



Framing Health Insurance Reform in Arizona
For Public Understanding and Support

A FrameWorks Research Report

Prepared for the FrameWorks Institute

by

Susan Nall Bales

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This Memo reports on findings from the FrameWorks Institute's research on how citizens in Arizona view the health care system in general, as well their reactions to a range of speculative reforms designed to expand coverage to include those currently without health insurance. This work was supported by St. Luke's Health Initiatives.

It has been extended and complemented by parallel research activity in California (funded by The California Endowment and California Wellness Foundation) and in New Hampshire (funded by the Endowment for Health).

The goal of this work, as stated by our research partners, Cultural Logic, was to investigate various communications options to see which were capable of moving "the public to a stance in which the idea that some individuals don't have health insurance seems strange, unnatural, and ultimately unacceptable." Arizonans' responses to a number of normative statements (or frames) for health care reform were tested as well as public understanding of, and support for, a set of model reforms developed by the funder.

To arrive at this conclusion, the FrameWorks Institute commissioned an integrated series of research projects, based on the perspective of strategic frame analysis. In addition to summarizing many of these findings, this Memo extends the descriptive research by providing another level of interpretation to guide the translation process of policy advocates as they seek to engage Arizonans in this debate. This memo is not intended to take the place of the research reports, which inform it.

Typically, FrameWorks Message Memos are used internally by policy advocates to shape communications strategy and messaging. In response to our funder's needs, this Message Memo departs from that tradition in several important ways. The first section of the report is intended to acquaint the interested public with the FrameWorks research results. While it repeats many of the themes advanced in Meg Bostrom's focus group analysis, it does not include the strategic and tactical recommendations put forth in that report. Indeed, the Public Knowledge report should be used as the internal document for Arizona's health policy advocates. The second part of this Message Memo is designed for internal use. Specifically, it makes recommendations designed to improve the public's engagement with the models developed for testing by Arizona's health policy experts.

FrameWorks wishes to thank Meg Bostrom of Public Knowledge and Axel Aubrun and Joseph Grady of Cultural Logic for the rich body of work that informs this Memo, and Franklin D. Gilliam, Jr., for his collaboration in the interpretation of the findings. While this Memo draws extensively from the work of other researchers, and reprises quotes and analysis from the focus group report prepared by Public Knowledge, the following conclusions are solely those of the FrameWorks Institute.

The Research Base

In Arizona, the following research was conducted:

- 6 focus groups in Arizona with engaged citizens in Prescott and Phoenix.

Four groups were divided by education and occupation between blue and white collar constituencies. In addition, two groups in Phoenix were devoted to a mixed group of ethnic citizens and another of ethnic community leaders, defined as holding leadership positions in voluntary and civic groups. All groups were conducted September 15 – 16, 2003 (published as *On the Path to Reform: An Analysis of Qualitative Research Exploring Public Perceptions of Health Care in Arizona*, Public Knowledge/FrameWorks Institute, November 2003).

- a statewide phone survey of voting age adults' attitudes to health care, the health care system and health care reform. The survey base included an oversample of Latinos and residents in rural parts of the state. All interviews were conducted November 12 – December 4, 2003. This work was informed by FrameWorks' earlier and ongoing research on public attitudes to health care and health care reform in other states.

In New Hampshire, FrameWorks conducted the following:

- a comprehensive review of existing public opinion research on attitudes to health care, both nationally and within New Hampshire (published as *Patients Before Profits: Reforming the American Health Care System, A Meta-Analysis of Public Opinion*, Public Knowledge/FrameWorks Institute, November 2002).
- 26 in-depth interviews conducted with ordinary citizens (16) and individuals in positions of influence (10) in various parts of the state (published as *Health Insurance and the Consumer Stance: Findings from the Cognitive Elicitations in New Hampshire*, Cultural Logic/FrameWorks Institute, April 2003).
- 4 focus groups with engaged citizens (separated by gender) in Lebanon and Londonderry (published as *Getting Covered: An Analysis of Qualitative Research Regarding Health Care in New Hampshire*, Public Knowledge/FrameWorks Institute, April 2003).
- a content analysis of print media coverage nationally and in the selected state newspapers addressing health care and the uninsured over five months in 2002 (published as *A Content Analysis of Media Coverage of Health Care and the Uninsured 2002*, FrameWorks Institute, October 2003).

Additionally, findings from the California investigation also informs this analysis:

- an updated meta-analysis of existing public opinion about health care among Californians, based on an exhaustive review of more than 50 reports, presentations, press releases and surveys from existing, publicly available opinion research (published as *Californians on Health Care: A Meta Analysis of Public Opinion*, Public Knowledge/FrameWorks Institute, April 2003).
- 25 in-depth interviews conducted with ordinary citizens (15) and individuals in positions of influence (10) in various parts of California (published as *Human Right, Consumer Right and Mechanism: How Californians Think About Health Coverage*, Cultural Logic/FrameWorks Institute, June 2003).
- 9 focus groups conducted with engaged citizens in California, divided by

location and race/ethnicity as follows: (1) Riverside, May 8, 2003, Latino only; (2) Riverside, May 8, 2003, African American only; (3) Riverside, May 8, 2003, mixed group; (4) Fresno, May 10, 2003, Asian American only; (5) Fresno, May 10, 2003, Mixed group; (6 and 7) San Jose/Sunnyvale, May 27, 2003, 2 mixed groups; and (8 and 9) Los Angeles, May 28, 2003, 2 mixed groups (published as *Urgent Care: An Analysis of Qualitative Research Regarding Health Care in California*, Public Knowledge/ FrameWorks Institute, June 2003.

Where relevant, comparisons between Arizonans' attitudes and those of citizens in other states are drawn below. Note that survey research in both New Hampshire and California was conducted subsequent to this memo, and is summarized in other research materials provided on this CD. While those surveys add detail and nuance to the findings in this Memo, they do not fundamentally alter these recommendations.

The Approach

To this challenge, the FrameWorks Institute brought a group of communications scholars and practitioners with a unique perspective on communicating social issues. That perspective – strategic frame analysis – is based on a decade of research in the social and cognitive sciences that demonstrates that people use mental shortcuts to make sense of the world. These mental shortcuts rely on “frames,” or a small set of internalized concepts and values that allow us to accord meaning to unfolding events and new information. These frames can be triggered by language choices, different messengers or images, and these communications elements, therefore, have a profound influence on decision outcomes.

Traditionally, news media is the main source of Americans' information about public affairs. The way the news is “framed” on many issues sets up habits of thought and expectation that, over time, are so powerful that they serve to configure new information to conform to this dominant frame. When community leaders, service organizations and advocacy groups communicate to their members and potential adherents, they have options to repeat or break these dominant frames of discourse. Understanding which frames serve to advance which policy options with which groups becomes central to any movement's strategy. The literature of social movements suggests that the prudent choice of frames, and the ability to effectively contest the opposition's frames, lie at the heart of successful policy advocacy. A more extensive description of strategic frame analysis is available at www.frameworksinstitute.org.

While strategic frame analysis brings new methods to bear on social issues, this perspective only confirms something that advocates have known for years: communications is among our most powerful strategic tools. Through communications we inspire people to join our efforts, convince policymakers, foundations and other leaders to prioritize our issues, and urge the media to accord it public attention. Every choice of word, metaphor, visual, or statistic conveys meaning, affecting the way these critical audiences will think about our issues, what images will come to mind and what

solutions will be judged appropriate to the problem. Communications defines the problem, sets the parameters of the debate, and determines who will be heard, and who will be marginalized. Choices in the way we frame health care problems and the solutions that would address these problems must be made carefully and consistently in order to create the powerful communications necessary to ensure that the public will engage in this issue.

When communications is effective, research demonstrates that people can look beyond the dominant frame to consider different perspectives on an issue. When communications is ineffective and no dominant frame prevails, people tend to rely on “default” frames – less vivid and powerful frames that are, nevertheless, deemed relevant to the discussion and allow people to assign meaning to new information. Understanding this process makes it all the more important that policy experts and advocates understand the likely “default” frames that ordinary people will use in processing new information about health care reform, and that these same advocates are prepared to tell their story using frames that automatically link problems to solutions to policies.

Working from this perspective, the FrameWorks research was designed to explore the following questions:

- How do Arizonans think about health care and the larger context of the health care system? What, if anything, is broken? And what would fix the problem?
- Are there dominant frames that appear almost automatic?
- Are there default frames that are routinely relied upon to make sense of unfamiliar situations or policies?
- How do these frames affect policy preferences?
- How are these frames reinforced; what frames are available to people from media and the public debate?
- How can the problems affecting health care and uninsured populations in Arizona be reframed to evoke a different way of thinking, one that makes appropriate policy choices salient and sensible?

Research Findings: How Arizonans View Health Care

Arizonans are concerned, confused and cynical about health care coverage, the health care system and proposed reforms. While they are capable of sustaining a detailed and robust conversation about the issue, that conversation easily devolves into a series of personal horror stories related to perceived lack of personal access, affordability of coverage, and quality of care. Media coverage has contributed to public sophistication in the discussion of policy solutions – largely in the form of political reforms proposed by elected officials and candidates for public office. However, these solutions are not related in most people’s minds to a deeper understanding of how the health care system works and what exactly is causing its deterioration. Without this fundamental and foundational understanding, Arizonans are left suspicious of health care reforms, both big and small, as they assess the impact of proposed changes within a zero-sum framework that sees any improvement or expansion as achieved at someone’s expense.

The opinion climate in Arizona is the result of a number of patterns of thinking that, conjoined, leave the public more fearful than empowered to tackle the problems they readily perceive in the health care system. We enumerate below a number of the most important of these thought patterns.

Health care issues are top-of-mind for Arizonans. It is easy to engage Arizonans in a discussion of health care as among the most important issues facing the state. While residents of this state see health care as a major problem, it has not reached the crisis conviction that FrameWorks researchers observed in California, nor do they see the system as completely broken. Arizonans are concerned about the viability of the state's healthcare system but they are conflicted about how much change is needed to address the problems they readily identify. They believe the system is fundamentally flawed. However, they worry that government intervention will worsen the situation.

Among their major complaints is the belief that insurance companies, not medical practitioners, are now in control of health care decisions. They feel at the mercy of insurance companies, and wish someone would advocate for the best interests of the public. "I also think they need a go between, between the doctors and the HMOs because right now the doctor kind of listens to the HMOs because they want to get paid," an ethnic man who is a community leader in Phoenix stated. "They are only going to do what they are going to get paid for. HMOs aren't giving you what you need in order to get your health care, and you don't have anybody that is on your side that is mediating for you. So it's basically in their hands."

Even those who have insurance worry about bankruptcy due to an unexpected health problem that insurance will not fully cover. "If you can get it, it doesn't cover anything unless you just have the best insurance plan in the whole world," a white collar man from Prescott complained. "It will cover after \$5,000 or \$2,000 and then only like 70 or 80 percent of that, so no matter what happens, you're going to be broke when you're done, if you're sick." This sense of vulnerability leads people to conclude that anyone can join the ranks of the uninsured overnight.

Cost is the main concern for Arizonans, and affordability drives the energy on this topic far more than access or quality. Most focus group participants cite cost concerns as the most serious problem in health care. They are outraged by the high cost of insurance premiums. "It's too damn expensive to go to the doctor," a blue collar woman from Prescott complained. "What's important for me is the cost," a blue collar man from Phoenix asserted. "I don't make enough money as it is, and the way it works here in Arizona is your employer has to pay 50 percent of it. Well, my cost is \$500 after he pays 50 percent. I'd have to work two jobs just to pay for my insurance." "As soon as you add one more person to your coverage, it like triples," an ethnic woman from Phoenix complained. This focus on cost takes attention away from the system as a whole as it focuses on each individual's ability to purchase the product.

Importantly, access is redefined by people within a cost framework to mean health security, e.g. people worry that their own access to health insurance will be constrained by escalating costs. Reasoning on the basis of cost, the main goal of any health care reform should be to make the product more affordable for people; this, in turn, will “solve” the access problem.

Arizonans readily admit that service quality is declining in the state: it is difficult to find a doctor, get an appointment, and see a doctor. “Talk to the nurse, pay for the doctor,” as one Phoenix informant put it. “What ever happened to your doctor spending time with you?” asked a blue collar woman from Prescott. Lack of care is thus translated into a discussion about quality of care, e.g. the amount of time spent with a doctor as opposed to an assistant. Reasoning in this way, problems in the system are viewed as the result of a lack of available practitioners. As Arizonans see hospitals closing and read about nursing shortages, they worry about their own access to health services. Small towns and rural areas, for example, cannot afford to attract the expensive care they need to service their existing insured. By extension, then, adding more people to the system (the uninsured) at a time when doctors are scarce will only exacerbate the system’s weaknesses, not solve the problem of access. It is this kind of logic that prevents Arizonans from wanting to address the problem of the uninsured.

Residents believe Arizona has unique characteristics that make its health care system more vulnerable than that of other states. According to focus group respondents, the high cost of health care is due, in part, to Arizona’s unique demographic situation (i.e., the high proportion of senior citizens, the state’s fast population growth, and the state’s ability to attract immigrants.) “The rate of increase is much higher here because the age ratio is older,” an ethnic woman who is a community leader in Phoenix explained. “Our resources are drained by a lot of illegal aliens and immigrants,” a white collar man from Prescott remarked, “because they get health care regardless, if they are willing to go and show up for it.” “Our population is outgrowing what is available faster than anything else,” remarked a blue collar woman from Phoenix.

“We’re a border state and the influx of immigrants coming in with kids with health issues,” an ethnic man who is a community leader in Phoenix noted. “So with the unemployment and the illegals coming in, you end up with less than half of the population covering the half that is not insured.” The transient nature of the state and its burgeoning population lead people to conclude that health care problems will continue to grow; indeed, they literally “go with the territory.”

At the same time, Arizonans are aware and proud of the high quality of medical services and technology in the state. “Arizona has almost any specialty you need. Excellent care is here. We’re just outgrowing what’s available faster,” said one Phoenix informant. They believe the state attracts excellent health care professionals. Moreover, many are familiar with the reputation of the health institutions, and this further compounds their assessment that Arizonans have ready access to quality care. “A lot of people have to travel to other states because there weren’t the qualified neurosurgeons to do the

surgery,” points out a blue-collar Phoenix woman. “We have excellent neurosurgeons. We have almost any specialty you need, you can get in Arizona, between the University of Tucson, between St. Joe’s, Good Samaritan, you can get the care you need. It may be difficult at different times, but almost anything you can find,” she concludes.

There is also some sense that Arizona is a model for the nation. “People are looking at us,” says one Phoenix informant. “Our Medicaid system is a success.” But people also worry that there is little accountability once programs are introduced. They want more attention to how the programs run and more public information and transparency in the evaluation of existing programs. And they are open to looking at other states’ models to integrate proven innovations into the existing system. Importantly, they do not believe much of this planning, evaluation and program innovation is happening in the state. They seem to feel that the health care *system* is not as good as health care in the state.

Finally, most people are aware that people do succeed in securing care in Arizona regardless of insurance status or ability to pay. They know these costs are written off by health care providers. “I think that if you’re willing to work hard and look at it and fight for it, I think it’s out there to be found,” said a blue-collar woman in Phoenix. “I have learned... that nobody is going to hold up a sign and say if this your problem, this is where you have to go. Nobody has the answers; you have to go find it. But once you find it, it is there...” By implication, those without insurance either did not look hard enough or did not work hard enough to find the care that exists.

Because no one is left entirely without care, people fail to keep in mind *when* people get care or the consequences of delayed care. However, when prevention and wellness are explicitly raised, Arizonans are enthusiastic about getting ahead of health problems through early care and intervention. They understand this level of care as inexpensive and cost-effective.

As one white-collar Phoenix man explained, “For every 16 cents that you spend in preventive medicine, you’re going to have a savings of 84 cents in curative medicine. If we can change the focus to wellness from curative, then there is an enormous amount, an enormous benefit to be seen. It will take awhile for wellness to go through the system; however, there is great resistance on the part of people and on companies to accept the wellness provisions. Like well, we don’t want to pay for preventive. We just want to pay when they go to the doctor because they don’t see that long term benefit. Yet if we can get a wellness state of mind, in the long run everyone is healthier and the entire system benefits by far less problems.” This kind of thinking, though admittedly less developed and articulate, was present across the focus groups.

The operating model for health care that is most available to Arizonans is a consumer model. This chronically available model defines health care as a commodity to be purchased by consumers. The health care system is perceived as a private relationship between insured and provider. This model has comprehensive explanatory power, as it

provides a coherent conceptual frame for most perceived aspects of the health care system. Product, choice, vendor, cost, access are all neatly accounted for.

When operating in this model, health care is a private good and there is no role for the uninsured who are, by definition, non-consumers. Consequently, helping the uninsured is not the problem most Arizonans care about.

As Cultural Logic has pointed out, “the Consumer Stance largely preempts a moral perspective on the problem of the uninsured. From the perspective of a consumer, the fact that some people do not have health insurance loses much of its moral force. Not everyone has access to a given consumer good, for a variety of reasons, prominently including Individual Choice and Responsibility – if you really want to buy something, you do what it takes (saving, working hard) to buy it. And by the logic of the Consumer Stance, if you don’t have a particular good, it’s either because it wasn’t a priority for you or it was a luxury beyond your means and needs.”

This is not to say that other models are not available to people. Indeed, among some Arizonans, the “rights frame” is operable – everyone is entitled to a level of care, regardless of their ability to pay, and the health care system is seen as providing a public good. One white collar man in Phoenix explained this as an evolution in thinking:

“This is part of the paradigm shift in taking healthcare and beginning to view it more as something that should be here for everyone. If we go back to the type of society we had in the 30's, the 40's and even the 50's, boom economy, post-war baby boom, healthcare and insurance was a privilege. It was something special. Back in the 30's, the doctors came to your house. A lot of people couldn't even have the doctor come to their house. Now we have tremendous health technologies, a tremendous infrastructure and it is available and so this is something that we can do and that we should do and it has changed the paradigm and say healthcare isn't just for those who can afford it but there is a general level of wellness that should be provided because that is something that we will do.”

Second, while Arizonans are quick to assert that the state requires a safety net to catch those who fall through the cracks in the system, when reasoning within this frame, people are most likely to opt for the same kind of Safety Net policies that currently characterize the system. As Cultural Logic notes, “altruism only takes you so far...it does not necessarily lead to a sense of responsibility for others or to a deeper understanding of the systemic causes of the problem.”

As in FrameWorks’ research on public attitudes in California and New Hampshire, Arizonans lack any understanding of linked fate beyond the negative. There is little evidence of a sense of the advantages of risk-sharing or of cost-sharing across a wide pool or people. Indeed, a good part of the challenge in engaging Americans in the health

care reform debate hinges on the ability of health care policy experts to move this perception of linked fate from the pejorative to the positive.

For many Arizonans, the health care system is viewed as a zero-sum game, in which any improvement in one group's care must be achieved at the expense of another. In evaluating prospective policy proposals, people defaulted to the consumer model by making the first question to be addressed: what will it do to my health care plan? The model is, thus, a zero sum game. There is only so much of the product available, and any redistribution will be accomplished at someone's expense. It is clear from FrameWorks' research in New Hampshire, California and Arizona that many Americans, regardless of their insurance status, fear they will lose ground if reforms are implemented; they are wary of anything that might take their current coverage away

While they are sympathetic with the plight of the uninsured, focus group participants also resent that poor people can get free health care, while they have to work hard to pay for health care. "We work to have private insurance and then people who get state Medicaid sometimes have better insurance coverage than we do and we work hard for our insurance," an ethnic woman from Phoenix complained. "I'm not denying...but sometimes it feels like we're being punished because we work."

Most focus group participants understand that they end up paying for the uninsured in some way -- through higher premiums, increased taxes for state insurance programs, etc. "If you go to an emergency room, they must treat you whether you can pay or not," a white collar man from Prescott remarked. "And so it costs hospitals dollars that they pass on to everybody else. It's like uninsured motorists that you pay for in automobile insurance. You're paying for people who don't have insurance."

Even when Arizonans admit to a broader social responsibility, the cost of covering the uninsured is a daunting obstacle. "Can do, must do, should do," said one white collar Phoenix informant. "How do we fund it?"

Reasoning from this perspective, reform appeals that address access through a narrow focus on covering Arizona's uninsured population are viewed by most as exacerbating problems in the system, not resolving them. Focus group participants recognize that a variety of different kinds of people in different life circumstances can be uninsured. "Many independent contractors," a white collar man from Phoenix remarked. "Many blue collar people and many people that have pre-existing conditions or were laid off and were out of the system and did not exercise their health care or couldn't afford to. So I think it cuts a very broad swath through our society." "A lot of single mothers," a white collar man from Prescott stated. "A lot of people who are young, who are working part time two jobs because the employers will not give them 32 hours." "This county probably has one of the higher cost of living and a lower average income," a white collar man from Prescott explained. "It's full of people who are working close to minimum wage, two or three close to minimum wage jobs and, of course, they don't get insurance."

Since few focus group participants understand that all state residents are connected in one health care system, several suggest that the vast majority of reform policies with which they were presented aimed at solving the wrong problem. They do not see how addressing the uninsured will address their concerns about cost or service quality.

“All of this addresses buying insurance, getting more people insured,” a white collar man from Prescott said in response to the recommended models. “Nothing says anything about value for services rendered. We can continue to pay more and more and more and tax and tax and tax and more people will be insured, and as he says costs will go up. What about the other side of the coin that says what's fair market value? Why does a transplant cost \$150,000?” “I still think the underlying problems aren't being addressed by this or the other proposals,” stated an ethnic woman who is a community leader in Phoenix, “because these proposals are kind of aimed at trying to work within the existing system to find a way to fund health care for folks that don't have it. But a lot of the reason why it is so unaffordable has to do with some bigger aspects of how some of these insurance companies are being run.” “To just say that we're just going to deal with health care insurance is sort of ignoring what the elephant is going to look like two or three years from now,” remarked a white collar woman from Prescott.

As is evident from the above points, covering the uninsured is not perceived by most people as the major problem confronting the health care system. Moreover, people's innate desire to “do the right thing” on this issue is easily trumped by the reasoning that comes with the Consumer Model in which lack of coverage is explained by bad choices made by people or lack of discipline and responsibility in saving to afford health care.

The discussion of disparities is quickly associated with issues of race and ethnicity in Arizona. This discussion about which group lacks access at what expense to other groups derails political support and constrains constituency building. By reminding people that they are working hard to “buy” a precious commodity that protects them and their families, comparisons to others who may not be perceived as “worthy” are inevitable.

Even among the ethnic community leaders who comprised one focus group, the assessment that people had access but lacked responsibility prevailed. “I work with parents and families and it is twisting their arms to get them to take their babies for checkups...they have access, and if they don't have the motivation, it won't happen.” Thus, both information and motivation are perceived as explanations for lack of access, as opposed to more structural and systemic problems such as part-time jobs or declining family benefits packages.

By contrast, discussions about reforms where responsibility was rewarded met with broad support. And when confronted with a description of the situations and places in which

the health care system did not reach – from downsized workers to pre-existing conditions – Arizonans were better able to overcome racial and ethnic stereotypes and to see problems as systemic, not personal. This, in turn, led them to engage more actively with proposed reforms.

Specific proposals to improve the state's health care system easily default to established patterns of reasoning, and leave Arizonans' confused and frustrated. Without a deeper understanding of the causes that are driving the system's deterioration, Arizonans cannot connect the various proposed solutions to the problem. And without an understanding of their participation in a broader risk pool in which full participation is advantageous, they cannot understand the values that would lead them to conclude that covering the uninsured would lead to better health in the state, and a better overall health care system.

At the same time, Arizonans long for true reform and wish someone would advocate for the best interests of the public. "I also think they need a go between, between the doctors and the HMOs because right now the doctor kind of listens to the HMOs because they want to get paid," an ethnic man who is a community leader in Phoenix stated. "They are only going to do what they are going to get paid for. HMOs aren't giving you what you need in order to get your health care, and you don't have anybody that is on your side that is mediating for you. So it's basically in their hands."

Importantly, they do not trust government to play this role. While they want government intervention to protect them from runaway costs and greedy insurers, focus group participants also worry that government will make things worse. Prescott residents are particularly wary of government involvement in health care. "I don't trust the government to manage the money to do that," a blue collar man from Prescott asserted. "There is too much corruption." "It seems to me, my whole life, if you really want to screw something up, get the government involved," stated a blue collar man from Prescott. So they find themselves caught between two choices -- insurance company greed or government inefficiency. "Well, insurance companies are in the business to make money," stated a white collar man from Prescott. "They're not in the business to provide medical care...so if you shifted it to government, which isn't there to make money but they've got a corner on inefficiency. Is that where we want to put the money? Do we want to put it in an inefficient system that is fraught with bureaucracy that probably will cause the administrative costs to skyrocket compared with an insurance model?"

Though they are concerned about government's role in health care, during the course of the conversation people became more receptive to a public dialogue to address this problem. At the beginning of the conversation, people felt more attention was being brought to the health care issue but that not much progress was being made. "It's more in a headline, front line type of thing where it has become the big issue now," a blue collar woman from Prescott stated. "It's being brought to the forefront of conversations. They're realizing this is an important thing that needs to change and get fixed." "But it's such a snarl, rat's nest of bureaucracy and just red tape and foolishness," a blue collar man from Prescott noted.

By the end of the conversation, several were enthusiastic at the prospect of this problem being taken seriously by public officials. “It sounds like they are actually trying to make an effort,” a blue collar man from Phoenix remarked. “That’s what stands out to me is that they’re having groups like this and getting our opinions, and trying to make a difference and I think that’s great.” “I would say it’s been eye opening to see the situation more as not just for myself, personally and my family, but moreover as a whole,” a blue collar woman from Phoenix stated. “To learn other problems and situations, to take that into effect.”

“So take the four plans and dissect them and put together a good plan,” said one Phoenix informant. “It needs to be done right...come up with a ten to fifteen year plan,” another replied. The yearning for responsible, effective management of the health care system should not be underestimated by health care advocates and public officials. Should Arizonans be able to connect a broader array of problems associated with the system to specific solutions, there is potential ground for public support for a wide array of reforms.

Advancing Public Understanding of Reform Models and Proposals

Given this opinion climate in the state, and the established patterns of reasoning associated with this issue, how can health care reform advocates invent a smart strategy for moving the issue forward?

Public Knowledge concludes, on the basis of the focus group analysis, that “a compelling frame to build public support for addressing the uninsured would include the following elements:

- a perspective of the state as one health care system in which everyone participates
- an emphasis on the situations that lead to a lack of insurance
- a connection between the preventive aspects of universal coverage and the cost savings to the state as a whole
- a description of health care reform as a stepped approach, a long-term plan.”

FrameWorks wishes to advance six considerations that must figure in any campaign to secure access for the uninsured in this state. We believe these recommendations are best viewed as parts of a total strategy which also includes a policy agenda and a mobilization or organizational plan. Following these recommendations, we make a series of suggestions toward such a broader strategy.

1. Any set of proposed solutions requires an introduction that establishes the health care system as the focus, and redefines the problem as systemic – fixing the system so it works better for our state. Without this priming, people will automatically default to the Consumer Product model, with cost as the problem and individual purchasing power and security as the main consideration. This introduction should avoid all acronyms and technical language. It should explain how the system works in lay language. And it should make explicit the fact that the system works best when everyone is part of it.
2. It may prove helpful to invoke Arizona’s unique geography and demographics as a driver for change, i.e. because of our climate and location, people want to live here. This is not going to change any time soon, so we need to get ahead of the health care problems that come with this situation.
3. Make responsible planning for Arizona’s healthy future the goal. You want to tap into the sentiment recorded in the focus groups that we should “take time and do the right thing,” and their appreciation for leaders who are “trying to get our opinions and make a difference.”
4. Stress the role that philanthropy and civic organizations are playing in bringing disparate factions together and convening thoughtful leaders in the state to develop consensus and get ahead of the problem before it gets worse.
5. Define the end product as a step-by-step plan for fixing the health care system in Arizona. Don’t focus solely on access. Make sure the plan is understood to include reforms that would address problems of cost and quality as well as access. Define the models covered in the report as steps toward a blueprint that will include a number of other important repairs to the system.
6. Redefine “the uninsured.” Do not use the term. Do not define lack of access as associated with groups or individual victims. Explain the situations in which people lack insurance and try to do so in the most common way: divorced, downsized, first job, early retirement, etc. Also, industries or job categories that lack access can be used to explain structural deficits in the health care system.
7. Frame each policy proposal carefully, using values to explain why and how these reforms will address existing documented problems. Do this before you explain how each policy works. Make sure policies are explained in the simplest language possible (when people don’t understand, they default).
8. Don’t appeal to personal experience – this will only remind people of what they thought to be true. The goal is to move people to conclude, as one focus group participant did, that “it’s been eye opening to see the situation more as not just for myself, personally and my family, but ...as a whole.” Be careful not to slip into

explanations that reinforce the Consumer Product model or emphasize individual choice or personal responsibility.

9. Don't use victim frames, sympathy appeals or individual case stories. First, framing research shows these do not aggregate to policy prescriptions in most people's minds. Second, they tend to create backlash associated with race, ethnicity and poverty.
10. Use business spokespersons and medical professionals to inoculate against charges of socialized medicine, on the one hand, and Harry and Louise syndrome on the other. Even if they cannot agree on a solution, these messengers can attest to the definition of the problem and the need for solutions and action.

Specific Do's and Don't's for Arizona

- Don't begin the conversation with the public by loading up on statistics. This will only cause people to default to their dominant frames of cost and consumer thinking.
- Do translate the numerous numbers into social math (for more on this technique, see the FrameWorks toolkit on this CD, or refer to the FrameWorks website).
- Don't wait to introduce solutions.
- Do accompany every problem with a solution; by bundling each identified problem with the solution that would address it, you can inoculate against the assumption that this is another dire social problem for which no solutions exist.
- Don't focus on educating the public about the exact percentage of the uninsured; they know it's a big problem, even if they overestimate it numerically.
- Do deepen their understanding for the number of situations associated with the uninsured: first job, part-time, retired early, divorced, downsized.
- Don't push the crisis frame, nor overstate the problem.
- Do contest the consumer model, but not explicitly; explain health insurance as a system in which we are all connected.
- Don't introduce reform models without giving people values frames from which to view them; numerous explications of policy options will be misunderstood and, therefore, default to existing frames.
- Don't focus all solutions on government; even if government is the locus for change, it should be set up by calls for involvement from business and the medical professions.
- Don't reinforce the dominant frame by depicting healthcare as consumption and the citizen as a health care consumer.
- Don't put all the emphasis on access. Don't begin the conversation with "the uninsured."
- Don't tell victim stories. Do tell stories about the places the system is broken. When talking about groups of people affected, tell these as structural stories: sort by type of job or situation, not by poverty status.

- Do address an array of health care problems that cover quality, access and cost; position the situations that result in lack of insurance as the first among an array of problems that need to be addressed, constituting responsible reform.
- Don't use jargon, which further throws people back on their dominant frame.
- Do explain any proposal in very simply language.
- Don't assume that expert short-hands (universal, actuarial, disparities, etc.) translate for most people the way they do for experts.
- Do explain the overall plan for remediation in ways that invite ordinary people in to the debate.
- Do not leave unspecified the process for reforming the system. Assign responsibility and spell out how it could happen for each proposed model.
- Don't remind people of their own health care situation or attempt to personalize the appeal; this is likely to remind people of their own insecurities, not move them to solve the systemic problem.

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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