

**Washington Health Choices:**  
*Taking the Pulse of the Community*

**Pilot Project**

**Survey Findings**  
**November 2002**

**HumanLinks Foundation**  
**Health Improvement Initiative**

# **Washington Health Choices:** *Taking the Pulse of the Community*

## **Pilot Project**

### **Survey Findings** **November 2002**

#### **HUMANLINKS FOUNDATION**

The HumanLinks Foundation is working to empower our communities through grassroots efforts to address and improve the systems of education, health care and sustainable agriculture

#### **VISION**

To empower Washington's communities to be among the best educated, healthiest, and most socially responsible in the nation.

#### **MISSION**

To identify, foster & support resources in the community that further the organization's vision, which will be accomplished through mentoring, financial support, and creating opportunities for collaboration, alliances, and synergy between various organizations.

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Regence Health Care

Washington Academy of Family Practice Physicians

Washington Health Foundation

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**Video produced by Stratcom**

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# EXECUTIVE SUMMARY

In 2002, over 250 East King County citizens participated in a pilot project to discuss and share their opinions on a number of health care issues. These discussions took place in the community at local Kiwanis, Rotary, Chamber and other meetings. Participants had an opportunity to view a video that highlighted key health care questions and to discuss with their neighbors and colleagues how they felt about current topics such as promoting healthy behaviors, paying for health care and insurance, and caring for the uninsured. Participants also completed a fifteen-question survey.

Policy makers and key health care organizations agreed to be "receptors" and consider this information as guidance for making tough decisions about the future of health care. These receptors included the Governor's Access to Health Insurance project, Washington Health Foundation, Public Health Department of Seattle/King County, Washington Academy of Family Practice Physicians, Regence Health Care, Overlake Hospital Medical Center and Evergreen Healthcare.

Citizens attending meetings were keenly aware of many health care issues raised and were able to articulate their concerns. They were unhappy with insurance companies and the high cost of medications. Some thought the insurance companies made all the money at their expense. Many believed that the high cost of insurance premiums was unreasonable and out-of-line for families today. They were upset with pharmaceutical companies because they didn't feel consumers should have to pay the cost of their marketing and media campaigns. They wanted to know why the drug advertisements were necessary given their doctors prescribe their medications, not them.

Based on the survey responses, there does not appear to be a general consensus on whether the health system is meeting the health needs of citizens - 30% indicated they weren't sure, 26% said they didn't think the system was meeting needs and 14% thought it was doing a good job.

Respondents recognized that practicing healthy behaviors is important. They preferred to offer rewards to citizens who practice healthy behaviors rather than penalize those who engaged in risky behaviors. In individual survey responses there was overwhelming agreement that people had a responsibility to reduce health care costs by practicing healthy behaviors and taking preventive health measures. Citizens also agreed that it was part of their responsibility to use the hospital emergency room only for emergencies and ask their provider if less costly treatments are available for the medical problems they face. Citizens were less sure of their responsibility to reduce costs when it meant foregoing expensive technology when their recovery was expected to be less than 15%

Over and over again they called for more options in health care coverage. They expressed interest in being able to access health insurance coverage that included just catastrophic care or just basic coverage. In the individual survey responses, one of the services citizens indicated

they would be willing to pay higher premiums for was coverage for preventive health care. In response to a question about what would make our health care system successful, the most frequent response was “provide access to a basic level of care for everyone”.

While frustrated at not being able to get care from their providers, citizens weren't angry at their providers. They understood why a physician might turn them away if they were on Medicaid or Medicare, and they were sympathetic to the fact that physicians have to be paid for their services.

Overall citizens expressed support for providing health care coverage to the uninsured saying that they wanted basic care to be available to everyone. Sixty percent of people completing the survey said they would be willing to pay higher taxes or insurance premiums so that those who are low-income and have no health insurance can get health care. Thirty-eight percent said they would be willing to pay \$5 to \$10 a month more and 27% said they would pay more than \$10 a month.

Approximately 90% of participants had health insurance. Two thirds of them felt certain that their coverage would be available and affordable in the next three years. For 56% of citizens participating, employers were paying all or part of their insurance premium. When citizens were asked how much they would personally pay for comprehensive insurance, 42% said they were willing to pay no more than \$150 per month. Thirty-two percent said they would pay \$150 - \$250 per month and only 19% said they would be willing to pay more than \$250 per month. If however, they were given \$250 for a health benefit, 69% said they would put all that money toward buying comprehensive coverage. Twenty-one percent would only put part of the money toward health insurance coverage.

The citizens participating in this project are not necessarily representative of the citizens statewide. In general the majority of participants were middle to high income, employed, insured, predominantly female, married, and considered themselves in good health. It is for this reason that HumanLinks proposes to expand this project statewide so that citizens in all 39 counties can have an opportunity to voice their concerns and so that local variation can be noted and recognized.

Starting in March 2003, HumanLinks proposes to begin a series of similar meetings in each of the counties in the state. Input from these meetings will be collected, collated, analyzed and presented to the 2003/2004 Legislature.

# OVERVIEW

This report is a summary of the pilot project, Washington Health Choices: Taking the Pulse of the Community. It was initiated by the HumanLinks Foundation in March, 2001. The goal of the pilot was to develop and test materials and processes to engage the community in a dialogue about health care priorities, and to utilize the findings of these community conversations to spark strategies and partnerships to improve healthcare access.

This report discusses the background for the project, the materials and processes developed and the results of the community meetings held in the pilot area, East King County. It is the intention of HumanLinks to build on this experience and create a toolkit that can be used by communities around the state to take the pulse of their citizenry with regard to health care issues. With the completion of this pilot project HumanLinks is ready to take the project statewide. Next steps and timelines are included in this report.

# Background: Planning and Implementation

The HumanLinks health care initiative, **Washington Health Choices: *Taking the Pulse of the Community***, evolved from a series of Roundtable meetings held with key health care stakeholders in the Eastside communities of King County.

Throughout the Roundtable meeting series these stakeholders discussed their fears and concerns that the current system for healthcare was fragile at best, unsustainable at worst. (See Appendices A, Roundtable Participants) There was a sense that band-aid solutions had been tried and hadn't succeeded in reforming healthcare with anything but short term "quick fixes". There was a sense that, at the moment, there was no "next great idea" for health care reform.

Legislative representatives in these meetings stated clearly that after the fiasco of health reform attempts in the early 1990's, members of the legislature would be looking to citizens to direct the focus of future health reform efforts. It was acknowledged that at the time of the Roundtable meetings no one was engaging citizens in this kind of dialogue.

It was also the strong feeling of the Roundtable that education beyond messaging via "15 second sound bites" was necessary if citizens were to be engaged in a discussion about reshaping health care delivery and financing. These are complex topics and require more information, education and thought than is possible through simple media messaging.

As a result of these meetings, the Roundtable directed HumanLinks to research citizen engagement models. The Roundtable wanted a model that fostered education, citizen input into health care decision-making and sustained citizen involvement and opportunities for building effective collaboration. After considerable review, the Roundtable decided to employ the technologies of a process that had previously been successful in Washington State, **Washington Health Choices**. ( See Appendix B, Goals and Objectives) This process consisted of establishing a pilot project service area, setting up and conducting community meetings within that service area, producing a provocative issue video, conducting a uniform data collection process at the meetings, and synthesizing the results into a final report.

After reviewing research from the Oregon's Health Decisions program, the Roundtable suggested enhancing this process by recruiting receptors that could benefit from wide spread citizen input on key health issues. These receptors were organizations that were currently involved in health policy development and decision-making. The receptors could get involved in the design and implementation steps of the project, review the findings of the project, and incorporate the findings into their health policy considerations.

HumanLinks recruited the following receptors: the Governor's Access to Health Insurance project, Washington Health Foundation, Public Health Department of Seattle/King County, Washington Academy of Family Practice Physicians, Regence Health Care, Overlake Hospital Medical Center and Evergreen Healthcare. All receptors were invited to:

- Host community meetings for constituents/employees.
- Train members of their organization to serve as project volunteers for the community meetings, both as facilitators and recorders of those meetings.
- Review, edit and contribute to the Survey Instrument to capture specific areas of interest for the receptors.
- Receive periodic updates and the final report.
- Utilize the findings from the final report to influence their policy development work.

Once the receptors were on board, the next step was to identify community organizations to partner with to conduct the community meetings. Because it was generally acknowledged by the Roundtable that inviting people to meetings to discuss health care would generate low participation, we chose instead the strategy of requesting time on the agendas of established local meetings. Sixteen community meetings were scheduled and local Kiwanis, Rotary, Chambers and League of Women Voters groups were included as partners. Meetings were also convened in partnership with the local hospitals, some area churches, and local neighborhood associations, senior centers and retirement communities. While this strategy was very successful in getting “face time” with a number of constituencies, it did not achieve either the social or economic diversity the project required.

Four meetings specific to minority outreach to the Hispanic, Asian, Vietnamese and African American communities within our designated service area were added. (See Appendix C, Meeting Schedule). While the majority of participants at these multicultural meetings spoke English, translation assistance was available either through other participants or specified translators. Survey forms were all written in English.

Each meeting was led by a team from the project with one member serving as meeting facilitator to direct the discussion and one as meeting recorder to document comments. The meeting format included a brief introduction and overview of the project followed by the showing of a seven-minute video developed for the project. The video was designed to serve as a trigger for discussion and as such, identified key health care value questions, but did not offer solutions. (See Appendix D, Meeting Materials). Following the video the facilitator initiated a group discussion using the questions raised in the video. Participant comments were recorded and appear in the appendix of this report. The remaining meeting time was spent having participants complete a written survey (See Appendix E, Survey). Because many people indicated an interest in having others who were not in attendance at the meeting participate in the survey, the survey was made available online, in partnership with the Washington Health Foundation, at [www.whf.org/hl\\_survey.html](http://www.whf.org/hl_survey.html). This website was printed on business cards and distributed to all meeting participants. The results of the data collection are discussed in another section of this report.

Given the number of meetings planned and the time required for facilitation and recording, HumanLinks recruited and trained volunteers to be part of the project team. Volunteers included members of the Roundtable and citizens from the pilot site area. Volunteers participated in an initial orientation training session and then were available to facilitate and record community meetings. (See Appendix F, Facilitator Training)

The written survey distributed at each meeting included a form for participants to complete if they were interested in being part of an ongoing in-depth study circle on health care issues. Fourteen percent of participants from the meetings indicated an interest in pursuing this process in depth.

One of the volunteers compared the project and its process to an hourglass. From the beginning broad community participation was sought. Through the meetings, citizen input was gathered, narrowing the focus of discussion to specific health care issues. With the results summarized and analyzed, the information was then ready for broad dissemination to receptors and other policy makers.

Following the completion of the sixteen meetings, HumanLinks convened a debriefing session of receptors, volunteer facilitators and recorders and members of the original Roundtable sessions. This final step resulted in identification of what worked and what needed improvement. Before offering this project for replication to other communities around Washington State, modifications to the meeting format, survey and video will be made based on lessons learned in the pilot phase.

# Process Critique

As the project evolved we learned a number of things about how to involve and stimulate the community to participate in health care discussions. We found that the success of our meetings related to: working with already existing groups; being flexible with our time schedules and the time needed on an agenda; offering community members an opportunity to share their health care story/experiences; utilizing community representatives as volunteer facilitators and recorders; and identifying community leaders to champion our efforts and solicit meeting participants.

As was noted earlier, the majority of meetings were scheduled with existing groups who held regular weekly or monthly meetings. These groups offered us the opportunity to present information and solicit views as part of the coordinated agenda. Benefits of working with these groups included:

- Members already had the meeting on their calendar and did not need to be notified in advance. Location and times were preset.
- Members regularly attended the monthly or weekly meetings of the group. Attendance was good.
- Members generally knew each other in some capacity or at least had met together before. They were comfortable talking with each other about a variety of issues.
- Members tended to be from the community where the meeting was being held.
- There was usually a meeting coordinator to help arrange the meeting, let us know how many participants to expect and introduce us to the group.

While the benefits strongly outweighed the disadvantages, there were a few disadvantages that we encountered.

- Time on the agenda was limited. Meetings were often held at lunch or before work so participants had to leave right on time. Sometimes there was not enough time to complete the discussion and/or the survey. This was the biggest drawback.
- A few of the meeting rooms were noisy or busy or not set up in a way that was conducive to group discussion
- Participation was limited to group members. We didn't get much economic or social diversity among the participants.
- Once or twice meetings were rescheduled and we were bumped from the agenda at the last minute because of other priorities.
- Some groups were so busy it was hard to find free time on their agenda. It sometimes took several calls and sufficient lead time to set up a meeting.

Given these issues we believe that conducting meetings as part of regularly scheduled groups was the most efficient approach to use. We did also hold a few stand-alone meetings that were

advertised widely through a neighborhood or church, and even with community leaders actively encouraging individuals to attend, the participation was relatively small.

While not the intent of our effort, we learned some significant information about how to hold a successful community meeting and believe it's important to pass this experience along. The lessons we learned are noted below.

<b>Table I Successful Community Meeting Tips</b>	
<b>Keep presentation materials short and to the point.</b>	The video lasted seven minutes. Given that it was designed as a trigger for discussion, it could be shortened, tightened and condensed to five minutes in order to keep the attention of the group and maximize the time that participants have to talk. It also needs to address prescription drug use, a key issue raised at a number of community meetings.
<b>Allow maximum time and opportunity for community participation.</b>	Participants came to the meetings with their own stories and experiences. They wanted to share those as well as state their opinions. Usually there wasn't enough time for in-depth discussion. The facilitator often had to "go with the flow" and give as many individuals as possible a chance to participate. At times it was difficult to wrap up discussion and shift the participant's focus to completing the individual survey.
<b>Be flexible and prepared for meetings of varying formats and lengths.</b>	When the project was originally conceived, a format for holding one hour to one and a half hour meetings was designed. A set group of questions and scenarios for discussion was planned. At meetings where this was the only meeting topic, each of the questions were discussed in some detail. Scenarios were however not needed since participants brought their own experiences, and were more interested in discussing them than ones included in the project. At a number of meetings the time for discussion was limited, sometimes to 30 minutes. This did not allow for a full discussion of the questions or full participation by all members. Unfortunately there wasn't a pre-established format for these shorter meetings.
<b>When possible, use facilitators who are familiar with the community or can relate to participants.</b>	Our facilitators were from all age ranges. Most of them lived in the community and were familiar with community issues and resources. For example, senior citizen facilitators were very effective at leading discussions with senior groups.
<b>Allow sufficient advance time to set-up meeting dates.</b>	Given that the focus was to get time on the agenda of existing community groups, flexibility and willingness to accept meeting times often a month or more away was essential. For meetings set up specifically for purposes of this project, advance notice was needed to recruit community participants.
<b>Be prepared to work in diverse environments.</b>	For each of our meetings a television and VCR were needed. Each meeting room was different as far as the equipment available, the acoustics, size and seating configuration. Often times televisions, chairs and tables had to be moved, VCR hook-ups tested and extension cords sought out, sometimes delaying the meeting or resulting in the meeting going forward without use of the video.

**Table I (continued)  
Successful Community Meeting Tips**

<b>Group sizes of 10 – 15 were the best</b>	In very large groups, it was hard to get people involved in the discussion. A number of people left the meeting not having participated in the discussion or the survey.
<b>Keep the surveys simple and responses consistent.</b>	While the survey wasn't long, the questions were complex and required a lot of thinking and hard decision-making by participants. This took time, sometimes more time than was available. Questions needed to be simplified. The format for answering questions varied as well. For some questions respondents were asked to circle one answer while in others they were asked to check two or more responses. This caused confusion and resulted in some responses being thrown out. For seniors, surveys written with a 14 or larger font size were easier to read and complete. Surveys printed on one side of the paper were more often complete than those using double-sided pages.

# Results

This section reports the findings from the individual surveys along with a summary of the key points identified at the community meetings.

Twenty community meetings were held and a total of 221 people filled out the Washington Health Choices-Taking the Pulse of the Community individual survey. One hundred thirty-nine participants completed a survey during a community meeting where the survey was handed out. Forty-three citizens participated in specific meetings for multicultural groups and thirty-nine completed the survey online and did not attend a meeting.

## Participant Demographics

In general the majority of participants were middle to high income, employed, insured, predominantly female, married, and considered themselves in good health. Sixty-two percent of all participants were female and 33% male (6% unknown). The majority, 64%, were 19-64 years of age. Only 3 participants were less than 18 years of age. The remaining 29% were senior citizens over the age of 65. Sixty percent were married. With regard to income, 58% had an income over \$45,000 and 29% indicated their income was less than \$45,000 (12% did not answer). Only 20 participants (9%) had an income less than \$10,000. The group was culturally diverse. Seventy-nine percent were Caucasian, 10% Asian/Pacific Islander, 6% African American, 5% Hispanic, 2% Other and 7% unreported. Most participants came from a household of 1-4 people, the largest percent, 30%, being a family of two. Fifty-seven percent of participants were employed and 56% indicated that their employer paid at least a portion of their health insurance. Ninety-one percent indicated they currently have health insurance coverage. Eighty-five percent considered their current health to be good, very good or excellent.

## Demographics by Groups

There are a few demographic differences in the populations that participated in the three groups. (See Appendix G, Demographics).

***The Meeting Group*** consisted of those citizens who participated in one of the scheduled community meetings. Generally they were members of an organization like Kiwanis, Rotary or a senior organization. Compared to the other two groups, the Meeting Group included a higher percent of senior citizens. (44% compared to 2% and 5% in other groups). A greater percent of this group lived in one and two person households. Fifty percent were unemployed, yet the majority, 89% had health insurance. Forty-seven percent indicated that at least a portion of their insurance was paid by an employer. About thirty percent had incomes less than \$45,000.

***The Online Group*** was the only group that did not attend a meeting. They were informed of the online survey and encouraged to complete and submit their findings online. This group, as a whole, appeared to have the highest incomes. Eighty-seven percent had incomes over \$45,000

with 41% having incomes over \$100,000. Over 80% of this group were employed and 77% had at least a portion of their insurance paid by an employer. Eighty-two percent were married with 87% living in households of 2-4 people. Only 5% were senior citizens.

Participants for *The Multicultural Group* were recruited for participation in the project through the Public Health Department, Seattle/King County and were the only group paid to participate. Members of this group were either Hispanic, Asian/Pacific Islander, Native American, Vietnamese, African American or members of other ethnic groups. They were younger and tended to have smaller incomes and larger households. Forty-nine percent of the attendees had incomes below \$45,000, compared to 8% of online respondents and 30% of meeting group members. (Some respondents did not answer.) Forty-five percent lived in households of four or more people compared to 15% of Meeting Group members and 33% of Online responders. Like the Online group, over 80% were employed and 95% had health insurance. Sixty-seven percent had, at least, a portion of their insurance paid by an employer.

## Survey Findings

Results of the surveys are compiled and discussed below. For each survey question, the question is listed, the results discussed for all survey respondents and then differences in group responses are noted. (See Appendix H, Responses by Groups) The groups discussed include:

- Those who participated in a meeting – Meeting group
- Those who attended the multicultural specific meeting – Group MCM
- Those completing the survey online – Online Group

### **QUESTION 1: THE HEALTH SYSTEM OF WASHINGTON STATE DOES A GOOD JOB OF MEETING THE HEALTH NEEDS OF ITS CITIZENS.**

There doesn't seem to be a major consensus among the respondents on whether the health system is meeting the health needs of citizens - 30% indicated they weren't sure, 26% said they didn't think the system was meeting needs and 14% thought it was doing a good job. (Table II) One person commented that they felt that Washington State is doing a good job of meeting health care needs only if a person is or has a strong advocate.

The responses across meeting groups are somewhat different when examined individually. (Table III) The greatest number of respondents in the Meeting Group, 30%, were unsure if the system was meeting health needs whereas the greatest number in the Multicultural group, 28%, agreed the system was meeting health needs. Online participants were pretty much split – 36% unsure and 36% disagreed.

<b>Table II-Question 1 Responses</b>		
<b>Question 1: The health system of Washington State does a good job of meeting the health needs of its citizens.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	5	2%
Agree	31	14%
Not sure	66	30%
Disagree	57	26%
Strongly disagree	16	7%
No answer	46	21%
Totals	221	100%

<b>Table III-Question 1 Responses by Meeting Group</b>						
<b>Question 1: The health system of Washington State does a good job of meeting the health needs of its citizens.</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
Strongly agree	0	5	0	0%	12%	0%
Agree	15	12	4	11%	28%	10%
Not sure	45	7	14	32%	16%	36%
Disagree	34	9	14	24%	21%	36%
Strongly disagree	7	2	7	5%	5%	18%
No answer	38	8	0	27%	19%	0%
Totals	139	43	39	100%	100%	100%

**QUESTION 2: I WOULD CONSIDER OUR HEALTH CARE SYSTEM TO BE A SUCCESSFUL SYSTEM IF IT ACCOMPLISHED THE FOLLOWING:**

Participants seem to be confused by the directions for this question. They were asked to make two choices, however many of them selected more than two responses. For future iterations of this survey, this question will need to be changed to a format more similar to other questions on the survey.

Of the respondents who completed the question correctly, 21%, the largest response, felt that the health care system would be successful if it provided access to a basic level of care for all. (Table IV) This was universally the highest ranking response across all three groups.

Some people added other suggestions to this question.

- Stop taking the control of prescription medications away from the doctor.
- Give priority to those "down on their luck". Give priority to children, especially from low-income families.
- Bring access to needed services to each individual.
- Provide adequate health care for all.

<b>Table IV-Question 2 Responses</b>		
<b>Question 2: I would consider our health care system to be a successful system if it accomplished the following: (Participants were allowed two non-ranked choices.)</b>		
<b>Categories</b>	<b>Combined Responses*</b>	<b>Percent of Total Combined Responses*</b>
Increased the average lifespan	5	1%
Reduced the number of infant deaths	4	1%
Made technological advances readily available to citizens	11	2%
Other	10	2%
Treated everyone with compassion	14	3%
Make advancements in the treatment or elimination of major diseases	13	3%
No answer	14	3%
Improved the quality of life	29	7%
Increased healthy behavior in the population	42	10%
Provided programs and services that helped prevent disease-e.g. vaccines, genetic counseling	51	12%
Reduced the cost of health care	54	12%
Provided access to a basic level of care for all	95	21%
Too many answers	100	23%
Totals	442	100%
*Percent of total responses based on total number of combined responses (participants could choose multiple answers) versus single response per participant.		

**QUESTION 3: I BELIEVE IT IS PART OF MY RESPONSIBILITY TO REDUCE HEALTH CARE COSTS BY PRACTICING HEALTHY BEHAVIORS-E.G. EXERCISE, EAT RIGHT.**

Overwhelmingly the participants believe it is part of their responsibility to reduce health care costs by practicing healthy behaviors. Sixty-one percent strongly agreed and 33% agreed with this statement, a total of 94% in agreement. The response was similar across all meeting groups.

<b>Table V-Question 3 Responses</b>		
<b>Question 3: I believe it is part of my responsibility to reduce health care costs by practicing healthy behaviors-e.g. exercise, eat right.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	135	61%
Agree	73	33%
Not sure	7	3%
Disagree	4	2%
Strongly disagree	2	1%
No answer	0	0%
Totals	221	100%

**QUESTION 4: I BELIEVE IT IS PART OF MY RESPONSIBILITY TO REDUCE HEALTH CARE COSTS BY TAKING PREVENTIVE HEALTH MEASURES-E.G. VACCINATIONS, MAMMOGRAMS.**

Again there is strong support by the community that they, as individuals, are responsible for reducing health care costs by practicing preventive health measures. 62% strongly agree with this statement and 32% agree. This sentiment prevailed in each of the meeting groups, however, one person noted that, “ These (preventive) services are very expensive if you only have minimal health coverage.”

<b>Table VI-Question 4 Responses</b>		
<b>Question 4: I believe it is part of my responsibility to reduce health care costs by taking preventive health measures-e.g. vaccinations, mammograms.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	138	62%
Agree	71	32%
Not sure	4	2%
Disagree	8	4%
Strongly disagree	0	0%
No answer	0	0%
Totals	221	100%

**QUESTION 5: I BELIEVE IT IS PART OF MY RESPONSIBILITY TO REDUCE HEALTH CARE COSTS BY USING THE HOSPITAL EMERGENCY ROOM ONLY FOR EMERGENCIES.**

Overall 93% of respondents agreed or strongly agreed with this statement. (Table VII) They felt it was part of their responsibility to reduce health care costs by only using the hospital emergency room for emergencies. Looking at responses by meeting groups (Table VIII), it appears that the multicultural meeting group participants did not as strongly agree with this statement as the other two groups. Eighty-two percent of multicultural group members either agreed strongly or agreed compared to 96% and 97% in the other groups. 12% of multicultural group participants disagreed or disagreed strongly with this statement compared to 2% or 3% of participants in the other groups.

Some people commented that they could agree with the statement provided citizens were educated to know the difference and had other choices of health care available. The question was also raised “What about people who have no other source of health care?”

<b>Table VII-Question 5 Responses</b>		
<b>Question 5: I believe it is part of my responsibility to reduce health care costs by using the hospital emergency room only for emergencies.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	138	62%
Agree	68	31%
Not sure	5	2%
Disagree	6	3%
Strongly disagree	3	1%
No answer	1	0%
Totals	221	100%

<b>Table VIII-Question 5 Responses by Meeting Group</b>						
<b>Question 5: I believe it is part of my responsibility to reduce health care costs using the hospital emergency room only for emergencies.</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
Strongly agree	85	24	29	61%	56%	74%
Agree	48	11	9	35%	26%	23%
Not sure	2	3	0	1%	7%	0%
Disagree	3	2	1	2%	5%	3%
Strongly disagree	0	3	0	0%	7%	0%
No answer	1	0	0	1%	0%	0%
Totals	139	43	39	100%	100%	100%

**QUESTION 6: I BELIEVE IT IS PART OF MY RESPONSIBILITY TO REDUCE HEALTH CARE COSTS BY ASKING MY HEALTH CARE PROVIDER IF LESS COSTLY TREATMENT OR MEDICATION IS AVAILABLE FOR MEDICAL PROBLEMS I MIGHT HAVE.**

While there is a pretty strong sentiment that individuals have a responsibility to reduce health care costs by asking if less costly treatments are available, the sentiment is not as strong as other responsibilities citizens believe they have in reducing health care costs. 76% agree or strongly agree they have a responsibility, but 12% aren't sure and 10% disagree or disagree strongly.

In examining responses by groups (Table X), it appears that the uncertainty lies primarily with the multicultural group. 21% of respondents in this group were unsure compared to 9% or 13% in the other groups. The multicultural group also had fewer responses that strongly agreed with this statement, 16% compared with 35% or 41% in the other two groups.

<b>Table IX-Question 6 Reponses</b>		
<b>Question 6: I believe it is part of my responsibility to reduce health care costs by asking my health care provider if less costly treatment or medication is available for medical problems I might have.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	71	32%
Agree	98	44%
Not sure	26	12%
Disagree	18	8%
Strongly disagree	5	2%
No answer	3	1%
Totals	221	100%

<b>Table X-Question 6 Responses by Meeting Group</b>						
<b>Question 6: I believe it is part of my responsibility to reduce health care costs by asking my health care provider if less costly treatment or medication is available for medical problems I might have</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
Strongly agree	48	7	16	35%	16%	41%
Agree	66	18	14	47%	42%	36%
Not sure	12	9	5	9%	21%	13%
Disagree	8	7	3	6%	16%	8%
Strongly disagree	2	2	1	1%	5%	3%
No answer	3	0	0	2%	0%	0%
Totals	139	43	39	100%	100%	100%

**QUESTION 7: I BELIEVE IT IS PART OF MY RESPONSIBILITY TO REDUCE HEALTH CARE COSTS BY FOREGOING EXPENSIVE TECHNOLOGY IF THE CHANCE OF MY RECOVERY IS LESS THAN 15%.**

Compared to previous responsibilities, citizens were less sure of their responsibility to reduce costs when it meant foregoing expensive technology when recovery is less than 15%. 43% agreed or strongly agreed with this statement, while 30% said they were unsure. Twenty-six percent disagreed or strongly disagreed with this statement. (Table XI)

There was some variation by groups in responding to this question. Members of the multicultural group were more likely to disagree or strongly disagree with this statement, 42% compared to 20% or 31% in the other groups. (Table XII)

<b>Table XI-Question 7 Responses</b>		
<b>Question 7: I believe it is part of my responsibility to reduce health care costs by foregoing expensive technology if the chance of my recovery is less than 15%.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	33	15%
Agree	62	28%
Not sure	66	30%
Disagree	38	17%
Strongly disagree	19	9%
No answer	3	1%
Totals	221	100%

<b>Table XII-Question 7 Responses by Meeting Group</b>						
<b>Question 7: I believe it is part of my responsibility to reduce health care costs by foregoing expensive technology if the chance of my recovery is less than 15%.</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
Strongly agree	21	5	7	15%	12%	18%
Agree	46	8	8	33%	19%	21%
Not sure	43	11	12	31%	26%	31%
Disagree	19	11	8	14%	26%	21%
Strongly disagree	8	7	4	6%	16%	10%
No answer	2	1	0	1%	2%	0%
Totals	139	43	39	100%	100%	100%

**QUESTION 8: I BELIEVE IT IS IMPORTANT THAT INDIVIDUALS HAVE HEALTH INSURANCE COVERAGE.**

Ninety-three percent of respondents were in agreement, either agreed or strongly agreed, that having health insurance is important for individuals. This overall agreement was found in each of the groups.

<b>Table XIII-Question 8 Responses</b>		
<b>Question 8: I believe it is important that individuals have health insurance coverage.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	149	67%
Agree	58	26%
Not sure	11	5%
Disagree	1	0%
Strongly disagree	1	0%
No answer	1	0%
Totals	221	100%

**QUESTION 9: IF I HAD TO PAY FOR A COMPREHENSIVE (PHYSICIAN CARE, HOSPITAL SERVICES AND PRESCRIPTION DRUG COVERAGE) HEALTH INSURANCE POLICY FOR MYSELF, I WOULD BE WILLING TO PAY:**

Responses to this question need to be considered carefully. Some people answered the question as if they were being asked to pay an additional amount to what they currently pay for insurance and others responded as if this were the total cost of insurance. We received comments like: “I’m already paying. I’m not sure if I could afford more.” “I’m on a limited income of \$400.” “I have no idea what a fair cost would be. I would try to pay whatever it took to get such insurance.”

Before this question is used in the statewide survey it will need to be rewritten and clarified.

<b>Table XIV-Question 9 Responses</b>		
<b>Question 9: If I had to pay for a comprehensive (physician care, hospital services and prescription drug coverage) health insurance policy for myself, I would be willing to pay:</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
0-\$50/month	35	16%
\$51-\$150/month	60	27%
\$151-\$250/month	71	32%
\$251-\$350/month	31	14%
\$350+month	11	5%
No answer	13	6%
Totals	221	100%

**QUESTION 10: IF I HAD NO HEALTH INSURANCE AND WAS GIVEN \$250 PER MONTH AS A HEALTH BENEFIT. I WOULD:**

This question was designed to get a sense of how people might react if given money to purchase their own health insurance. The insurance cost figures included were only estimates, not tied to any specific plan. The majority, 69%, of respondents indicated that they would use \$250 to purchase comprehensive health care coverage. About 91% indicated that they would use some or all of the money to purchase health insurance coverage. In comparing responses across groups the major difference was for the online group. 82% of these respondents indicated they would use all of the money to purchase insurance compared to 65% and 67% of the multicultural and member group. (See Appendix H)

Comments received ranged from disbelief at the idea to suggestions on how to make this money go farther if they were given it.

- I would bargain shop for insurance and save the rest to cover out-of-pockets expenses like over the counter medications, preventative exams, etc.

- I would use the money to invest in order to create an emergency fund.
- I'm not sure. It would depend on what was available. I think this is a terrible idea.
- I can't figure out how this would work
- I believe the majority of people would buy no health insurance and keep the money for something else.

Comparing responses to this question by the income level of respondents showed a striking similarity between those with incomes over \$100,000 and those with incomes less than \$10,000 (Table XVI).

<b>Table XV-Question 10 Responses</b>		
<b>Question 10: If I had no health insurance and was given \$250 per month as a health benefit. I would:</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
<b>Option A:</b> Use the \$250 to buy a health insurance plan with comprehensive coverage.	153	69%
<b>Option B:</b> Use \$200 to buy a health insurance plan that has broad coverage, but has a high deductible and co-pay (Use the remaining \$50 for something else.	28	13%
<b>Option C:</b> Use \$125 to buy a plan that provides only catastrophic coverage (coverage for major expensive health problems only) (Use remaining \$125 for something else.)	20	9%
<b>Option D:</b> Buy no health insurance. Keep the money for something else.	1	0%
<b>Option E:</b> Other, please specify	7	3%
No answer	12	5%
Totals	221	100%

<b>Table XVI-Question 10 Responses by Income</b>						
<b>Question 10: If I had no health insurance and was given \$250 per month as a health benefit. I would:</b>						
<b>Household Income Levels</b>	<b>Percent Question 10 Option A</b>	<b>Percent Question 10 Option B</b>	<b>Percent Question 10 Option C</b>	<b>Percent Question 10 Option D</b>	<b>Percent Question 10 Option E</b>	<b>Totals</b>
Under \$10,000	65%	25%	10%	0%	0%	100%
\$25,000-\$44,999	74%	9%	9%	2%	5%	100%
\$45,000-\$99,999	81%	11%	4%	0%	4%	100%
Over \$100,000	60%	19%	15%	0%	6%	100%
Note: Out of 221 participants, 190 or 86% responded to both questions (Question 10 and Household Income Level).						

**QUESTION 11: I WOULD BE WILLING TO PAY MORE FOR HEALTH CARE INSURANCE IF IT:**

Participants were allowed to choose multiple answers. Respondents were most willing to pay more for health insurance if they were allowed to choose any health care provider they wanted, had coverage for the majority of their prescriptions, got dental coverage and/or had coverage for check-ups and preventive health care. These priorities were the same across all three groups.

In addition to the choices listed on the survey, participants wrote in additional services and choices they would be willing to pay more for. Services added were alternative medicine, optometry and fertility counseling. Choices included the desire for more physician autonomy, direct access to specialists, ability to get physician appointments more quickly, freer access to the emergency room, more flexibility in adding family members to a plan, and more information about quality care.

<b>Table XVII-Question 11 Responses</b>		
<b>Question 11: I would be willing to pay more for health care insurance if it: (Participants could check all answers that applied)</b>		
<b>Categories</b>	<b>Combined Responses</b>	<b>Percent of Combined Total Responses*</b>
None of the above	8	1%
No answer	8	1%
Other, please specify	18	2%
Covered new technology and experimental treatments	72	8%
Included coverage for mental health and substance abuse treatment	83	10%
Allowed me to go directly to a specialist without a referral	102	12%
Covered dental care	126	15%
Let me choose any health care provider I want	144	17%
Covered the majority of prescription drugs	146	17%
Paid for check-ups and preventive health care-mammograms, shots, other health screens.	159	18%
<b>Totals</b>	<b>866</b>	<b>100%</b>
*Percent of total responses based on total number of combined responses (participants could choose multiple answers) versus single response per participant.		

**QUESTION 12: IF YOU HAVE HEALTH INSURANCE COVERAGE NOW, HOW CERTAIN ARE YOU THAT YOUR COVERAGE WILL BE AVAILABLE AND AFFORDABLE TO YOU IN THE NEXT THREE YEARS?**

While the majority of respondents felt certain they would have coverage that was affordable in the next three years, 28% very certain and 38% somewhat certain, almost one third were not certain. (Table XVIII). Participants in the multicultural group expressed a slightly higher level of uncertainty than participants in both other groups, 42% compared to 31% and 26% (Table XIX).

At the meetings, some citizens noted they were worried about whether they would be able to maintain health coverage if they lost their job. Also health insurance costs and availability were noted as big concerns for those seeking self-employment.

When responses to this question were examined by respondent income (Table XX), respondents whose income was less than \$10,000 appeared more uncertain about whether they would have health insurance coverage in the next three years- 40% unsure compared to 26%-31% for those with higher incomes. Fifteen percent of the respondents with incomes less than \$10,000 currently are uninsured.

<b>Table XVIII-Question 12 Responses</b>		
<b>Question 12: If you have health insurance coverage now, how certain are you that your coverage will be available and affordable to you in the next three years?</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Very certain	61	28%
Somewhat certain	83	38%
Not certain	66	30%
Don't have coverage now	5	2%
No answer	6	3%
Totals	221	100%

<b>Table XIX-Question 12 Responses by Meeting Group</b>						
<b>Question 12: If you have health insurance coverage now, how certain are you that your coverage will be available and affordable to you in the next three years?</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
Very certain	44	9	8	32%	21%	21%
Somewhat certain	52	13	18	37%	30%	46%
Not certain	36	18	12	26%	42%	31%
Don't have coverage now	1	3	1	1%	7%	3%
No answer	6	0	0	4%	0%	0%
Totals	139	43	39	100%	100%	100%

<b>Table XX-Question 12 Responses by Income</b>					
<b>Question 12: If you have health insurance coverage now, how certain are you that your coverage will be available and affordable to you in the next three years?</b>					
<b>Household Income Levels</b>	<b>Very Certain</b>	<b>Somewhat Certain</b>	<b>Not Certain</b>	<b>Don't Have Coverage Now</b>	<b>Totals</b>
Under \$10,000	20%	25%	40%	15%	100%
\$25,000-\$44,999	29%	40%	31%	0%	100%
\$45,000-\$99,999	30%	41%	28%	1%	100%
Over \$100,000	28%	43%	26%	2%	100%
Note: Out of 221 participants, 194 or 88% responded to both questions (Question 12 and Household Income Level).					

**QUESTION 13: IF THE GOVERNMENT WERE TO DEVOTE MORE RESOURCES TO IMPROVE ACCESS TO HEALTH INSURANCE, WHICH SEGMENT(S) OF THE UNINSURED POPULATION SHOULD BE TARGETED FOR HELP?**

This is another question that seemed to cause confusion. Respondents often checked more than the requested number of responses and, as a result, their responses could not be included. For those who completed the question as directed, the highest response rate given any one choice was 17%. Seventeen percent of respondents felt that all segments of the uninsured population should be equally treated in the government allocation of resources to improve access to health insurance. Seventeen percent also felt that low-income children should be targeted for additional resources to improve access to health insurance. These two choices also received the highest number of responses in each of the three groups.

A few comments related to choices were also noted on the survey forms. One individual felt the government shouldn't devote any more resources. One person wrote that resources for low-income children should only be for those who are legal aliens or citizens and another wanted to see temporary assistance with time limits for individuals who have lost their coverage due to a job loss. Another comment received suggested that all populations should be treated equally for preventive health care.

<b>Table XXI-Question 13 Responses</b>		
<b>Question 13: If the government were to devote more resources to improve access to health insurance, which segment(s) of the uninsured population should be targeted for help? (Two choices unranked allowed)</b>		
<b>Categories</b>	<b>Combined Responses*</b>	<b>Percent of Combined Total Responses*</b>
Individuals who have lost coverage due to job loss.	51	12%
Low-income children.	74	17%
Parents of children covered by public programs.	10	2%
Low-income adults without children.	3	1%
Chronically ill or disabled adults who are unable to work.	48	11%
Minority or ethnic groups that are disproportionately uninsured.	7	2%
Individuals living in economically depressed areas of the state.	4	1%
Individuals working in low-wage industries.	12	3%
Early retirees without access to Medicare.	14	3%
All segments should be treated equally.	73	17%
Void-too many answers	88	20%
No answer	58	13%
Totals	442	100%
*Percent of total responses based on total number of combined responses (participants could choose multiple answers) versus single response per participant.		

**QUESTION 14: I AM WILLING TO PAY MORE EITHER IN TAXES OR IN HEALTH INSURANCE PREMIUMS, SO THAT THOSE WHO ARE LOW-INCOME AND HAVE NO HEALTH INSURANCE CAN GET HEALTH CARE.**

For all respondents, 60% indicated they were willing to pay more so that low-income individuals can have health care, 18% strongly agreed to this and 42% agreed. There were a few variations when the results were reviewed by groups. The multicultural meeting group (23%) and the online respondents (28%) appeared to feel more strongly about this statement than the meeting group (14%), while the meeting group appeared more uncertain about what they thought. (Table XXIII) Twenty-nine percent of the meeting group were not sure whether they were willing to pay more compared to 16% of the multicultural group and 18% of the online group.

<b>Table XXII-Question 14 Responses</b>		
<b>Question 14: I am willing to pay more either in taxes or in health insurance premiums, so that those who are low-income and have no health insurance can get health care.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
Strongly agree	40	18%
Agree	92	42%
Not sure	54	24%
Disagree	23	10%
Strongly disagree	3	1%
No answer	9	4%
Totals	221	100%

<b>Table XXIII-Question 14 Responses by Meeting Group</b>						
<b>Question 14: I am willing to pay more either in taxes or in health insurance premiums, so that those who are low-income and have no health insurance can get health care.</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
Strongly agree	19	10	11	14%	23%	28%
Agree	55	19	18	40%	44%	46%
Not sure	40	7	7	29%	16%	18%
Disagree	17	3	3	12%	7%	8%
Strongly disagree	0	3	0	0%	7%	0%
No answer	8	1	0	6%	2%	0%
Totals	139	43	39	100%	100%	100%

**QUESTION 15: I AM WILLING TO PAY THE FOLLOWING AMOUNT MORE PER MONTH IN HIGHER PREMIUMS OR TAXES TO COVER THE UNINSURED IN WASHINGTON STATE.**

A very small percent (8%) of respondents indicated that they were not willing to pay any more in taxes or premiums to cover the uninsured. The largest percent, 38%, indicated that they would be willing to pay \$5 to \$10 per month. Twenty-seven percent noted that they would pay more than \$10 per month.

Looking at the groups individually (Table XXV), the biggest response in all three groups showed that respondents were willing to pay \$5 to \$10 per month. Compared to the two other groups, the multicultural group respondents seemed more interested in paying less than \$5 while the online group expressed more interest in paying more than \$10 per month.

In an effort to determine if the responses to this question were related to the income of participants, responses by income were examined. (See Table XXIV) Those participants with incomes less than \$10,000 were the most likely to not want to pay any higher taxes or premiums to cover the uninsured. Twenty percent responded by checking “none”

compared to only 4% - 9% of individuals with higher incomes. Overall however, the largest percent of respondents in all income groups indicated they would be willing to pay \$5 - \$10 per month more in higher taxes or premiums to cover the uninsured.

<b>Table XXIV-Question 15 Responses</b>		
<b>Question 15: I am willing to pay the following amount more per month in higher premiums or taxes to cover the uninsured in Washington State.</b>		
<b>Categories</b>	<b>Responses</b>	<b>Percent of Total Responses</b>
None	18	8%
Less than \$5/month	18	8%
\$5-\$10/month	84	38%
More than \$10/month	60	27%
Not sure	26	12%
No answer	15	7%
Totals	221	100%

<b>Table XXV-Question 15 Responses by Meeting Group</b>						
<b>Question 15: I am willing to pay the following amount more per month in higher premiums or taxes to cover the uninsured in Washington State.</b>						
<b>Categories</b>	<b>Meeting Group Response</b>	<b>MCM Group Response</b>	<b>Online Group Response</b>	<b>Meeting Group % of Total Response</b>	<b>MCM Group % of Total Responses</b>	<b>Online Group % of Total Responses</b>
None	10	6	2	7%	14%	5%
Less than \$5/month	9	8	1	6%	19%	3%
\$5-\$10/month	50	17	17	36%	40%	44%
More than \$10/month	40	6	14	29%	14%	36%
Not sure	16	5	5	12%	12%	13%
No answer	14	1	0	10%	2%	0%
Totals	139	43	39	100%	100%	100%

<b>Table XXVI-Question 15 Responses by Income</b>					
<b>Question 15: I am willing to pay the following amount more per month in higher premiums or taxes to cover the uninsured in Washington State.</b>					
<b>Household Income Levels</b>	<b>None</b>	<b>Less than \$5/month</b>	<b>More than \$10/month</b>	<b>Not sure</b>	<b>Totals</b>
Under \$10,000	20%	35%	10%	15%	100%
\$25,000-\$44,999	9%	47%	23%	9%	100%
\$45,000-\$99,999	5%	42%	39%	9%	100%
Over \$100,000	4%	38%	33%	15%	100%

Note: Out of 221 participants, 189 or 86% responded to both questions (Question 15 and Household Income Level).

## **Summary of Recurring Themes from Community Meetings**

At each of the community meetings, there was a designated recorder who wrote down the comments and opinions expressed by participants. A summary of the major themes from the community meetings is outlined below. (For full documentation of meeting minutes, see Appendix I, Meeting Notes) These themes do not address every point raised, rather they identify reoccurring themes that were discussed at multiple meetings. As noted earlier, people completing the survey online did not attend any meetings.

In all meetings, there was a relatively high level of awareness and ability to articulate on health care issues. People who had health insurance paid by their employer generally felt good about their health care benefits and coverage. Good insurance was typically equated with having coverage for the majority of needed services and having reasonable deductibles and/or co-payments.

Often times, however, these same people expressed fear about what the future holds. They didn't know where they would get coverage or how they would pay for care if their employer dropped them, they lost their job, became self-employed or if they retired. There was an expressed concern that only those who are rich will be able to get coverage in the future.

### **Health Insurance and Health Insurance Companies**

Overall, participants viewed the health insurance companies as the bad guys. According to participants, insurance companies:

- Decrease coverage, increase premiums, and maintain solid profit margins at the expense of insurance purchasers.
- Don't offer enough low cost coverage options.
- Have shifted an unreasonable amount of health care costs to individuals/families to pay out-of-pocket without help and these costs keep going up.
- Dictate what services will be covered.
- Need more competition. There aren't enough insurance companies in the state to choose from. This is the government's fault for creating an unfriendly insurance environment.

### **Health Care Coverage**

- People want low-cost insurance coverage options to be available.
- There was interest in being able to purchase plans that offer the following a) basic coverage only, b) catastrophic coverage only, c) rewards for healthy behavior, d) preventive care, and e) coverage for less costly alternatives.
- While people don't condone risky behavior, they don't all want to penalize those who practice risky behaviors. They want to educate them, and some want to hold them

accountable to regulations or fines. The majority favors rewarding healthy behaviors rather than punishing risky behavior.

- There is a general consensus that everyone should have health care coverage.
- Those who pay their own health care costs want to be able to do so with before tax dollars, just like employers do for employees.
- Some people identified a need for expanded coverage -services like mental illness.

## **Providers**

There was a general sense of support for practitioners.

- Participants expressed sympathy for physicians saying they were not getting paid adequately for their services. (e.g. Medicare reimbursement in this state is too low, insurance companies pay too slowly and not enough.)
- Participants expressed concerns that they may lose their doctor because the physician opts out of a plan such as Medicare or Medicaid.
- A few participants mentioned that they felt that physicians needed to think more about the cost of care they were prescribing, and the tests they were ordering. They also wanted their physician to involve them in a discussion of the cost of services.
- Patients want their doctors to have time to spend with them.

## **Uninsured**

- Overall there was support for providing health care coverage for the uninsured. Participants expressed need for a safety net for those who can't afford to pay for their own coverage. They wanted basic care to be available to all and stated that we as a society need to support people around us to make our community successful.
- There was acknowledgement that some people can't take care of themselves – disabled, mentally ill.

## **Prescription Drugs**

Prescription drugs and their costs were talked about at almost every meeting, particularly by senior citizens. Topics included:

- Consumers should not be paying for the cost of marketing and media campaigns by the pharmaceutical companies.
- Medications are cheaper to purchase in Canada. This isn't right.
- Prescription costs are too high.
- Medicare doesn't cover the high cost of prescriptions. We need a Medicare prescription benefit.
- "Charity care" plans by pharmaceutical companies are difficult to get into and don't really work.

## **Possible Solutions**

While there was no consensus on any solution, a number of solutions were offered by participants:

- A health care tax to pay for health care coverage.
- Education for citizens so that they know what health care costs; what their responsibility is as far as controlling costs; what the benefits of preventive care are; and how to use health care services efficiently.
- Explore the health care systems of other countries- some countries do it better than the USA. Specifically named at different meetings were Sweden, Holland, France, Great Britain, Australia and Costa Rica (Costa Rica uses a model that relies heavily on nurses).
- Community rating.
- Set limits on malpractice and liability lawsuits.
- Basic health care for all- more expensive, high tech care only if you can pay.
- Prioritize what we pay for.
- Create a subsidy for low income health care paid by insurance companies – like realtors and developers do for low income housing
- Universal health care for all paid for by the government.

# Next Steps

With the completion of the pilot project, HumanLinks is ready for the next steps. This section outlines final wrap up activities for the pilot project and steps necessary to take the project statewide. Activities include:

- Complete our obligation to our pilot project receptors. This means meeting with each receptor to review the findings of the project, elicit their responses, concerns, suggestions for improvement and willingness to remain involved with a statewide effort.
- Disseminate the written report and/or executive summary of the pilot project to key policy makers, chairs of the legislative health care committees, participating community groups and the media through the vehicle of key communicator messages (op-ed pieces, community newsletters, etc.)
- Make revisions to materials and processes based on input from the pilot and the receptors. Compile this information in a toolkit format.
- Assemble a state-wide coalition of community partners to facilitate and collaborate on expanding the effort statewide during the spring of 2003.
- Assemble a HumanLinks team to work with collaborative partners to organize and implement the project in communities in all 39 counties.
- To launch the statewide effort, plan and hold a kickoff event featuring a key national speaker. Seek cosponsors for this event. Address the importance of informed community conversations in setting the stage for meaningful healthcare dialogue.
- Offer to share our expertise and experience in doing community meetings with other groups
- Complete all activities so that we can go to the 2003/04 legislature with concrete recommendations
- In January, 2003, convene study circle(s) in East King County drawing upon the individuals who expressed interest in a more in-depth conversation about health care. Begin to look at issues identified at East King County community meetings. Invite hospitals and other receptors to participate and/or present to study group members.

- Use the power of community response to draw in policy makers to create and design solutions

<b>Table XXVII Project Timeline</b>	
<b>Completion date</b>	<b>Activity</b>
November/December 2002	Present report to receptors. Secure commitment for statewide effort.
November/December 2002	Revise materials and processes and develop final toolkit
	Secure statewide partners
	Assemble HumanLinks state team
	Plan kick-off for statewide effort
	Publicize the initiative
January 2003	Launch study circles in East King County
March 2003	Hold Kick Off Event
March 2003	Begin statewide effort – select and begin project in 10 counties around the state- start with larger, more populous counties.
April 2003	Select and begin project in 10 more counties
May 2003	Select and begin project in 10 more counties
June 2003	Select and begin project in 9 more counties
	Data entry and recorder summaries will be ongoing
July 2003	Progress report for receptors
September 2003	Complete all meetings
	Finalize data entry and complete analysis
	Develop report for the legislature.