



Helping the Public Reason about Health Coverage
Findings from TalkBack Testing of Simplifying Models

A FrameWorks Research Report

August 2004

RECOMMENDATIONS

Based on a combination of extensive cognitive analysis and empirical testing with over four hundred individuals, Cultural Logic is able to recommend a specific approach to explaining the uninsured problem to the American public. Information communicated in the way described below is perceived as interesting and relevant, and helps lay people understand and engage with the issue in productive ways.

The recommended models are also memorable and repeatable – they have the potential to enter public discourse, as well as being attended to by individual Americans. In sum, they can serve as tools to initiate a shift towards new public understandings of the health coverage issue.

Importantly, the recommended models are also designed to avoid triggering the common tendency to see the situation in stark, oppositional terms, according to which the health care system is either American (with all its imperfections) or “Socialized” (an unacceptable alternative). This stark (and false) choice represents the single biggest hurdle in communicating to the public about changes to our current system, but the research reported on here suggests it is not an insurmountable one.

More generally, one of the key goals of the simplifying models recommended here is to move people beyond an Individual-centered view of the issue – focusing on the plight of uninsured individuals, for example, or on quality and choice from an individual consumer perspective – and towards a “Top Down” view, which focuses on the system as a whole. The absence of a Top Down view is the most significant missing ingredient in public discourse on the problem of uninsurance. Promoting this view would help the public think more concretely about broad change, and would help engage them as “Responsible Managers” on the issue.

There are several well-established moral arguments relating to the problem of the uninsured, and we do not suggest abandoning them. On the other hand, it is clear that to have the best chance of succeeding, advocates need to supplement these moral arguments with a practical, Top Down explanation that provides the public with a clearer view of the causes of the problem, and which prepares them for reform.

The Central Simplifying Model: The Infrastructure We Never Built

There is a problem at the heart of this issue which most Americans fail to grasp, and cannot focus on: Unlike other developed countries, the United States lacks an overall system for linking people with health coverage plans. The current hit-or-miss approach involving employers (offering coverage at their own discretion) and various public institutions (such as Medicare and the military health programs) is not a system, but the piecemeal product of various historical and economic accidents. The goal of this simplifying model is to establish in lay people’s minds the idea that there is currently a void where there could and should be something more structured. (Note that this does not necessarily mean a single-payer plan, although the model is of course compatible with such a plan.)

In this model, the lack of a modern, efficient, and reliable approach to health coverage is contrasted with familiar examples – water systems, power grids, the Internet, the highway system, and telephone systems – modern networks and delivery systems that are essential to the American economy and quality of life. By comparison, our current approach is like counting on buckets and wells, county roads, and local generators. The model has a number of positive effects on lay people’s thinking, discussed in greater detail in the body of the report:

- It establishes that the current system is abnormal and unacceptable – rather than the default norm.
- It leads naturally to Top Down rather than Individual-based thinking – it frames the problem as one that must be addressed at the system/policy level.
- It adds practical dimensions to people’s thinking and helps advocates make the case that the current approach is Inefficient, Inadequate, Unreliable, Obsolete, and Destructive – rather than trapping the discourse in moral terms, as mean and unfair.

The next two models are very helpful supplements to this one, and focus on impacts of the uninsurance problem, again at a systemic level.

“Missing Pillars”

This model has proven effective as a way of conveying the idea that the stability of the health care/coverage system as a whole depends on the percentage of Americans who have coverage. According to this model, insured people are the “pillars” that hold up the system by regularly paying in, and the uninsured are the missing pillars. Their absence creates increasing instability in the system.

For many people, this model sets up a “vicious circle” concept – as people are lost from the system, the burden becomes greater on others, and they too become “missing pillars,” making the problem even worse.

Note that, if not handled carefully, this model can tend to sound like a condemnation of the uninsured – this problem can be avoided in a discussion that establishes that the system is to blame, that the individuals in question are not deliberately choosing not to have coverage.

Note too, that this model is not intended to act as the central simplifying model. By itself it does not necessarily lead people past the notion that health coverage is simply too expensive.

“ER Blockage”

This model presents another basic cause-and-effect story that helps people understand the problem from a broader perspective. It points to the many people who are without coverage, and who are using ERs as substitutes for the “normal channels” of health care. The consequence is that ERs are “clogged” with so many people that they can no longer

function normally, and may even break down altogether. This is a system breakdown that affects all of us – even those of us with health insurance.

This model does not offer as big a picture as the Infrastructure We Never Built or even Missing Pillars, but it is a very sharp, concrete example, that can serve as effective support for the other models.

Note that, like “Missing Pillars,” this model can be misinterpreted as an invitation to “blame the uninsured” unless handled carefully. But when framed properly, as a problem with the system, it shifts thinking to a broad, concrete problem, whose obvious solution is to move more people back to the normal channels.

BACKGROUND

Access to health care is a topic which most Americans recognize as an important issue and a pressing problem. To quote one of the subjects we spoke to during the course of the research reported on here, “It’s hard to bring up health care without people realizing it’s a serious problem.” From the speeches at the Democratic convention to polling data about Americans’ concerns, there is ample evidence that the issue is “out there.” Unlike many issues where advocates are concerned about the progress they are able to make in elevating their issue onto the national agenda, this issue already enjoys high levels of attention and energy.

The job for health advocates, then, is very different from the job that faces advocates on issues where even basic awareness is lacking. The problem, rather, is that the patterns of reasoning people bring to the issue often do not help them engage in productive ways (see below). In particular, while many average Americans are thinking about problems associated with insurance, they are often not thinking in ways that help them to take responsibility, or motivate them to press leaders forward in helpful directions. One of the chief goals for advocates is to create an atmosphere of public attitudes and discourse which will make it safe and even essential for policymakers to find substantive, practical solutions to the current crisis in health coverage.

EMPIRICAL METHODOLOGY

This research was conducted for the FrameWorks Institute and supported by grants from the HNHfoundation in New Hampshire and the California Endowment (Los Angeles, CA).

The recommendations presented in the report are based on empirical research with over four hundred subjects, involving a broad range of methods designed to explore different aspects of lay people’s responses to new information and concepts related to health insurance and the uninsured. A number of data-gathering techniques were used over the course of the project, including phone interviews, written questionnaires filled out in classrooms and public places, one-on-one conversations, and “TalkBack chains,” discussed below. In each case, the work involved a balance of testing the effectiveness of a given message, as well as gathering further qualitative data about the types of resistance that new information encounters, and other features of the “cognitive terrain” that a simplifying model must help negotiate. The process can best be described as a single, extended period of pilot testing and refinement.

The bar is very high in this type of research. Explanations that seem clever and effective on paper often turn out to be hopelessly inadequate tools in the context of a discussion where the goal is to shift a lay person’s thinking. Through repeated experiments and adjustments, it is possible to gradually arrive at messages that can be counted on to have the desired communications impact most of the time. In this section we describe the types of materials and interactions that were used in the empirical research and testing.

Types of Stimulus

“Term-only”: In some cases, subjects were presented with a term with no explanation, e.g.

The term “coverage grid” is unfamiliar to most people.

Explanatory Paragraphs: In other cases, subjects were presented with a paragraph-length explanation of a concept, e.g.

Experts feel that the US health care system is becoming unstable for one main reason, which they call the Eroding Foundation problem. Insured people are the foundation that holds up the health care system – they support it by paying in for their care. When people lose coverage the foundation erodes because they are no longer paying in regularly, and not helping support the system. This erosion is threatening the stability of American health care.

Types of task

Term-based speculation: In some cases, subjects were asked to speculate about the meaning of a term, e.g.,

What do you imagine that the term “Health Coverage Grid” refers to?

Policy-related questions: Some subjects were asked questions about topics related to policy preference, e.g.

Who is responsible for solving this problem?

TalkBack: Many subjects were asked to repeat information and explanations they had just been presented with, in their own words (see Types of format, below).

Types of format

Several different formats were used, including:

- Written questionnaire
- In-person interview (10-15 minutes)
- Telephone interview (10-15 minutes)

- “TalkBack chains”

This method is the most unique to simplifying models research. The aim of the method is to test whether subjects are able to teach their new understandings relating to health insurance (including terms and concepts) to naïve subjects. An assumption behind the method is that in order for new understandings of the health insurance issue to enter public discourse (and the culture, broadly speaking), they must be quickly graspable and repeatable by lay people, and must be robust enough to resist distortion and modification in the course of transmission.

Subjects are read an Explanatory Paragraph, usually more than once, and given a minute or so to ask for clarification. When new subject(s) enter the room, the previous subjects are asked to pass the information along to this next link in the “chain,” without any help from the researcher. Subjects are not allowed to take notes, so whatever information is passed along must be remembered and, to some extent, cognitively reconstructed. New subject(s) then enter the room, the first subject(s) leave, and the chain is continued.

Subjects generally work in pairs, to reduce the chances that the chain will fail due to a single individual who (for whatever reason) does not do a good job of absorbing the information. Chains extend as long as four generations (not including the researchers’ initial presentation of information):

Initial presentation → 1st generation TalkBack → 2nd generation TalkBack
 → 3rd generation TalkBack → 4th generation TalkBack

TalkBack testing creates an extraordinarily demanding challenge for any potential new ways of framing. As each “generation” of subjects acquires the material, individuals have an opportunity to distort what they have learned, and to introduce unwanted elements. The strongest models show some ability to self-correct – i.e., to lead subjects back towards the original explanation, even if they themselves were given a somewhat distorted version of the stimulus.

All TalkBack sessions were videotaped for later analysis.

Recruitment methods and sample

Subjects were recruited through a variety of methods. For in-person pilot tests in Washington DC, subjects were passers-by recruited in various public settings. (Subjects in all phases of research were offered small incentives for participation, such as a \$5 Starbucks coffee certificate.) For telephone interviews, subjects were recruited through ads placed in local “craig’s list” web sites – e.g. in Atlanta, Chicago, Phoenix, Seattle and New York. Classroom subjects were graduate and undergraduate students in anthropology classes. Passers-by were recruited to fill out written questionnaires in Vermont, Colorado, and New York City. TalkBack subjects in New Hampshire were

recruited by local business leaders, who, in turn, were recruited by the Endowment for Health. TalkBack subjects in Boston (mostly tourists) were recruited in public locations.

The range of subjects included broad diversity in terms of gender, ethnicity, age, and educational background, and also included a mix of parents and non-parents. The New Hampshire subjects in particular represented considerable diversity. They were employees at various levels in several very different workplaces – a restaurant and meeting facility, a book distributor, two auto dealerships, and a large communications company.

Summary of Research Methods

The research involved just over 400 subjects, and took place between March and July, 2004.

<i>Method</i>	<i>Number of Subjects</i>
Exploratory in-person interviews	20
Classroom questionnaires	41
Written questionnaires (passers-by)	165
Phone interviews	85
TalkBack chains	<u>100</u>
Total	411

THE SIMPLIFYING MODELS APPROACH

There are many different approaches to communicating about public policy issues, which involve distinct ways of trying to persuade and motivate. Advocates on the issue of the uninsured have tried a number of these – including making people aware of the suffering that the uninsured often endure, explaining some of the causes of the problem, and proposing specific remedies. More generally, some of the strategies that guide communicators’ approaches to advancing an issue include appealing to people’s consciences on behalf of someone or something that needs their help, providing them with facts about the problem, and reminding them of the values at stake (Compassion, Safety, a concern for the Legacy we are leaving our children, etc.).

The simplifying models approach is based on a different general direction, which aims at *providing people with conceptual tools that can allow them to reason about and engage with the problem in a more productive way*. Findings from the social sciences, as well of the experience of communications practitioners, point to a strong connection between understanding and engagement.

In order to be helpful (i.e. both informative and “catchy”), such a conceptual model must be fairly simple and concrete – such as a vivid metaphor – while also capturing the essence of an expert perspective. For example, research conducted by Cultural Logic and FrameWorks has shown that most Americans lack any real understanding of how global warming occurs, and that talking about the problem in terms of a simplifying model like “carbon dioxide blanket” makes it significantly easier for people to understand and engage with the issue. This is a matter of providing a mental model where none existed before.

While people know a lot about the general area of health and health coverage, previous research has established that there are also significant gaps and distortions in their reasoning (see below), which make the issue a candidate for the simplifying models approach.

Generating possibilities

Candidate simplifying models come from a number of different sources, and are generated throughout the process of analysis and testing. In addition to educated brainstorming, steps taken to generate possibilities have included soliciting suggestions from experts and advocates (including the Endowment for Health), reading a variety of materials produced by the field, and discussion with other FrameWorks researchers, who bring their own experience and perspectives to the issue.

Directions vs. Specific language

Importantly, the development of simplifying models does not begin with the identification of potential “sound bites.” Instead, much of the analysis and research involves considerations at a more conceptual level. The conceptual directions explored in this research are discussed below.

In the next section we discuss some of the cognitive obstacles to productive engagement established in previous research and during the course of the current project. These are the patterns which a simplifying model message would attempt to circumvent.¹

OBSTACLES AND GAPS IN CURRENT REASONING

Counterproductive patterns

In previous rounds of research², Cultural Logic identified several cognitive and cultural models which have special prominence in Americans' reasoning about health insurance. The most important of these are a Consumer Stance – which focuses on quality and choice, for example – and a fairly common belief (particularly in California) that Americans have a Right to Health Insurance. In this section we briefly discuss some of the current patterns in reasoning about health insurance – including both previous findings, and insights which emerged during this round of research – and their implications for the simplifying models project.

Hair-trigger response to “socialized medicine”

An overriding pattern of cognition that communicators must contend with is the extremely strong tendency for messages that come anywhere near the topic of a single-payer solution to evoke “rhetorical mode.” Many Americans have strong feelings about this topic (whether they understand the idea well or not), and tend to revert to familiar ideas and scripts when the idea comes up (even if indirectly), at the expense of new learning. Naturally, it is especially problematic when people *object* strongly to the idea of socialized medicine. But even when people are in favor of the idea – as most are, according to some research – it is often counterproductive to send the conversation down that particular path, unless it can be steered very carefully.

¹ For a fuller discussion of the principles and rationales of the simplifying models approach see FrameWorks' KidsCount Ezine 19: “Opening Up the Black Box: A Case Study in Simplifying Models” – by Axel Aubrun and Joe Grady with Susan Bales, 2002, <<http://www.frameworksinstitute.org/products/issue19framing.shtml>>.

² The previous research, commissioned by the FrameWorks Institute for the Endowment for Health (New Hampshire) as well as for the Wellness Foundation and the California Endowment (California), was conducted by Cultural Logic in the Fall of 2002 and Spring of 2003, and involved in-depth interviews with a diverse group of forty-one citizens and leaders in those two states.

Consumer Stance

The most common pattern in people’s understanding of health insurance, even among those who have fought to reduce the problem of uninsurance, frames health insurance as something very much like a Consumer Good. In this frame of understanding, insurance involves a relationship between a customer and a provider, where the customer expects high quality, a reasonable price, and a certain degree of choice in selecting which “product” to buy.

While this stance is natural on some level – and is encouraged by providers as well as by some advocates – it also has destructive implications for the public’s reasoning about the insurance issue:

- Its emphasis on costs and benefits largely preempts a moral perspective, drawing people away from altruistic thinking towards the uninsured. (“If they want insurance they should save up and buy it.”)
- It can even obscure the very existence of the uninsured (who, after all, are not “customers”), by highlighting only the individual relationships between provider and insured.
- It obscures “big picture” or “top down” understandings of health coverage as a helpful *system* involving many parties.
- It obscures any role for government and policy – except that it reinforces skepticism about “Socialized Medicine,” which hardly sounds like a high quality service.

A focus on personal costs

One of the most significant realities in the domain of health and insurance is that the costs of both care and coverage are rising at an alarming rate, with far-reaching consequences. While it is appropriate (and inevitable) for average Americans to be concerned about costs, the concern typically focuses on the costs to an individual or family, rather than any larger picture of costs at a higher level. Concern about costs typically amounts to one highly charged aspect of the Consumer Stance, and stands in the way of broader understanding. The mere sense that “it’s got to get less expensive” is a motivation of sorts, but does not help people think about the problem in a productive way.

The Uninsured as a pitiable minority

Some of the common ways of understanding the issues related to health insurance have both productive and counterproductive implications. The sympathy that many people feel for those with no health insurance can obviously provide some motivation to help. On the other hand, this stance comes at a cost. Like any instance of compassion it can also reinforce a distinction between “us” (those who have insurance) and “them.” Uninsurance from this point of view becomes a problem we “really ought to” do the right thing about – partly in order to feel good about ourselves – but not an issue which touches us directly. While we do not recommend that advocates abandon the very valid moral arguments for

increased access, the research does suggest that appeals to altruism have limits, and must be supplemented with arguments of other kinds.

The Uninsured as a sign of changing American demographics

People often contrast the health care situation today with the situation that they or their parents once knew. One common pattern of reasoning is to associate the plight of the uninsured with recent immigrants and other growing minorities. Besides being unfair and inaccurate, this generalization keeps people from focusing on the limitations of the coverage system we have.

The “right” to health insurance

This way of framing the issue, common among advocates, is obviously both appropriate and motivating on one level. On the other hand, by its nature it also tends to evoke “rhetorical mode,” in which people are ready to argue a point and dig in. After all, it is a relatively confrontational frame, which demands that some people stop denying others their due.

It is also an argument which it is natural for many Americans to reject: In the context of the American individualist ethos, people’s rights are much more about *freedom from* constraints than about *access to* goods and services.

Like the “Plight of the uninsured” perspective discussed above, the Right stance can be very effective, particularly with certain audiences, but is not enough, in itself, to win the day for advocates.

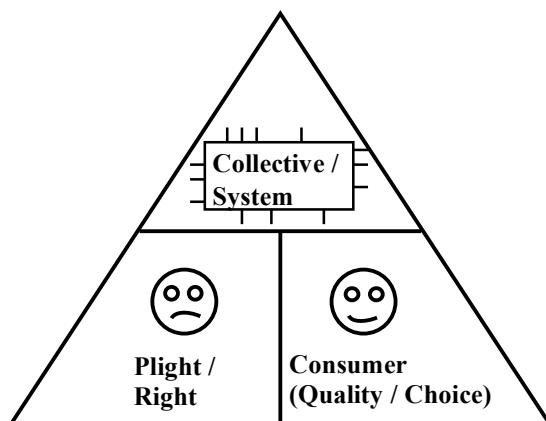
Fairness

Closely related to the Plight and Right frames, there is a fairly widespread sense that it simply isn’t fair how health care and coverage are distributed – the affluent have no problems, while “the rest of us” (as Democrat John Edwards would say) must live with anxiety about insurance for ourselves and our families. Again, this frame is certainly motivating, to certain groups at certain times, but it also has downsides and is insufficient in itself. It allows the many people who are relatively comfortable with their situation to dismiss the problem as just another on the list of problems facing the unfortunate have-nots in our society. Like the other moral arguments mentioned in this section, it is a valid and important point, but not one that has the capacity, by itself, to disrupt the powerful Consumer Stance towards health insurance. After all, there is widespread inequality of all kinds in our capitalist society, which is, for the most part, completely accepted.

Individuals vs. Systems

The models described above, some of which advocates would recognize as problems and some of which they have worked to promote, each have something in common: They frame health insurance issues primarily in terms of *individuals* rather than a broader

system or context. One of the central goals of the simplifying models work, therefore, was to explore ways of shifting people to a “higher” perspective, which is where causes can be understood and solutions can be enacted.



Individual vs. Collective Understandings

Gaps in reasoning

In addition to the cognitive obstacles in current reasoning about health insurance, the research – both prior to and during the course of the simplifying models project – identified a number of cognitive gaps or “blind spots,” areas where average people do not understand, or have a hard time thinking about, an important aspect of the issue which experts are familiar with. Each of these, in some sense, constitutes a direction which simplifying models might constructively focus on.

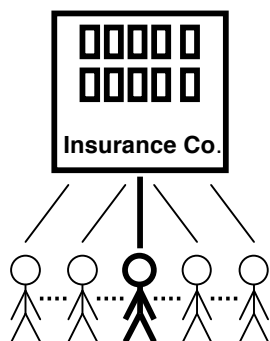
Distinction between coverage and care

It is difficult for average Americans to maintain a distinction between health care and health coverage as they reason and talk about the topics. One of the most frequent patterns in conversations was the tendency for people to slip from one to the other, particularly, from the topic of health insurance to the topic of the health care system. Health care – from trips to the hospital, to symptoms of illness, to interactions with doctors and nurses – is much more vivid in people’s minds than most issues relating to insurance. Naturally, this makes it more difficult for people to focus on problems that are specifically related to coverage, even though from an expert perspective the two are very distinct, if closely related. This slipperiness is sometimes reinforced by journalists and even advocates who move back and forth between the two without signaling the distinction.

One specific challenge this confusion creates is the sense that we currently have a health coverage “system” – in fact, we may have a system for health *care*, but we have a piecemeal, hit-or-miss approach to health *coverage*. (See the last part of this section.)

“Horizontal” relationships in insurance

If people typically think about health insurance from an individual, consumer perspective – i.e. as a “vertical” relationship between consumer and provider – they are much less aware of the ways in which the various members of a plan are causally connected with each other. Insurance might be thought of as a way of pooling resources among a group, for example, or for spreading and minimizing financial risk. These frames are hardly present in lay people’s thinking about the issue.



Vertical vs. Horizontal Relationships

More generally, average Americans have little understanding of how insurance companies “work” – how they make money, why they are able to offer reduced costs for care, and so forth.

Causes of uninsurance

Many average Americans have a sense that a large and growing number of people and families are going without insurance, but the research establishes that their understandings of the causes of the problem tend to be vague and shallow. For instance, they understand that people go without insurance because it is expensive, or because their job doesn’t offer it, without understanding why the situation has deteriorated so far over the past several decades – e.g. because of the changing nature of employment and benefits, and rising costs in the health care system.

Public systems/providers

Experts in the field are very much aware of the distinction between private providers and public programs such as Medicare, Medicaid and the systems set up to serve members and veterans of the military. The public, on the other hand, is not very aware of this distinction, or the government’s role in providing health coverage for many millions of Americans.

A central gap: the health insurance distribution “system”

Closely related to the previous point, most Americans have no conscious picture of the current American approach to health coverage – i.e. predominantly employer-based, supplemented by extensive public systems and programs. The following is an excerpt from a lecture on health financing in a seminar on Democratic Politics and Policy, by political scientist Mark Glaser of the New School's Graduate School of Management, January, 1996:

[S]everal fundamental questions must be answered in every country. About who is eligible for care under an official system, which people go to what health care providers, relationships among doctors, among hospitals and so on, but above all the flow of money, how you get money from the economy and how you pay the health-care providers.

The fundamental point that every modern society has *some* approach to financing health care – whether through a national plan or through the (uniquely) American employer-based approach – is missing from average Americans’ thinking about issues related to insurance. The American approach is often taken as a natural, unquestioned and even invisible “given.” Even when people express their desire for a national system of some kind, they typically have only a vague idea what this would mean – often, the idea of doctors who work for and are paid by the government. This confusion is troubling not only because it is a basis for the demonization of “socialized medicine,” but because it obscures questions about coverage, as distinct from care. In short, where experts draw arrows characterizing the routes by which citizens might hypothetically receive health coverage, average Americans more or less draw a blank.

GENERAL OBJECTIVES FOR THE SIMPLIFYING MODEL

Introducing a new understanding into a person's patterns of reasoning is a very difficult challenge, particularly when the topic is one that people have many well-established ideas about. Health is such a topic: People are able (and often eager) to talk at length about the various problems with the health care system, with medical billing, with insurance companies, with their personal health, etc. Like child development, health and health insurance are topics where people usually have no burning questions in their minds. They are not aware that they lack fundamental understanding, and are not "hungry" for information (unless it is information that can help them personally achieve better care or coverage). The process of trying to shift people's thinking in new directions can be compared with sumo wrestling, where part of the challenge is simply shifting an enormous weight. In this section we discuss some of the conceptual strategies that have the potential to shift people to a new perspective on the issue of insurance.

In addition to avoiding the "cognitive landmines" – the negative patterns of reasoning that are too easily triggered by any mention of the health care system – a simplifying model for the problem of uninsurance should meet a number of general criteria:

Creating the sense of a concrete, practical problem

For reasons touched on above, advocates on the issue of the uninsured stand to add power to their messages if they can evoke motivations beyond the moral perspectives of altruism, assertion of rights, and insistence on fairness. These arguments, while valid, do not take advantage of another powerfully motivating perspective, which entails looking at the world as a "Responsible Manager." If the problem of uninsurance can be framed in concrete and understandable terms, as one that affects all of us, then people can be motivated to take responsibility for the issue in a new way, rather than merely hoping someone eventually "does something" about the problem. A simplifying model can potentially frame the issue in a way that gives people a new and vivid sense that something can and must be fixed, that it is irresponsible and unreasonable to leave the problem unattended, like a leaking roof.

Moving from individual to collective perspectives

As outlined above, one of the most fundamental problems in current understandings related to health insurance is the dominance of individual perspectives – particularly the Consumer Stance, but also including sympathy for the Plight of the uninsured and other morally unassailable views. A simplifying model must help people achieve something more like a "big-picture" understanding of the problem. There are two primary directions for framing the problem as one that concerns everyone.

Establishing connections between insured and uninsured

There are a number of very real and objective ways in which people who do have insurance are worse off as a result of the fact that many people don't. These include public health considerations³, as well as financial and other impacts discussed below.

Transcending the individual level

Another promising strategy for bringing together the interests of the insured and uninsured is to provide a frame that doesn't refer to individuals at all. Models of communities, organizations and systems have this quality, and several possible directions along these lines were explored.

Establishing causal stories

Findings from the cognitive sciences, and experience in other issue areas, tell us that when people understand causal connections – between people, between events, etc. – they are empowered to think about a topic in a more engaged and constructive way. Among the causal stories relevant to the problem of the uninsured are the ones about impacts of the problem on the society as a whole (mentioned above), as well as explanations of why costs have risen, how uninsurance leads to the closure of emergency rooms, how changes in the employment rate lead to changes in the percentage of companies offering health benefits, and so forth.

Additional desiderata

In addition to working towards the objectives outlined above, an effective simplifying model should:

- Be easy to understand, remember and repeat
- Be compatible with expert understandings
- Be expressible in language appropriate for policymakers (i.e. not too odd, metaphorical, “soft,” etc.)
- Seem like a literal description, rather than a metaphor or other linguistic flourish
- Lend itself to pictorial explanations
- Illustrate the inherent limitations of the current, employer-based approach
- Be compatible with nationalized coverage, *without triggering rhetorical mode*.

³ This direction was not seriously considered as a basis for a simplifying model, mainly because the negativity of the frame (suggesting that we should be frightened of uninsured people) would be likely to create as many problems as it solves, at least if used as a central message.

AN EFFECTIVE SIMPLIFYING MODEL

Missing Health Coverage Infrastructure

By the conclusion of the research, one model had proven most effective at avoiding the cognitive problems discussed above, shifting people to more productive patterns of reasoning about the issue of health coverage, and meeting the other communications criteria on various levels.

In this model, health coverage is framed as a basic necessity, like water, electricity, communication, and transportation. The current “employers plus” approach to ensuring that people have access to it is contrasted with the modern networks we have built to meet those other needs:

Health Coverage Infrastructure

In the last 50 years the United States has built a series of modern networks that are essential to our economy and our quality of life – our power grid, phone systems, water systems, interstate highways, and the Internet. But with health coverage we’re stuck in the 1940s, because we never built a modern Health Coverage Infrastructure. Instead, we still have job-based insurance, which has become an increasingly hit-or-miss, inefficient and unreliable approach. We have the equivalent of scattered wells, individual generators, and county roads but no Health Coverage Infrastructure we can rely on, no system for making sure that people have health coverage.

The simplifying model makes the public smarter on the issue of health coverage

At one level, this simplifying model is effective simply because it makes people smarter about the issue of health coverage. Conversations that follow the introduction of this model tend to be richer and more focused, and to accept more new information about the issue. For example, this simplifying model allows advocates to describe our current approach as “obsolete,” “piecemeal,” “patchwork,” “hit-or-miss,” and to point out a number of consequences that are consistent with the model (and with reality):

- The current approach is very *unreliable/unstable* – a person’s insurance can go away tomorrow, or double in cost, because employers/companies make decisions (about benefits and everything else) based on shifting economic conditions.
- It’s more and more *inadequate* – it misses more and more people (now over 44 million), because fewer and fewer jobs are full-time, permanent positions with good benefits.
- It’s extremely *inefficient* – lots of money is “wasted” because there are so many different parties involved, charging administrative costs plus profit.

- It's *destructive* to the health care system, because of ER Blockage and the Missing Pillars problem, discussed below.
- It's not due simply to changing American demographics, but rather to an earlier lack of investment and planning that is catching up with us now.

The simplifying model does well in "rhetorical mode"

In addition, the simplifying model is designed to survive and be helpful in the strongly polemical environment that tends to surround any public discussion of health coverage reform.

- *A job that the Federal Government could be involved in*

The types of infrastructure mentioned in the prime establish a pattern of planned projects that are typically American, and that are a good fit with the mission of our Federal Government – whose intervention in some capacity, whether regulatory or as a single-payer will be necessary to meaningful reform. Even Libertarians accept the necessity of government involvement in building and maintaining our interstate highway system. As one respondent put it, "*A national healthcare (sic) initiative would not be inconsistent with other services offered by the government.*"

- *Neither Socialism nor Capitalism*

It is extremely difficult for both Conservatives and Liberals to avoid talking about health coverage reform without choosing between seeing health coverage as either a free market product or socialized medicine. "Threading the needle" between the two false choices is essential to moving the discussion forward, and this simplifying model is designed to do just that.

- *Feels like a rhetorical tool*

One of the problems facing advocates is the fact that while ordinary people feel like they want major changes in our health coverage system, they don't have the conceptual and rhetorical tools to talk – and to give voice to their strong emotion – about the issue. This simplifying model strikes people as something they can use in their everyday conversations. As one subject put it, "*I can't wait to use this idea on my right-wing father-in-law.*"

As a *secondary* point, the current system also creates tremendous suffering and unfairness. This point is secondary not in that it is unimportant, but in that it is not the way to begin this particular discussion.

The importance of the lack of a vivid term

On other issues, it has been very effective to identify a particular label which evokes a concrete image and refers to the essence of the simplifying model. "Carbon dioxide

blanket” is a helpful way of referring to the mechanism that causes global warming, and “brain architecture” is a helpful way of referring to the neural structures that are affected by a growing child’s interactions. Terms like these serve as a conceptual hooks which can draw people into a new mode of reasoning and around which they can organize new knowledge.

On this issue, however, it is not as clear that such a term could be helpful – first, because the central concept is something which is *missing* (unlike the two cases just mentioned); and, more importantly, *because concrete terms for the missing structure (e.g. Health Coverage Grid, Insurance Pipeline) easily trigger rhetorical responses opposed to socialized medicine.* In short, this is a concept for which it may be helpful to stop one step short of offering a concrete image.

Missing system vs. No system

One of the interesting questions which the research addressed was whether the current job-based approach to health coverage is best characterized as a broken system (e.g. a Collapsing Pipeline which *used to* meet our needs but has cracked beyond repair due to shifts in the economic landscape), or a system which is missing because it has simply never been built. In the end, we conclude that the latter approach is more promising. This is largely because the models, like Collapsing Pipeline,⁴ that were tested as concrete ways of expressing this point were perceived too strongly as analogies. That is, the factual statement that the changing nature of jobs and employment has made job-based health coverage less reliable, while interesting and compelling in its own right, .

Two Supporting Models

“Missing Pillars”

It makes intuitive sense that if the public could understand that as more and more people are forced out of the coverage system, the system as whole. Costs of coverage go up for everyone, and eventually the infrastructure of health care itself suffers. Using a simple metaphor can help people quickly and easily picture the consequences of the diminishing numbers of premium-payers:

⁴ *Coverage Breakdown*

Experts say that the most urgent problem in the American health system is what they call *Coverage Breakdown*. The job-based health coverage system is like a rickety old water system that has broken down and is failing to reach over forty million Americans. With the shifting nature of employment, the old insurance delivery system can no longer get the job done, because it’s based on a 1940s world where everybody worked for decades at the same job, there was no downsizing, flextime, etc. Coverage Breakdown is leaving the country with an unstable, patchwork water supply instead of a working system.

Missing Pillars

Experts feel that the US health care system is becoming unstable for one main reason, which they call the *Missing Pillars* problem. Insured people are like the pillars that hold up the health care system, by paying in, whether a little or a lot, for their care. People without insurance still use the Health Care System, but they are missing pillars because they are not paying in regularly, and not helping support the system. These tens of millions of missing pillars are threatening the stability of the health care system.

The point of this approach is to change the public's focus. Rather than drawing attention to the *growing* pool of uninsured people, the paragraph shifts the focus on the *diminishing* pool of payers. This model has the advantage of clarifying the concrete effects on the larger system of uninsurance. Rather than focusing on the point of view of individual consumers, the model frames the issue from a systems-centric perspective.

A factor that limits the applicability of this model is its tendency to lead, by itself, to inferences about the causes of people dropping out of the system. A common pattern is for respondents to focus on the high cost of insurance premiums as the problem.

“ER Blockage”

Another approach for leading people away from an individual or consumer-centered perspective on the problem is to draw attention directly to the consequences of uninsurance on the health care infrastructure. The most effective case to focus on are the increasing closures of trauma centers – partly because these have been in the news, especially in California.

ER Blockage

Experts feel that the most serious problem in the American health system is what they call “ER Blockage.” Millions of people currently don't have insurance, so they don't use the normal channels for health care, and are clogging the emergency rooms instead. This has blocked up the operation of all ER's and forced many to shut down because ER's are very expensive to run and cannot turn patients away. ER Blockage is an early sign of big trouble in the whole health care system. The only way to solve ER Blockage is to keep people in the regular system by making sure they have access to health coverage.

In cognitive terms, this model leaves people with no option but to consider the system-wide implications of a growing number of uninsured. The closure of ER's is something that affects all of us, and even more significantly, it is something that affects a concrete reality – something other than family budgets. The model is limited, however, by its lack of attention to the sources of the problem of uninsurance, and it does not give a sense of what is needed to solve the problem. As with *Missing Pillars*, respondents often infer that premiums need to be made more affordable (with no sense of how that might

happen). In addition, in some cases the model leads people to blame the uninsured, and to make special reference to populations of immigrants.

CONCLUSION: THOUGHTS ON FUTURE RESEARCH

Simplifying models, especially those aimed at helping the public understand a topic as controversial and complex as health coverage, are necessarily works in progress. This project is no exception. While we feel that a corner has been turned with the research conducted thus far, it is painfully clear that more work remains to be done. Several issues stand out as requiring further attention:

Comparative/quantitative testing of terms

The testing in this round was qualitative, and would be strengthened by quantitative comparisons with statistical validity – e.g. about which terms are better remembered, or are more strongly associated with correct inferences about health coverage.

Continuing refinement of specific language and terms

The paragraph is effective, but it is clear that within the general model, many choices need to be explored – in particular, given that the model is designed to be used by advocates, it is of critical importance that the boundaries of acceptable paraphrase be established, beyond which the model will lose much of its efficacy.

Development of explanatory visuals to support the language-based simplifying models

It is clear that simple visual explanations of topics such as Missing Pillars, ER Blockage, and possibly the needed infrastructure of health coverage, would help reinforce these key ideas.

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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