
THE DEBATE THAT WASN'T: THE PUBLIC AND THE CLINTON PLAN

by Daniel Yankelovich

Prologue: *Not since the repeal of the Medicare Catastrophic Coverage Act of 1988 has health care reform been first the "hero," then the "gout" of the American policy scene in such a short period of time. As was the case after the repeal of Catastrophic in Congress, policy experts and opinion leaders have spent many hours debating what went wrong with the Clinton plan. Explanations range from blaming the plan itself, with its endless complexity and poorly understood provisions, to blaming the Clinton administration for its inability to articulate its vision to a confused, often frightened public. Not to be discounted is the role of special-interest groups and the millions of dollars spent on mass-media campaigns to discredit the plan. However, U.S. opinion polling expert Daniel Yankelovich believes that the problem is more deeply rooted, and therefore more troubling, than any of those reasons. The problem, as he states in this paper, is a "disconnect" between the American public and its leaders. That is, although elites have no problem conversing with one another, they carry out "a bizarre dialogue of the deaf with the people. As far as the American people are concerned, Yankelovich says, "the great health care debate of 1994 never took place." Successful reforms in the future hinge on the nation's ability to mend this "disconnect" and begin genuine public deliberation on a topic that is so crucial to the future health and economic well-being of the nation and its citizens. Yankelovich, who holds a graduate degree in psychology from Harvard, is chairman of DYG, Inc., a firm that tracks social trends and public attitudes. He is president and cofounder of The Public Agenda Foundation, a nonpartisan, nonprofit organization dedicated to improving the quality of public debate on important policy issues. The invited comments of Drew Altman and Karlyn Bowman, and comments of Murk Goldberg and Uwe Reinhardt, follow Yankelovich's paper.*

Barely half a decade after the resounding defeat of the Medicare Catastrophic Coverage Act in Congress, supporters of the Clinton administration's health care bill suffered an even worse defeat, one that hurt the administration's political fortunes and also failed to win some badly needed reforms of the health care system. What is it about health care reform that causes our political leadership to stumble so? Why does the public seem so supportive at some stages of the reform process, while at other stages its support vanishes and even turns against the reformers? Is the public fickle? Perverse? Easily manipulated by those with the deepest pockets to pay for negative advertising? Or are there other factors at work that explain the repeated miscalculations of our political leaders? From the perspective of the public, why did the Clinton health care plan fail?

A Failure Of Deliberation

Because all complex phenomena have multiple causes, the choice of which cause to highlight depends on one's purpose. My purpose here is twofold: to understand how to avoid this kind of failure in the future, and to learn how to get health care reform back on track—that is, to learn how to shape health care reforms that reflect the values and priorities of the American people. With these purposes in mind, I suggest that the defeat of the two health care initiatives—catastrophic coverage for the elderly in 1989 and the Clinton reform plan in 1994—both reflect a massive failure of public deliberation.

The electorate and the nation's leadership class (which includes leaders of medicine, industry, education, the legal profession, science, religion, and journalism, as well as national and community political leaders) do not seem to be able to converse with one another productively. Instead, they talk at each other across a void of misunderstanding and misinterpretation. The failure of health reform is a direct consequence of this “disconnect.”

The nation's leadership and the public are carrying out a bizarre dialogue of the deaf. The nation's elites have little trouble conversing with one another, but when it comes to engaging the public, there is an astonishing lack of dialogue. Public relations, punditry, advertising, speechifying, spin-doctoring, and so-called public education—these mechanisms of top-down communication abound. The absence of plain give-and-take between leaders and the public is striking.

President Clinton's reform plan was not shaped by discussion with citizens about rising health care costs and what to do about them—a process whereby reform proposals are continuously adapted to the rhythm of public understanding. The plan was the product of experts and experts alone. Technical experts designed it, special interests argued it, political leaders

sold it, journalists more interested in its political ramifications than its contents kibitzed it, advertising attacked it. There was no way for average Americans to understand what it meant for them. The political reality is that Americans were not prepared to and did not, in fact, deliberate on the scope, magnitude, and nature of the reforms the Clinton plan proposed. This makes moot the question of whether the reforms were the right ones—some were, some were not. But the public did not directly engage any of them.

The downfall of the Clinton health care plan unfolded with the inexorability of Greek tragedy. First, we watched the administration respond to opinion polls and other political signals that persuaded it that health care reform was the public's top priority and seduced it into believing (falsely) that the public supported its reform proposals. Then, as the administration climbed further and further out on a limb of commitment to its reform plan, we saw public support mysteriously fade away. We watched, with fascination, as this weakening of support made it sickeningly easy for the opposition to cut off the limb. The administration fell bitterly into the dust of defeat, without ever really understanding what happened. The spectacle makes compelling drama and good partisan politics. But defeats of this sort deepen public cynicism and weaken the fabric of American life.

The blame for this failure of public deliberation lies squarely at the feet of the American leadership class. Public deliberation requires that leaders engage the public in debate on choices that the public can understand and is prepared to confront. This requires skillful leadership that the leadership class, with all of its communication skills and resources, failed to provide. Its failure was spectacular in scope, which makes this post-mortem of the Clinton plan so important. If our society is to continue to function, this kind of failure cannot be repeated too many times.

In the early stages of deliberating any issue, average citizens probably will not be knowledgeable about its specifics. The purpose of debate and deliberation is to give people time to understand the costs and benefits of alternative choices and, if there are tough choices to be made (as in health care), the opportunity to mull them over. (Admittedly, the word deliberate is too rationalistic in its overtones. More often than not, the so-called debate is informal and messy, charged with irrational and emotional elements. Yet somehow it takes place, and the public's work gets done.) When a reform fails to win public support, it is either because the American people have deliberated and rejected it, or because deliberation did not take place. When people lack the opportunity to work through what the proposed changes mean for their lives, fear of change itself takes over, and people settle for the status quo, however unsatisfactory, preferring it to change they do not understand and have not seriously considered. This is

what happened in both waves of health care reform.

My reading of public opinion is that had serious deliberation taken place, older Americans would have supported the catastrophic coverage reforms passed by Congress in 1988. Congress was obliged to reverse itself in 1989 not because older Americans had rationally judged the reforms and decided against them but because they were afraid of being railroaded by changes they were never given the chance to deliberate. Studies conducted by DYG, Inc., after Congress flip-flopped emphasize a characteristic of older people we sometimes overlook: an initial resistance to change, especially if there is no opportunity to ponder it. The DYG studies show that Americans age sixty-five and older were initially the group most resistant to all health care reforms when they first heard about them. But unlike younger Americans, they were the only group whose support for reform actually increased after they had wrestled with the trade-offs that reform would entail.¹

We will never know what might have happened if the Clinton administration had given the public a better opportunity to absorb, digest, and consider their plan carefully. The survey data show that the plan lost public support because its opponents found it easy to raise the public's fears about reforms people did not understand. To fill the vacuum, opponents conjured up the prospect of ever more impersonal "cattle car" care, regulated by the federal government, with higher out-of-pocket costs for care, higher taxes, less choice, lower wages, and increased unemployment.

My interpretation is that, unlike the catastrophic coverage bill, the public would have rejected the Clinton plan as it was presented to them, if a majority of voters had carefully considered the plan on its merits. When one opens a policy to deliberation, one also opens it to the possibility of revision. Deliberating is not the same as selling or persuading. President Clinton fully accepted this reality in his relationship to Congress: He explicitly told Congress that his plan was negotiable except for one item, universal insurance coverage. And in the end, he was willing to negotiate about this as well. But the opportunity to deliberate and negotiate was not available to the public. If it had been, the outcome would have been different. If the reform plan had been critiqued and revised through a process of give-and-take with the public, we would, in my judgment, have a health care reform package today—an incremental one, to be sure, but one that could evolve toward the goal of health care that responds to the public's priorities.

As far as the public is concerned, the great health care debate of 1994 never took place. In light of the intense discussion of health care reform in the past several years in Congress, the media, and the health care professions, the proposition that there was not much public deliberation is far from being self-evident. From the presidential election of 1992 to mid-

1994, citizens who were even half awake could not escape the unending stream of newspaper articles, public opinion polls, political speeches, and television ads on various aspects of health care reform. The president and the First Lady made this issue the centerpiece of their legislative strategy. Countless congressional committees made it their special preserve, struggling for months to achieve compromises that were widely publicized. Few issues interested the public more intensively. And the public did, after all, change its mind about the Clinton health care plan. In what sense, then, did the public fail to deliberate the president's plan?

The Public's State Of Mind Before The Clinton Plan

When President Clinton formally introduced his plan for health care reform in September 1993, the public had been waiting for a long time, and expectations were high. Nor were they disappointed by the president's speech announcing his plan. Indeed, the entire country responded enthusiastically to the principles the president enunciated. Concern with rising health care costs had been growing; people had long traded horror stories about hospitals that charged seven dollars for two aspirin tablets and thousands of dollars for minor outpatient surgery, and about insurance companies that took away people's coverage just when they were in most dire need. The public was also mindful that many Americans had no health insurance whatsoever, and a majority believed that this was morally wrong and should be corrected. To average Americans, health insurance that could never be taken away and achieving universal coverage while simultaneously controlling health care costs had enormous appeal.

Polls several weeks after President Clinton's speech showed a nearly two-to-one margin of approval of the plan (57 percent versus 31 percent opposed).² In subsequent months the public heard a lot about it: the 500-member task force meeting behind closed doors to hammer out its shape and form, the complexity of its provisions, the firmness of the president's commitment to providing every American with health coverage, the controversy about the plan's costs and whether or not these would result in new taxes, the superb mastery of the plan's complexities exhibited by Hillary Rodham Clinton in her encounters with Congress. The odd phrase "managed care" penetrated public consciousness, without depositing much residue of meaning. People acquired these and other bits of information about the plan but never learned much about its contents. To this day, the contents of the Clinton plan remain a mystery in the public mind.

By July 1994, nine months after the announcement, the public's favorable endorsement of the plan had eroded from 57 percent to 37 percent.³ To comprehend what happened in this brief span of months, one needs to

understand that at the time that the Clinton plan was presented, Americans did not react to it with wholly open minds. The public held a number of strong preconceptions, some contradictory, that affected both their initial positive reaction and their subsequent disillusionment.

An analysis of public opinion poll data shows that prior to the plan's introduction the public mind-set showed the following characteristics.

Health care as a right. The belief that health care is a right is deeply ingrained in the American consciousness, especially government's obligation to ensure health care for those who are too poor to pay for it. When any benefit is regarded as a right, Americans automatically assume that it is the government's responsibility to honor it. The public has held this conviction for more than half a century. A 1938 Gallup poll reported that 81 percent of adults nationwide believed that "government should be responsible for medical care for people who can't afford it." Fifty-three years later the number was 80 percent—a remarkably stable conviction. DYG's annual trend study also shows that more than three-quarters of the public consistently express the conviction that "access to health care should be a fundamental right."⁴ A Harris poll found almost universal agreement (91 percent) with the idea that "everybody should have the right to get the best possible care—as good as the treatment a millionaire gets."⁵

High levels of personal satisfaction. A number of polls have asked Americans how satisfied they are with the medical care they and their families receive. While polls vary somewhat, all show the overwhelming majority of Americans reporting high levels of satisfaction. A Yankelovich Partners survey conducted in the same month in which the president's plan was revealed reported an 80 percent level of satisfaction.⁶ A Roper survey, also conducted in 1993, showed some decline over a twenty-year period in people's satisfaction with the quality of their medical care—from 83 percent to 73 percent—but no erosion in the "availability of medical care you get when you need it"—75 percent in 1973 and 74 percent in 1993.⁷

Mounting concern about the U.S. health care system. Even though most Americans were satisfied with quality and availability, they nonetheless felt that the medical system was troubled. A variety of polls convey a feeling of mounting crisis. One reports the public's conviction that the nation should "overhaul the entire system," rising steeply from a 25 percent minority in 1983 to a 55 percent majority a decade later.⁸ Another poll shows that eight out of ten Americans believe that "we are headed toward a crisis in the health care system."⁹ A 1991 Gallup poll records a whopping 91 percent majority who believe that "there is a crisis in the health care system."¹⁰ Every year since 1982 the Harris poll has been asking whether people believe that the health care system needs only minor changes, fundamental changes, or a complete rebuilding. In 1992, a presidential

election year, a majority opted for completely rebuilding the system.”

Pinning the blame on the professions. It is important to know why the public feels that the health care system is in deep trouble, because it goes a long way toward explaining the public’s later reaction to the Clinton plan. Although Americans are well satisfied with the quality and availability of health care services, they are quite unhappy about the ballooning costs of health care. Asked in a 1993 Gallup poll about the “main problem facing health care in the U.S. today,” most people named rising costs (74 percent)-nine times as many as cited problems with access (8 percent) and eighteen times as many as cited problems with quality (4 percent).¹² In a 1991 Gallup poll, in response to an open-ended question, 42 percent of adults nationwide volunteered that “the biggest problem with health care in the U.S. today is cost” (42 percent is a huge response to an open-ended question).¹³ In another 1991 poll, 75 percent of Americans said that they felt the cost of health care was much higher than it should be.¹⁴ And a Roper poll found that almost two-thirds of Americans feel that “the cost of the medical care [they] receive is unreasonable.” Most of them feel that it is very unreasonable. Gallup reports that almost four out of ten people say that they have put off going to a doctor because of high cost.¹⁵

What really angers Americans are the causes of rising health costs, as they perceive them. The public blames the health system: hospitals, lawyers, physicians, and drug companies. Asked to identify who or what is most responsible for these higher costs, the vast majority in a 1991 Time/CNN poll cited hospital costs (83 percent), awards in malpractice suits (75 percent), physician fees (73 percent), fraud and abuse in the health care system (72 percent), and the costs of medications (70 percent).¹⁶

Small wonder, then, that public confidence in medicine as a profession has been eroding for decades. In the 1960s the level of confidence in the medical profession was almost twice that of all other institutions (73 percent versus 40 percent). By 1993 Americans’ confidence in all institutions had dropped, but medicine’s fall was far more precipitous: to an astonishingly low 22 percent, falling for the first time ever below the level of other institutions (23 percent).¹⁷

Given this perception, it is not surprising that most Americans resist making sacrifices to correct a problem they think the doctors and lawyers have caused. The vast majority rejects the idea that the explosion of health costs must lead sooner or later to “limits on what health care is available to the average person.” Only 20 percent of adults nationwide endorse this view, while an impressive 77 percent majority insists that the cure to rising costs is “to cut the waste, high profits, and fraud in medicine.”¹⁸

Robert Blendon concludes that “the public has come to equate health care reform with relief from the rising health care costs now faced by

American families.”¹⁹ Since the public blames the system, not itself, it understandably rejects calls for sacrifice and behavior change, on the assumption that if the system is to blame, then the system should take the hit, not the innocent victims and bystanders who constitute the public.

This perspective puts the public on a collision course with the majority of experts. In the experts’ view, the two main causes of rising costs are the aging of the population and the explosive costs of new technologies and medical advances. The majority of the public brushes aside both of these explanations. People believe that technology reduces costs (which it does in most fields), and they resist the idea that an aging population adds significantly to costs. Understandably, then, the experts see reform as necessarily entailing some sacrifice on the part of the public (for example, helping to pay for the higher costs and forgoing services experts regard as not strictly necessary or cost-effective).

Lack of realism. Since most Americans attribute the rising costs of health care to waste, fraud, greed, and inefficiency, they assume that whatever is wrong can be fixed by cracking down on these expressions of venality, and that the money saved can be used to add health care benefits at no extra cost. This is what most Americans mean by reform. The wish list of the majority of Americans at the time President Clinton presented his plan is impressive in both its breadth and its lack of realism.²⁰

A driving sense of urgency. In the last two years of the Bush presidency, the economic recession frightened many middle- and lower-income Americans. Hourly wages had been stagnant for years. Even dual-income households were having difficulty making ends meet. Workers were growing progressively more worried about job security, and their nervousness spilled over to concern about their health care. Their reasoning: “We can somehow manage to cope if we lose our jobs (or one of us does), but if we also lose our health care insurance, we’re sunk. We won’t be able to cope.” This fearful logic was reflected in public opinion polls, which placed concern about health care in the number one or two spot in public priorities.

Growing Reservations

A closer look at the quality of the public’s support for President Clinton’s plan gave warning of the erosion that was to come. In the week following his address to the nation, people were asked how much they knew about the plan. Only 21 percent said they knew a lot about it.²¹ This low number is not surprising, because the plan was new and the specifics were not clear. But when people were asked a similar question the following month, even fewer people (17 percent) felt that they knew a lot about the plan.²² And a month later in November, those who felt that they knew a lot about it had

fallen still further (to 13 percent)!²³

This lack of knowledge persisted throughout the congressional debate. By August 1994 a Harris poll found that fewer than one out of five Americans felt that they were very well informed about the debate in general (13 percent) or specifically about how the various reform proposals would help them and their families (15 percent). Significantly, only a tiny minority (5 percent) believed that television and other news media did an excellent job in explaining the reform proposals to them, with almost two-thirds (64 percent) rating the media's explanations as only fair or downright poor.²⁴

What little the public did know about the plan had planted worrisome suspicions. I single out three as contributing most to the public's growing rejection of the plan.

The high costs of universal coverage. The first had to do with the president's commitment to universal health insurance as a moral principle on which he would not compromise. Undoubtedly, President Clinton was encouraged by what appeared to be solid public support for his position. According to my count, in seventeen different national polls the average level of support for universal health insurance was an impressive 71 percent.²⁵ Unfortunately, however, public support was far less solid than these polls suggested. What most people really mean when they say they support universal coverage can be paraphrased this way: We don't believe anybody should be deprived of care because of money. We support the president's goal of insurance for all that can never be taken away, but only if the nation can afford it and it doesn't limit choice of doctors or raise taxes or cause employers to cut jobs.²⁶

This sentiment reflects the public's prior conviction that reform is possible without requiring any real sacrifice on its part. As the cost dimensions of the reform plan were scrutinized more closely in Congress, people began to suspect that maybe extending a generous package of health care benefits to the thirty-nine million or so Americans who lacked insurance was not a sure-fire method of controlling costs, especially when employers began to balk at footing the bill. The vast majority of Americans share the president's desire to extend health care coverage, but in a climate of economic insecurity they are unwilling to do so at their own expense. And they gradually came to feel that it would come about at their expense.

Too comprehensive. A second reason for growing doubts about the plan relates to its comprehensiveness. Overall levels of satisfaction with quality and access plus public enthusiasm for the miracles of technology make people apprehensive about overhauling the whole system. Practical-minded Americans think the government should fix only the broken parts of the system. As we have seen, public dissatisfaction is sharply focused on

rising costs, not on the health system overall. As the plan's opponents raised people's fears about the comprehensiveness of the plan, the public felt that it did not know enough about it to endorse such sweeping changes.

Antigovernment feeling. A third major reason for the public's rejection relates to growing antigovernment sentiment. Since President Clinton was elected in 1992, resentment of government has intensified. The 1994 elections made it clear that Americans blame big government for many of the nation's problems. The Clinton plan was successfully labeled by opponents as a big-government plan; this added yet another nail to its coffin.

The Absence Of Serious Deliberation

The essence of the deliberative process is that it forces people to come to grips with reality. The persistence of wishful thinking and the failure to wrestle with hard choices are sure signs that deliberation has not occurred. The public's continuing belief that they can have it all—quality and convenience and high-tech medicine and lower costs—shows that people have not yet confronted reality and worked through the hard choices that must sooner or later be made. The public avoids making hard choices by hiding behind the mantra of “cutting waste, fraud, and abuse.”

The Clinton administration, for its part, failed to disabuse the public of the notion that the no-free-lunch law of economics had not miraculously been suspended for health reform. Polling data clearly show that Americans do not understand the extent to which the habits and demands of the public contribute to cost escalation. They do not realize the extent to which an aging population, scientific advances, and a payment system that systematically hides the costs of health care from consumers, among other forces, are important drivers of health costs. They do not understand what their choices are and what sacrifices and benefits each choice entails. The closer one looks, the less evidence one sees of serious public deliberation.

When Public Deliberation Is Indispensible

Before proposing a strategy for initiating genuine public deliberation on health care in the future, I wish to make a brief comment on when public deliberation is required. It is not necessary on all issues. Lots of programs get passed by Congress without needing public deliberation to support them, and without arousing public resistance. But for several reasons, a serious deliberative effort is indispensable to health care reform and issues of equal importance. The reasons are almost self-evident and so need not be labored at length. Public deliberation is required when an issue meets one or more of the following criteria.

It is important to people's lives. This is certainly the case with health care reform. Since most Americans are satisfied with their own health care provisions, without deliberation public support for change is necessarily fragile. (Unless they fully understand and accept the reasons for it, satisfied people will resist change on matters important to their lives.) Without deliberation their support will crack as soon as it is attacked.

It calls for sacrifice. Public deliberation is essential when proposed reforms call upon people to accept sacrifices and trade-offs that may cost money, cause inconvenience, make people modify their behavior, or compromise important values. When legislation calls for sacrifice, voters insist on having a say in its formation. If they do not have a say, they will oppose the reforms. This is what happened to catastrophic health coverage for the elderly in 1988. It also applies to many aspects of the Clinton plan.

Special interests oppose the reforms. Public deliberation is especially important for reforms that run afoul of special interests. Special interests exert their greatest power when the public is indifferent or fearful of change; it takes a strong shove from the public to give political leaders the courage to stand up to wealthy and powerful special interests capable of mobilizing their constituencies overnight and pouring resources into efforts to defeat members of Congress who oppose them.

Any of these three reasons would be enough to make public deliberation indispensable. The fact that all three apply so cogently to health care reform is compelling evidence that if success is to be achieved, this requirement cannot be slighted.

The Sequence Of Reforms

A successful strategy for health care reform must have two elements, one that focuses on the sequence of reforms, the other on the public deliberation process. The reality that leadership is most prone to overlook (at its peril) relates to timing. The public will not support far-reaching reforms until mentally and emotionally ready to do so. With a genuine deliberative process, the public can be prepared to face the tough decisions on health care reform within three to five years. Let us assume that Congress passes a limited reform package in 1995 or 1996. If at the same time a real debate were launched on aspects of health care that require change and sacrifice on the part of the public, more difficult reforms could be passed in the next congressional session, followed by still more difficult reforms by 2000.

Leadership is so deflected by other obstacles to health care reform that it gives scant attention to what should be its prime consideration, namely, that the American people must play a key role in reforming the health care system, which ultimately must reflect the deepest values of our society.

Perhaps as a nation we really are willing to devote a far larger proportion of our gross domestic product (GDP) to health care than other nations are. Maybe we are prepared to sacrifice other good things to try to save the lives of premature infants and to follow every possible technological lead at public expense. But we will never know what we truly value until we face the reality that ever-increasing amounts of medical care may mean abandoning other values of equal or greater importance to our society.

In the long run, no health care reforms will endure that do not conform to society's core values. The only way to design such reforms is to give citizens the opportunity to deliberate hard choices. But these choices cannot be dumped on the public all at the same time. This was a major error the Clinton administration made, because the plan's authors were not concerned with the sequence of reforms from citizens' points of view.

What choices is the public prepared to deliberate, and in what sequence? In the aftermath of the Clinton plan's defeat, a number of reform ideas are floating around Congress. The public is now ready to accept some of them, and the prospects for translating these into law are good. The present Congress is likely to pass insurance reforms that will make it easier for people to carry their health insurance from job to job and more difficult for insurance companies to blackball people with preexisting conditions. Congress probably will also encourage individual states to experiment more freely with reforms, and it may start to curb some of the legal excesses that cause physicians to practice costly defensive medicine. It may even take a step toward universal coverage by extending health care benefits to the children of families whose incomes are too high to make them eligible for Medicaid but not high enough to afford health insurance.

A national consensus now exists on the desirability of all of these reforms. Unfortunately, the reforms are more complex and expensive than many of their proponents admit. Also, most of them arouse the opposition of special-interest groups. Despite these obstacles, however, some of these limited reforms are likely to be enacted. None demands public sacrifice or large changes in behavior; thus, there is no need for further public deliberation. And the reforms can be accomplished without having to repair the larger gap between leaders and the public.

Public deliberation is most urgently needed for reforms that require the public to make sacrifices. Sooner or later, the health care system must require public sacrifice, because the American people demand more medical care than they are willing to pay for. This demand places immense strains on the system. As Americans age and as technology expands the capabilities of medicine to cure disease and enhance quality of life, the desire of people to take full advantage of these advances grows ever stronger. The question for society is how best to accommodate this desire.

The central issue in health care reform, therefore, is how best to respond economically to insatiable public demand. Which aspects of health care should fall under the rules of the market by which people get only what they pay for, and which aspects should fall under the rules of entitlement by which people receive health care benefits as a matter of right whether or not they can pay for them? We can best prepare ourselves to confront these basics by debating the dilemmas of health care reform in a sequence proposed by two research organizations that have been studying the public's relation to health care for a long time.

The Public Agenda/Kettering plan. The Public Agenda and Kettering Foundations have proposed a sequence of subjects for health care reform arranged in ascending order of difficulty from the public's perspective. Their research has led them to conclude that the public has yet to confront three major dilemmas of health care reform.

The first is how to retain (and if possible improve) the health care benefits of those who now have them, extend some of these benefits to those who now lack them, and at the same time keep public costs under control. While Americans would like to expand health coverage to everyone, the majority are more concerned with holding onto existing benefits while at the same time enjoying lower taxes, reducing the federal budget deficit, and keeping their employers prosperous. The dilemma is how to balance these desires without placing a crushing burden on those who foot the bill—either employers or taxpayers. This dilemma is being confronted at the micro level at almost every large place of employment in the economy. It is creating tensions in labor negotiations and fueling the movement toward managed care. As time passes, the debate will intensify at the macro level both in individual states and at the national level.

The second dilemma is one that the public is even less ready to confront. It concerns the desire to curb the growth of health care costs and at the same time continue to enjoy the benefits of state-of-the-art, high-technology medicine. With less than 5 percent of the world's population, the United States has half of the world's computed tomography (CT) scanners and two thirds of the world's magnetic resonance imagers (MRIs). Since World War II Americans have enjoyed the most advanced and sophisticated medical care in the world and have been largely shielded from the cost of paying for it. Experts in the field are accustomed to heated debates over the usefulness of new technologies such as a clot-dissolving drug (tissue plasminogen activase, or TPA) that is marginally more effective for some patients but costs in excess of \$2,000 a dose—ten times more expensive than other existing treatments. Yet few of these debates have filtered down to the general public. Americans are not yet ready to wrestle with these kinds of decisions. It will take several years, much skill, and special

effort on the part of leaders to encourage a deliberative process whereby people are willing to face this dilemma head-on.

The third dilemma, which Americans are least ready to confront, is the conflict between reducing costs and doing everything possible to save lives. Americans seem ill equipped to participate in decisions that involve rationing and life-and-death issues. It will take several years, and skilled leadership, to engage public deliberation on this inescapable aspect of health care.

It should not be assumed that the outcome of a successful deliberative process on all three of these dilemmas, considered in sequence, will be confined to laws and government regulations. Nor need they force average citizens to make life-and-death decisions for their loved ones under circumstances charged with anxiety and feelings of helplessness. In these arenas, the private sector rather than government and the medical profession rather than individuals will assume most of the responsibility. But the public is not off the hook. It must participate in these and other difficult decisions, as consumers, employees, and citizens. The government also is obliged to play an important role in those aspects of health care deemed to be rights that cannot be decided solely on the basis of ability to pay.

A Different Model Of Public Communication

Let us turn finally to the process aspects of a strategy for long-term health care reform. Leaders will find that when it comes to resolving these three dilemmas they cannot rely on the skills associated with the familiar top-down communication model. They have a huge incentive to acquire the new skills needed to stimulate public deliberation: Not only are these skills needed for health care reform, but they are also a prerequisite to overcoming the larger communication gap between leaders and the public.

In my book, *Coming to Public Judgment*, I develop a new communication model that can accomplish these objectives—if the political will to do so exists.²⁷ The model, which I refer to as the Public Judgment Model, defines three stages through which public opinion must evolve on complex issues such as health care. Each stage is divided into substages, adding to a total of seven steps. The journey from the raw opinion characteristic of step one to the considered judgment at step seven is arduous. The seven steps are (1) awareness; (2) developing a sense of urgency; (3) reacting to early proposals; (4) confronting one's own wishful thinking and other forms of resistance; (5) choicework—deliberating the pros and cons of the hard choices, weighing trade-offs, and clarifying priorities; (6) cognitive stand-reaching a provisional decision; and (7) coming to full deliberative judgment.

In practice, of course, evolving from raw awareness to mature judgment is not nearly as orderly as this model would suggest. But extensive research

shows that issues such as health care sooner or later pass through all of these stages of public deliberation. Typically, it takes years to make the journey through all seven steps. More often than not, people get stalled at the resistance stage (step four) or the choicework stage (step five) and can remain stalled for years, even for decades. Our mass media and policy-making institutions do an outstanding job in the early stages—helping to create public awareness of issues, drumming up a sense of urgency, and floating trial balloons to elicit people's early reactions. Sad to say, however, they are ill equipped to help the public navigate its way through the middle and late stages. Perhaps the most serious drawback to media communication with the public is that it does not take the public's resistance into account. When resistance is low, the process of leaders transmitting messages to the public via the mass media to increase public awareness may work. But when resistance is intense, as in health care, the process quickly proves either ineffectual or self-defeating.

Where does health care reform stand in terms of this seven-step model? Through what steps has it already progressed? What comes next?

Awareness. Americans had their consciousness raised about swelling health care costs in the mid-1970s. From then until the early 1990s awareness grew slowly, always lagging behind an ever-worsening situation.

Urgency. The upset senatorial victory of Democrat Harris Wofford (who ran and won on health care) in Pennsylvania in November 1991 finally gave the issue strong political urgency.

Initial reactions. Not until the presidential election of 1992 did people begin to pay serious heed to specific proposals for reforming the health care system. In an October 1992 *Fortune* article, nearly a year before President Clinton announced his health care plan, I applied the Public Judgment Model to health care.²⁸ At that time, health care had clearly arrived at step two, rising urgency, and had just begun to advance to step three. The public was beginning to react to ideas about ways to control costs (through the practice of preventive medicine, through limiting damages in malpractice settlements, through greater access to health maintenance organizations [HMOs] and other forms of managed care, and through making individuals more cost-conscious about their own health care purchases). The public was enthusiastic about all of these ideas.

Resistance. This is the critical stage, and the least well understood. In this stage the public confronts its own wishful thinking and begins to acknowledge the reality that attacking waste and greed is not the panacea that will magically solve the problem of guaranteeing high-quality medical care for everyone without bankrupting the nation. President Clinton's promise of health insurance for everyone that could never be taken away had the unintended consequence of reinforcing the public's wishful think-

ing, thereby preventing the public from confronting its own resistance.

Choicework. People remain stalled until their resistances are worked through. Only then are they ready to take the fifth step, “choicework.” This is the hard work of deliberating the pros and cons of alternative policy choices. At this stage people wrestle with the hard choices and trade-offs involved in the various health care dilemmas. The public has not yet reached this stage on any important aspect of health care that requires citizens to make sacrifices or accept real change.

Cognitive stand. After the choicework stage comes a sixth step, at which people reach tentative conclusions, largely cognitive in character. For example, people may agree intellectually on the need for curbs on heroic medicine, without fully realizing all of the emotional and moral implications as, for example, when they have to face forgoing high-tech interventions that could conceivably prolong life for a loved one. The public has not reached this stage on health care reform.

Judgment. In the seventh and final step, people add strong elements of emotional and moral conviction to their cognitive conclusions. If in the example above people did confront the decision on whether or not to “pull the plug” on a loved one and fully accepted all of the practical, emotional, and moral consequences of their decisions, they would have reached full deliberative judgment. The public is years away from reaching this stage.

Concluding Comments

In this paper I have hypothesized that the Clinton health care plan fell victim to the larger disconnect between our nation’s leaders and its citizens. If it hadn’t been for the disconnect, the public would have been more directly engaged in the health care debate of the past few years. If the public had been so engaged, something positive might have been salvaged instead of a crashing defeat: Out of the give-and-take between the public and leaders, a viable plan with strong public support might have emerged.

Even now only the most limited short-term reforms are likely to succeed, because long-term reform will require Americans to make sacrifices and hard choices, which they will not make unless the larger disconnect is addressed.

In this paper, I propose for further discussion a strategy for stimulating a five-year process of public deliberation on health care. Embarking on this process will be of great benefit to our society: The strategy that will work best for health care reform will also help to fix the larger communication failures that extend beyond health care to so many issues distressing the nation. The leadership skills needed for discussing health care reform with the public are the same as those required for dealing with crime, education

reform, welfare reform, race relations, and other important issues. If we are able to resolve our health care dilemmas and fix the larger disconnect at the same time, our democratic process will be the winner.

My late wife, Mary K. Yankelovich, conducted the data search for this paper and made other invaluable contributions. Shortly after the paper was finished, she was killed in an automobile accident, abruptly snuffing out (at age thirty-six) her great gifts of caring and understanding.

NOTES

1. DYG, Inc., for the American Association of Retired Persons. See "Health Care Reform in America: Where the Public Stands" (Washington: AARP, March 1992).
2. Yankelovich Partners for Time/CNN, October 1993.
3. *Ibid.*, July 1994.
4. DYG, Inc., "SCAN—A Trend Identification Program" (annual trend study).
5. Louis Harris and Associates, 1987.
6. Louis Harris and Associates, September 1993. See also K.H. Bowman, *The 1993-1994 Debut;! on Health Care Reform: Did the Polls Mislead the Policy Makers?* (Washington: American Enterprise Institute for Public Policy Research, 1994), 3.
7. Bowman, *The 1993-1994 Debate on Health Care Reform*, 5.
8. *Wall Street Journal/NBC*, September 1993.
9. CBS/*New York Times*, August 1991.
10. Gallup Organization, June 1991.
11. "The Public Decides on Health Care Reform," *The Public Perspective* (September/October 1994): 23.
12. *Ibid.*
13. Gallup Organization, June 1991.
14. *Time/CNN*, August 1991.
15. Gallup Organization, 1989.
16. Yankelovich Clancy Shulman for *Time/CNN*, August 1991.
17. R.J. Blendon, T.S. Hyams, and J.M. Benson, "Bridging the Gap between Expert and Public Views on Health Care Reform," *Journal of the American Medical Association* (19 May 1993): 2576.
18. The Gallup Organization for the Employee Benefit Research Institute, August 1992.
19. Blendon et al., "Bridging the Gap," 2574.
20. Harvard School of Public Health and Marttila and Kiley for The Robert Wood Johnson Foundation. See "A Survey of American Attitudes toward Health Care Reform" (Princeton, N.J.: The Robert Wood Johnson Foundation, June 1993); and *Wall Street Journal/NBC*, September 1993.
21. *Los Angeles Times*, September 1993.
22. *The Washington Post*, October 1993.
ABC News/Washington Post, November 1993.
24. Louis Harris and Associates for The Robert Wood Johnson Foundation, August 1994.
25. This result was obtained from a search of the archives of the Roper Center for Public Opinion Research at the University of Connecticut, Storrs, Connecticut, using the database, POLL.
26. For additional interpretation see D. Yankelovich, "What Polls Say—And What They Mean," *The New York Times*, 17 November 1994.
27. Yankelovich, *Coming to Public Judgement*.
28. Yankelovich, "How Public Opinion Really Works."