

Public Opinion on Health Reform in Rhode Island: Problem Definition and Patterns of Support

David A. Rochefort
Northeastern University
and Brown University

Kevin P. Donnelly
Northeastern University

“With costs soaring and millions of baby boomers about to go on Medicare, health care — and how to pay for it — is poised to emerge as the top domestic issue in the 2008 presidential campaign,” wrote Richard Benedetto of *USA Today* in February of 2006. Reflecting on this statement from the vantage point of December 2007, just days before the Iowa caucuses, it is impossible not to appreciate the author’s prescience.

National survey data confirm the high-priority political standing of health reform. In the Kaiser Family Foundation (2007) tracking poll, only Iraq surpasses health care as an issue that the public wants to hear presidential candidates talk about. The candidates themselves have responded to, and kindled, this popular concern through their numerous campaign ads, position papers, website messages, and interviews focusing on health care. Among this group, John Edwards was first to announce a detailed national health care reform plan in February of 2007. Hillary Clinton followed in September. Of necessity, the entire field of Democratic and Republican hopefuls has now articulated visions for health system overhaul, a cacophony of office-hungry voices centering on various employer and individual mandates for the former group and market-based solutions for the latter.

Meanwhile, the states are hardly sitting by idly as this national policy debate takes shape. Rather, they have been catalysts in health care’s rise on the political agenda, due to the policy innovations adopted in Massachusetts, Maine, Vermont, Illinois, Maryland, and elsewhere. In Rhode Island, Lieutenant Governor

This research was supported by grants from Northeastern University’s Provost’s Office, Arts and Sciences Dean’s Office, and the Corporation for National and Community Service Grant, “National Community-Based Research Networking Initiative,” administered by Princeton University’s Community-Based Learning Initiative in partnership with the Corella and Bertram F. Bonner Foundation.

2 Brown Policy Report/December 2007

Elizabeth Roberts recently launched a multi-step process involving industry stakeholders and the public that is intended to “lead to comprehensive reform of our health care system.” According to her timetable, Roberts will be introducing a package on health care reform in the 2008 legislative session.

Yet health care has consistently proved one of the most notorious minefields in all of American politics. Consider the last significant attempt at national health reform, which took place during the Clinton years. While this episode certainly dramatized the wealth and influence of special interests in the health care domain, as well as the difficulties of even a major presidential initiative within a divided Congress, arguably the greatest lesson to come out of this experience was the power of social perceptions—about the role of government, the nature of health care problems, and the feasibility of different policy reform strategies—in delimiting outcomes within the health policy making process. An overarching framework for analyzing this topic and its ramifications is the “politics of problem definition.”

Although a number of scholars have written about the importance of problem definition within the health policymaking process, little effort has been made to integrate the study of problem definition and public opinion research. Data collected in a recent Northeastern University poll of Rhode Island voters that was conducted at Brown University’s Taubman Center captures perceptions of key aspects of the health reform issue relevant to the emerging health reform process in this state. Following a review of key concepts in the problem-definition approach, the focus of this paper is twofold: first, to present these descriptive data about the way different groups of local voters “frame” the health care issue; and, second, to explore the connection between dimensions of problem definition, on the one hand, and attitudes toward health reform principles and policy options, on the other.

The Problem Definition Perspective: A Review of Key Concepts

The prominence of health care reform on the national and state agendas indicates broad agreement that rising health care costs and increases in the number of uninsured—now over 47 million—are

problems that require political action. Agreement that a problem exists, however, does not necessarily mean there is agreement about the nature of the problem itself. In fact, policymakers, issue stakeholders, and the larger public rarely understand problems in the same way. Perceptions surrounding the scope, severity, urgency, and origin of a problem can vary widely, often contributing to a wide range of preferred policy solutions. Such perceptions are shaped in large part by the way interest group advocates, political leaders, industry professionals, other interested parties, and the media describe and explain a problem, thus making *problem definition* a critical component of the policymaking process.

The impact of problem definition has come into sharper focus in recent years, but its importance has long been recognized. E. E. Schattschneider (1960) was among the first to point out that the supreme instrument of power in waging political conflict is the “definition of alternatives” (p. 66). He described the struggle for political priorities as akin to the “fog of war” (p. 67) made murky by competing definitions of the issues at hand. Building on Schattschneider’s insight, Roger Cobb and Charles Elder (1983) highlighted the use of rhetorical strategies and symbolism as means to limit or expand the scope of conflict. More recently, Deborah Stone (1997) refined our understanding of rhetoric in politics by examining the impact of causal stories in policy formation. Whichever causal mechanism becomes the accepted culprit will powerfully affect policy design.

Problem definition is also a key component of the process of agenda setting and is commonly discussed within that literature. John Kingdon (1995) notes that policy entrepreneurs will often attempt to *redefine* preferred policy solutions in order to fit existing problems. Baumgartner and Jones (1993) expanded on the concept of issue redefinition, noting that policy entrepreneurs can mobilize those left outside the system either to construct new institutional structures or breakup existing arrangements, driving an issue to the forefront of the agenda and perhaps leading to profound changes in the policy landscape. In this way, problem redefinition can lead to profound changes in the policy “equilibrium.”

In addition to available information and political argument surrounding a particular issue, culture and personal ideology are

factors that can play a significant part in shaping problem definition. At the same time, the process of problem definition can either stimulate or restrain preexisting inclinations.

As researchers apply the growing body of literature on problem definition to various areas of public policy, the need for a guiding analytical framework has become evident. In an effort to promote a more systematic application of the problem-definition framework, Rochefort and Cobb (1993) presented an “anatomy of problem description” delineating the main categories of discourse by which a problem is “constructed.”

The first category noted by Rochefort and Cobb is that of *problem causation*. Statements about the origin of a problem are inherent in the notion of problem definition, but within this broad category there are important variations. Is a problem described as being the result of an individual or impersonal cause? Such a distinction is profound as it is often found at the core of the liberal-conservative divide. The description of a problem’s cause can also include blame toward a particular group or individual, or the assignment of blame could be avoided altogether. Further, the origin of a problem could be defined as intentional or accidental, in line with Stone’s discussion, and simple or complex.

Beyond causality, the *nature of the problem* is another broad category of problem definition. The characteristics under this heading are important to consider because they can powerfully affect both the likelihood of political action and the design of policy solutions. Problem attributes include severity, incidence, novelty, proximity to the individual, or classification as a crisis.

Not only are problems described with certain attributes, but so too are the affected individuals and groups. Therefore, a related third category of problem definition encompasses the *characteristics of the problem population*. Is the group seen as worthy or unworthy of government assistance, threatening and strange, or as individuals who are generally familiar and foster feelings of sympathy?

Another distinctive area of problem definition involves the *ends-means orientation* of those defining the problem. In some policy disputes, advocates define their position in terms of a rational course

of action aimed at achieving a stated outcome. Other times, the means, not the ends, are the focus of those who are defining the problem. Rochefort and Pezza (1991) illustrated this phenomenon as it played out during the height of debate over a needle-exchange program. Proponents argued that the distribution of clean needles to IV drug users reduced transmission of the AIDS virus, whereas many opponents felt government support for illegal drug use should be the primary point of concern and a reason to block the proposed program irrespective of its possible effectiveness.

The last category of problem definition put forward by Rochefort and Cobb is the *nature of the solution*. Most fundamentally, does a solution exist? Agreement can often be achieved that a problem exists, but policymakers must also believe that government intervention will have a positive effect. Similarly, are the policy techniques available to government viewed as acceptable or unacceptable? The recent debate regarding government support for embryonic stem cell research serves as an example of how this dynamic can shape the political process. Finally, a solution will often be defined as being affordable or not, presenting policymakers with consequences to consider from a budgetary standpoint.

The concept of problem definition has been applied to many different public policy areas, among them health care. The most thoroughly studied health policy episode is President Clinton's attempt at national health reform. Writing shortly after the proposal of that initiative, Theodore Marmor characterized the battle over medical insurance as a "war of words" (1994, p.4). Along with American political and institutional barriers Marmor and Boyum cited the way in which the debate had been *framed* as one of the primary reasons to expect failure (1994). At the time, reform proposals were classified into three broad categories: pay-or-play, single-payer, and pro-competitive. Marmor and Boyum argued that such misleading labels had the adverse effect of stressing the differences between reform plans and obscuring the similarities. The result was an oversimplified debate that ultimately "hinders intelligent discourse and darkens the prospects for meaningful reform" (Marmor and Boyum, p. 133).

Following the failure of the Clinton plan, Skocpol (1997) examined the rhetoric that had been employed by candidate Clinton

6 Brown Policy Report/December 2007

to sell his vision to voters, noting that for the most part people liked what they heard. His broad “message” combined security, savings, choice, simplicity, responsibility, and quality. However, Skocpol argues that President Clinton’s later “anemic” (p. 107) explanation of how his health reform plan would work left the door open for opponents to define details of the proposal on their own terms. As a result, his system of government regulations and financing was successfully portrayed as a “big government” solution that would exacerbate existing problems.

Relying on Kingdon’s agenda setting framework, Jacob Hacker (1997) explored the “genesis” of the Clinton plan, noting that “very little intellectual energy” went into developing a clear explanation of the policy proposal, and as a result, there was simply no “readily available fund of rhetoric on which the president’s advisors could draw” (p. 139). In short, the vagueness of the term “managed competition” confounded the nature of the President’s proposed solution, lending a significant rhetorical advantage to opponents of the plan.

The significance of problem definition is not unique to the Clinton health reform proposal, however. In fact, Hackey (1997) argues that similar “symbolic politics” were at work in the 1990s as they were in the 1940s. Dating back to the Truman plan, opponents have deliberately branded national health insurance as a “compulsory” or “big-government” solution, and counter to such higher-order American symbols as liberty and freedom (see, also, Cobb and Elder, 1983).

Deborah Stone (1997) has pointed to the creative use of “causal stories” as another theme cutting across health policy debates in different time periods. For example, Stone argues that during the 1960s advocates for Health Maintenance Organizations (HMOs) claimed that limited access of poor people to health care was caused by the “solo-practice” delivery system. Yet the same proponents argued to the Nixon administration that HMOs were the answer to the cost-containment problem, claiming that high costs were a result of fee-for-service payment (p. 207).

More recently, Weissert and Weissert in *Governing Health* (2002) devoted considerable attention to problem definition, calling it

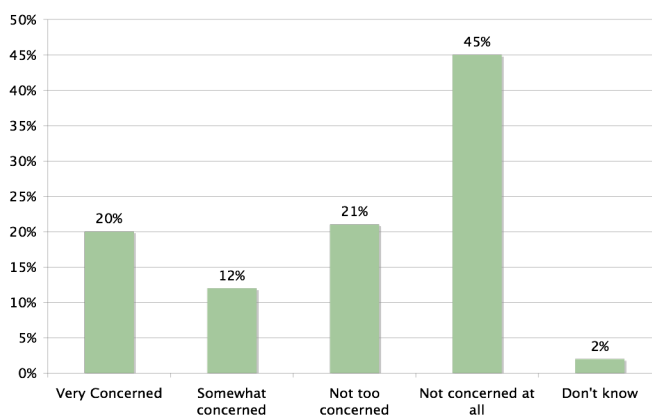
“crucial” to health policy development (p. 262). Following a comprehensive review of problem-definition scholarship, these authors argue that in order for fundamental reforms to come about, those affected by the problem must have attractive features, government action must be viewed as appropriate, and solutions must be considered feasible (p. 280). The cumulative message is clear—the framing of health care issues is central to the success of health reform proposals.

With this review of relevant scholarship as backdrop, we turn now to the question, How do Rhode Island voters frame the contemporary issue of health care reform? Our data come from a survey designed by a team of undergraduate and graduate students who were enrolled in an upper-level community-based research seminar at Northeastern University. The project was under the direction of the senior author and included the second author as a participant. The Brown University Public Opinion Research Center implemented the survey, interviewing a total of 410 adults age 18 years and over by telephone on October 27-28, 2007. The sample was drawn from a statewide list of registered voters, with a margin of error of approximately plus or minus five percentage points.

Problem Definition in the Rhode Island Survey on Health Care Reform

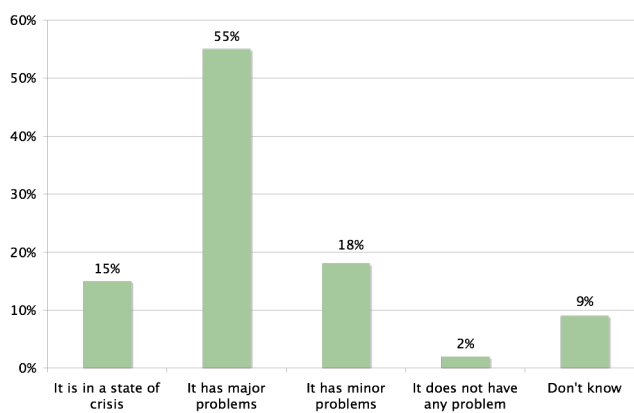
According to a recent report issued by the Rhode Island Office of the Health Insurance Commissioner (2007), the rate of uninsurance in the state could climb from 13 percent in 2005 to 20 percent by 2010. The Northeastern survey captures the *proximity* of this coverage issue in terms of the number of Rhode Island voters who feel personally at risk due to this growing problem. A substantial percentage of respondents in our survey are already directly affected by coverage gaps. Ten percent do not have coverage, and 16 percent live in a household where at least someone lacks insurance protection. Even among insured individuals in the survey, however, a combined 33 percent say they are “somewhat” or “very” concerned about losing their current coverage.

Figure 1
Concern About Losing Health Insurance



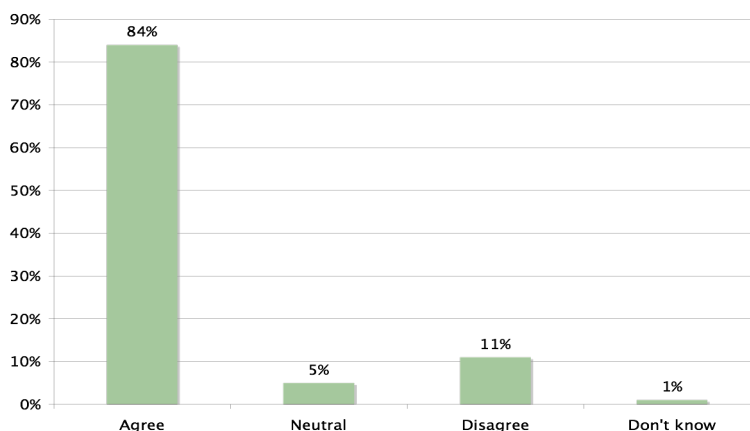
As already noted, *severity* is an important attribute of a social problem. A majority (55 percent) of respondents in this survey believe Rhode Island’s health care system “has major problems.” An additional 15 percent describe the state’s health care system as being in a “state of crisis.” To the contrary, only 18 percent feel that the health care system has “minor problems,” while two percent say it has “no problems.”

Figure 2
Statement that Best Describes Health Care System In Rhode Island



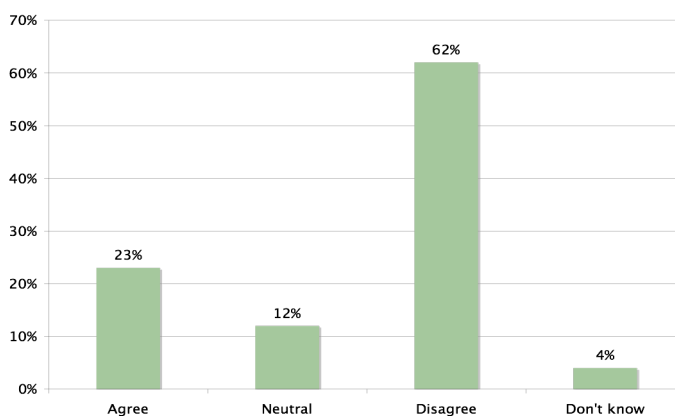
The nature of a problem can also be considered in terms of its relationship to fundamental values such as individual rights. Problems perceived in these terms typically garner special attention within the political sphere. With this in mind, it is noteworthy that 84 percent of survey respondents feel that “health care is a right no one should be denied.” Only 11 percent disagree with this statement.

Figure 3
Health Care Is a Right that No One Should Be Denied



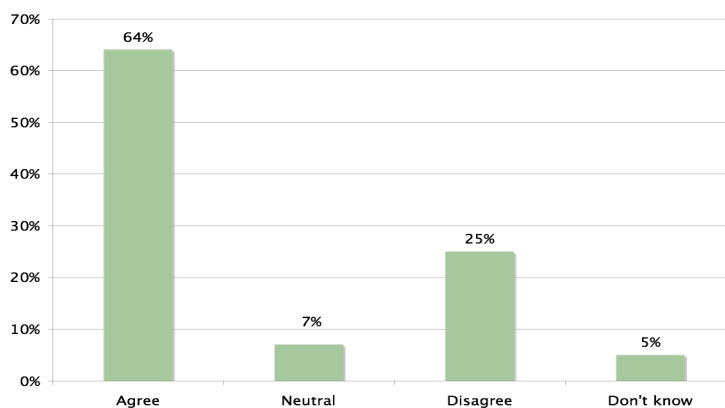
What about the perception of those affected by lack of health insurance? When asked to react to the statement that the uninsured are “partly to blame for having this problem,” a majority (62 percent) of Rhode Island voters respond negatively. Thus, most survey respondents perceive the uninsured to be victims of a systemic, rather than individually-based, problem. A relatively small minority (23 percent) assign a certain level of blame to the uninsured for their situation.

Figure 4
Those Without Health Insurance Are Partly to Blame
for Having this Problem



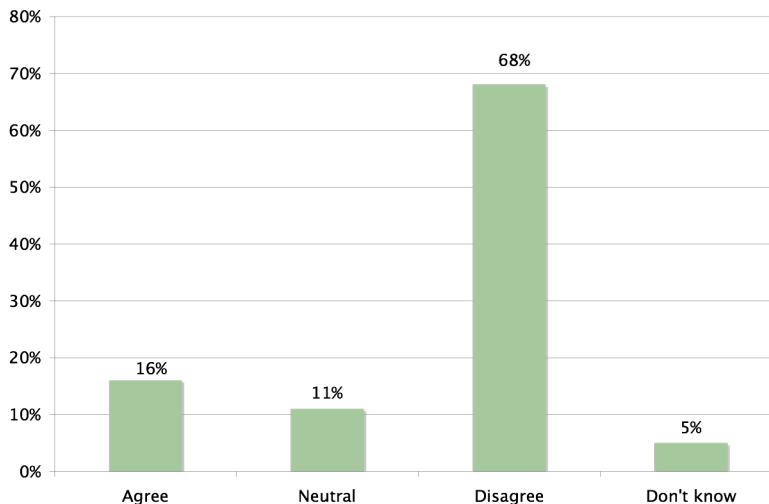
When asked whether “health care reform should be seen by state policy makers as a moral issue,” 64 percent respond affirmatively. This finding confirms a strong ethical component to public construction of this issue. It also helps to explain why many voters give such a high priority to action in this area.

Figure 5
Health Care Reform Should Be Seen by State Policy Makers
as a Moral Issue



Finally, the challenge of health care reform inevitably invokes beliefs about the role for government. Here, a large majority (68 percent) of survey respondents reject the statement that the “problems of the health care system will eventually be solved by private businesses and health insurance companies without government stepping in,” indicating a strong desire for intervention by public officials.

Figure 6
The Problems of the Health Care System Will Be Solved
Without Government Intervention



Problem Definition as an Explanatory Variable

An important question not well examined in the existing literature is how well the problem-definition orientation of individuals serves to predict actual public policy preferences. The Rhode Island opinion poll, which included a series of items examining attitudes toward both the general idea of health reform and specific policy options, allows us to analyze this topic.

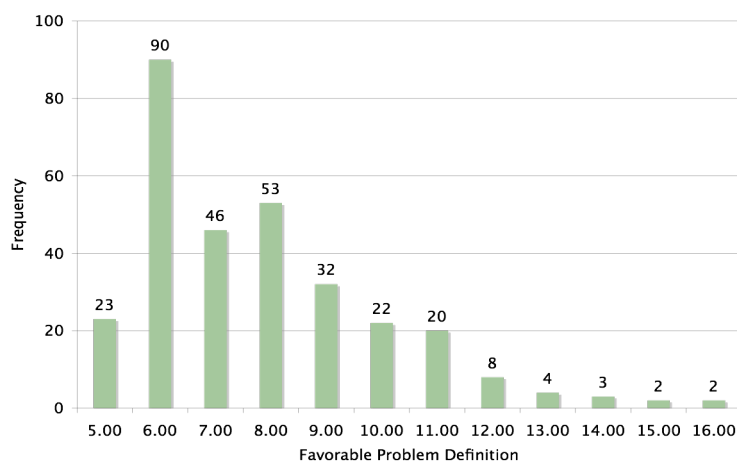
First, a Favorable Problem Definition scale was formed by aggregating responses to several of the individual problem-definition

questions that have been previously presented. Five items were included and are paraphrased below:

- Description of health care system in RI
- Health care is a right
- People without health insurance are partly to blame
- Health care reform should be seen as a moral issue
- The problems of the health care system will be solved without government

With the exception of the first item, which has four response categories from “state of crisis” to “no problem,” all questions have the same three response categories of “agree-neutral-disagree.” After reversing the “agree” and “disagree” options of the second and fifth questions to make the sequence of preferences parallel for all five items, a summary scale was computed leaving out any cases in which there were missing values for one or more of the included questions. The result is a scale ranging from 5 to 16 points in which the lowest possible value represents a “favorable” problem-definition response to all of the stated questions, while “16” represents consistently “unfavorable” responses. The distribution of values measured by this scale appears in Figure 7 below.

Figure 7
Favorable Problem Definition Scale
(N = 305)



Public Opinion on Health Reform in RI

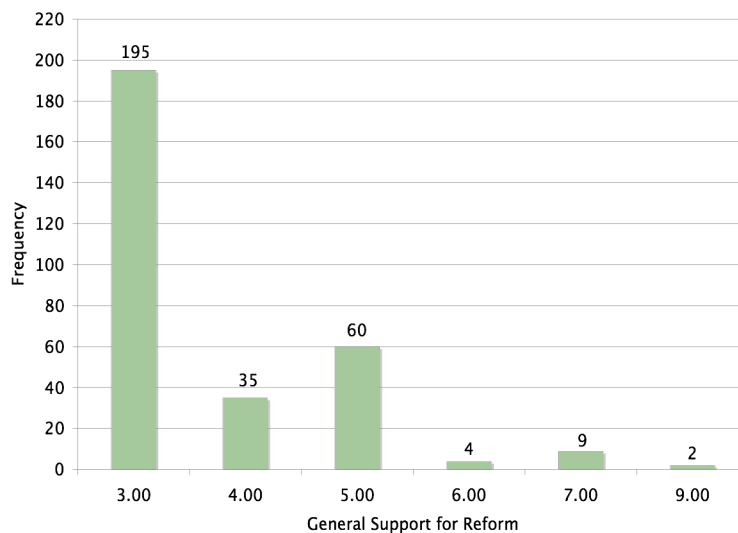
13

In similar fashion, a second scale was created to measure “General Support for Reform” among our survey respondents. Here, three questions are included:

RI policy makers should not attempt reform because it is too controversial politically
I care about everyone having health insurance coverage
I care about controlling health care costs

These three items shared the same Agree-Neutral-Disagree response options. After reversing the Agree-Disagree scoring for the first item, the result was a scale whose values range from “3” (greatest support for reform) to “9” (least support for reform).

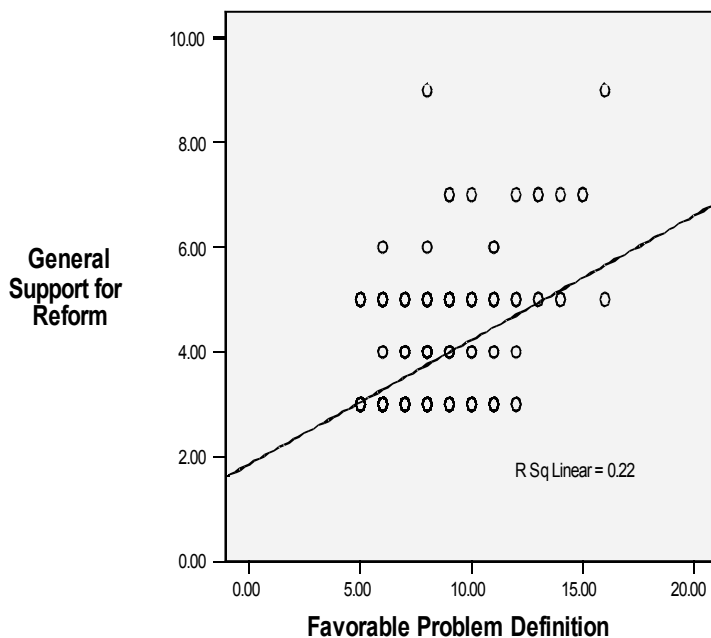
Figure 8
General Support for Reform Scale
(N = 305)



Does a favorable problem definition among voters predict general support for reform? To answer this question, we carried out a

regression analysis of our two scales. The results are both significant ($p < .000$) and moderately strong ($r = .469$). In statistical parlance, a favorable problem definition score “explained” or “accounted for” 22 percent of the variation in general support for reform. A regression coefficient of .237 confirms the expected direction of this relationship: as respondents’ answers to our problem-definition questions move away from the most favorable extreme, their general attitude in support of health care reform also declines.

Figure 9
 Favorable Problem Definition as a Predictor of
 General Support for Reform
 N = 305



Support for health care reform in general is one thing, willingness to back a concrete policy option is another. In fact, the contemporary health policy debate features an array of (sometimes bewildering) proposals giving different emphasis to the roles and

responsibilities of government, employers, insurers, and individuals. A natural follow-up to our finding of a relationship between favorable problem definitions of the health issue and general support for reform is the consideration of problem-definition orientation and its connection to specific policy approaches. Figure 10 presents the response frequencies for seven questions in our survey dealing with contending practical strategies for health reform.

To examine how well problem-definition orientations predict specific health reform policy preferences, a regression analysis was run between Favorable Problem Definition and each of the items in Figure 10. (After excluding “don’t know” responses, the coding scheme for the policy questions ranged 1 to 3.) Figure 11, which presents our findings, reveals an interesting pattern. Two relationships that are positive and significant below the .05 level, and a third that almost makes this standard ($p=.069$), describe policy approaches that emphasize government using its authority either to expand coverage directly or by strong regulatory action vis à vis insurers. A significant *negative* relationship is found between favorable problem definition and the strategy of using individual tax breaks to expand coverage, meaning that as the former increases, support for the latter decreases. And no significant associations are found between problem definition and the policy approaches of an employer mandate, individual mandate, increasing patients’ financial responsibility, or creating financial rewards and penalties for healthy lifestyles and behaviors.

Figure 10
Distribution of Preferences for
Alternative Health Reform Approaches

Policy makers could...	Agree	Neutral	Disagree	DK
Require all businesses over a certain size to offer coverage to employees or pay into a government fund.	75%	7%	13%	5%
Create tax breaks so that people without health insurance would be responsible for purchasing it own their own.	52%	16%	25%	8%
Use existing or new government programs to cover the uninsured.	60%	12%	21%	8%
Increase patients' financial responsibility through larger deductibles and copayments.	20%	14%	60%	6%
Mandate that all uninsured adults must buy health insurance if the cost is affordable.	58%	10%	28%	5%
Set standards for all health insurance plans to ensure comprehensive benefits and limited costs for all patients.	83%	6%	7%	4%
Change the system so that government takes over the functions of private health insurance companies.	29%	13%	51%	8%
Establish stronger financial rewards and penalties for insured individuals depending on whether they adopt healthy lifestyles, including taking advantage of services to prevent illness.	57%	11%	25%	7%

Figure 11
Relationship between Favorable Problem Definition and
Health Reform Policy Preferences

	Regression Analysis Results			
	r	b	p	N
Employer Mandate	.089	.037	.123	299
Tax Breaks	-.172	-.075	.003	298
Use government Programs	.275	.119	.000	298
Increase patients' financial responsibility	-.080	-.030	.169	297
Individual Mandate	.001	.000	.989	297
Set standards for health insurance plans	.106	.034	.069	296
Government takes over private insurance	.139	.061	.017	294
Establish rewards/penalties for individuals	.001	.000	.991	293

Conclusion

In an article published in the journal *Health Affairs*, Blendon, Benson, and DesRoches (2003) examined the policy implications of public opinion polls on health care. Based on ten nationwide surveys conducted between 2002 and 2003, these researchers sought, among other aims, to identify those health reform approaches most likely to receive popular support. Although much ambivalence existed in regard to comprehensive system changes based on either a single-payer model or tax-credit strategy for replacing the employment-based insurance system, Blendon and his colleagues noted high levels of support for providing coverage for the uninsured through expanded public programs, an employer mandate, and tax breaks. "Taken together," they wrote, "these data suggest that Americans are less supportive of major reform—either through government or changing the current workplace insurance system—than they are of

incremental proposals for reducing the number of uninsured Americans” (p. W3-408).

Four years later, in the midst of an energetic discussion of health reform on both national and state levels, our survey of Rhode Island voters confirms strong backing for a host of measures to lower the number of uninsured. The proposals highlighted by Blendon, Benson, and DesRoches have favorable standing in our sample, as does the newer mechanism of an “individual mandate.” Consistent with national data, Rhode Island voters are also uncertain about a wholesale take-over of the private insurance system by government. On the other hand, the public does not approve of health insurers being allowed to undermine the comprehensiveness of health insurance coverage or shift more of the costs of care to the consumer.

Beyond these broad descriptive trends, our analysis has also shown the value of a problem-definition perspective in identifying patterns within the make-up of public opinion on this issue. First, support for health care reform is significantly greater among those who believe in the urgency and morality of addressing this problem, consider it a matter of rights, and perceive that intervention in the contemporary health sector is a necessary government action. Second, these “favorable problem definers” are also more likely to prefer strong government action within the design of reform while disapproving, or being neutral, on strategies focusing on the individual. Interestingly, amid general public ambivalence toward the possibility of a government-run health system, it is this group of favorable problem definers who give significantly more support to this option.

Two important topics for future research are worth mentioning here. One is the relationship between problem-definition orientation and conventional political ideology. Are favorable problem-definers on health reform simply the same people who call for vigorous government policies across a spectrum of policy domains because of their belief in activist government generally? Or, does the problem-definition variable serve to distinguish subgroups *within* the liberal and conservative camps? Second, how susceptible to change are problem definitions on the subject of health policy reform? If past experience is any indicator of what is to come, no major health policy initiative would be adopted without an intense period of debate in

which powerful interests, having impressive resources at their disposal, seek to reshape public perceptions of this issue. For those involved in waging this campaign, the extent to which measurable shifts in problem definition do occur among the mass public will be one important barometer of political success.

References

Baumgartner, Frank R. and Jones, Bryan D. 1993. *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.

Benedetto, Richard. 2006 (February 17). "Health Care Costs Could Loom Large in 2008 Election." *USA Today*.

Blendon, Robert J., Benson, John M, and DesRoches, Catherine M. 2003. "Americans View of the Uninsured: An Era for Hybrid Proposals." *Health Affairs*, Web Exclusive (August): W3-403 - W3-414.

Cobb, Roger W., Elder, Charles D. 1983. *Participation in American Politics: The Dynamics of Agenda Building, 2nd ed.* Baltimore: Johns Hopkins University Press.

Hacker, Jacob. 1997. *The Road to Nowhere: The Genesis of President Clinton's Plan for Health Security*. Princeton: Princeton University Press.

Hackey Robert B. 1997. "Symbolic Politics and Health Care Reform in the 1940s and 1990s." In *Cultural Strategies of Agenda Denial: Avoidance, Attack, and Redefinition*, ed. Roger W. Cobb and Marc Howard Ross. Lawrence: University of Kansas Press.

Kaiser Family Foundation. 2007. Kaiser Health Tracking Poll: Election 2008. Issue 5, December 2007. <http://www.kff.org>.

Kingdon, John. 1995. *Agendas, Alternatives, and Public Policies, 2nd ed.* Boston: Little, Brown.

Marmor, Theodore R. 1994. *Understanding Health Care Reform*. New Haven: Yale University Press.

Marmor, Theodore R., and Boyum, David. 1994. "American Medical Care Reform: Are We Doomed to Fail?" In *Understanding Health Care Reform*, ed. Theodore R. Marmor. New Haven: Yale University Press.

Rhode Island Office of Health Insurance Commissioner. 2007. An Analysis of Rhode Island's Uninsured: Trends, Demographics, and Regional and National Comparisons. Providence, September 9.

Rocheftort, David A., and Cobb, Roger W. 1993. "Problem Definition, Agenda Access, and Policy Choice." *Policy Studies Journal* 21 (Spring): 56-71.

Rocheftort, David A., and Pezza, Paul. 1991. "Public Opinion and Health Policy." In *Health Politics and Policy*, ed. Theodor J. Litman and Leonard S. Robins. New York: Delmar.

Schattschneider, E. E. 1960. *The Semisovereign People: A Realist's View of Democracy in America*. Hinsdale, IL: Dryden Press.

Skocpol, Theda. 1997. *Boomerang: Health Care Reform and the Turn Against Government*. New York: W.W. Norton & Company.

Stone, Deborah. 1997. *Policy Paradox: The Art of Political Decision Making*. New York: Norton.

Weissert, Carol S. and William G. Weissert. 2002. *Governing Health: The Politics of Health Policy, 2nd ed.* Baltimore: The Johns Hopkins University Press.