

**Citizens' Health Care Working Group
Public Meeting
Wednesday, December 14, 2005
Washington, DC**

Meeting Summary

Attendees

Members

Randy Johnson, Chair
Dotty Bazos (by phone)
Frank Baumeister
Montye Conlan
Richard Frank
Joe Hansen
Therese Hughes
Catherine McLaughlin
Deborah Stehr
Chris Wright
Don Young

Staff

George Grob, Executive Director
Jill Bernstein
Craig Caplan
Carolyn Dell
Jessica Federer
Margretta Kennedy
Andy Rock
Connie Smith
Caroline Taplin

Other Participants

Surjeet Ahluwalia, *AmericaSpeaks*
Jon Comola, Consultant (by phone)
Michael Garland, co-founder, Oregon Health Decisions (by phone)
Hala Harik Hayes, *AmericaSpeaks*
Mark Marich, PFI
Jack Molnar, Consultant (by phone)
Jonathan Ortman, PFI
Mary Ella Payne, Associate to Pat Maryland
Carole Reagan, Associate to Joe Hansen
Tish Tanski, *AmericaSpeaks*

MEETING SUMMARY

The Chairperson began the meeting at 9:00 a.m., reviewing the **Agenda** and expressing thanks to staff and contractors for their work to assure success of the Working Group's efforts.

Referring to the **Draft Questions for the American People** (Word Document), the Executive Director described the staff work on draft questions for use structuring community meetings, to be posted on the web, and for use in randomized representative national surveys. He emphasized that the most important order of business at today's meeting, however, was to determine what questions will be used to initiate the dialogue at the community meetings. These should be the most important questions to which the Members wanted answers.

The co-founder of Oregon Health Decisions commented favorably regarding the strength of the research design and its inclusion of a random survey as well as the opportunity to collect information at the community meetings. He observed that, while participants at the meetings will be a non-random sample, that, since demographic data will be collected on the participants, it will be possible to identify what sort of bias was built in. Regardless of the scientific rigor of the sample of participants at each meeting, the meetings will be a very rich source of qualitative information allowing the group to go into very great depth about values and preferences of the participants. Information regarding the participants' values can be captured and interpreted using comparisons with the random studies. He cautioned against trying to use too many closed-ended questions at the community meetings and emphasized the opportunity for qualitative information.

Members praised the materials sent to them and requested that staff provide a brief review of public opinion polling data, before the Working Group began its discussions.

Jill Bernstein, Staff to the Working Group, made a presentation regarding **Public Opinion, Health Care Coverage, Costs and Financing** (Power Point Presentation). She presented the results of an extensive review of data bases resulting from dozens of national polls and identified some of the consistent findings relevant to the Working Group's project. No polling data collected for political parties was used in this analysis and the analysis avoided references to advocacy organizations. In conducting its analysis of data; Staff did not rely on others' analyses, in order to avoid incorporating known or unknown bias from the polling organizations. The focus was on the objective data collected. Being able to compare data from different organizations and sources provided a range of agreed upon findings for further analysis.

Members and Staff discussed various aspects of the questions used in national polls and the resulting data and whether particular questions should also be used for the community meetings or for other purposes by the Working Group. In response to comments regarding specific subpopulations, it was noted that meaningful analysis of some more fine-grained subjects are not possible from national polling data without sufficient units of such data.

Concerns expressed about the questions:

- The uncertain effectiveness of using questions that seem too general and too familiar;

- Phrasing of the questions (including questions about technology, the chronically ill, and the blind, aged and disabled) and whether data reflecting national norms will adequately reflect regional variations;
- Having a place, in the proposed questions, where a participant can comment on other issues, not raised by the questions (for example, stem cell research) and allowing a way for the public to provide new perspectives;
- The need to determine whether the draft survey questions were intended for online, over the telephone, and/or for meetings, in order to know on what basis to provide comments and advice to the staff;
- Practical, cost, resource advantages and whether to use questions that have been previously used and answered;
- Use of questions to use as “markers” (standard questions that are also used routinely in national polls) in order to be able to compare how respondents at community meetings compared to those responding to national polls;
- Whether, to the set of questions used at the initial meetings, others can be added that derive from feedback and comments from the initial meetings;
- The need to add questions that addressed the cost-quality tradeoffs that need to be made;
- A perception that the draft questions recommended by staff might foreclose choices by respondents;
- Whether the proposed questions were leading and implied that health care was a commodity and that, as such, will leave people without coverage;
- The absence of questions about quality;
- Questions are needed for things like whether categorical eligibility is working; and
- The option of beginning questions/meetings with stories, leading to a discussion of health care information and facts, then moving to questions and dialogue.

Use of questions at community meetings:

- How to script what can be anticipated will be the direction of the conversation knowing that doing so may limit the informal audience response; also, whether to cover a longer list of questions superficially or a shorter list in greater depth;
- Support from the contractors is flexible; to ensure consistency in data collection, similar questions can be asked at each meeting;
- If greater variety was desired in the opportunities for public comment, different questions can be asked;
- For each separate meeting segment, participants can be asked a different major open-ended question;
- A core set of questions can also be handed out to meeting participants at the end of the meetings;
- The meetings will begin with an information session to better assure a subsequent “informed dialogue”; and
- The Working Group is trying to do three things: benchmark the questions, probe what isn’t known and let people talk.

Need for a “core” set of questions:

- Probing questions, taken from a set of “core” questions, can be used to follow-up on the discussions resulting from initial open-ended questions, can be used that solicit poll results from the meeting participants on selected issues during the meetings;
- The core set of standardized questions can also be provided to community meeting participants at the end of each meeting, posted on the Working Group Web site for visitors to answer, and used in random surveys;
- The core set of closed-ended questions is essential in order to enable data to be collected and analyzed; and
- The core question survey needs to include introductory passages that provide some information to the respondent before asking the questions, to insure that the response is informed to the degree possible.

Conclusions of the Working Group:

- The community meetings need to begin by informing the public about health care;
- The Working Group needs to know what people want and are willing to pay for, not merely what’s theoretically “right” in the view of the experts;
- The questions that will be used to frame the discussion at the community meetings need to be decided on, some may be in the document prepared by staff, or may be others entirely;
- Selected topics can be pursued in greater depth at the community meetings using probing further and some of the core questions;
- Systematic collection for data for analysis will be facilitated using key-pads for onsite polling;
- Demographic data obtained from community meeting participants will permit comparisons with the national polling data and probing, in greater detail, the differences that may emerge;
- Core and polling questions should include questions asked in random national surveys before so that it is possible to benchmark the responses of the particular groups of respondents to strengthen the analysis of responses to other questions being asked. (Some questions from national polls were used recently during a presentation by one of the Members to their community. The results were not the same as in the national polling. This information was relevant to the subsequent discussion and self-examination of the participants. Such comparative data will also better inform the decisions of the Working Group regarding recommendations.)
- There needs to be a way to ask fundamental questions such as the degree to which respondents agree that insuring access to health care for all should be the public policy of the country;
- The option of mandates for both business and employees needs to be evenly presented; the fundamental question is whether mandatory participation in health care is going to be public policy.
- References to the “government” should be replaced by broader terms, such as, “society.”
- Questions should deal with access, quality, and cost so as to retain the ability to address the four questions in the law.
- All factors are interrelated—access relates to cost, which relates to who pays—it is hard to answer any one without answering the rest; and

- Questions for the community meetings need to be bold and begin with open ended-questions that encourage new thinking from the public.

Online questionnaire:

- The proposed questions are okay as a starting point for developing a set to put on the web and for use in the telephone questionnaire and random survey.
- The online survey and telephone survey need specific closed-ended questions.

Jonathan Ortman discussed *How Community Meetings Will Be Structured* (See also Slide Presentation).

Once the Working Group has decided what it wants to gather from the public, ways to structure the meetings and questions to ask in either open- or closed-ended fashion in order to obtain useful responses, can be considered. For each area to be addressed, the Working Group has to decide whether it wants greater depth or more breadth. The distinction between informing the public and hearing from the public needs to be clear; the key question for the Working Group is what it really wants to know.

Options for structuring of community meetings:

- Ask the public what their vision of a perfect health care system is and begin some discussion and ask them to identify some values they have.
- Use open-ended questions, these work best.
- Sprinkle closed-ended questions throughout the sessions.

Discussion guide:

- To have an informed dialogue; before getting to the specific questions, the discussion guide can include boxes of text that provide specific factual information first;

Potential Signature meetings:

- Approach to be used in the meetings: video introduction; welcome & introduction; explanation of process; and vision and values in health care. There will be laptops at each table to be used in the discussion component;
- The meeting agenda will cover, for instance: benefits and services; delivery; financing; tradeoffs; community leader review;
- As different ideas are “voiced” (entered into the laptops) from the different tables, a “theme team” reviews these items, consolidates and reflects these onto the large overhead screens that everyone in the hall can see. Information about the subject can be provided and the people at the individual tables can discuss these comments.

How to Proceed During the Remainder of Today’s (December 14) Meeting:

- Use the questions developed by staff and identify which will be good probing questions and which can be used for broad topics;
- Focus on the content during the Working Group meeting, rather than spending too much time on reordering materials;
- Address the process questions and delegate it to the staff and then spend Working Group time on deciding what topics it wants to probe at the Community Meetings; and
- Tell the staff to get back to the Working Group with suggested high level questions.

Further Discussion of Questions and Community Meetings:

Joe Hansen – We need to ask people more than what they want because otherwise they'll put everything on the list and they'll want to hand onto what they already have. The issues are: how do people want to pay for what they want, how should the system be changed, and how do they want to deal with the outcomes of these changes. I believe that the public is ahead of us on wanting change.

Randy Johnson – I agree we need to focus on how to balance the desire for benefits with the cost impact? How will community meetings help us get answers to this? Also, who is going to provide the information on which people will be asked to respond?

Michael Garland – You need to distinguish between the questions you want to ask experts versus those you want to ask the public. The public knows their hopes, fears, desires; you want the community meetings designed to ask questions that draw on what the public is most able to contribute.

Richard Frank – I'm concerned about the "community leader review" you have included in your draft agenda for the close out at the end of each community meeting: how do we avoid having the VIP who wants to make a campaign speech or who is strongly partisan?

Jon Ortman – You make it clear at the outset, in any initial discussion with them or in the way they are introduced that no formal remarks are appropriate – just a short set of comments to show, symbolically, that someone has been listening to the day's discussions.

Randy Johnson – Do we generally agree that we want to structure the questions around quality, cost, and access rather around the four questions from the law?

Joe Hansen – Maybe so; I'd be concerned about how we would make recommendations if we don't focus on quality, cost, and access. I was uncomfortable with the set of questions we were given and want to hear from the whole group about how we restructure them.

Catherine McLaughlin – Let's stick with the draft questions and ask the staff to provide some information at the beginning of each section and include information on cost, quality, and access in the lead in to each question.

George Grob – We need to decide what to keep and what to discard of the questions and then we can focus on what areas to probe further in the meetings.

Richard Frank – Staff has heard this discussion; we should just tell them how many questions we want and let them restructure the questionnaire including a core set of questions. If everyone agrees to the idea of benchmarks, maybe we only need about 12 items/questions.

Jon Ortman – Are you going to ask questions to elicit just the values, hopes, and fears, or are you going to ask more technical questions of the public?

Catherine McLaughlin –I agree (with Michael Garland’s remark) that we should exploit what the average citizen will know most about; they may not know about or be able to provide informed responses regarding more technical areas. We ought to: ask the compare/advantage questions that meeting participants will know about, ask fewer questions, reframe the questions, and simplify the language of the questions since this language is more what an expert would respond to.

Therese Hughes – While citizens may not have technical expertise, they will have opinions regarding the subjects and may surprise us. I think we should ask them more rather than fewer questions at both the broad as well as the more technical level.

Joe Hansen – There’s going to be a cost to making changes in the health care system and the public is astute enough to be asked about their preferred tradeoffs.

Catherine McLaughlin – A more technical area I was referring to specifically are the tax code questions; I don’t think we’re likely to get useful information from average citizens about those; answering them in a meaningful way requires more information than most people have.

Richard Frank – There are a couple things that show up repeatedly that we need to benchmark; but these should be limited in number because they are a tool for use in looking at the other responses from the public.

Jill Bernstein -- This brings up our circular problem. It is easier to ask the questions that will enable us to make the policy decision based on knowing their values. It will help if the Working Group will identify the higher and lower level questions, or decide which questions should be treated as broader questions and which as more specific, or closed-ended, questions—possibly to be used as part of the “core” set and as polling questions. It is an issue of distinguishing between a few questions for the meetings versus a set of survey/polling questions that will be asked without first having to provide too much lead-in information.

Joe Hansen – Regarding how the questions are framed, we need to be careful that the questions don’t appear to imply one answer is preferred over another; it’s important that the questions don’t “lead” the respondent in one direction or another. For example, in the draft set of questions, I would argue against advocating mainly an employer-based health insurance system.

Jill Bernstein – Do we want to ask about people’s broad preference for what they want in a health care system, like what we have now or something like Canada has? It seems to me that people know how to answer a question like that.

Joe Hansen – If you ask that particular question you may freeze up the entire subsequent discussion. We need to impart information regarding what we’ve already learned about the health care system, but we want to do so in a way that doesn’t influence the respondents.

Dotty Bazos – Although we want to ask whether people want a health care system that works for everyone; but won’t everyone understand what that might mean and therefore answer that question differently?

Montye Conlan – I think there are hot button topics that we need to avoid.. Beginning with people’s stories appeals to me because it allows us to capture peoples reality more than relying on analysis of data into rows, columns or matrices.

Jon Comola – You have results of others’ research and you’ll have your own random survey. These are important because you’ll be able to demonstrate a factual basis for recommendations that you make.

George Grob – I’ve heard that you want a smaller number of questions and you want to use questions from national polls to benchmark the groups of respondents we hear from in our meetings and surveys. We need to focus on what topics you want to probe.

Richard Frank – I think the editing of the questions for purposes of the core set of questions—that will be used in surveys and on the web—can be done easily by email.

George Grob – The following presentation of policy proposals is an example of what we would plan to provide at future monthly meetings of the Working Group, to promote your discussion and deliberations.

Craig Caplan, Staff, Citizens’ Health Care Working Group, discussed *Policy Proposals* (See Power Point Slide Show).

In the slide presentation, the terms “comprehensive” and “incremental” are used to describe potential changes in the health care system. Both terms refer to the scale of changes; “incremental” as used here, means making adjustments to, but keeping the basic systems of, the current set of institutions and arrangements of the health care system. “Incremental” can also mean to implement changes in sequential or piece by piece basis. *Comprehensive* changes to the health care system could be made *incrementally*; therefore, a 10-year “roadmap” might include a vision for comprehensive changes to the system with a phased, incremental, plan for these changes.

Catherine McLaughlin – We need to seek public input regarding whether the American people want incremental (in the sense of adjustments to the current system) or comprehensive reform. We need to include specific questions about this. We need to decide how to conduct effective discussions at the meetings that will enable us to arrive at recommendations. These need to reflect what we heard in Oregon; we should be looking at the kind of choice that Oregon was proposing. The two key questions we need to ask are: one, do Americans want comprehensive or incremental reform and, two, should we shift from rationing care by categorical eligibility to universal coverage with the focus on what services are covered.

Dotty Bazos – I agree; let’s ask about people’s desire to shift from categorical eligibility to one of broader coverage.

Richard Frank – We need to focus on the tradeoff between cost and choice; then drill down to what kind of choices they want. Also, we should ask whether they feel differently about whether they have a choice of doctor when they’re sick versus when taking a drug. Then, we should ask whether different administrative mechanisms will make people feel differently about choice.

Randy Johnson – We are already giving financial incentives to doctors regarding the services and drugs they provide. I'm not sure we need to ask about it since we're already moving in this direction—employer-sponsored plans are already moving in that direction.

Richard Frank – Since only about five percent of employers currently offer consumer-directed health plan options, it's premature to conclude that the change (from zero to five percent) represents a trend. However, it is relevant to ask whether Americans would like this approach called to go from five to 70 percent in the future.

Catherine McLaughlin – We also need to distinguish between asking employees what they think or prefer versus what employers are actually doing.

Therese Hughes – I strongly agree; even the employer community might want to know, while we're still at the five percent level, before they spend more money moving in that direction—and before the percentage is greater—whether this is solution some currently believe it to be. There is disagreement over whether it is the right direction in which to move.

Richard Frank – There are a series of questions we need to ask about financing: getting people to think about the differences in changes in the income taxes people pay; thinking about sales tax on non-necessities; changing exemptions. I don't know how you'd ask these; maybe taxes should be raised for more expensive plans above the median. Then, we need to find out how people view those things and about getting premium changes.

Don Young – There's an important distinction between costs and financing; financing addresses the question of who pays. Some of us may use the term "costs" to refer to resource costs.

Therese Hughes – Income testing needs to be included; we need to include the presumption that all people are covered. Also, we should ask about means-testing Medicare.

Jill Bernstein – In the private insurance sector there are plans that charge higher income people more.

Joe Hansen – We already have a tax that is not means tested: Medicare.

Richard Frank --- We use a whole bunch of ways of financing health care in this country: income, sales tax, payroll tax, etc. How do people feel about those different mechanisms? Whether you want to expand coverage, or improve quality, it's going to cost money and you have to find a way to pay for it. Whatever we recommend is going to cost money and we need to weigh in on how that will be financed.

Catherine McLaughlin – Rather than simply listing wants, we need to ask about tradeoff preferences. If each person only has a certain amount of money, which bundle of services do they want to buy with that money? We can make these questions more comparable among the different uses. What we really want is the comparisons in the way the questions are asked. We need to force choices through asking people to RANK choices. There are several categories where the strongly agree scale doesn't make sense. It's not helpful to simply have the same scale for all the questions. Change the format to ranking or choice format for some of the questions. Take them out of the current questions list ranking and put into other formats.

Richard Frank – Each person is going to look at these tradeoff questions from the point of view of what's of most interest to them personally.

Catherine McLaughlin – In the Maine meetings process (conducted by *AmericaSpeaks*, under contract to the state) and in the PBS media outreach and town meeting approach, people changed their views (from the first engagement with the issues to the end, revealed by using similar questions at the beginning and end of the engagement process) as a result of the educational and interactive process.

Frank Baumeister – What we don't know is whether the people kept those changed views.

Randy Johnson – I agree, it is important how people will be asked about and how they will make these tradeoffs.

Dotty Bazos – The same thing holds true for tradeoffs for consumers and patients; it will be another drill-down question. It's very counterintuitive for people to know what treatments they need or that their physician may be scheduling return visits around their (the physician's) schedule, not necessarily in direct response to the patient's medical needs.

Frank Baumeister – We've heard from experts and learned that health care is expensive. We've heard it said that having electronic medical records (EMRs) will reduce costs by up to 40%. Dr. Wennberg says that some geographical areas have much lower costs. We hear that for some conditions, Americans may only get 55% of the recommended care. Something's wrong with the system. Businesses can't afford it any more; they're going broke; we can't compete on a world-wide level. We've heard that Medicare is going broke; we can't afford it either. States are going broke due to Medicaid. We hear that the pharmaceutical companies are charging too much.

We need a set of questions leads to answers that will help us figure out how to fix the system; the current draft set doesn't do this. Government isn't all bad but there's a perception it is bad. I believe that we need a public-private cooperative. It needs to involved rebates somehow and needs to address terrible end of life care, among many other features.

Randy Johnson – Questions I recommend we add include: end of life care; one asking how people feel about pay-for-performance; and one on medical liability and the link between costs and liability.

Richard Frank – I think we ought to leave it on the table: tort reform; pay for performance—being able to fire your doctor if he doesn't do a good job.

Catherine McLaughlin – Realistically, we may not be able to ask all the questions we'd like to in the time we have.

Jonathan Ortman – There need to be four big questions with a number of smaller questions underneath them; we'll cover as much as we can. For our model, we spend about 45 minutes per main question; you can answer a key pad question in about 60 seconds, but you can spend a variable amount of time discussing the subject. An example of a fundamental would be whether we should require everyone to be insured.

Catherine McLaughlin – That’s a question I’d like hear discussion about and responses to.

Jonathan Ortman – Agreeing about the value or agreeing in principal is one thing; another is whether, mechanically, it is essential—for the health care system to work—that everyone must participate.

Catherine McLaughlin – I worry that in the tradeoff questions we get to a lot of questions that have been asked and it’s not exploiting the capacity of the meeting structure. I’d like to ask the bigger questions and then drill down, to start at a much broader level. The experts and the polls suggest that the people are way ahead of the policy makers but what the specific changes they want made is not clear. The online questions can be more closed-ended. We’re not going to know if the American public is ahead of us if we don’t use this opportunity to pursue it.

Richard Frank – I’d like to add questions about long term care: whether there ought to be tax advantages, what people want, should people be forced to save, should people be allowed to play games with their assets to avoid having to pay themselves. People haven’t engaged in addressing their potential long term care needs and the financial implications.

Randy Johnson – I agree; we’ve offered long term care plans in the corporate arena and few employees have chosen it. So far the American public has shown by their actions they aren’t willing to move in this direction; how do we obtain answers that will be useful?

Richard Frank – Research has shown there are a number of causes for this, including adverse selection and the existence of Medicare. We need find out how worried people are about it.

Joe Hansen – On the web, there won’t be discussion before the questions are asked; we need to have time to review those questions, too. I’d like to know how the public feels about various kinds of mandates. We also need to define what we mean by long term care and the various definitions of health savings accounts; some people have a broader definition of this.

Richard Frank – I include under long term care: end of life care, home health, respite care, and typically nursing home care. I leave out post acute care.

Deborah Stehr – Long term care isn’t just an elderly issue and it’s a piecemeal broken system; financing also covers state payment systems.

Chris Wright – Long term care can mean cradle to the grave.

Dotty Bazos – The time element is missing here. Is there a way to denote the questions so meeting participants recognize that? It’s different being a patient versus being a consumer; the perception of whether you have health care that works is different depending on whether you’re a consumer (and are able to shop for care coverage in advance) or a patient (and therefore, needing care immediately on a real-time basis).

Randy Johnson – Regarding the roadmap; what are the steps we take to get there? Do we want to ask the public about timetables?

Therese Hughes – I think that should stay within the Working Group. We might also ask a question about people’s perceptions of the importance of (national and local) leadership. Changes in the health care system have often been made as a result of actions by an elected official who had a health care problem that has happened to his family. We can also look at issues of primary and preventive care; those are going to lower costs.

Joe Hansen – Maybe we need to ask who is responsible for fixing the problems. We are here to build some political will after talking to the American public so that it becomes possible to make changes.

Frank Baumeister – We have an opportunity to take a message to Congress. The journey is to get there. Whoever presents this to the Congress and the President has an opportunity to say something to them about health care in America today. The one area in this world where caveat emptor—let the buyer beware—should not apply, is health care. As a doctor, I don’t care who the individual is I’m treating, it’s the treatment that matters. We need to be all for one and one for all regarding assuring necessary health care. That message should come out strong when we come out with recommendations. And I think we’ll hear that from the American people when we start begin community meetings.

There is a more basic question of financing about where the public dollars come from and go and where the private dollars come from and go; we need to look at the federal-state cooperation and funding arrangements.

Therese Hughes – Industry has something to do with financing, also.

George Grob – What are the four main questions that we should use for the meetings?

Jonathan Ortman – We’re on the right track. Personal stories are a great way to communicate in real terms about whom the American system is configured wrong for; it is not configured well; so many people are uninsured, among other problems. Also we can ask a question about roles and responsibilities; should we ask the public about whether they believe everyone should participate in some way?

Richard Frank – I think the Congress will be disappointed if we come back with only the very high level recommendations, such as saying that some form of universal health insurance is desired by the American people.

I think we need to talk to some sick people about issues important to them; talk to people who are dealing with the health care system on a daily/regular basis; the Working Group is set up particularly well to give us an entree into those communities.

Dotty Bazos – Maybe we should set aside three community meetings to address these questions with people who are confronted with these issues right now.

Jonathan Ortman – Would the American Hospital Association be willing to help with that?

Randy Johnson – I want to take up the question about enabling people to respond in an informed manner; how do we make sure that people are responding in an informed way?

Hala Harik Hayes – We’re preparing a discussion guide that will have information and data based on documents you’ve already developed. The discussion guide will be used for the informing portion of the meetings. We’d also look at other key facts.

Catherine McLaughlin – What’s the vetting process for the discussion guide and the survey questions?

George Grob – The Working Group needs an opportunity to vet the document. We told the contractors that we want to make the document easier but keep to the material in the documents we’ve already produced. If we can have a staff/contractor review, we can share it with the Working Group for review and vetting. Once we have that, then we’ll combine with the questions and some carefully crafted introduction to each of the sections to each of the four question areas.

Jonathan Ortman – The part I’m most concerned about are the initial questions, the large questions that you want to address since we’ve got the first meeting on January 17th. The background, discussion guide relates to the key facts that you’d like to have known about why this is an issue and the key things you’d like them to know in order to have this discussion. The mission should be to help the public examine its own understanding it wouldn’t otherwise see without this process—to help people connect with their true feelings about health care.

Randy Johnson – It’s a huge job; not only to get the facts and figures right, but to achieve a balance.

Hala Harik Hayes – The discussion guide is a condensation of the Report to the American people, the Invitation, and the slide show.

Therese Hughes – Another area that needs to be addressed in the meetings and materials is the future of medical advances: stem cell, technological advance, new drugs. We should hear from the public on this. This does relate to cost and access.

Catherine McLaughlin – If we can’t expand the pie, how do we divide the pie? The Oregon approach was to switch from categorical coverage to universal coverage but then address what services people are eligible for.

George Grob – Another way to look at it is the question about what people are going to pay for. How much a person wants to pay is separate from what they think they should pay for.

Chris Wright – Another way to ask the questions is: “How should new medical advances (e.g., stem cell research, pharmaceuticals, etc.) be funded?”

Joe Hansen – We have very difficult questions to ask the American people: what do we want to cover and should health care be public policy? If you take the capitalistic features out of medical research, it seems dangerous because it will stop medical advances.

Montye Conlan – This list of services in the draft questionnaire is kind of a laundry list of reforms; I’d like to see bold reforms that we can try out on the public; such as switching from

categorical coverage to universal coverage (with setting levels of services that will be available). Let's not go down a long list of specifics; we should come up with a broad umbrella under which these will fall.

Randy Johnson –If people responded, “yes, we must have universal health care coverage.” Then, this list we've been constructing are the possible things we'd ask about: “what do you really mean by this universal coverage?” and “how are you going to pay for this?”

Montye Conlan – Let's keep coming up with bold ideas rather than these little specifics.

Jonathan Ortman – This is consistent with the question I like to ask the public: “just dream a little with me.” For example, there was a report in the paper yesterday about the impact of broad band.

Hala Harik Hayes – We can look at the following criteria for deciding on the kinds of questions you want to use in the meetings; they should:

- seek bold solutions;
- be well suited for the community meetings, not for online questionnaires;
- be items we don't have lots of information on regarding how the public feels;
- be ones the working group needs answers in order to make recommendations; and
- cover areas that can actually be influenced.

George Grob – We can either approach the discussion topics as the four issues or the four questions.

Jonathan Ortman – What are the most important issues that we will want to have discussed at these meetings? The most important is the tradeoffs question. Think about what are the most tradeoff questions to ask.

Randy Johnson – Can PFI and *AmericaSpeaks* come tomorrow morning with advice about what they believe are the four most important questions to ask, having heard today's discussion?

Jonathan Ortman – We would use the following as a starting point; what do you think about these potential questions?

- What should the role of the individual be?
- What should be the expectations of the private sector?
- What's the best way to ensure that the American health care dollars are used wisely?
- How can we improve the delivery of health care?
- Is there a certain amount of health care that is reasonable for all Americans to expect regardless of ability to pay?
- Should every American be covered?
- What can be done to address the double-digit price increases for health care in America?

Randy Johnson – How are you going to use our reactions?

Joe Hansen – If we get the discussion guide and the basic facts, then we'd have the underpinning that will make me more comfortable about having the discussion.

George Grob – The first thing to decide is what the questions will be about, the framework.

Randy Johnson – To reiterate, they shouldn't be leading questions.

Catherine McLaughlin – That's determined by the style of the question or the way it is asked.

The chairperson adjourned the public meeting at 4:30 p.m.