Oregon Health Decisions

Health Values Survey 2004

Health Values Survey 2004

Report Authors

Michael Garland
Project Coordinator
Oregon Health Decisions

and

James Oliver
Biostatistics Intern
Oregon MPH Program
Oregon Health & Science University

November 2004

Survey conducted for Oregon Health Decisions by
Market Decisions Corporation, Portland, Oregon
Funding provided by the Office for Oregon Health Policy and Research
Data gathered for the Oregon Health Policy Commission

Oregon Health Decisions
7451 SW Coho Ct. # 101
Tualatin OR 97062

Table of Contents

Executive Summary

The *Health Values Survey 2004* explores public attitudes about health care in general and about several potential strategies for the Oregon Health Plan. Oregon Health Decisions directed the survey with funding from the Office of Oregon Health Policy and Research. The goal of the survey is to provide data to the Oregon Health Policy Commission to complement information developed through its series of Community Meetings held in the fall of 2004. Market Decisions Corporation of Portland conducted the survey using a random sample of 531 Oregonians in the period between September 14th and 28th 2004. Several items were repeated from two earlier surveys* produced by Oregon Health Decisions in 1996 and 2000 to uncover trends in public opinion on these issues. Eight major themes showed up in the survey data.

Access and costs are chief concerns of the public.
Top of the mind responses and prompted questions revealed that access for all Oregonians and affordable care are major concerns for Oregon citizens. The patterns in 2004 are consistent with the findings in 1996 and 2000.

Basic care for all continues to be a widely distributed, intensely held social goal.
All three surveys found a widely distributed and intensely held value for guaranteeing access for all to basic and routine care.

Access for all, "Yes." But some financial participation is expected.
Oregonians expressed a preference for policy options that include personal contribution on a sliding scale by persons who would benefit from guaranteed access to care. A preference was also expressed for higher contributions from persons with "unhealthy lifestyles." These preferences are consistent with findings in the previous surveys.

Having people stay uninsured, relying on emergency room care with cost shifting, is not an acceptable policy.
When questioned about strategies for dealing with the problem of securing health care for persons without health insurance, Oregonians do not regard the current status quo of relying on emergency room care an acceptable solution. A variety of options involving the use of tax-based programs, employment-based insurance, sliding-scale premiums, and buy-in options to public programs received majority approval.

Infants and small children should be given highest priority among age groups.
When asked to indicate which age groups in the population should be given priority when resources are limited, Oregonians identified infants and children up to age 6 as the favored group. This response is consistent with findings in the previous surveys

* For a copy of these survey reports contact Oregon Health Decisions at (503) 692-0894.

Preventive and primary care are regarded as top priority for health service guarantees.
Giving highest priority to preventive and primary care services when resources are constrained was a widely distributed and intensely held opinion. This question was not asked in the previous surveys.

Keep people enrolled and cut services when fiscal pressures require new limits.
Oregonians broadly and intensely prefer this core principle of the Oregon Health Plan compared to the practice of reducing enrollment to save money. The response is consistent over all three surveys

Cost and effectiveness of services, aid to sicker persons, and keeping health problems from getting worse won approval as guides for trade-offs.
When considering policy options affecting the Oregon Health Plan and help for uninsured persons, Oregonians favor several approaches compatible with the guiding principles of the Oregon Health Plan's prioritized list.

Survey Data

Background

Market Decisions Corporation of Portland conducted the survey for Oregon Health Decisions between September 14th and 26th, 2004. Several items in the survey were repeated from previous surveys conducted in 1996 and 2000.

Objectives

- Identify the public's major concerns about health care in Oregon
- Determine the distribution and intensity of opinions about the relative importance of several key features of Oregon's health care system
- Elicit public opinion about priorities among groups of persons and categories of health services when funding requires limits on access.
- Identify public values about access for all to health care
- Identify public preferences for policy options affecting the Oregon Health Plan
- Identify public preferences for financing access to health care for persons who do not have health insurance.

Methodology

The survey was conducted via telephone using a random sample of 531 Oregonians. The survey was conducted in Spanish for those respondents who preferred to listen and respond in Spanish. The sample had an overall consistency with the U.S. Census (American Community Survey Profile, 2003). Approximately 85% had a high school diploma or higher; 59% were married; 85% were white and 8% were Hispanic; 33% had income below $25,000; 60% of the respondents were over age 45 (compared to 50% in the Census data); and the mean household size was 3.91 (compared to 2.47 in the Census data).

Limitations

The data in this survey have limitations. However, they are modest and cumulatively cannot explain the huge differences found in some of the survey responses. For example, if we had the ability to perform a survey without limitations, we would still find that an overwhelming majority of respondents believe that affordable health care is extremely important.

- ***Sample size***
  The sample was 531 people. When compared to the 2000 survey, this sample size is adequate to detect differences between proportions of at least .0573. For example, if 77.54 % thought affordable insurance was extremely important in

2000 and in 2004 83.27% thought affordable insurance was extremely important, we would expect that the survey has ample power to detect this difference if it truly exists. Similarly, surveying 531 people provides extremely high power to detect differences of .10 or greater when comparing the 2004 HVS to the 2000 HVS. Providing ample power to detect differences as small as .03 would require a surveying 2069 people.

- ***Selection bias***
  This is a telephone survey. People without telephone service, people whose telephones do not accept randomly dialed calls, people who are not home when called, and people who refuse to take part in the survey are not included. Since it is not known if this group of people differs from people who participated, it is possible that some selection bias occurred. The selection process was intended to produce a sample representative of all Oregonians. In fact, the sample was demographically very similar to the entire Oregon population according to 2003 US Census data, which argues strongly against selection bias.
- ***Sampling error***
  The 2004 survey has a maximum sampling error of $\pm$ 4.3%. This means that if we find 52% of respondents believe that affordable insurance is extremely important and 48% do not, there is essentially no difference here since this result falls within the maximum sampling error. The sampling error is highest when responses are close to 50% and is lower when responses move farther above or below 50% (75% or 25% will have a smaller sampling error; 85% or 15% will have an even smaller sampling error). Thus, if 93.9% agree that employed Oregonians without health care insurance should have access to health care with sliding scale payment, we can be very confident that the vast majority of Oregonians would also agree with the proposition.
- ***Insurance status***
  Inconsistency in two survey questions about insurance status resulted in 23 invalid responses (4.4%). It is not known if these were simply due to data entry errors, if respondents intentionally provided these conflicting answers, or if respondents misunderstood one or more questions. Because of this, it is not known if data on insurance status accurately reflects the insurance status of all Oregonians. Those without health insurance represent between 11.5% and 16.7% of respondents depending on the interpretation of the data.

Summary and Conclusions

Access and costs are chief concerns of the public. The survey began with a top-of-the-mind question to see what people, without prompting, would identify when asked, "In general, when you think about health care in Oregon, what do you think is the number one problem that needs to be solved?" Problems of cost and access figured in 70.2% of the responses, with 21.5% saying that "lack of access for all" was the number one problem. This is a consistent pattern with the surveys in 1996 and 2000 where both of these concerns were at the top of the list. However, this year there was a marked increase in the number of times respondents indicated that lack of access for all was the number one problem on their minds.

Affordable care continues to be seen as an extremely important focus for health policy efforts. When asked to rate on a 10-point scale the importance of several aspects of health care, 79% of respondents used a "10" to rate "affordable health care for you and your family." In the two previous surveys this item also received high importance ratings with 63% (2000) and 67% (1996) of respondents giving it a score of 10.

Basic care for all continues to be a widely distributed, intensely held social goal. When asked to indicate whether they agree or disagree with the proposition that "All Oregonians should be guaranteed *basic and routine* health care services," a strong majority (64%) said they "agree strongly" and an additional 21% said they "agree somewhat." This overwhelming majority of 85% agreeing with the proposition is consistent with previous surveys where overall agreement levels were 92% (2000) and 87% (1996). It should be noted that a companion proposition, "All Oregonians should be guaranteed *any needed* care," drew considerably less agreement in all three surveys. The "agree strongly" levels were ten or more percentage points lower when the proposed guarantee was seen as unlimited.

Access for all, "Yes." But some financial participation is expected. Several modes of contribution from those receiving benefits were probed in all three surveys. Concepts of sliding scale or shared contributions were positively viewed. The idea of requiring higher contributions from persons with unhealthy lifestyles received widespread approval. Respondents disapproved in strong majorities with strategies that involved no financial contribution from those receiving benefits.

Having people stay uninsured, relying on emergency room care with cost shifting is not an acceptable policy. In all three surveys, respondents resoundingly rejected the proposal to formally endorse the status quo. The respondents were asked to consider the following proposal. "Have these people (the uninsured) go without health insurance. They would probably use the emergency room for health care with the cost offset by those who can afford to pay for health care." The "disagree" responses showed a strong majority in all three surveys. In previous surveys, we did not distinguish between opinions about this strategy when applied to employed vs. unemployed persons, but did

so in the 2004 survey. A small difference showed up but did not alter the rejection of this practice as a matter of policy.

Infants and small children were given the highest priority. The order of priority is consistent between 2000 and 2004. (The question was asked in a different form in 1996 so we leave it out of the comparison.) We asked people to indicate why they selected their first priority group to elicit the values implicit in the choice. The focus on infants and young children related to values of prevention, the dependency of this group, and the wisdom of helping them get off to a "good start."

Preventive and primary care are regarded as the top priority. The preference for giving highest priority to preventive and primary care services was extremely clear. We asked this question for the first time in the 2004 survey so there is no comparison available with the two prior surveys. The strong result in favor of preventive and primary care is compatible with several previous community meeting programs that Oregon Health Decisions has conducted since its inception in 1983.

Keep people enrolled and cut services when necessary. Respondents were strongly in agreement with the underlying strategy of the Oregon Health Plan to deal with limits by keeping people enrolled in care while cutting back on covered services. Firm commitment to this core principle of the Oregon Health Plan is evident in both the 2000 and 2004 surveys. (The question was not asked in 1996). The tradeoff was probed in two forms: "When money is limited for the Oregon Health Plan, leaders should reduce services but keep as many people as possible in the program;" and "When money is limited for the Oregon Health Plan, leaders should keep the full set of services and reduce the number of people in the program." Cutting services rather than people was the preferred strategy by a wide margin across (71% in 2000 and 77% in 2004). The reverse proposition, to cut people and keep all services covered, was rejected by similar margins (72% disagreed in 2000 and 66% disagreed in 2004).

Cost and effectiveness of services, aid to sicker persons, and keeping health problems from getting worse won approval as guides for trade-offs. There is a consistent agreement over the three surveys with the proposition that "The decision about what health care services to guarantee should be based on cost and effectiveness of the treatment." In 2004, 72% agreed, compared to 73% in 2000 and 71% in 1996.
Other potential tradeoffs were probed in 2000 and 2004. A majority of respondents in both surveys rejected the proposal to cover promising experimental procedures (63% in 2004 and 52 % in 2000). Majorities agreed with the idea of treating sicker persons first (59% in 2004 and 65% in 2000). The idea of giving priority to health problems that might develop into more serious problems drew strong approval in both years (75% in 2004, 65% in 2000). This last opinion is consistent with the preference expressed elsewhere to give priority to preventive and routine health care services.

Detailed findings

1. Top-of-Mind Issues

The first substantive question on the interview asked respondents to give their own, unprompted opinion about the number one problem facing health care in Oregon. The text of the question as asked in 1996, 2000, and 2004 is given below.

Q1 In general, when you think about health care in Oregon, what do you think is the number <u>one</u> problem that needs to be solved? (SINGLE MENTION; CLARIFY)

Table 1: Categories of Named Problems in 2004

	Frequency of mention	Percent of respondents
Access for all	114	21.5%
Cost of health care	83	15.6%
Affordable Insurance	67	12.6%
Don't know	53	9.9%
Cost of prescriptions	32	6.1%
Access for the poor	30	5.7%
Problems with OHP	20	3.8%
Access for children	10	1.9%
Access for the elderly	9	1.9%
Working uninsured	9	1.7%
Access to doctors	8	1.5%
Quality of care	6	1.1%
Limited rural access	5	1.0%
Limited benefits	4	0.7%
Preventive care	4	0.7%
Hassles getting health care	4	0.7%
Negative HMO	4	0.7%
Miscellaneous	54	10.0%
Refused	14	2.6%
Total	531	100.0%

Table 2: Categories of problems identified in 1996, 2000, and 2004

Frequency	1996	2000	2004
Highest	Cost of Health Care	Cost of Health Care	Access for all
Second	Affordable Insurance	Affordable Insurance	Cost of Health Care
Third	Access for all	Cost of Prescriptions	Affordable Insurance

Comment on Policy Implications

Oregonians have had an enduring perception over the period of these surveys that the costs of health care and access to care are continuing problems. When all the spontaneously named problems that refer to various distinct *cost factors* are combined, this was a major concern for one third to one half of the respondents in the surveys (41% in 1996; 52% in 2000; and 34% in 2004). Similarly, when all the spontaneously named problems that point to various distinct *access factors* are combined, the issue shows up as a vivid concern of respondents (39% in 1996; 49% in 2000; and 37% in 2004).

These top-of-the-mind problems were brought up with reference to the health care system generally. The focus is not restricted to the Oregon Health Plan or the issue of persons lacking health insurance. Public policies that offer success against the problems of cost and access in the health care system will likely require sacrifice and inconvenience for many Oregonians (choice, personal financial responsibility, taxes). It will, therefore, be useful for policy makers to show the connections between new policy directions and these enduring perceptions of health system problems. The public will likely respond favorably and be more willing to accept sacrifice or inconvenience if policy efforts offer hope of success on these two problem areas simultaneously. Conversely, if Oregonians perceive that policy efforts improve only one of these problems while exacerbating the other, they are likely to respond negatively.

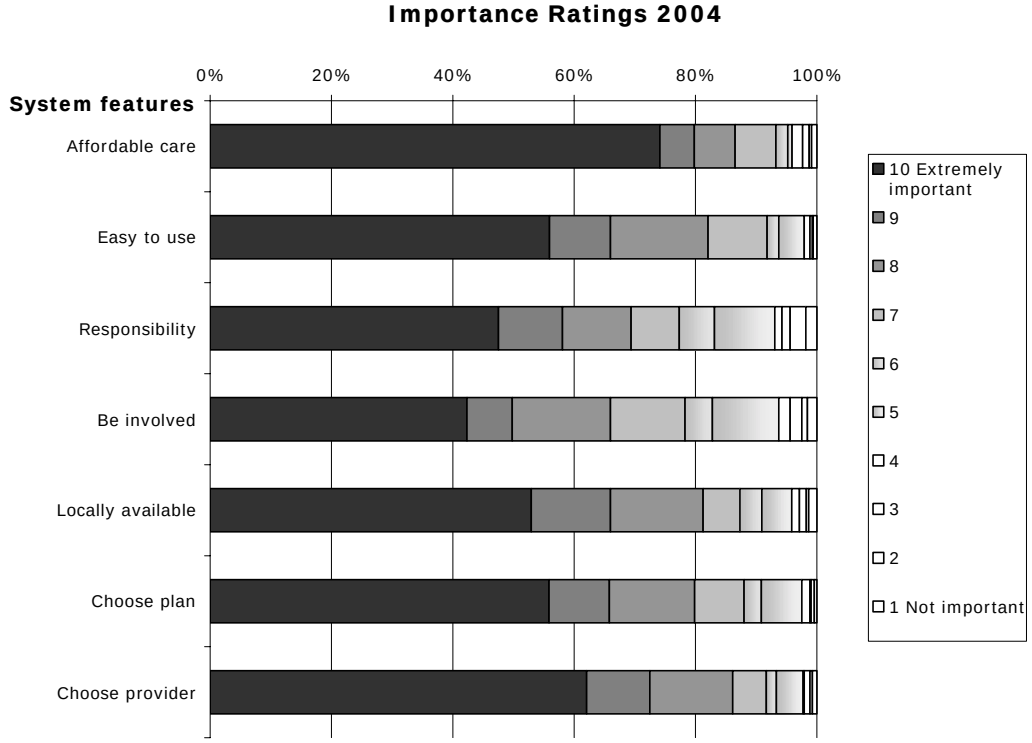
2. Comparative Importance of Various Features of Health Care

After soliciting unprompted ideas about major problems in the health care system, the survey asked respondents to rate seven features of health care on a ten-point scale to develop data about how important they considered these features to be for them personally. The text of the question is given below.

Q2 Now I'm going to read you a list of things about health care that may or may not be important to you. After I read each one, please rate it on a ten-point scale, where 1 is "not at all important", all the way up to 10, which is "extremely important". Let's start with ... (ROTATE)

A. Affordable health care for you and your family
B. A health care system that is easy to use
C. Persons taking personal responsibility for their own health care
D. Ability for people like you to be involved in decisions about improving the health care system
E. The availability of routine health care services without having to travel outside of your local community
F. Being able to choose your own health care plan
G. Being able to choose your primary care provider and specialists

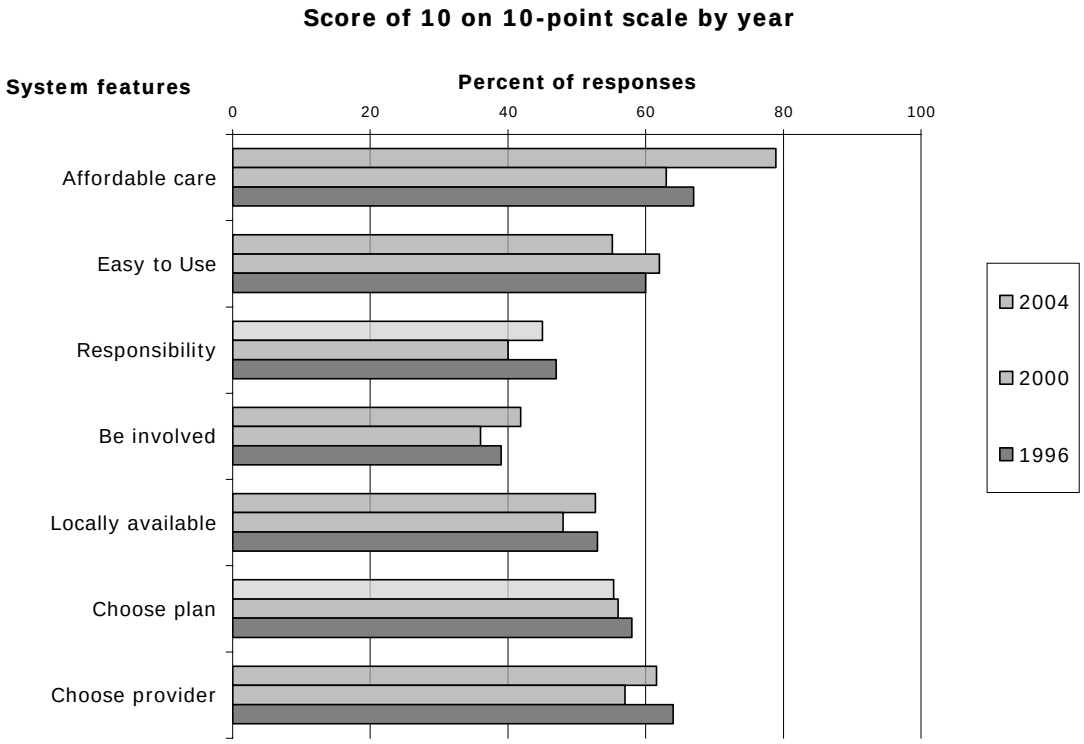
Figure 1: Ratings on 10-point scale of the importance to respondents of various features of the health care system



Comparison with previous years

Respondents in the two previous surveys were asked to rate all seven of the features used in the 2004 survey. Several additional items focused on quality and satisfaction were probed in previous years. For illustrative purposes Chart 2 shows the percent of respondents in each survey who gave the rating of "10" (extremely important) to the seven features.

Chart 2: Comparison of Importance Ratings in all Three Surveys



Comment on Policy Implications

Many Oregonians spontaneously cite cost of care as the number one problem in health care. In the latest survey, four out of five Oregonians rate that problem as extremely important. In all three surveys "affordable care" was consistently rated extremely important by large majorities of respondents. In the earlier surveys several quality of care features ("patients trusting their health care providers; having technically competent health care providers") were rated extremely high by similarly large majorities. These quality of care features were not studied in the 2004 survey, but on the assumption that similar patterns would have been seen, it is reasonable to conclude that policies aimed at cost control are likely to win public support, particularly if they can show that they include precautions to maintain various quality of care features while reducing costs and improving affordability.

3. Priority Judgments

Two sets of questions asked people to give their judgments about the problem of guiding public policy on the basis of priorities either for groups of persons or for categories of health services.

A. Priority among age groups

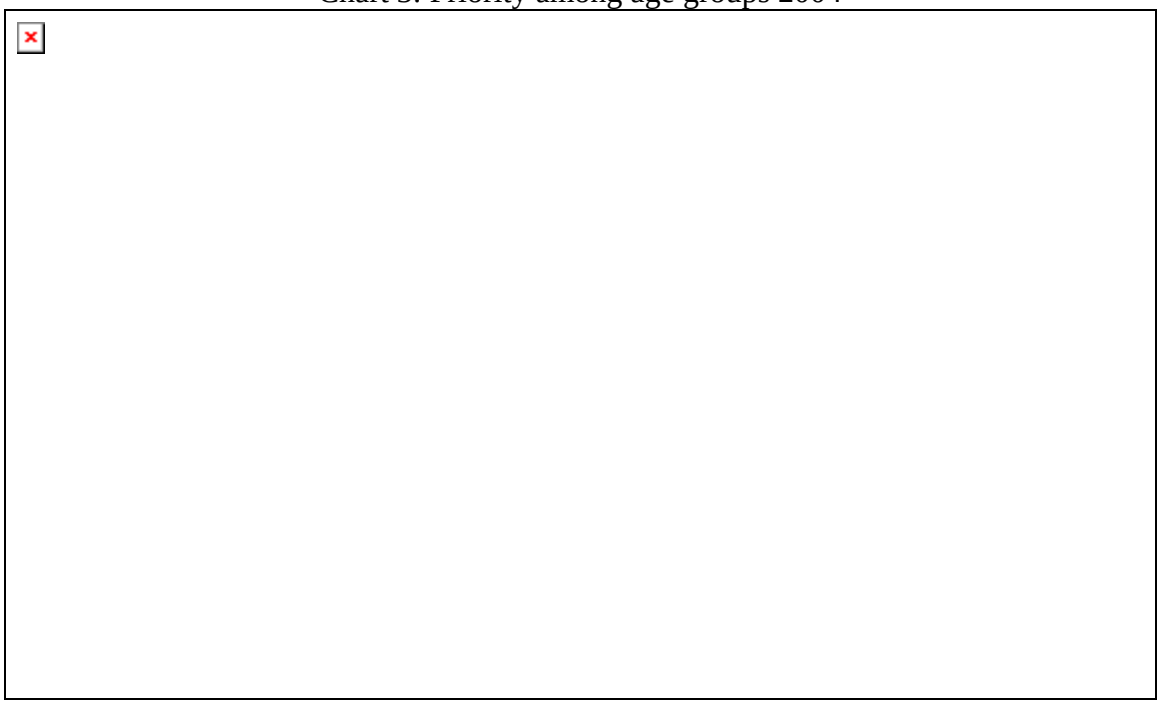
This question was asked in all three surveys, though in a different frame for infants and children. The text of the question asked in 2004 is given below.

Q3 **If health care dollars are limited and it is impossible for all Oregonians to have coverage, we'd like to know which types of people should be at the front of the line when it comes to dividing up health care dollars for all Oregonians. I'm going to read you a list of five different groups of people. (ROTATE ORDER OF LIST. READ ENTIRE LIST, THEN, CONTINUE WITH THE QUESTION.) If we can't afford to provide health care coverage to everyone, please tell me which group you think should be first priority? Second priority? Third priority? Fourth priority?**

A. Infants and small children up to 6 years old
B. Children age 7 to 17
C. Adults age 18 to 64
D. Adults age 65 and older
E. Pregnant women

Q4 And why do you think (INSERT TOP PRIORITY GROUP) should be the first in line if health care dollars are limited? (PROBE AND CLARIFY)

Chart 3: Priority among age groups 2004



Values underlying priorities

Comparisons among 1996, 2000, and 2004 responses
In the previous surveys first priority was consistently given to infants and small children and last priority was consistently given to adults aged 18 to 64. Respondents cited several values to explain giving the first priority to infants and small children: dependence, vulnerability, and the importance of prevention and getting off to a good start in life.

Comment on Health Policy Implications
Policy innovations that secure access for infants and children to appropriate preventive and supportive health care can anticipate public support. More than 10% of the respondents declined to respond to this request to set priorities among age groups. The high frequency of top-of-the-mind naming of "access for all" as the number one problem in Oregon's health care suggests that these results about priority among age groups ought to be regarded cautiously when contemplating new policy directions.

B. Priority among health services

This question was a new addition to the survey in 2004. The text of the question follows.

Q5 **Again, assuming that health care dollars are limited and it is impossible to cover all types of health services, we'd like to know which kinds of services you think are the most important to include in coverage for all Oregonians. I am going to read a list of 8 kinds of health services that I would like you to rank in order of importance from "1" which is most important to least important which is "8". Let me read the whole list once and then I will repeat and you can tell me the order. (ROTATE ORDER OF LIST.)**

A. Preventive and primary care services (such as immunizations, cancer screening tests, and regular checkups)
B. Hospital services
C. Care for chronic health problems (such as diabetes or high blood pressure)
D. Dental services
E. Prescription drug coverage
F. Vision care
G. Mental health services
H. Substance abuse treatment

Refuse to rank order

(ASK Q5Q IF Q5A = "REFUSE TO RANK ORDER")

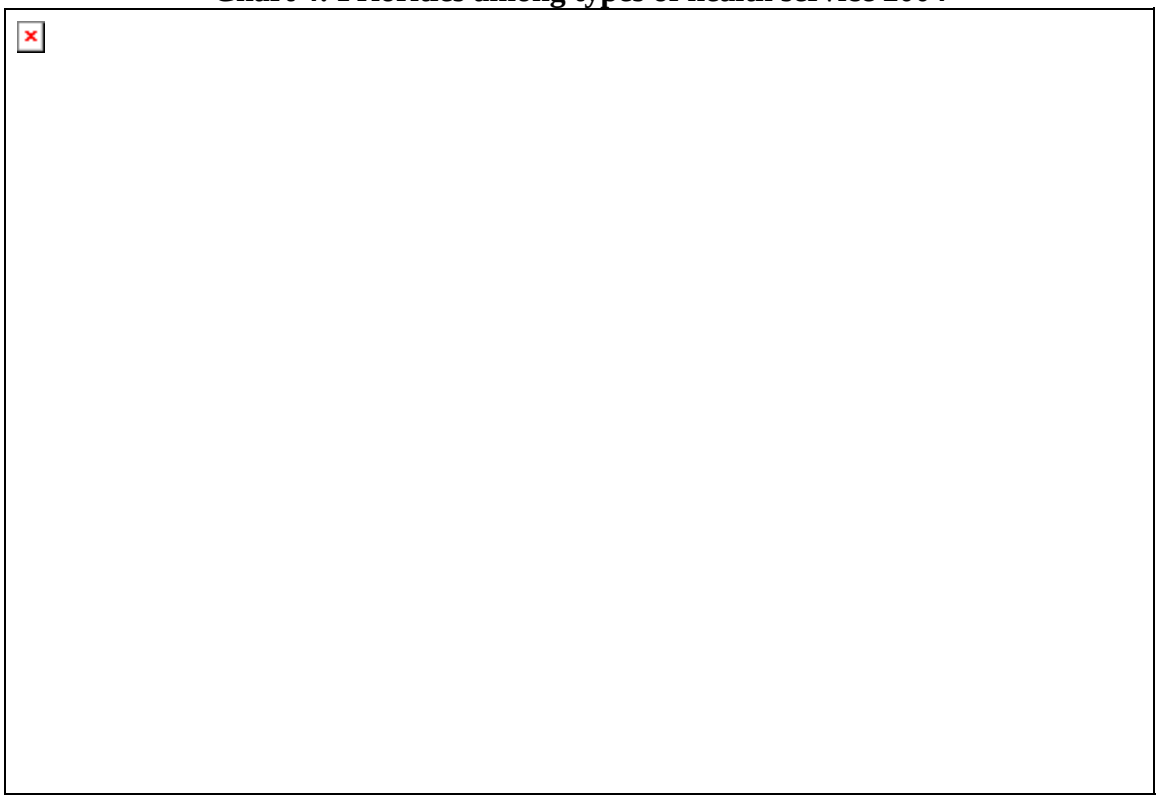
Q5Q I understand it can be difficult to prioritize these things, which one would you say it is most important to allocate funds to?

Q5X **Which of these services is it least important to include in coverage for all Oregonians?**
Repeat list from above.

Q6 **And why do you think (INSERT TOP PRIORITY SERVICE) should be a high priority service for all Oregonians to have when health care dollars are limited? (PROBE AND CLARIFY)**

Q7 **And why do you think (INSERT LOWEST PRIORITY SERVICE) should be a low priority service for all Oregonians to have when health care dollars are limited? (PROBE AND CLARIFY)**

Chart 4: Priorities among types of health service 2004



Values underlying high priority judgments

Respondents overwhelmingly identified preventive and primary care as the highest priority service. Other categories received a top priority rating from some of the respondents. An examination of the values identified in response to the follow-up question reveals that people are attracted to prevention because they see it as a pragmatic way to keep costs down while improving individual and social wellbeing. They see fiscal prudence and efficiency as reasons to give priority to prevention. Other responses attach these same values to hospital care for acute health events, mental health services, chronic disease services, and addiction treatment. Respondents identified several other values in this inquiry into their priority judgments.

- Information about one's own health is reassuring and empowering (e.g., screening test results).

- Services are important that treat individuals for problems that lead to other social problems if untreated (e.g., getting prescriptions, mental health, chronic diseases).

- Services are important when they benefit a large portion of population.

- Health services are important when they save life and show compassion for those with severe acute and chronic problems.

- Seeking equity at a basic level shows solidarity with those facing expenses beyond their means and fulfills a responsibility members of society have toward each other.

- Health services are important when they improve economic productivity, societal wellbeing.

Values (negative) underlying lowest priority judgments.

When people gave reasons for the services they gave lowest priority to, they frequently and vigorously pointed to the idea of personal responsibility for one's own health. Because treatment for substance abuse was most often identified for lowest priority, respondents expressed the belief that this is a self-inflicted problem and people have to take responsibility for what they have done to themselves and take charge of their lives. Remarkably harsh attitudes toward addicts were expressed frequently. Addicts were said to be outside the zone of social solidarity--people with that problem do not deserve assistance. Other services that tended to be selected for lowest priority were Dental Care, Vision Care, Mental Health Care, and Prescription Drug Coverage. Respondents appealed to a variety of values to explain why these services were not as important as ones they placed higher (e.g., preventive care, hospital care, chronic disease care).

- Services are less important if they are not essential to a normal functioning life or not focused on a real health problem.

- Less expensive services do not require social financing mechanisms (like insurance and government programs).

- Lower level need (not life-threatening, not a widespread health problem, one that doesn't impact society broadly) does not merit social financing.

- Voluntary programs offered by civic and faith -based organizations are better social strategies for providing assistance for lesser health problems.

- Services that have low effectiveness do not merit social financing.

- Social financing of lesser needs produces wasteful use of limited resources (overuse of prescription drugs and other ineffective services).

- Society (historically) regards certain services as something people should pay for on their own (eyeglasses, prescriptions).

- A service is less important if people with the particular problem do not contribute to society.

Comment on Policy Implications
The positive values identified with the upper end of the priority for services recommendations from respondents are remarkably similar to values reported by Oregon Health Decisions from the community meeting process integral to the development of the prioritized list of health services by the Oregon Health Services Commission (*Health Care in Common*[*]*).* The negative values associated with the lower end of the priority recommendations echo a concern for personal responsibility found in the 1989 list. Because this survey's prioritizations of age groups and services blend judgments of facts and values, they need to be used cautiously in developing policy innovations. Expert opinions are more reliable in matters of fact and probability. Still, the general public is the reservoir of community values, and these opinions are useful indicators of what might be anticipated as the public response (positive or negative) to new policies that involve either age group priorities or a new configuration of health service priorities.

4. Opinions about access and limits

The question was asked in all three surveys with a slight modification in 2004 (one statement was dropped from the list: "those who can afford health care should pay more to help off-set the cost of those who cannot afford to pay).

Q8 **Now I'd like to read some general statements about health care and find out whether you agree or disagree with each one. Let's start with (ROTATE LIST), do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree?**

A. All Oregonians should be guaranteed basic and routine health care services
B. Persons with unhealthy life-styles should pay more for health care coverage
C. The decision about what health care services to guarantee should be based on cost and effectiveness of the treatment
D. All Oregonians should be guaranteed any needed health care services

[*] Published 1989. Available from Oregon Health Decisions, (503) 692-0894.

Chart 5: Opinions about Guaranteeing Access to Care and Setting Limits

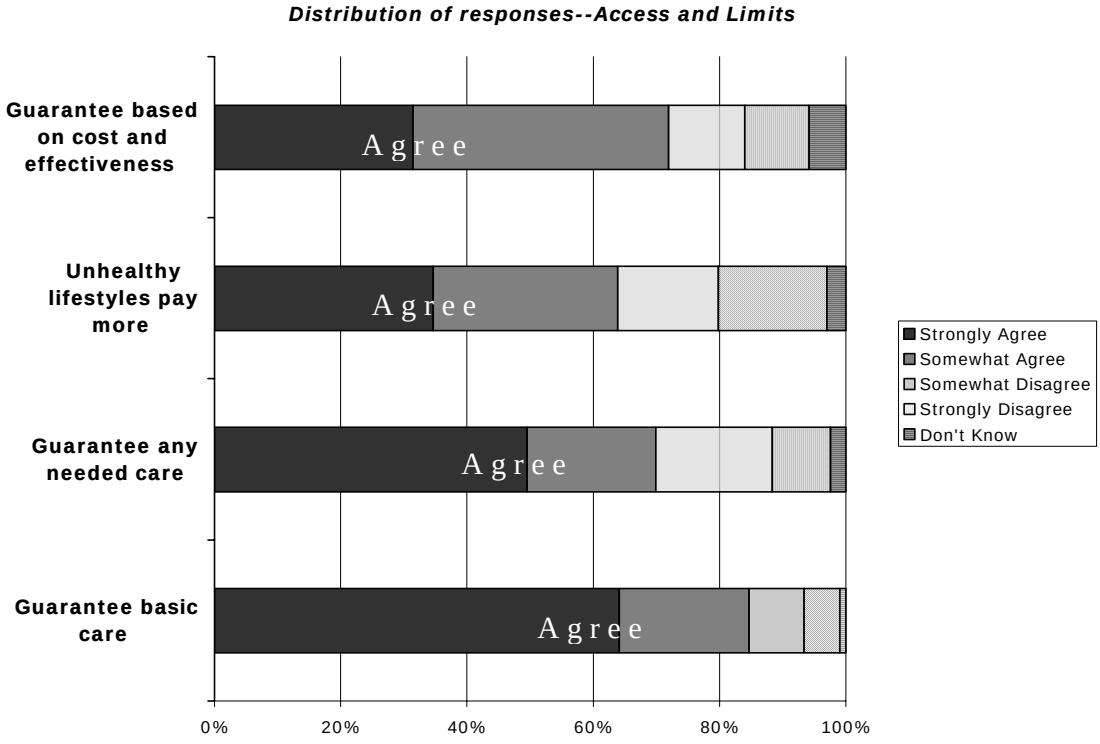


Chart 6: Guaranteed Access to <u>Basic and Routine</u> Care
Responses in 1996, 2000, and 2004

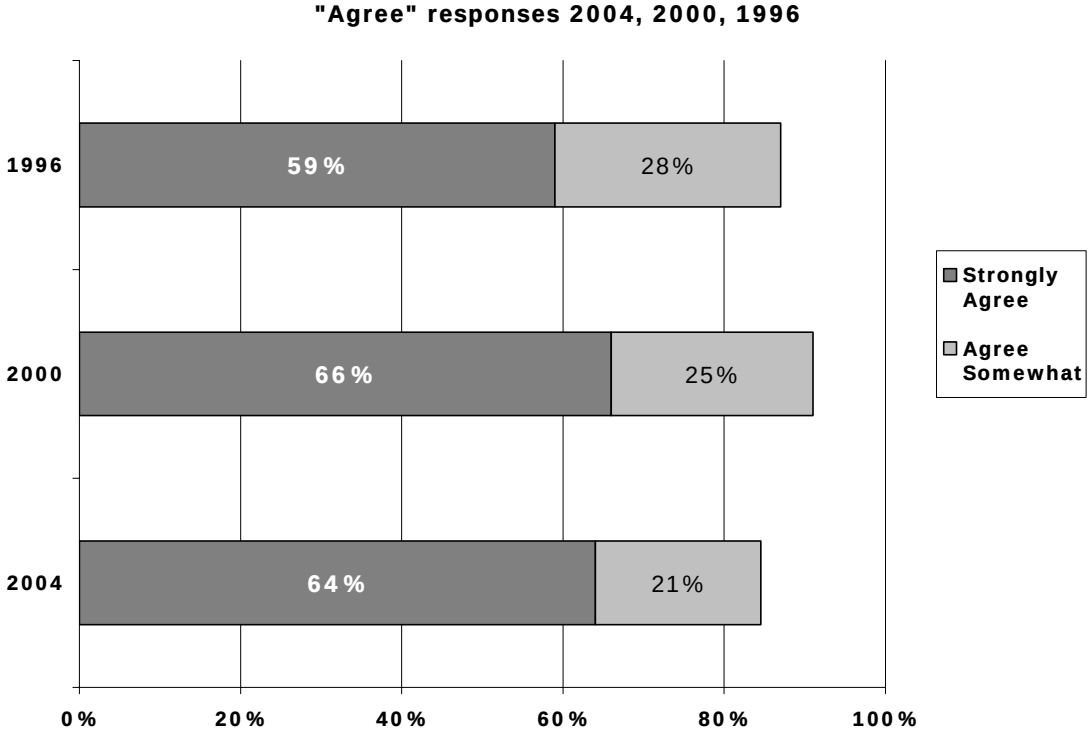
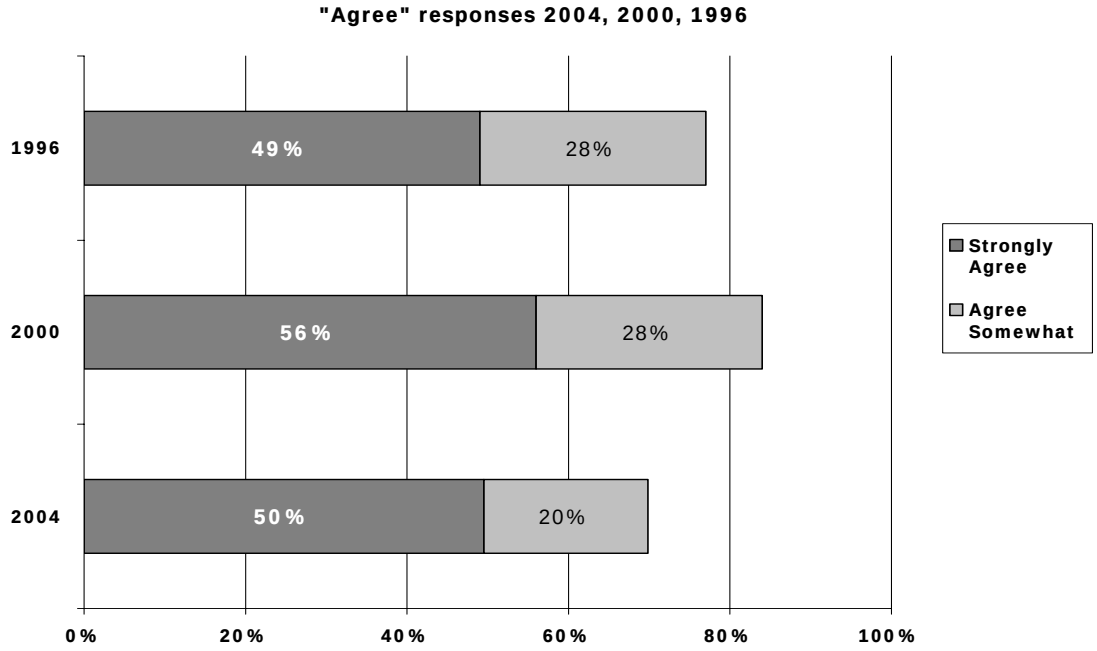


Chart 7: Guaranteed Access to <u>Any Needed</u> Care
Responses in 1996, 2000, and 2004



Comment on Policy Implications
These data show an enduring, widespread, and intensely held commitment to the social ideal of guaranteed access for all Oregonians to health care. They also show that the public distinguishes between "basic care" and "any needed care" when thinking about the question of what ought to be guaranteed. The previously noted data on the public's concern about costs and affordability indicate that policy innovations that work at both costs and access simultaneously have the best chance of being received favorably by Oregonians. Other data from this survey on methods of financing for expanded access suggest that Oregonians look to familiar mechanisms of social financing for health care (employment-based insurance, employer contribution to premium costs, and tax-supported public programs). Oregonians also expect some form of cost sharing to be part of new policy directions that seek to extend coverage to currently uninsured persons (see data on uninsured persons shown below).

5. Oregon Health Plan strategies

This question was asked in the same form in 2000 and 2004. It was not asked in 1996. The questions probe the extent to which Oregonians' values are in line with several basic principles of the Oregon Health Plan. The issue of a trade-off between eligibility and services was explored in two formulations. The text of the question follows.

Q9 **Now I'd like to read some statements that concern the "Oregon Health Plan." This is the government program for persons whose income falls below the Federal Poverty Level, or slightly above it. I want to find out whether you agree or disagree with each one. Let's start with (ROTATE LIST), do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree?**

A. The Oregon Health Plan should pay for experimental treatments that seem promising even though they have not been proven to be effective

B. When money is limited for the Oregon Health Plan, leaders should reduce services but keep as many people as possible in the program

C. When money is limited for the Oregon Health Plan, leaders should keep the full set of services and reduce the number of people in the program

D. The Oregon Health Plan should pay for services provided to the sickest individuals first. Those with mild forms of treatable conditions may not have treatments paid for

E. The Oregon Health Plan should pay for treatments for health problems that are likely to progress to a serious and potentially life-threatening condition first. Effective treatments for conditions that are not likely to become serious or life-threatening may not be paid for.

Chart 8: Policy Options and the Oregon Health Plan—responses in 2004

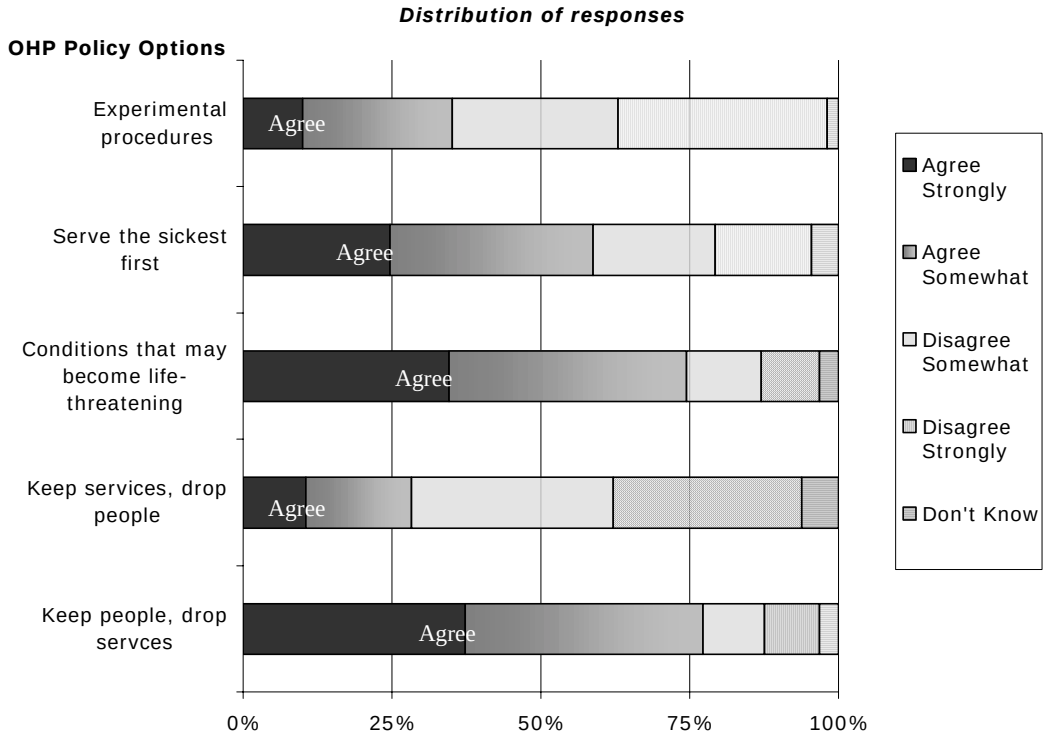
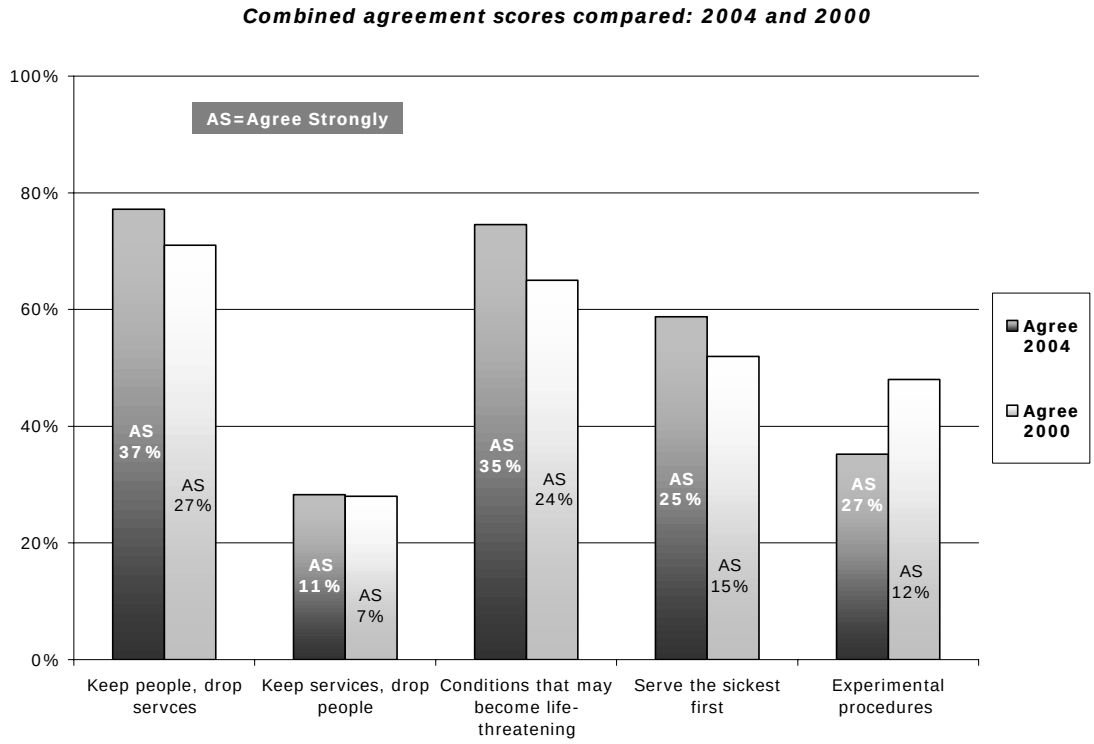


Chart 9: Oregon Health Plan Policy Options – Comparisons 2000 and 2004



Comment on Policy Implications.

Oregonians continue to embrace the central principle of the Oregon Health Plan to make budget trade-offs by reducing services rather than enrollment. Current OHP policy requires a reduction in enrollment as an emergency response to budget shortfalls. Policy-makers are at odds with the values of the public regarding trade-off decisions. This situation creates a challenge for policy makers to communicate effectively with the public in order to maintain public support for the OHP or to develop support for a successor model for the Oregon Medicaid program.

6. Strategies for financing care for uninsured persons

The text of the question was revised for 2004 to distinguish between strategies for *employed* and *unemployed* persons who do not have health insurance.

Q10 At present, more than 400,000 Oregonians are uninsured for health care. Two thirds of these people are employed or are the dependents of workers. One third of these people are unemployed. I'd like to know how you think coverage for uninsured individuals who are ***NOT* EMPLOYED should be paid for. I'm going to read you a list of options, Let's start with … (ROTATE LIST). Do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree with this option?**

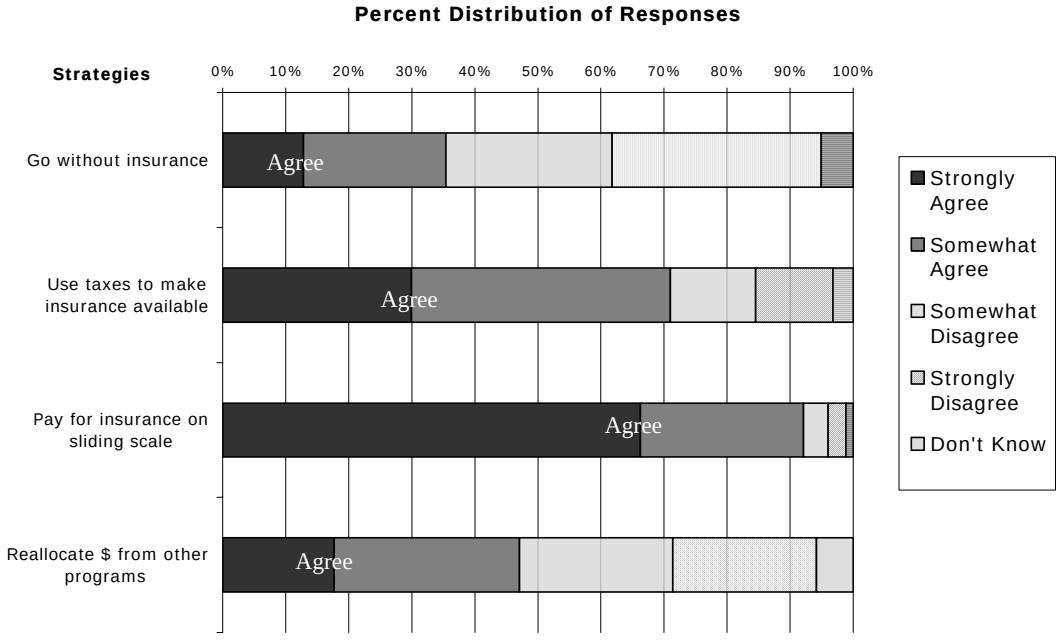
A. Have these people go without health insurance. They would probably use the emergency room for health care with the cost offset by those who can afford to pay for health care

B. Using taxes to fund programs that make health insurance available to uninsured persons.

C. Having individuals contribute to the cost of insurance based on their ability to pay

D. Government leaders taking money from other public programs to pay for expanded health care programs

Chart 10: Strategies for Unemployed Persons Who Have no Health Insurance



Q11 **Now I'd like you to think about those working Oregonians who do not have health insurance available to them through work. I'd like to know how you think coverage for uninsured individuals who *ARE* EMPLOYED should be paid for. . I'm going to read you a list of options, Let's start with … (ROTATE LIST). Do you strongly disagree, somewhat disagree, somewhat agree, or strongly agree with this option?**

A. Have these people go without health insurance. They would probably use the emergency room for health care with the cost offset by those who can afford to pay for health care

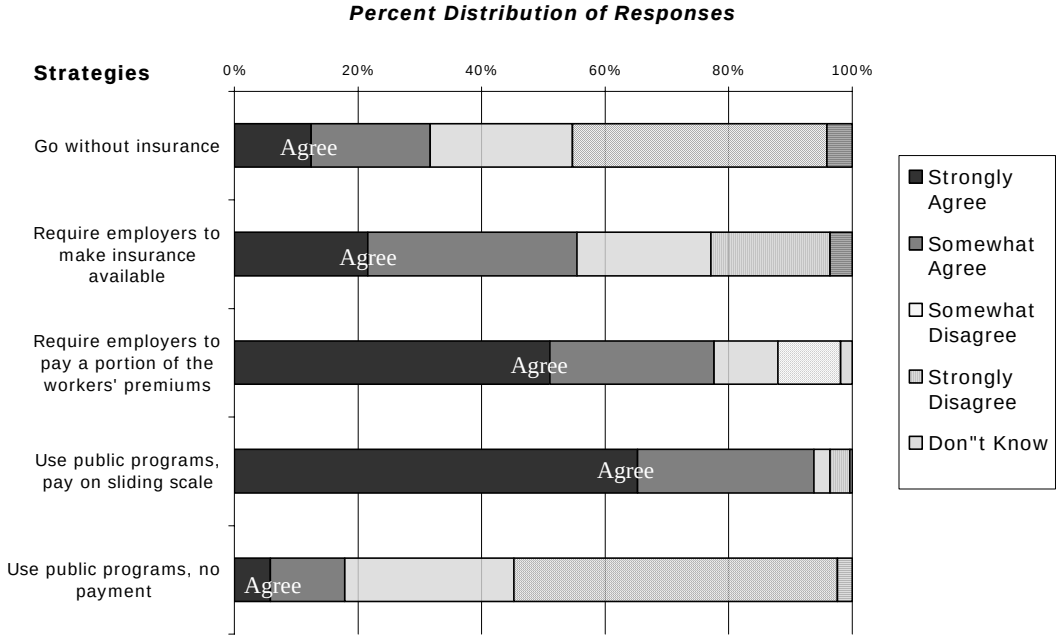
B. Require employers to make health insurance available to their employees, but do not require employers to pay for the coverage

C. Require employers to make health insurance available to their employees and require employers to pay for at least a portion of the coverage

D. Allow working Oregonians without health insurance to use public health care plans, such as Medicare or the Oregon Health Plan, but require them to pay for part of the cost, based upon their income

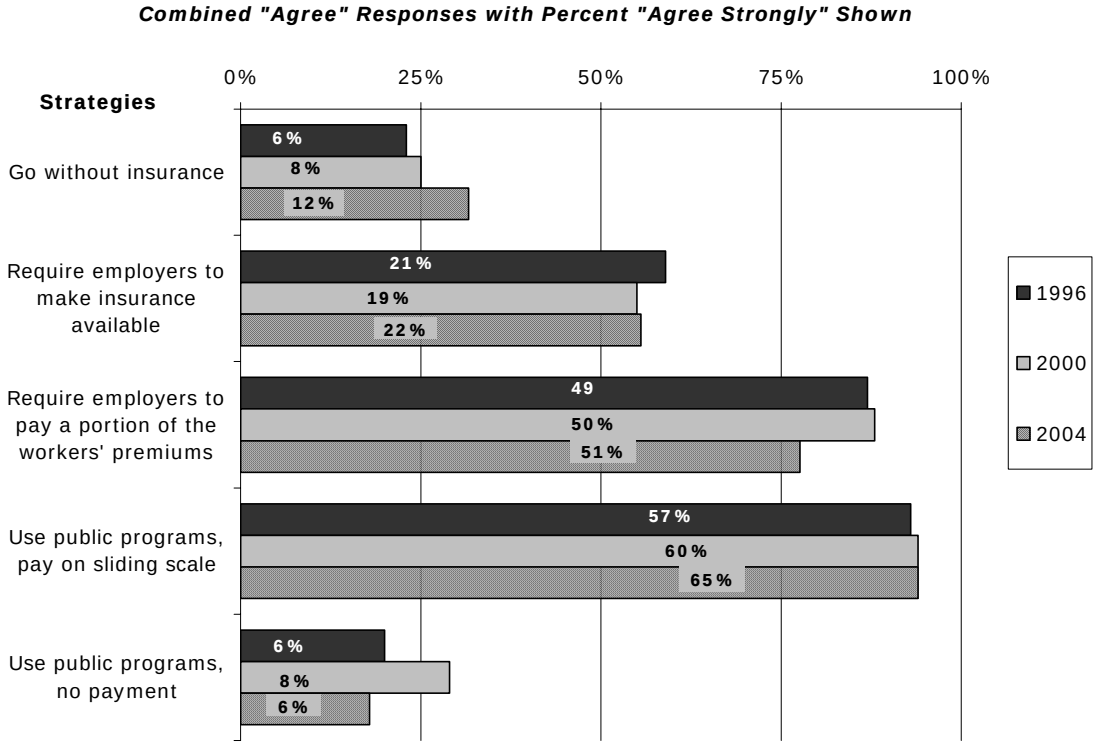
E. Allow working Oregonians without health insurance to use public health care plans, such as Medicare or the Oregon Health Plan without any personal contribution to the cost

Chart 11: Strategies for Employed Persons Who Have No Health Insurance



Comparisons among 1996, 2000, and 2004 responses
All three surveys asked the same questions about strategies to help employed persons who are uninsured get coverage. The response data are nearly identical across all three surveys.

Chart 12: Strategies to Help Uninsured Workers get Coverage—1996, 2000, 2004



Comment on Policy Implications

These responses indicate that the public rejects a strategy to embrace the current state of affairs in which persons without health insurance avoid seeking care unless an emergency arises. This judgment is consistent with the opinions about access and affordability expressed elsewhere in the survey responses. Positive preferences cluster around strategies that include participation in the costs of coverage, whether these involve being able to buy in to public programs or purchase private health insurance. Consistent across all three surveys is a strong preference for employer and employee sharing the cost of insurance coverage. Policy innovations in line with these opinions will lead away from the reliance on emergency room care as a safety net, will build on existing employer based health care models, will create buy-in models to expand public programs, and will involve sliding-scale cost sharing by persons benefiting from expanded access.

7. Demographic Profile of Survey Sample

The composition of the sample is presented in the following tables along with Oregon Census data (column labeled "OR percent")

Gender

	Frequency	Percent	OR Percent
Male	253	47.6%	49.3%
Female	278	52.4%	50.7%

Age groups

	Frequency	Percent	OR Percent
18-19	4	0.8%	**----**
20-24	20	3.7%	9.1%
25-34	88	16.5%	18.8%
35-44	100	18.8%	19.1%
45-54	118	22.2%	20.1%
55-59	53	10.0%	7.5%
60-64	40	7.6%	6.0%
65+	109	20.4%	16.4%

Regions of the State (for sampling quotas)

Regions	Frequency	Percent
1. Clackamas, Multnomah, Washington	225	42%
2. Clatsop, Columbia, Tillamook	16	3%
3. Marion, Polk, Yamhill	65	12%
4. Benton, Lane, Lincoln, Linn	87	16%
5. Coos, Curry, Douglas, Jackson, Josephine	70	13%
6. Gilliam, Hood River, Sherman, Wasco, Wheeler	8	1%
7. Crook, Deschutes, Jefferson	24	4%
8. Klamath, Lake	11	2%
9. Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, Wallowa	27	5%

Urban/Rural

(Based on Rural Health Program zip code designations)

	Frequency	Percent
Rural	242	46%
Urban	289	54%

Race/ethnicity

	Frequency	Percent	OR Percent
American Indian or Alaska Native	9	1.7%	0.9%
Asian	8	1.5%	3.2%
Black or African American	5	0.9%	1.5%
White	453	85.4%	82.2%
Hispanic	43	8.1%	9.2%
Other	6	1.2%	2.9%
Refused	7	1.2%	---

Marital status

	Frequency	Percent	OR Percent
Married	313	58.8%	54.2%
Widowed	49	9.3%	6.2%
Divorced	60	11.9%	12.1%
Separated	13	2.4%	2.2%
Never married/single	93	17.5%	25.3%
Refused	3	0.5%	------

Number of children

	Frequency	Percent
0	322	60.7%
1	72	13.6%
2	77	14.5%
3	34	6.3%
4	15	2.7%
5	4	0.7%
6	2	0.3%
Refused	7	1.2%

Household size

	Frequency	Percent
1	110	20.6%
2	188	35.4%
3	76	14.4%
4	87	16.4%
5	32	6.1%
6	19	3.5%
7	6	1.1%
8	5	0.9%
11	1	0.2%
Refused	7	1.2%

Health Insurance Status

	Frequency	Percent	Valid percent
No	68	12.8%	13.4%
Yes	440	82.8%	86.6%
Invalid*	23	4.4%	
Total	531	100%	100%

* Respondents said they had insurance but changed answer at verification question.

Annual Household income

	Frequency	Percent	OR Percent
Less than $10,000	54	10.2%	9.3%
$10,000-24,999	120	22.6%	21.6%
$25,000-34,999	67	12.7%	12.4%
$35,000-44,999	52	9.9%	----
$45,000-49,999	48	9.1%	----
$50,000-74,999	65	12.3%	19.8%
$75,000-99,999	47	8.8%	9.3%
$100,000 or more	35	6.7%	11.0%
Refused	41	7.8%	----

Education

	Frequency	Percent	OR Percent
Not a high school graduate	81	15.2%	12.3%
High school graduate	92	17.3%	27.3%
Some college (less than Bachelor)	191	35.9%	33.7%
College degree (Bachelor or higher)	166	31.3%	26.4%
Refused	2	0.3%	----

Voting in recent elections

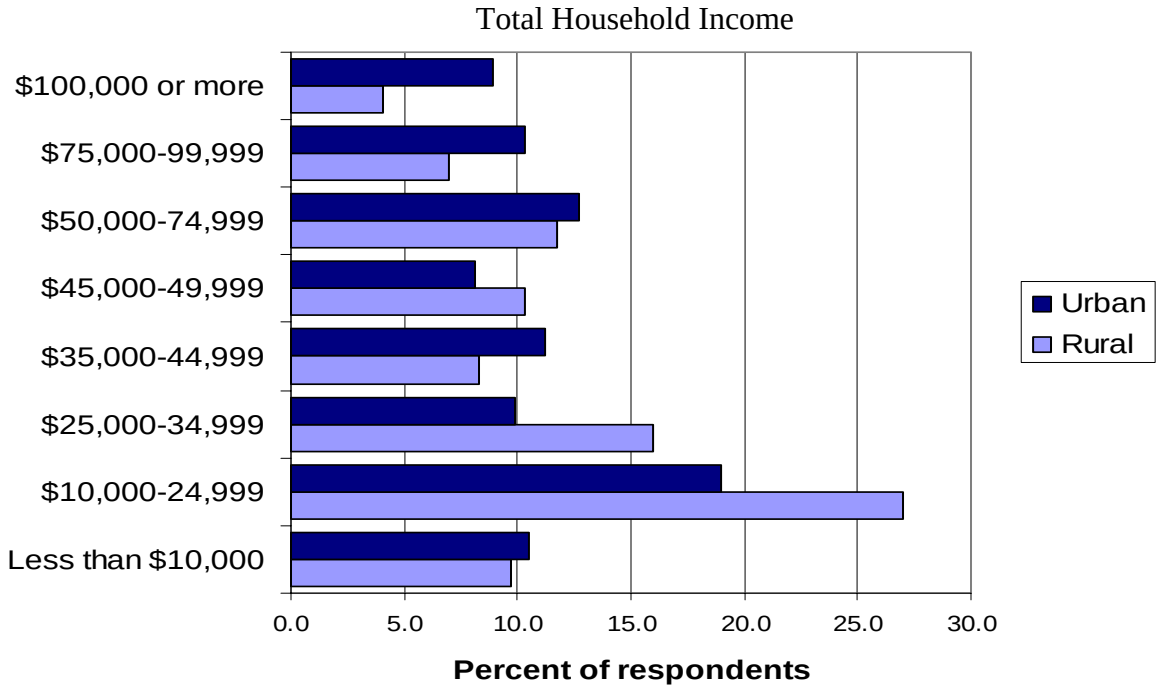
	Voted in Last General Election	Voted in Bush vs. Gore Presidential Election
Yes	70.8%	75%
No	28.8%	25%

Appendix: Comparisons of Urban and Rural Responses

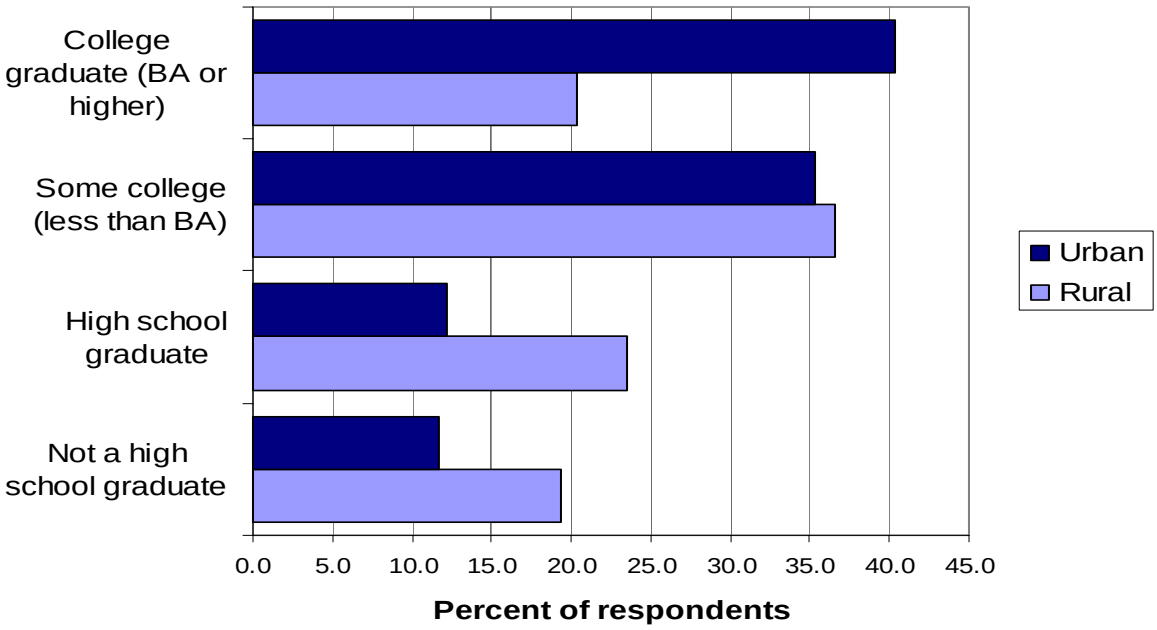
Urban total	**289**
Rural total	**242**

We do find some modest difference in the distributions of household income. There are more striking differences by education. Otherwise, the two groups are surprisingly similar demographically. Differences are small and the vast majority fall within the sampling error. Intuitively, if one includes income and education in a logistic regression analysis, one has also addressed urban and rural differences. If either education or income is found to be an important predictor of any specific survey variable, then differences between urban and rural communities will likewise become important.

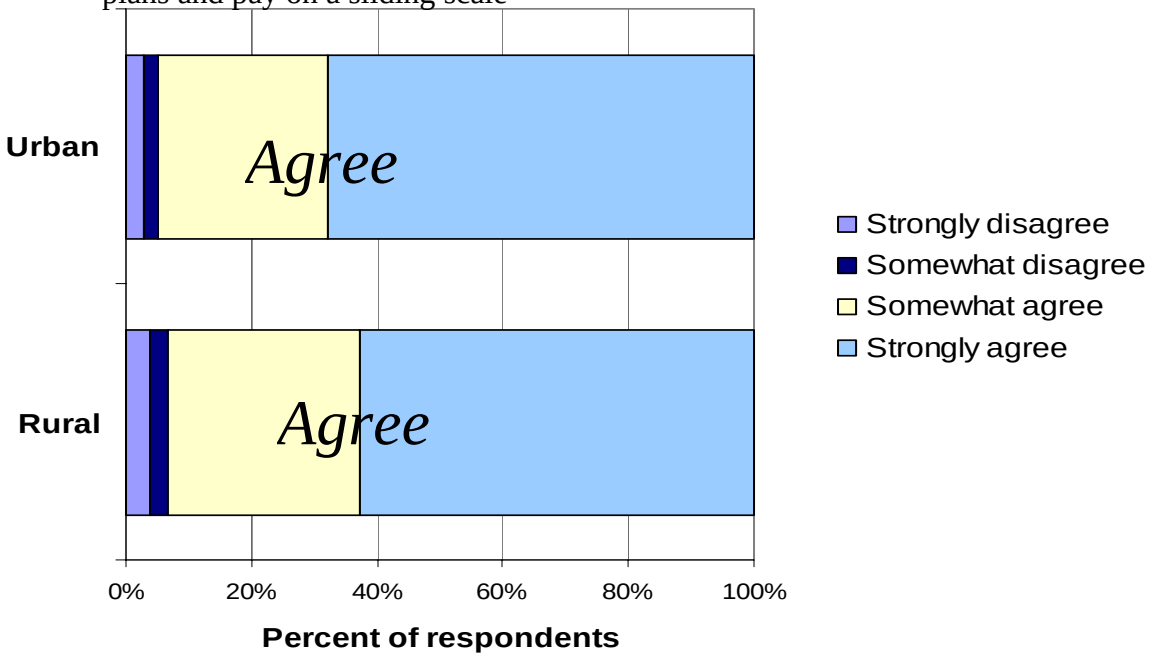
Any real or perceived differences between urban and rural respondents are not reflected in the survey. In fact, responses to the questions seem to have very modest differences when comparing urban to rural. Again, these differences tend to fall within the range of sampling error. What is even more striking is the degree of similarity in responses when comparing urban and rural participants. For example, there is practically no difference in the overall agreement and disagreement to the two statements about allowing working Oregonians to use public health care plans.

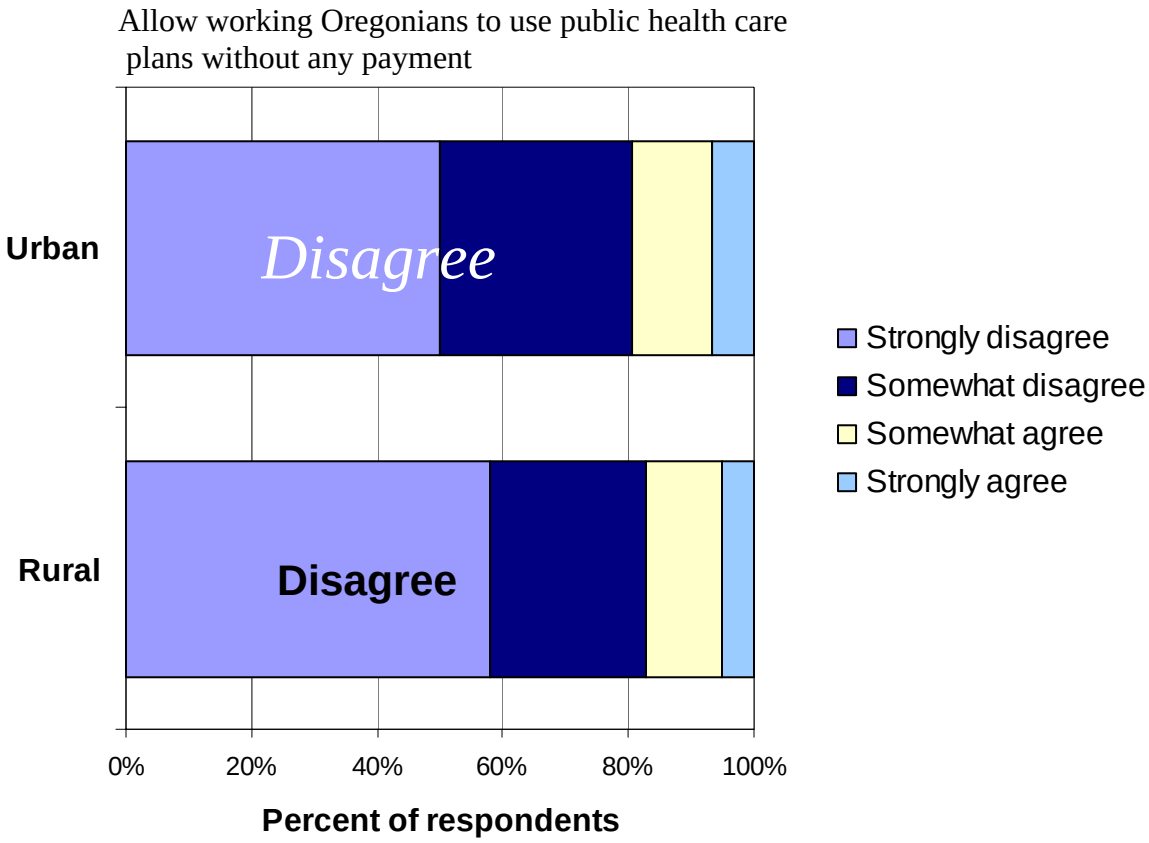


Education



Allow working Oregonians to use public health care plans and pay on a sliding scale




Allow working Oregonians to use public health care plans without any payment
Urban
Rural
Disagree
Disagree
0%
20%
40%
60%
80%
100%
Percent of respondents
Strongly disagree
Somewhat disagree
Somewhat agree
Strongly agree