



Human Right, Consumer Right, and Mechanism:  
How Californians Think About Health Coverage

**A FrameWorks Research Report**

June 2003

## **BACKGROUND**

The research summarized here builds on a previous round of research conducted in New Hampshire by Cultural Logic for the FrameWorks Institute, and discussed in an earlier report (*Health Insurance and the Consumer Stance: Findings from Cognitive Elicitations in New Hampshire*, Aubrun & Grady 2003). We recommend that readers review the earlier report, but since that will not be practical in all cases, we have repeated or summarized portions of the previous findings where appropriate in this report.

Admittedly, the situations in California and New Hampshire are different in a number of obvious ways – the size and diversity of California’s population, and the fact that a larger proportion of its population lacks health coverage, are all aspects of the challenge facing the nation’s largest state. Indeed, over 6 million Californians currently must find ways of paying for health care without the benefit of insurance, while the problem affects fewer than 100,000 New Hampshireites.

Yet, there are also some clear similarities between the two states. In both cases, the health of the uninsured is clearly at stake, since people without insurance are more likely to become ill, less likely to receive care, and more likely to die than those who have it. In California as well as New Hampshire, this is a problem that faces not only the destitute and the unemployed but also those with jobs. And due to rising costs and the rising premiums that companies will charge their employees for coverage (when the companies can afford to offer insurance at all), the numbers of uninsured are expected to grow.

Another similarity – and one that the research reported here addresses directly – has been the public’s slowness to respond to what strikes many advocates as an economic and public health crisis. In both California and New Hampshire, while the insurance problem is a serious one for the state – including economic consequences associated with a less healthy population – and while polls consistently show that people place health coverage among their top concerns, movement toward solutions is excruciatingly slow and sustained collective action by, and engagement with, the public has proven difficult.

As part of its ongoing mission to see that more Californians have access to health care, the California Wellness Foundation commissioned the FrameWorks Institute to engage in a series of research projects – including the work reported on here – to discover how the very ways Californians think about health care might contribute to the slow progress on the issue, and how that thinking might be shifted in productive directions. This report is another step toward closing that knowledge gap.

## **RESEARCH METHOD**

### **Subjects**

The analysis presented here is based on interviews conducted by Cultural Logic with a diverse group of fifteen average citizens and ten individuals in positions of influence in the state of California. Members of the public were recruited in various parts of the state, including Los Angeles, San Francisco, Oakland, and Sacramento, and interviewed in their homes or workplaces, or in public places. Because the research coincided with “Cover the Uninsured Week,” researchers were able to attend public forums in Sacramento and San Francisco.

The overall sample included 14 women and 11 men. Subjects' ages ranged from early twenties to mid sixties, with most subjects in their thirties, forties, and fifties. Ethnicities included European-American (11), African-American (5), Asian-American (5), Hispanic (3), and South-Asian (1). A range of political orientations (6 conservatives, 3 Independents, 16 liberals) was also included, on the assumption that ideology represents an important factor in thinking about the insurance issue.

Occupations in the average citizen sample ranged from elementary school teacher to administrative officer in the National Guard; musician; recent college graduate (job-seeker); paralegal; database worker for the government; and non-profit administrator, among others. The influentials sample included, for example, the President and CEO of a major Bay Area chamber of commerce; the executive director of a small San Francisco nonprofit organization concerned with educational issues; the political director of a major Bay Area union; the president of a Los Angeles public relations firm, who also serves on many civic boards, and a member of a downtown Los Angeles business development board.

### **The Cognitive Approach**

Subjects participated in one-on-one, semi-structured interviews (“cognitive elicitations”), conducted according to methods adapted from psychological anthropology. The goal of this methodology is to approximate a natural conversation while also encouraging the subject to reason about a topic from a wide variety of perspectives, including some that are unexpected and deliberately challenging.

This type of data-gathering – and the analysis of transcripts, based on techniques of cognitive anthropology and linguistics – yields insights not available from standard interview, polling or focus group techniques. It doesn't look for statements of opinion, but for patterns of thought that may even be unconscious. It doesn't look for familiarity with issues in the news, but for more well-established and long-standing, default reasoning patterns. Some of the clues to these important patterns come from topics that are *omitted*, moments of *inconsistency* where one understanding clashes with another, and the *metaphors* people use to talk about a subject. Furthermore, the method is designed to explore the differences between *rhetorical mode* – in which people define themselves in opposition to other groups and perspectives, and repeat ideas and phrases familiar from public discourse – and *reasonable mode* – in which they reflect their own experiences, think for themselves, and are more open to new information. Put briefly, this analysis focuses on *how* people think rather than *what* they think. (See the Appendix for a fuller discussion of Cultural Logic's cognitive approach.)

Cognitive research works on the premise that unconscious, default understandings of the world (cognitive and cultural *models*) can guide people's understanding of an issue in ways they don't even recognize. One of the most important aspects of these default models is that they often lead people to understandings that they might reject at other moments of more careful reflection. For example, many people express the mistaken sense that uninsured people still get the care they need to lead healthy lives (i.e., in emergency rooms). When questioned further, they may quickly recognize that a person can't rely solely on emergency care and still count on being healthy. The mistaken belief

is a consequence of an unconscious prototype about what kinds of care people need – namely, care that deals with life-threatening emergencies, the kind of care that people can and do receive in emergency rooms. People routinely make another, related mistake, when they “forget” that insurance plays a critical role in the routine maintenance of our health. This misperception (which obscures the importance of insurance in people’s day to day lives) is the product of an oversimplified cognitive model of insurance, in which it is only about preventing catastrophes. In each of these cases, *people know better on some level*, and yet easily slip into the mistaken view because of some well-established, default understandings of the world. These hidden, underlying understandings can be very difficult to challenge and displace, and, if they are not accounted for, they can derail communications.

## KEY FINDINGS

Due to its unusual history, California comes to the health coverage conversation with two clear advantages over most other states.

- There is a widely (though not universally) shared belief that health coverage is a matter of moral principle and a basic right.

Residents, like other Americans, often see California as a progressive state – on the forefront of civil rights struggles (such as those won by farm workers, gays, and women, since the 1970s), as well as of environmental issues (unleaded gasoline, gas taxes, catalytic converters, offshore drilling, etc.). Health coverage is in some ways poised to become the next in this series of important causes the state has pioneered.

- Californians are used to taking a Big Picture perspective on any number of issues.

The fact that California is a large and rapidly changing state, with significant immigration both from abroad and from other states moves people away from complacency. Similarly, recent statewide crises – power shortages, budget shortfalls, etc. – have forced ordinary citizens both to consider the Big Picture and to experience a sense of general breakdown, a feeling that “something needs to be done.”

As a result of these existing advantages, it is tempting to focus communications on the statewide plight of the uninsured: “Once people know that many folks’ basic rights are not being guaranteed, they’re sure to become engaged.” The findings reported on here, however, suggest that limiting communications to this goal is problematic, for several reasons:

- A Rights perspective on health care is inherently rhetorical and oppositional in ways that can alienate many potential supporters while energizing the opposition.
- Just as importantly, the Rights frame tends to evoke a third and extremely influential perspective – the Consumer Stance.

From the perspective of the Consumer Stance, insurance is understood as an individual relationship between insured and provider, rather than a collective relationship which allows people to pool resources and spread risk.

The Consumer Stance – which has been promoted by health industry advertising, but also has deep roots in American consumer culture, individualism, and conservative values – is easily triggered and strongly distorts the public’s thinking about health coverage in a number of mutually supporting ways:

- It places the emphasis narrowly on quality and choice.
- Its emphasis on costs and benefits largely preempts a moral perspective on the problem of the uninsured, drawing people away from altruistic thinking.
- It obscures the very existence of the uninsured, in favor of the individual relationship between provider and insured.
- It obscures “big picture” understandings of health coverage as a helpful *system* (especially in combination with typical conservative world views).
- It easily evokes the unhelpful frame “Socialized Medicine.”

In part because of the power of the Consumer Stance, appeals on the basis of “doing the right thing” for the uninsured – while effective to a degree, and morally valid – also evoke thinking about individual choices, responsibility, and fate. Anecdotes about the needy are in themselves of limited effectiveness, and can have unanticipated effects – such as underscoring the difference or separation between an “Us” (who have coverage) and a “Them” (who don’t).

More generally, when forced into a choice between the Consumer Stance or Rights Stance, most people will, often unconsciously, default to the Consumer Stance – a tendency that was effectively exploited by the makers of the Harry and Louise ads.

We therefore recommend that the emphasis on the moral reasons for solving the health care problem be strongly supplemented by a key ingredient, namely the Mechanism of health coverage.

- The Mechanism of health coverage can be defined as something like a tool for managing costs, in which risk is shared by the group.
- An effective Mechanism view of health coverage should reinforce the idea of universal participation – the fact that some people are uninsured should be seen as a threat to the Mechanism.

Adding a Mechanism view to the public conversation about health coverage has two important effects on thinking:

- It avoids the choice between “My interests” and “The interests of the Uninsured,” instead shifting the focus to a Mechanism that protects all of “Us.”
- It encourages people to move from the Consumer Stance to the Responsible Manager Stance, in which threats to the Mechanism are taken very seriously.

There are a number of ways to promote Mechanism thinking, in ways that are resistant to Consumer Stance reactions:

- Drawing attention to the phenomenon of Cost-Shifting which occurs when those with coverage must indirectly pay for those without.
- Emphasizing Prevention, as a way of easing the pressures on the system.
- Describing a “Basics Plus” approach, in which at the very least everyone is enrolled in a “no frills” plan, and then those who can afford more buy additional insurance.
- Using concrete examples, analogies, and simplifying models to help the public grasp the basic idea of the Mechanism of health coverage.

Californians’ relative awareness of big picture issues and relationships gives them a head start in internalizing one or more of these Mechanism concepts, and moving beyond the Consumer Stance. When moral arguments – framed in terms of Rights, Safety Nets, a Decent Society, etc. – are presented in combination with a Mechanism frame, the result should be a population that not only agrees that “something should be done,” but has a sense that something *can* be done and has a clearer picture of what shape that “something” might take in solving the problems.

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The next sections of the report discuss the cognitive models that are most relevant to communicating with Californians about the topic of health coverage: health insurance as a human right, Big Picture thinking about health coverage, the Consumer Stance toward health coverage, and the Mechanism perspective on health coverage. Three appendices discuss the thinking of influentials, associations with the word “System,” and the cognitive approach.

## HEALTH INSURANCE AS A HUMAN RIGHT

A striking and encouraging aspect of Californians' thinking about health coverage is that quite a few people think of health care as something like a basic right. Many Californians may have internalized the Clinton message that Americans have a "right to health care," but more fundamentally this pattern undoubtedly reflects the state's progressive tradition – on environmental issues, for example – and especially its history of civil rights struggles, on behalf of migrant workers, gays, etc. The result is that the language and assumptions of a "rights perspective" come naturally to many in the state.

This good news is, of course, tempered by a set of opposing patterns in Californians' thinking, some of which are discussed in the next section (on the Consumer Stance), and some of which are discussed here because they entail specifically negative responses to the idea that everyone is entitled to basic health coverage. The bottom line is that the "rights perspective" is a double-edged rhetorical sword. It is so charged that it can serve some important purposes, but cannot, by itself, be the recipe for effective communications statewide.

### Belief in the "Right to Health Care"

Compared with New Hampshire, the "right to health care" view is stronger in California – not surprisingly, given the more liberal ambient political atmosphere in the state.

*I'm more one who believes in socialized medicine and, you know, in giving power to the people to have the basics that they need, like utilities and health and things like that. (Liberal female)*

*A: I think people feel like it's something that just should be a given.*

*Q: Without paying for it?*

*A: Yeah, without paying for it. That it should be like the public school. It should be available for you to have. (Liberal female)*

*We all live together and we are responsible for helping each other out when we need to. Everybody should have health care. Should be able to eat. Be housed. (Conservative female)*

According to this way of thinking, health care is one of a number of kinds of public goods that should be available to everyone. As the examples above illustrate, people think of their own analogies for how health care might work, including public education. Social security is another:

*Q: What about the idea of a pool of money for health care so everyone puts in a little bit and those that need it can take from that?*

*A: Kind of like social security?*

*Q: I guess so.*

*A: It would be interesting to try it. You know again, you have to look at who is administering it. Is it going to become a huge bureaucracy, like the Social Security administration has become, and then it winds up costing more. But I mean it is kind of an interesting [idea] – I mean Social Security has worked for, what, the last sixty years? It might work. (Conservative female)*

Though they may be skeptical about government (particularly, California government) competence, people often agree that it would be appropriate to find a way of providing health care to everyone.

### **Rejection of “Welfare Rights”**

If the understanding of health care as a basic right were universal and predominant, of course, then it should be easy to persuade citizens of the state to enact programs to provide universal coverage. For several reasons, though, it is clearly not enough simply to invoke the right to health care.

One of the key dividing lines between the world views of liberals/progressives on one hand and conservatives on the other is in their different understandings of rights – particularly when it comes to so-called “social welfare rights,” those which refer to a positive good which a person is entitled to (as opposed to “liberty rights,” which concern a person’s various freedoms). Put simply, conservatives are less likely to feel that society “owes” people things like food, housing, and medical care, and more likely to feel that these must be earned:

*[Health care] is considered a right, not a privilege – but it really is a privilege. (Conservative female)*

*Q: If people are working hard to support their own families and provide for them, should they also have to pay for their neighbor’s health care?*

*A: See well, that is where I differ because I don’t think so. I don’t think so myself. Because, you know, from a responsibility level, it’s like you work hard and they choose not to. (Conservative male)*

*Q: Does it seem like health insurance should be the same way or does it seem different than education? Is it kind of a basic right?*

*A: Basic right? Not a basic right but I could see a basic level being provided to everyone. And then if you have the means, you can purchase more or purchase extra. (Conservative female)*

Note that this last woman resists the idea of a right per se, although she does agree that everyone should receive a basic level of care.

In addition to being derailed by the Consumer Stance (Harry and Louise were concerned about quality and choice in their personal plans), the Clinton health plan, which was sometimes framed in terms of a “right to health care,” ran up against exactly such resistance.

### **“Rights” Thinking and Opposition**

More subtly, the language of rights is an example of the kind of discourse that easily evokes “rhetorical mode” – a way of thinking that is about arguing, establishing one’s identity, focusing on disagreements, and defending one’s ground. Rights – including human rights, civil rights, women’s rights, gay rights, etc. – are nearly always discussed in connection with something that people should have but don’t. That is, the contexts in which rights are relevant are oppositional in nature.

#### *Contexts in which People Think about Rights*

There is more to the story of rights than a simple belief that everyone is entitled to health care. The idea of rights entails more specific kinds of scenarios – for example, when we think about rights, we generally focus on who has them, who is being denied them, and why.

The Rights model of health coverage is often triggered by a focus on the suffering of people who seem to have few or no options. (Otherwise, it comes more naturally to think of one’s own situation – i.e., to operate in the Consumer Stance.) In the following exchange, a conservative woman comments that people with low incomes are “short-changed” by the current system – in this context it is natural for her to agree that others have an obligation to help and that health care is something like a right:

*A: I would think that it is the lower income, working people are the ones who are short-changed with health care. I don’t know about insurance, but health care. Because they can’t afford the insurance and they can’t qualify for the programs.*

*Q: So the next question is, if people are working hard to support their own families and provide for their own families, should they also have to pay for their neighbor’s health care? Do they have an obligation somehow to help out their neighbor?*

*A: Yes. Yes, I think so.*

*Q: Maybe just talk me through why they have an obligation.*

*A: Because we all live together and we are responsible for helping each other out when we need to. Everybody should have health care. Should be able to eat. Be housed.*

*Q: So it is sort of a basic right?*

*A: Yes. (Conservative female)*

At a different point in the conversation (cited above) this same woman denies that health care is a right, but here she accepts the idea, partly because she begins by focusing on the plight of people who have few options.

For liberals, those whose rights are at stake nearly always include the working poor.

*I think there's a lot of people that work and don't have any health insurance or very minimal health insurance. I think the way that corporate business is structured nowadays, there's a lot of basically full-time people that are working on what used to be considered part-time benefits, conditions of a part-time worker – like no health insurance ... I think that it's becoming one of the things that separates somebody who's middle class or upper middle class doing pretty well and somebody who's considered working class, lower class, lower working class, the laboring class. (Liberal male)*

Note that conservatives are more likely to have the mistaken impression that the uninsured are mainly unemployed. (See the section on Consumer thinking for more discussion of this point.)

*Q: What kind of people are uninsured?*

*A: People without much money. People unemployed. Probably. Kids no longer covered by their parents. Right off the bat, they think nothing is going to happen to them. (Conservative female)*

*Who Denies us our Rights?*

When Californians are thinking in “Rights mode,” they agree on two chief “culprits” who have stood in the way of universal coverage in California: politicians who “never get anything done,” and big businesses who resist any change that may cost them money. Both groups are perceived as powerful and unaccountable.

*There's too much greed in hospital ownership in this country for it to happen. There's not enough caring for human beings in this country for that kind of socialization. There's too much money involved. There'd be trillions of dollars at stake. (Liberal male)*

*Q: Why would it be that other countries could be able to afford [universal coverage] and the US could not afford it?*

*A: Because there are too many politicians trying to make decisions. ... I think they can't come to an agreement on things ... There is too much opposition for this point or that point, that they can't even make a universal agreement on something*

*like that. ... And then, of course, you have the private companies that don't want to lose anything in the process.*

*Q: Do you think that is part of it too? The private insurance companies?*

*A: Well yeah, the money. That's their money. Their business. (Conservative female)*

This conservative woman generally does not express enthusiasm about social programs. Nevertheless, she believes on some level that everyone should have access to health care, that squabbling politicians are failing at their job, and that a powerful insurance industry is also obstructing progress. As a conservative, of course, she is somewhat more eager to put the blame on government, as she makes clear a moment later:

*Q: What would you say would be the main reason why we can't achieve universal health care in this country?*

*A: Politicians*

### **Inherent Limitations of a Rights/Compassion Perspective**

The idea of rights draws heavily on altruistic and compassionate impulses. The idea of a right entails a disadvantaged group who lacks it, and places an obligation on others to help. While compassion can be an effective motivator in a case like this (and certainly a fitting one), there are inherent limits on it as a source of motivation. First, because people can interpret “the compassionate approach” in different ways – see, for example, George Lakoff’s discussion of conservative beliefs that discipline, limits, denials and “tough love” are forms of compassion (*Moral Politics*, 1996). Furthermore, altruism is of course susceptible to being trumped by more personal perspectives, even in the most well-meaning individual – see the discussion of the Consumer Stance below.

Finally, and most subtly, a compassionate, altruistic stance can lead to an unproductive sense of Us/Them thinking. The disadvantaged individual is conceived of as a fundamentally separate and different kind of person. “The uninsured,” “the poor,” and “the unemployed” are, by definition, other kinds of people, from the perspective of the insured, middle-class person. In this way, an altruistic approach is subtly divisive in a way that can hinder “big picture” thinking.

### **A Variation on Rights: The Safety Net**

The idea of rights has a variant which is more broadly accepted. Conservatives, who generally resist rights-based thinking, nonetheless agree that it is wrong to simply let people “die in the streets.” Everyone believes in the importance of a safety net of some kind. Importantly, though, conservatives tend to believe that this safety net should hang at a suitably low level – i.e., it should protect people from death but not much else.

*My understanding is there's got to be some sort of state-funded program out there that would, you know, if it was a life-threatening kind of situation, they are going*

*to take care of you regardless [of whether you have health coverage].  
(Conservative male)*

For liberals, the ideal level for the net is higher – it should protect people’s health more generally (i.e., not just save them from death) and should also protect them from financial ruin:

*We ought to be able to [provide universal coverage]. And I think that people would like the idea that there would be a safety net for them. I mean they wouldn’t have to drop all the way into some kind of poverty before there was a safety net that would make sure that they had health insurance. (Liberal female)*

The idea that people should receive help in emergencies (and more specifically, in emergency rooms) presents an opportunity: it is one of several broadly accepted ways of talking about a moral obligation to help those who need medical care and might serve as a wedge leading to other uncontroversial ways of addressing the topic of universal coverage. (See Recommendations below.)

## “BIG PICTURE” THINKING ABOUT HEALTH COVERAGE

California is a big, complex state, with big, complex problems – and Californians tend to have a correspondingly bigger and more complex view of the world than those elsewhere (e.g., in New Hampshire). An important factor contributing to their somewhat richer perspective (particularly for those in the large areas near Los Angeles and San Francisco) is their exposure to a wide variety of ideas and experiences – through travel, the movement of large numbers of people in and out of the state, plus a great deal of ethnic and cultural diversity. The result is that Californians, while not necessarily experts in issues related to health care, have a “head start” in grasping the nature and urgency of the problem. The elicitation research suggests that this is probably the most important aspect of “the California Difference.”

### Awareness of Broad Societal Problems

One of the characteristic aspects of Californians’ thinking is that they tend to be relatively aware of broad societal problems – more so than people in New Hampshire, for example. In this sense, they have a more expert-like perspective on certain issues than is typical among members of the public.

One reason is that a series of recent crises – e.g., in education and the energy system – have raised awareness of statewide issues and systems.

*I think there are certain industries that need to be regulated by the government. I mean like with the energy crisis, we know that deregulating energy is sometimes not the best thing to do, you know? And I feel the same way about health care. At least to a certain degree. (Liberal male)*

Such events are edifying in that they raise awareness of complex causal systems, and raise concern that these systems have the potential to break down. The definition of these problems as public in nature is another important aspect of this awareness. Sensitivity to public health issues is an example:

*I’ve already had to deal with my kids being exposed to tuberculosis, so yeah. Thank you, Ronald Reagan. For letting go all the mentally ill. (Liberal male)*

*Q: Do you worry about the spread of diseases by having people in the population not covered? Like tuberculosis or hepatitis or?*

*A: Right. Yeah. Because those are severe diseases. These are diseases that have to be treated or you will die. So that is a concern.*

*Q: How do you think that will work? I mean why is it a threat? How does it connect to health insurance?*

*A: People are not getting treatment. If they don't have health insurance, there are probably a lot of people not even going for treatment. Not even being diagnosed with what they have. You know, tuberculosis is a cough to begin with. They may just think it is a cough. So a lot of people may have diseases they are not even aware of. (Conservative female)*

(Note that concerns about public health are higher in more diverse urban areas than in the relatively homogenous suburban areas around Sacramento.)

Furthermore, California's diversity, plus its sheer size, mean that Californians are used to seeing complex state-wide issues, such as the varied impacts of immigration, in the headlines.

*Q: Do you think that this is a major problem in California right now or in the country, the fact that a lot of people don't have insurance?*

*A: Yeah, I think it's a huge problem, especially in a state like ours that's very expensive to live in and again there's a higher rate again of immigrants who are not getting care, and now the economy's so bad here. (Liberal female)*

Overall, the awareness of statewide "breakdown" of certain kinds also leads to a sense of urgency. There is a widespread sense that the state faces a variety of problems that represent a general threat to Californians' well-being. This sense of urgency represents a source of potential motivation that can be tapped in support of the health care issue. (Note, though, that framing the issue in terms of "crisis" is not, in itself, productive. See discussion below of the importance of conveying greater *understanding* of the causal mechanisms and potential solutions involved.)

### **Systemic Understanding of Health Coverage Issue**

While Californians' broader awareness does not necessarily extend specifically to greater understanding of health insurance issues, it means that they may be primed to consider systemic aspects of the topic.

*Q: Are there any impacts on a community or a state if a lot of people don't have health insurance?*

*A: I would say yes to a point, because eventually somebody has to pick up that bill. And as they pick up that bill, it is pretty much going to be the state. So the state falls in shortfall then other programs are going to go in shortfall and then here comes the big domino effect. (Liberal male)*

*It seems like it used to be maybe you could get the slack taken up somewhere but it seems like that slack is almost non-existent now. Maybe if you wait at the clinic, if you wait at the county hospital, if you wait for a long time, you might be*

*able to have it adequately treated, but it seems like that system is getting more and more strained to the point where something's got to give I'm sure. (Liberal male)*

*Q: Do you think you can get a check up even if you don't have health insurance?*

*A: I think you write them a check, I think you give them some money, like you give them \$50 or something; I think it's way more effective; I think it's a bad idea to have insurance so you can go to the doctor. Because you can pay it out of your pocket, it's a fixed cost and it's more efficient than the insurance company giving it back to them. That's a crazy system. (Independent male)*

*Q: Do you think insurance companies should be able to choose who they insure?*

*A: No, no. I mean I think the system should be set up so that everybody's insured because that's the way our, that's the way our system works instead of national health care, we have private health care so they have to take the responsibility of I think the same responsibility that a national health care would take. (Liberal female)*

### **Conservative and Liberal Understandings of “System”**

While real progress on the health coverage issue probably must involve an increased public understanding of the causal connections and bureaucratic arrangements associated with the issue, there are important differences in how various people understand the notion of a system per se. In particular, the word “system” appears to have very different associations among conservatives and liberals.

Over the course of a lengthy conversation, for example, one conservative woman's usages of the word “system” all imply negative associations – with bureaucracy, mediocrity and constraints. E.g.,,

*Q: If people are working hard to support their own families and provide for them, should they also have to pay for their neighbor's health care?*

*A: The democratic system. Hmmm. Well I think every able-bodied person should be working.*

In liberals' thought and discourse, by contrast, “system” appears to be a more salient idea and a much more neutral term – it can refer to causal and social systems that are either good or bad. (See Appendix 1 for a list of *all* usages of the word “system” by one conservative and one liberal subject.)

This important and enlightening difference seems to reflect the greater emphasis on individual liberty and responsibility in conservative worldviews, and liberals' relatively greater attention to broader conditions and systemic causes.

In the end, the word “system” itself may be problematic from a communications perspective as it may present another roadblock to constituency building.

## THE CONSUMER STANCE TOWARD HEALTH COVERAGE

Discussions in the previous sections – highlighting Californians’ relatively strong belief in the “right to health care,” and their awareness of big picture issues – might suggest that a kind of civil rights campaign, highlighting the uninsured and their right to coverage would be the right way to approach this issue. Citizens like this one sound like they could be easily brought on board:

*For the reasons I’ve cited, there should be universal access to health care. Infections, especially airborne ones, don’t know whether or not you’re a citizen or you have the right to be here or the like. Aside from that it’s a basic decency principle. What happened to being concerned about other people’s welfare? Am I behind? Was that a fad? (Liberal female)*

As discussed earlier, though, the Rights approach is also likely to be counterproductive in some important ways. For one, it raises the rhetorical stakes and turns a number of people off immediately.

A subtler but just as important weakness of the Rights approach is the predominance of the Consumer Stance toward health insurance – the 800 pound gorilla in the room. (The “Harry and Louise” ads, focusing on people’s concerns about quality and individual choice in the health care arena, worked by deliberately triggering this stance.) In order to be successful, any communications efforts on the issue will need to take account of this dominant mode of thinking, which poses a significant obstacle to engaging public support for solutions. While this cognitive stance cannot be replaced or displaced – it is simply too well entrenched – it represents a pitfall that can be negotiated.

### Defining the Consumer Stance

Most of the subjects we spoke with, most of the time, conceived of health insurance as a product or service owned by an individual and offered by a provider. That is, they thought of health insurance in terms of an individual exchange relationship between consumer and provider.

*Q: Speaking of kids, how would you explain to an eight year old what health insurance is?*

*A: Well, Dad goes to work at a job and as part of his benefits, whether it be vacations or perks of the jobs, one of the things, you need to pay for is your health and your well-being, whether it is mental or physical and just general health issue. Taking care of your teeth, taking care of your eyes. (Liberal male)*

As a result, other important ways of thinking about health insurance were minimized. In particular, two alternative frames are excluded by the Consumer Stance. Among our informants, insurance was less likely to be thought of as either:

- A relationship between the members of a plan or community, all of whom are in some sense pooling resources in order to spread and minimize risk, or
- A basic (human) right, which is owed to members of a decent society.

This finding is important given the natural tendency of advocates' communications materials to appeal to either or both of these alternative frames.

### **The Psychological Significance of the Consumer Stance**

The Consumer Stance determines the lived experience of health coverage for most people. That is, it gives this issue its felt "shape" and "texture" in the minds of the public. A basic finding of this research is that any communication about health coverage will be filtered and interpreted through this largely unconscious but deeply entrenched cognitive model. There are several reasons that the Consumer Stance is so dominant in people's thinking about health coverage:

- The Consumer Stance is "easy to think" – it provides a coherent and user-friendly vocabulary for thinking and talking about the issue.

The language and concepts relating to Consumers are clear, familiar and strongly associated with each other. Thinking of insurance coverage as a "product" and of the provider as a "vendor" provides people with a coherent and natural set of related questions, that have to do with buyers, sellers, agreements, prices, etc: "Am I getting the best quality for my dollar?" "How nice/fair is the company?" "What new and other products are available?" It is easy to be "fluent" in these concepts.

*You are paying premiums that then will assist you when you do need to see a doctor or hospitalization or pharmacies and it will pay a portion of the cost, not everything will be left for you to pay 100%. (Conservative female)*

- The Consumer Stance is experienced as morally right.

The fact that health coverage has become a product to be bought and sold has come to seem completely natural to most people. Although they usually don't give it much thought, they are quick to notice (and often to resist) changes to its status – for example suggestions that health coverage might be a (owed) right rather than a (purchased) privilege. The fact that other relationships to health coverage might be possible – and in fact do exist in other countries, in certain states, or for certain categories of Americans – is seen either as a special case with a special explanation or as unnatural and even morally wrong.

In cognitive terms, the Consumer Stance toward health coverage has become strongly connected to deeply held values, such as the American emphasis on individual autonomy and freedom of choice. In psychological terms, this means that challenges

to a Consumer view of health coverage can easily trigger a strong rhetorical response, in which the issue is treated as an indicator or “litmus test” of group identity, rather than as an issue to be considered to be thought about with an open mind.

*But even for the middle class person, you can still get pretty good care. Where if you are in a socialized system, you just kind of have to take what you can get. Whatever they give you. Here we still have some choices. (Conservative female)*

As this quote shows, the Consumer Stance is closely tied to deeply held American values.

- Because it triggers economizing behavior and thinking, the Consumer Stance is psychologically engaging.

Aside from its natural coherence and moral rightness, the Consumer Stance implies a set of strategic choices that encourages active engagement on the part of the public. Making decisions about products and budgets usually requires one’s full attention because the choices aren’t always obvious.

The fact that the decisions have important personal consequences (what kind of coverage is available?, how much will the premiums cost?) – in other words, that there are significant *stakes* – and further that the relationship between vendor and buyer is perceived as largely a zero-sum game, is a recipe for both psychological investment and resistance to considering alternatives.

### **How the Consumer Stance Distorts Thinking about Health Insurance**

The Consumer Stance is characterized by several (mostly unconscious) patterns of thinking that constrain the public’s thoughts and feelings about the issue of health coverage, and make it difficult for them to hear – let alone to support or act upon – the policy solutions proposed by advocates. Note that some of the patterns of reasoning described here occur even when people “know better” on some level.

- The Consumer Stance places the emphasis narrowly on quality and choice.
- The economizing character of the Consumer Stance largely preempts a moral perspective on the problem of the uninsured.
- The Consumer Stance obscures the very existence of the uninsured, in favor of the individual relationship between provider and insured.
- Once the relationship between provider and buyer has been established, the Consumer Stance implies a hierarchical relationship, and a passive attitude on the part of the consumer.
- The Consumer Stance makes it hard to imagine alternatives, which seem less natural and less real.
- The Consumer Stance makes it difficult for people to grasp or retain fuller explanations of how health insurance is supposed to work, and how to fix it if it doesn't.
- The limited perspective offered by the Consumer Stance leads to a sense of a world that is beyond the control of the consumer, and to a feeling of insecurity.
- The Consumer Stance, which triggers a “buying” and “selling” frame, downplays the role of the government.
- Similarly, the Consumer Stance frames health insurance companies as merchants whose only responsibility is to provide a reasonable product at a reasonable price (as opposed to the administrators of a public good).
- It leads directly to the unhelpful frame “Socialized Medicine.”
- The Consumer Stance frames “passing along the costs” to those of us who pay our premiums, as the main impact of the uninsured on the larger community.
- The downside is that, while there is some logic and truth to this view, it easily casts the uninsured in a negative light as “freeloaders.”
- On the positive side, the idea of passing on the costs is one of the few common perspectives that leads to a vivid sense of a causal connection between the uninsured and “the rest of us.” This represents potential that might be built on in a positive way. See the section on “Connecting the Dots” for further discussion.

### **Convergence Between Consumer Stance and Conservative Values**

Unfortunately, some of the default understandings of the world that define conservative thinking tend to reinforce (and be reinforced by) the distorting effects of the Consumer Stance. As a consequence, elicitation research suggests that conservatives are particularly susceptible to some key misperceptions of the health insurance issue – in particular, they are likely to be wrong about who lacks coverage and why. Conservatives are more likely to believe that those without insurance are unemployed or that insurance is not particularly important to them.

*Q: What kind of people are the uninsured? ...*

*A: I would say younger people. Probably between that age of 18 and 24 ... They may not choose it because they are naïve. Or they may not have it because they are not going to school, and they are not [covered] with their parents, and they are working at, let's say, a Taco Bell that does not provide insurance – which I think they do – but, you know, they just may say, “oh well that's going to cost me \$14 a month” or whatever the number may be and so they don't. (Conservative male)*

*Q: So what kind of people are the kind of people who don't have insurance?*

*A: Well, probably unemployed. Folks who are below the poverty level or maybe even slightly above the poverty level. (Conservative female)*

These are not simply factual mistakes that can be corrected by presenting data. The belief that most uninsured people are unemployed, or that they simply do not care much whether they have it, arises from some assumptions about the world (cognitive models) that are so deeply engrained that they really are more like prisms through which the world is seen. The first is a cognitive model of the Working Person as someone who is responsible and solvent, and enjoys a reasonable standard of living. According to this model, if you are working, you probably are insured. A second cognitive model is the understanding of Self-Determination – people make their own choices and determine their own outcomes. If people don't have insurance, it is because they either don't want it or haven't worked hard enough to get it.

Importantly, these default patterns of thinking don't just lead to the idea that those who are uninsured should work harder to provide for themselves – they actually lead to a distorted view of the world, one in which working people, *by definition*, have insurance, and most people who lack it have chosen not to acquire it. *They make the true nature of the problem harder to see.*

In each of these cases, the default understanding is consistent with the Consumer Stance toward health insurance, which focuses on individuals and their choices. The Consumer Stance reinforces these mistaken views and is also reinforced by them.

### **Roots of the Consumer Stance**

The fact that the Consumer Stance toward health coverage is so strongly established in the public's mind, is in good measure a direct consequence of the immense “educational” efforts on the part of the health industry over the last several decades. Whether promoting health insurance, pharmaceuticals, hospitals, exercise, or health foods, marketers have to appeal to the public's ability to choose between competing products. Advertisers typically acknowledge and emphasize this choice (e.g., “the healthy choice”), and over the long term have strongly reinforced the Consumer Stance toward health coverage. (See ad below.)



*My mind. My body. My spirit. My health.*

Of course, insurance advertisers were not starting from scratch in framing insurance as a consumer good – the roots of the Consumer Stance are as deep as the strains of individualist thinking in American culture. The foundational right to “the pursuit of happiness,” for example, has never moved far from Adam Smith’s individual-based economic theory.

But advertisers have effectively built on these old foundations to construct a powerful cognitive edifice which now constrains thinking about systemic solutions to health care problems in a variety of counterproductive ways.

## **A SENSE OF THE MECHANISM – THE MISSING LINK IN THE PUBLIC CONVERSATION ABOUT HEALTH COVERAGE**

By itself, the direct opposition between the two main models of health coverage – Right to Coverage and Consumer Rights – is a battle that advocates of universal health coverage are unlikely to win. The missing ingredient is a public understanding of the *Mechanism* of health coverage. Adding a Mechanism to the public conversation provides a way of reconciling these two cognitive stances, by replacing the choice between the rights of the Uninsured and My rights as a consumer, with a focus on the system that we all depend on: It shifts the focus from “Me or Them” to “Us/It.”

### **What is the Mechanism?**

By “Mechanism” we mean a way of thinking about health coverage, rather than a particular object or policy. The Mechanism can vary in specificity or even in conceptual level, but should define *a system in which everyone participates*. As with the Mechanisms of minimum wage or automobile insurance, the sense should be conveyed that the Mechanism cannot work if some people are left out. In the case of health coverage, the Mechanism should imply universal enrollment.

### **How Mechanism guides thinking**

Research in the cognitive and social sciences suggests that when people have a sense of understanding how something works, they are more likely to feel that they can and should take some responsibility for making it work better. Consider two understandings of what a car is: something that’s fun to drive (a Consumer view, based only on the benefits one gets out of the object) vs. a working machine that needs maintenance (a responsible owner’s/mechanic’s perspective). The responsible owner understands that the car has a structure and parts that need to be taken care of in order to work properly.

In many everyday cases, seeing how something works (i.e., understanding a mechanism) is enough to make responsible action more likely – once we realize that a door has a delicate hinge, we are likely to swing it more gently. Furthermore, many people have a strong sense, bordering on a moral principle, that if a mechanism isn’t working properly, we should do something about it.

### *The Ozone Layer Precedent*

To take an example with relevance to public policy, once the public understood the localized thinning of the ozone layer as something like a hole in a metaphorical roof (which protects us from damaging radiation), there was strong public movement toward banning the products that cause the problem. People acted like homeowners in this case, once they had a (rudimentary) grasp of how the ozone layer works and how it has been damaged. The Reagan Administration’s Consumer-centered recommendations – suggestions to “wear hats and sunscreen” – were explicitly rejected by the American public in favor of a Mechanism-centered approach (“ban CFCs”).

### *The Mechanism(s) of Health Insurance – Horizontal Relationships*

In the present case, the goal would be for more members of the public to have a grasp of the causal mechanisms surrounding health insurance – in short, how health insurance works – and therefore to take more responsibility for it.

From the perspective of the Consumer Stance, insurance is typically something like “an arrangement with a company that pays my medical bills.” From the Responsible Manager’s perspective, it might be something more like “a system for pooling resources and spreading risks across an entire community.” (Of course, this simple description leaves out many details, including the hypothetical preventive benefits of belonging to a health maintenance organization, etc.)

One important aspect of this understanding is that it makes clear that the Horizontal relationships between members are an important part of how insurance works. This understanding suggests implicitly that everyone who is part of the system is “in the same boat,” that one’s own benefits depend on other people’s participation in the system, that the “whole is greater than the sum of its parts,” and even that Universal Enrollment is a reasonable goal. Ideally, an understanding like this should suggest that there is simply something wrong with a picture in which there are people who are not part of the system.

Importantly, an appreciation of the Mechanism can work at more than one level – i.e., it can refer to national problem, or just as easily to our local hospital is being hurt by too many uninsured. Similarly, it can refer to the fact that some individuals are not paying into the system, or to the fact that some businesses are not participating, which is also hurting the system.

### **Ways of promoting Mechanism thinking in California**

Adding the ingredient of Mechanism to Californians’ thinking about health coverage will benefit more from a variety of communications measures, rather than from a single approach. In this section we suggest a number of steps that will each contribute to promoting Mechanism thinking.

- **Promote A Big Picture Perspective**

As pointed out earlier in the report, Californians begin with a natural advantage over Americans as a whole, in that they are predisposed to thinking of social and environmental issues in terms of the “big picture.” There is a natural complementarity between a bird’s eye view and an understanding of the larger mechanism. Whenever possible, advocates should remind the public of the bigger picture (without, however, lapsing into “wonky” technical details, or the easy but conceptually empty crisis frame).

One benefit of the Big Picture perspective is that it helps to inoculate the public against the tendency to let criticism of a *particular* proposed policy derail the *general* search for a solution.

- **Refer to the Conservation of Costs**

At the heart of the Mechanism view of health coverage is the notion that the system as a whole ends up paying the bills, regardless of whether or not given individuals have health insurance. From the point of view of the Mechanism, it therefore makes sense for everyone to be enrolled and paying in.

The fact that everyone's premiums go up when some are not covered, or that some businesses are at a disadvantage when others do not provide coverage, or that the state picks up the tab when employers do not – all of these observations are based on the idea that we are “in this together,” and works against the Consumer Stance idea that our fates are completely independent.

One current issue that seems to be widespread especially in the LA area is the closing of hospitals and emergency rooms. A number of informants were aware of the fact that hospital owners are trying to shut emergency rooms in order to avoid having to spend money on the uninsured.

*I think we have seen that over the last year or so, me personally the issue of the trauma centers, the trauma centers closing down here in LA County. We have an issue where the uninsured, obviously they are not able to be pro-active with their health care and at some point it becomes a critical stage where they come into trauma centers and so our trauma centers are underfunded. (Liberal male)*

- Emphasize Prevention

People are aware of prevention, but tend to think of health coverage in general and health insurance in particular as a kind of lottery – one needs insurance in case of accident. Reminding the public of the importance of prevention is both good public health, and also an excellent way of reminding them of the Mechanism (which benefits from an overall reduction of costs – see the previous point on Conservation of Costs). The Prevention message can focus on when people get care and where they get care, not just on who gets care. In this way, Prevention opens the door to an understanding of the situations that result from a badly maintained Mechanism, not just the stories of individuals which leads to Them vs. Us thinking.

*That ounce of prevention thing. A few dollars spent to be sure that you get medical check ups ends up with overloading the system with really you know much more debilitating problems. Seems like poor people again, the people who don't have insurance, don't see a doctor regularly. (Liberal male)*

*Yeah it does. So why not make it more controlled, more - what is the word I am looking for - more available. And that way you can hopefully control the cost because now the cost is uncontrollable. Preventative always makes more sense. (Conservative female)*

- Propose a “Basics-Plus” system of coverage

A coverage system that guarantees basic care to everyone regardless of ability to pay, while not precluding those with the means from purchasing a higher standard of care allows us to reconcile the Consumer Stance and the Rights Stance. In particular, it does much to preempt the specter of Socialized Medicine.

One advantage of the Basics-Plus approach is that it taps into traditional and well-established views of health care:

*And there are certain things I always thought when I was growing up – that there was some base line, that I could just go to a hospital. If was to break an arm or you know – now if I wanted glasses or caps on my teeth or a gold piece or whatever then those are things that I would obviously pay for, but I grew to know different (laughs). (Liberal male)*

- Find an appropriate role for Government

Even liberals in California are often leery of the Government's ability to effectively manage something as complex and important as health care.

On the other hand, even conservatives feel that there is a role for government, in two important senses, both of which promote Mechanism thinking:

- A responsibility to regulate the system

*Well I think health insurance companies need to be monitored, but when you do that, you know, doctors can't afford to be in business, and so that's a really tricky kind of thing. But pharmaceutical companies are really, I think, need to be monitored. We don't want to do that, we don't want to monitor folk who are employers or corporations, and create jobs and wealth, but we are also being taken to the cleaners. (Liberal female)*

- A responsibility to subsidize the system

As this person's reasoning makes clear, it is easy to tie government subsidies with an awareness of the larger Mechanism.

*Q: Another proposal is giving people who can't afford health insurance is giving them some sort of tax subsidy so that they can buy their policy. So credits of some sort.*

*A: I think that would probably encourage more folks to purchase and get on some sort of plan and therefore in the long run probably lessen the costs down the road in terms of trauma centers and when it becomes a real issue. (Liberal male)*

- Provide concrete examples, analogies, and simplifying models.

It is important to give the public easy ways of grasping an idea that is not currently their default way of thinking. One way to do this is through concrete examples that clarify some of the key concepts advocates are trying to convey. For example, a number of hospitals in New Hampshire are creating plans in which all uninsured individuals who visit the emergency room are signed up for what amounts to a *de facto* basic insurance plan through the hospital. They receive a “membership” card, and agree to make small, regular (sliding scale) payments. Discussion of this case can help make vivid the idea of a system which members of a community benefit from and also help to sustain.

Analogies can also be an effective way of clarifying important concepts and making them concrete and memorable. The idea of a “safety net,” is a simple example, and one which was explicitly offered by a number of elicitation subjects (typically, those with the best grasp of the issue). Another possible analogy would be to the state highway system – which must connect *all* locations in the state to be truly effective. Each of these refers to a single object or system which must be maintained in order to yield its intended benefits. (Note that Travelers Insurance’s umbrella logo suggests another vivid analogy, but one that effectively reinforces the individual Consumer Stance on insurance.) Less metaphorically, advocates can point out, for example, that health coverage shouldn’t cover fewer people *than auto insurance*.

Note that these examples have not been tested for their communicative effectiveness, and are merely intended to illustrate the idea of concrete images and analogies which have the potential to steer people away from consumer perspectives, and give them insights that human interest stories and anecdotes cannot. The development and testing of specific directions and language – including vivid, concrete analogies (*simplifying models*) – would be an effective next step in creating effective communications on the issue.

## CONCLUSION

In a state where there is considerable dissatisfaction with the current insurance situation, where the problem is often felt to be urgent, and where people often think in terms of a “right to health care,” how is it that public will has not been sufficient to ensure that a solution is found? The elicitation research suggests that the greatest obstacle to progress is the Consumer Stance toward health insurance. This view of the issue leads to a rejection (or at least a weakening) of the Rights perspective, and, equally powerfully, obscures the reality that public policy can be an effective way of dealing with millions of people’s collective unease – unease that often feels individual.

The depth of the Consumer Stance’s hold is illustrated by an observation made by one of our Influential interviewees in the Bay Area. This man, the political director of a large and powerful union, described a three-way breakdown of the kinds of concern people have about health insurance: People at the bottom of the economy are concerned with Access. People in the middle are concerned with Cost. And people at the top are concerned with Quality. While this is a perceptive analysis, each of these concerns is in fact a variant of a consumer view. None of them includes concern with the system as a whole, nor with the welfare of others besides oneself. If this informant’s characterization is correct, it points to the comprehensive effects of the Consumer Stance, and the need to establish new patterns of reasoning that can work around it. (It probably can never be displaced entirely.)

The solutions discussed in the report involve a “2 track” approach. On one hand, it is critical to give people a clearer and more vivid sense of Mechanism – that health coverage is a system that connects them and can be improved in order to protect everyone better. Californians have a head start in grasping this sort of “big picture.” On the other, the moral sense that everyone deserves at least a basic level of care – expressed either as an aspect of California’s continuing progressive tradition or, more modestly, as an aspect of the kind of Decent society we all aspire to live in – will play a role in keeping people focused on the ultimate goal.

***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](http://www.frameworksinstitute.org).

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Please follow standard APA rules for citation, with FrameWorks Institute as publisher. Aubrun, A., & Grady, J.E. (2003). *Human Right, Consumer Right, and Mechanism: How Californians Think About Health Coverage*. Washington, DC: FrameWorks Institute.

## **APPENDIX 1: INTERVIEWS WITH INFLUENTIALS**

In many respects, the influential Californians we spoke with reflected understandings similar to those of average citizens of the state. There was a sense of urgency about the problem of health insurance, reference to something like a right to health care, a tendency to slip into a Consumer Stance (among those with no special knowledge or experience related to the insurance issue), and certainly a broad awareness of statewide issues and causal relationships. Several aspects of influentials' thinking are worth singling out, however, and these are summarized below.

### **High awareness of political and technical aspects of the issue**

The health insurance issue is more “mature” in California than in New Hampshire, in the sense that more of the influentials we spoke to – including those with no special connection to the issue – were aware of various possible solutions, and some of the political, financial and technical pros and cons of each. While there can be no expectation that a given business or labor leader, for example, will be an expert on the issue, on the whole, California influentials are relatively primed for a productive dialog about possible approaches.

### **Concern about State Budget**

Compared with average citizens, Californians in positions of influence have a higher awareness of the state's economic problems, and the practical difficulties of enacting any plans that will cost significant money. Average citizens were comparatively willing to ignore economic realities and focus instead on problems and the importance of solving them. This means, of course, that communications that might be effective with the public will face greater scrutiny from influentials who are indispensable to real progress.

### **Skepticism of Government Management**

To a striking degree, the influentials we spoke with were skeptical about the state's capacity and competence to run any large health-related programs. This included individuals in groups traditionally associated with faith in government action. People with experience working closely with the state seemed, if anything, to have the greatest degree of skepticism.

### **Skepticism about Political Viability of Single-Payer Plans**

There was something approaching consensus among the influentials in our sample that a single-payer program probably will not be enacted anytime soon in California, due to powerful business interests that oppose it, plus the state's current financial state. This skepticism may reflect an appreciation of the political realities of the state, but obviously does not preclude the possibility that a single-payer approach could gain significant support with the right mobilization plan and the right leadership.

**Use of Specialized Terminology**

Like experts in any area, leaders familiar with the details of insurance policy were likely to use terms of art, such as “single-payer.” Elicitations and focus groups with members of the public have shown clearly that this terminology is likely to be confusing and off-putting if used in public forums. This is an area where leaders themselves may need to be trained (or at least reminded) to use accessible, concrete language when discussing the issue. Otherwise, the language itself may further the disconnect between solutions and perceived problems.

## APPENDIX 2: ASSOCIATIONS WITH THE WORD “SYSTEM”

The following excerpts include every usage of the word by two of the elicitation subjects, a moderate conservative woman and a liberal man. Throughout the conversation with the conservative woman, she consistently used the word “system” with negative connotations, e.g., associating the term with inefficient bureaucracy and unjustified constraints on liberty. The liberal male, on the other hand, uses the term more neutrally, to refer to any complex arrangements of cause and effect, which are often productive and necessary. The difference appears to reflect conservatives’ relative emphasis on individual liberties and responsibilities, and liberals’ relative sensitivity to contextual and systemic aspects of social problems.

### Conservative Female

*Q: If people are working hard to support their own families and provide for them, should they also have to pay for their neighbor’s health care?*

*A: The democratic system. Hmmm. Well I think every able bodied person should be working.*

*Q: And would it be people’s responsibility to pay for their neighbors, if their neighbors didn’t have health insurance?*

*A: I don’t like that system. I prefer not to.*

*Q: What are the impacts on the entire community or the state, if a lot of people didn’t have health insurance? What would the consequences of that be, I guess, for the society as a whole?*

*A: They would have more people using the UC Davis system were the indigent folks go and so that causes our taxes to go up. So it has a financial impact.*

*Q: Is there a reason why we couldn’t afford [universal health care coverage] here and other countries are able to afford to do it?*

*A: I’ve heard it is expensive. You know your taxes are definitely higher. And I have also heard and read that sometimes the type of care you get in a socialized system is not the best.*

*Q: So it might be that we have seen other countries, and [a national health plan] didn’t work there?*

*A: Right. Or you see how messed up the system is.*

*Q: If taxes were not the right way to go about it, what do you think should be the American solution or California solution?*

*A: Wow. I don't know. That's a tough one. You know if you have employers pay more into the system, they'll scream.*

*Q: Whose fault is it that some people don't have insurance?*

*A: I don't think it is anybody's fault. It is just the way our economic system is based in the US and certainly in California.*

*Even for the middle class person, you can still get pretty good care. Where if you are in a socialized system, you just kind of have to take what you can get. Whatever they give you. Here we still have some choices.*

*A: Kaiser is non-profit, right? There are some of them out there that are non-profit. I kind of like that.*

*Q: Does it just seem more fair?*

*A: Yeah. Because then they are putting their money back into their system. Now Kaiser does not have the best system, but people either love it or they hate it. It seems to work for a lot of people. That is almost the most socialized kind of system that we have in California. The Kaiser.*

*[L]ook at the school system. That is not something that California can be proud of. Although I guess we can say that everybody has access to education.*

### **Liberal Male**

*It seems like one of the many down sides to a capitalist system is that if you have money you can buy things and if you don't then there doesn't seem to be very much left over for people who are not really engaged at a high level in that game, in that pursuit. ... I think there's much more of a role for the government to play in creating that environment, you know.*

*I have a friend who got breast cancer and she hadn't been working for a long time, she had just separated from her husband, had 2 kids to take care of, all of that and then suddenly found out she had breast cancer. And was able to – really almost through a miraculous stroke of luck – was able to get doctors to take her case with what Medicare was paying. And sometimes they just helped to help, not even submitting their bills – you know things that weren't covered by Medicare. They just really helped get her through it, you know, mastectomy and chemo, radiation. It was just really incredible trying to see her trying to work the system.*

*It seems like it used to be maybe you could get the slack taken up somewhere but it seems like that slack is almost non-existent now. Maybe if you wait at the*

*clinic, if you wait at the county hospital, if you wait for a long time, you might be able to have it adequately treated, but it seems like that system is getting more and more strained to the point where something's got to give I'm sure.*

*I think that on a financial level it really impacts the future if you have a population of people that are not getting cared for, not getting treated. It seems like it has really significant consequences down the line, where you're going to have a nation of people that need a lot more attention, or a significant bunch of people in the country that need attention for things that are much more significant. In other words, not having had preventive care then will require, you know, much more than would have been required initially. That "ounce of prevention" thing. A few dollars spent to be sure that you get medical check ups ends up with not overloading the system with much more debilitating problems.*

*You come in as an obese, diabetic adult and the system now has to – if they can treat you or they will help you – it's now going to cost hundreds of dollars instead of a doctor's good offices of trying to shepherd you through a difficult period and treat you the right way. All of that stuff about "a society that doesn't spend money someplace, will spend it somewhere else."*

*I think that the attempt that the Clinton administration made in the first years to at least implement a national health system – which, you know, was such a big fight which got turned away, and they never really came back to it – that was a turning point, it seems like.*

*It seems like already so many people are finding it – you know, the system, the way things are set up – people are just making ends meet as it is, you know, so many of the poor and people who are immigrants and people who just through no fault of their own necessarily are trying to succeed, it just seefeels like it's a little onerous to put that burden [of paying for mandatory health insurance] on them*

*It seems like on some level, as much as we don't want to believe it, we are sort of one corporate body, cells within the system and if some of the cells get cancerous the rest of the cells are much more at risk for becoming cancerous, right? [regarding public health risks if many people are uninsured]*

*I think that's probably part of the reason that the system is overloaded – because the less people you have in the pool who are getting insurance, but still that money has to be spent somewhere, and people are making claims against that system.*

*It seems to me that the system is fundamentally pretty flawed, and I do think that we're all at risk in the sense that you can't just continue to have a system that works so poorly, or that's doing such a poor job of meeting the requirements of the entire population, and seems to be losing ground even at that. ... I think everybody's in danger of being submerged because, again, an insurance system only works if the inflow matches on some level the outflow, and it just seems like it's not. It doesn't seem like it's working at all.*

*I think that the alarm is probably more coming not just from an abstract sense of what's going on through information but a personal sense that this/if you have insurance anyway, you look at it and say seems like it's getting less and less coverage and still paying the same amount or doing whatever/it seems like there's got to be some sense that the system's not working right.*

*[In my union] there's a system in which you work for a certain amount of time and are able to build up hours into a [health care] fund and when you haven't worked at all, which I said I haven't recently.*

### **APPENDIX 3: THE COGNITIVE APPROACH**

This appendix discusses the assumptions and principles that form the basis for the “cognitive approach” taken by Cultural Logic.

#### **Frames**

Researchers who study cognition and culture have established that people understand all concepts in terms of related networks of ideas, also known as *frames*. For example, the concept of a “father” is not understood in isolation, but in connection with understandings of mothers, children, families, biology, responsibility, and so forth. People are usually unaware of the frames they are using, and the frames themselves are usually expressed indirectly. They are revealed most clearly in the language and reasoning a person uses in connection with a concept. Seeming contradictions in the way a person discusses a topic can be particularly enlightening, because they may reveal conflicting frames at work. It should be noted as well that “frame” is a general term — used somewhat differently in different disciplines — to refer to more specific concepts such as *cognitive model*, *cultural model*, and *cultural theory*, discussed below.

#### **Cultural models vs. cultural theories**

A cultural theory is a set of explicit propositions that describe the nature of some general phenomenon (*The Development of Cognitive Anthropology*, D’Andrade 1995). Cultural theories are typically the most apparent and immediately coherent structures of knowledge — the ones that are volunteered by focus group participants for example, and the ones that lend themselves to direct description and summary by the analyst. Cultural theories are closely related to public discourse and, because they are explicit understandings, to rhetorical positions adopted for purposes of argument.

A cultural model, by contrast, consists of a set of largely implicit assumptions that allows a person to reason about and solve a problem. A cultural model specifies relationships between a given concept and others — specific domains (e.g., School) are typically connected to broader cultural assumptions (e.g., understandings about Achievement or Growth). Cultural models are associated with private understanding and individual reasoning.

A classic example of the difference between cultural models and cultural theories is provided by Strauss’s study of blue-collar workers in Rhode Island (1992). Her informants clearly understood, and explicitly articulated to the interviewer, the American model of self-made Success. In some cases, they even claimed that this style of success was important to them. Close analysis of discourse, however, revealed that these men were actually basing their behavior on an implicit model of a Breadwinner, which is more strongly related to ideals of husband and father than to wealth and status.

Cultural models, while less explicit and more challenging to identify than cultural theories, typically have more directive force — i.e., they are more relevant to understanding what people actually do.

### **Cognitive Analysis**

An important assumption of this view of human motivation is that a variety of cultural models typically compete for expression in a given defined situation. Putting it simply, people often have conflicts about basic issues. For example, many Americans believe that a woman should work outside the home; a contradictory assumption, held by many of these same people, is that women should stay in the home and nurture children. Though contradictions such as this one often find partial resolution (e.g., through the contemporary American notion of the “Supermom”), typically such deeply held beliefs are compartmentalized; i.e., only one will be invoked in a given context.

Cognitive analysis first identifies the relevant deeply held models to which a given subject such as “School” is connected (literally or through metaphor). Second, it attempts to map the fault lines that predict which of the models will be expressed as action in a given situation, often triggered by particular cues. Third, it suggests a picture of the dynamic relationship between public messages, cultural models, and individual action around a given topic.

### **Metaphors**

It is a universal finding of cognitive linguistics that people use metaphors to think, speak and reason about the world, even on topics as familiar as “weather” — i.e., some of the cultural models used to reason about any given topic are metaphoric models. For example, teenagers are sometimes metaphorically understood as unfinished objects, materials that haven’t been formed into their final shape. The metaphors people use to think and talk about teenagers contribute to guiding adults’ behavior toward adolescents, including whether and how they choose to nurture, ignore, discipline, or otherwise engage with adolescents.

### **Cognitive interviews**

Because cultural models tend to be organized into distinct and recognizable patterns, they lend themselves to qualitative investigation. The cognitive interview format is designed to approximate a “natural conversation” (Quinn 1982). In an interview situation people are often most comfortable providing cultural theories (explicit and familiar explanations which are known to have general currency); the semi-structured interview puts them in a situation which encourages them instead to do their own reasoning about the issues we are interested in, i.e., to use the relevant cultural models.

Skilled interviewing shifts the informant away from a “performing” mode and toward a “training” mode. The natural give and take of a conversation puts informants in a position of teaching the interviewer how to think about a given issue. The analyst’s job is to identify cultural assumptions, first in the interview setting by responding to and subtly challenging or asking for clarification of intuited premises, and second in the analysis of transcriptions by making these assumptions explicit.

**Subjects and sample size**

Because a culture is defined by a set of broadly shared understandings and assumptions, studying cultural models is analogous to studying the structure of a natural language. One does not need a large group of speakers to determine the basics of a language's grammar and syntax — a few speakers will typically suffice. Similarly, working with only a relative few subjects, one can identify the commonly held belief system typical of those subjects' culture. In-depth work with a relatively small group of informants has been the norm in cognitive anthropology, allowing researchers to work more closely with subjects than is possible using large-scale methodologies. Findings from cognitive interviews may subsequently be expanded upon and refined through quantitative methods, which may establish, for example, how strongly particular models are held in different segments of the population. Where the cognitive approach identifies the nature of the models, carefully devised quantitative research, using fixed-form surveys for example, can establish the distribution of the models (see Kempton, et al 1995).