which the cultural models that we identify in our research and that we use as the basis of our general approach to social messaging apply to ALL cultures. That is, people want to know how inclusive our cultural models are and to what extent we see/look for/find differences across race, class or other cultural categories. Because our aim is to create messaging for mass media communications, we seek out messages that resonate with the public more generally and, as such, seek to identify cultural models that are most broadly shared across society. We ensure the models are sufficiently broad by recruiting diverse groups of informants in our research who help us to confirm that the models we identify operate broadly across a wide range of groups. Recruiting diverse samples in our cultural models interviews often confuses people who then think we are interested in uncovering the nuanced ways in which the models take shape and get communicated across those groups, or that we are interested in identifying different models that different groups use. To the contrary, our aim is to locate the models at the broadest possible levels (i.e., those most commonly shared across all cultural groups within a large social group) and to develop reframes and simplifying models that advance those models that catalyze systems-level thinking. The latter does not negate the fact that members of different cultural groups within a larger cultural group may respond more or less enthusiastically to the reframes, and this is one of the reasons why we subject the reframes that we recommend to our clients to rigorous experimental testing using randomized controls that more fully evaluate their mass appeal.

3. **Dominant and recessive models**
Some of the models that individuals use to understand the world around us are what we call “dominant” while others are more “recessive,” or latent, in shaping how we process information. Dominant models are those that are very “easy to think.” They are activated and used with a high degree of immediacy and are persistent or “sticky” in their power to shape thinking and understanding – once a dominant model has been activated, it is difficult to shift to or employ another model to think about the issue. Because these models are used so readily to understand information, and because of their cognitive stickiness, they actually become easier to “think” each time they are activated – similar to how we choose well-worn and familiar paths when walking through fields, and in so doing these paths become even more well-worn and familiar. There is therefore the tendency for dominant models to become increasingly dominant unless information is reframed to cue other cognitively available models (or, to continue the analogy here, other walking paths). Recessive models, on the other hand, are not characterized by the same immediacy or persistence. They lie further below the surface, and while they can be employed in making sense of a concept or processing information about an issue – they are present – their application requires specific cues or primes.

Mapping recessive models is an important part of the FrameWorks approach to communication science and a key step in reframing an issue. It is often these recessive patterns of thinking that hold the most promise in shifting thinking away from the existing dominant models that often inhibit a broader understanding of the role of policy and the social aspect of issues and problems. Because of the promise of these recessive models in shifting perception and patterns of thinking, we discuss them in this report and will bring these findings into the subsequent phases of FrameWorks’ iterative methodology. During focus group research in particular, we explore in greater detail how these recessive models can most effectively be cued or “primed,” as well as how these recessive models interact with and are negotiated vis-à-vis emergent dominant models.

4. The “nestedness” of cultural models
Within the broad foundational models that people use in “thinking” about a wide variety of issues lay models that, while still general, broad and shared, are relatively more issue-specific. We refer to these more issue-specific models as “nested.” For example, in our past research on executive function, when informants thought about basic skills, they employed a model for understanding where these skills come from, but research revealed that this more specific model was nested into the more general mentalist cultural model that informants implicitly applied in thinking this issue. Nested models often compete in guiding or shaping the way we think about issues. Information may have very different effects if it is “thought” through one or another nested model. Therefore, knowing about which models are nested into which broader models helps us in reframing an issue.

About FrameWorks Institute:
The FrameWorks Institute is an independent nonprofit organization founded in 1999 to advance science-based communications research and practice. The Institute conducts original, multi-
method research to identify the communications strategies that will advance public understanding of social problems and improve public support for remedial policies. The Institute’s work also includes teaching the nonprofit sector how to apply these science-based communications strategies in their work for social change. The Institute publishes its research and recommendations, as well as toolkits and other products for the nonprofit sector, at www.frameworksinstitute.org.

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4 The occupational screening measure rests on a fundamental relationship between personal experience and cultural models that Shore describes, “… cultural models are brought to life in relation to personal experiences. My concept will be a pastiche of personal and cultural models. In many cases my personal models of marriage are likely to be more salient to me than any conventional representations. This is especially true when one understands a concept through long and deep experience.” Shore, B. (1998) What culture means, how culture means, p. 38. Worchester, MA: Clarke University Press.


Although informants expressed both blind faith and the seemingly contradictory path to failure, it is critical to keep in mind that the existence of seemingly contradictory beliefs is by no means exceptional – conflicting and contradictory assumptions applied in understanding the same issue are relatively common in human cognition. These apparent contradictions demonstrate a basic feature of how humans make sense of information; we apply existing categories and mental structures to process and make sense of incoming information. These mental models are often activated by specific contextual cues such as those in a given conversational, physical and sensory context. Individuals apply one strategy of meaning making in one context, while in another context with slightly different cues, they apply the apparently conflicting model (see Appendix for more detailed discussion of features of cultural models and cognition). As such, differential cuing of mental models can result in seemingly contradictory surface talk about the same issue.

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