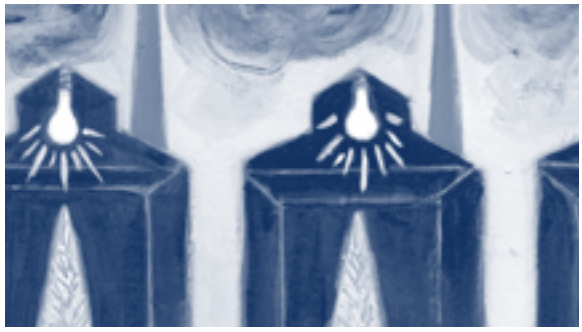

Using Public Engagement to Inform the Future of Health Care in Maine:

Talking About "Tough Choices"

by Ronald E. Beard

Tish Tanski

The biennial state health plan mandated by Maine's innovative Dirigo Health Reform Act guides how the state makes decisions about using its health care resources. Public engagement in the development of this plan was made an explicit goal. This article by Ron Beard and Tish Tanski and the commentary that follows by Wendy Wolf discuss how nearly 400 Maine citizens were involved in a virtual town meeting in May 2005 that provided input on the state's health plan. The collective voice of citizens involved in this forum has proven to be an important input in the ongoing efforts of policymakers to devise a responsive health care system, a system that will enable us to achieve the lofty goal of making Maine the "healthiest state in the nation."

MeHAF

Sponsored, in part, by the *Maine Health Access Foundation*, an organization committed to promoting affordable and timely access to comprehensive, quality health care, and to improving the health of every Maine resident.

Access to comprehensive, high-quality, affordable health care is a significant issue for people in Maine as well as the rest of the nation. Policy leaders and health care experts are grappling with the many challenges posed by our nation's market-based health care system. Health care costs consume a growing percentage of our gross domestic product, yet the health status of U.S. residents ranks 24th among countries in the world—just behind the tiny island of Cyprus (World Health Organization 2000: 176).

In Maine, the scenario is similar. Between 1980 and 2000, average health care costs in Maine rose 9.4% annually (Kaiser Family Foundation 2000). Employers, the traditional source of coverage for a significant majority of those under age 65, increasingly are canceling insurance coverage or shifting costs to their workers (Edwards et al. 2002; O'Hara and Pohlmann 2005). As a result, it is becoming more difficult for many individuals and families to get timely, high-quality health care.

Although every state currently is struggling with these issues, Maine has forged a national reputation for leadership in developing innovative solutions to health care problems. In 2000, the Maine legislature adopted a strategy to reduce prescription drug costs through the Maine Rx program, which allows Maine government to negotiate prescription drug prices with manufacturers. In 2003 a newer version, Maine Rx Plus, was enacted.[1] Also in 2003, the legislature passed a bill entitled "An Act to Provide Affordable Health Insurance to Small Businesses and Individuals and to Control Health Care Costs" (H.P. 1187 - L.D. 1611). This legislation created Dirigo Health, a broad reform effort intended to increase access to health care and health care quality while containing cost for the state's 1.3 million residents.[2] The Dirigo Health Reform Act has put Maine in the forefront of states crafting innovative health policy strategies, and the nation is watching how this plan unfolds.

DIRIGO'S STATE HEALTH PLAN

The 2003 Dirigo Health Reform Act legislation is comprehensive reform that simultaneously focuses on creating more affordable health insurance coverage and on controlling costs and improving quality. The legislation also mandated the creation of a biennial state health plan to guide how Maine makes decisions about how we use our health care system and resources. This state health plan "must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on statewide cost, quality and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care and promote the development of the health care workforce" (2 MRSA c. 5, Sec. B-1, §103).

The state health plan must satisfy requirements spelled out in the legislation. (See sidebar.) Specifically, the plan must be used in determining the amount in the capital investment fund, which determines the level of resources allocated annually for building major new health care facilities and for purchasing capital equipment that is approved under the state's Certificate of Need Program. The state health plan also will inform the lending decisions related to health care issues of the Maine Health and Higher Education Facilities Authority, an entity that provides eligible non-profit colleges, universities and licensed health care facilities access to capital markets by issuing low-cost, tax-exempt bonds and lending the proceeds to finance or to refinance the acquisition, construction, and renovation of facilities.

STATE HEALTH PLAN REQUIEMENTS

A. Assess health care cost, quality and access in the state;

B. Develop benchmarks to measure cost, quality and access goals, and report on progress toward meeting those goals;

C. Establish and set annual priorities among health care cost, quality and access goals;

D. Prioritize the capital investment needs of the health care system in the state within the capital investment fund, established under section 102;

E. Outline strategies to:

(1) Promote health systems change;
(2) Address the factors influencing health care cost increases; and
(3) Address the major threats to public health and safety in the state, including, but not limited to, lung disease, diabetes, cancer and heart disease; and

F. Provide recommendations to help purchasers and providers make decisions that improve public health and build an affordable, high-quality health care system.

STATE HEALTH PLAN INPUT

Legislation mandates that the following bodies provide input to the governor in developing the state's biennial health plan:

Advisory Council on Health Systems Development: The 11-member advisory council, appointed by the governor, with approval of the legislature's Joint Standing Committee on Health and Human Services, is charged with collecting and coordinating data on the development of health systems in the state, synthesizing relevant research, and conducting at least two public hearings on the plan and the capital investment fund each biennium. Membership composition strives to ensure representation from individuals with a wide range of expertise, including health care delivery, long-term care, mental health, public health care financing, private health care financing, health care quality, and public health; there also are two representatives of consumers and one from the Bureau of Health. The governor is required to seek nominations for appointment from the public, from statewide associations representing hospitals, physicians, and consumers, and from individuals and organizations with expertise in health care delivery systems, health care financing, health care quality, and public health.

Maine Quality Forum (MQF): The Maine Quality Forum is part of Dirigo Health and is governed by the Dirigo Health Board of Directors. It is charged with collecting, reporting, and disseminating research; promoting best practices; collecting and publishing comparative quality data; promoting electronic technology; promoting healthy lifestyles; reporting to consumers and the legislature; and making recommendations for the state health plan.

Maine Quality Forum Advisory Council: The 17-member council, appointed by the governor, with approval of the legislature's Joint Standing Committee on Health and Human Services, provides expertise in health care quality to assist the MQF. It convenes a group of health care providers to provide input and advice, makes recommendations regarding quality assurance and quality improvement priorities for inclusion in the state health plan, and serves as a liaison with other organizations working in health care quality. The required membership compo-sition strives for broad representation, and includes seven provider members, four consumer representatives, four employer representatives, one from a private health plan, and one representative of the MaineCare program. The governor is required to seek nominations to the MQF Advisory Council from the public and from an array of statewide organizations representing a wide range of constituencies.

Certificates of need, or any other public financing that affects health care costs, may not be approved or provided by the state unless organizations demonstrate that the plans for new facilities or major equipment complement and advance the goals and budgets explicitly outlined in the plan.

The legislation directs the governor to seek input in developing the state health plan from, at a minimum, the Advisory Council on Health Systems Development, the Maine Quality Forum, and the Maine Quality Forum Advisory Council (all bodies that were created by the legislation; from a statewide health performance council) and from other agencies and organizations. (See sidebar.)

2004 State Health Plan

Because the Dirigo Health Reform Act became effective midway through a biennium, the structures

and funding were not yet in place for developing the required two-year state health plan in 2004. The Advisory Council on Health Systems Development and the Governor's Office of Health Policy and Finance therefore prepared a one-year transitional plan. Five components in the planning process for the first biennial state health plan were specified in this interim 2004 plan (Governor's Office of Health Policy and Finance 2004: 8). These were

- Establish a baseline of credible, regionalized data on cost, quality, access and health status;
- Gather input through three regional workgroups to engage all stakeholders to examine data, set regional goals and benchmarks;
- Design and execute a statewide public engagement strategy called "Tough Choices" to determine the public's priorities for health and health care;
- Establish statewide health expenditure targets; and
- Gather a state-level synthesis of regional and state health plans.

Public Engagement

Officials in the Governor's Office of Health Policy and Finance were concerned that a key set of stakeholders—everyday Maine people—would not have sufficient opportunity through the formal mechanisms required by the new law or through traditional hearings and public forums to provide input on how Maine's health care system should be in the future. In fact, the Governor's Office of Health Policy and Finance noted that "data can provide baselines and identify choices…but public engagement is required to set priorities that reflect Maine's values and can be embraced and sustained by Maine people. Similarly, goal-setting requires the involvement of all key players and open discussion of how progress toward meeting goals will be determined" (2004: 45).

Public engagement in the development process for the health plan was therefore made an explicit goal in the 2004 one-year transitional plan. Officials in the Governor's Office on Health Policy and Finance wanted to go beyond conventional focus groups or surveys, which typically capture the opinions of individuals and interest groups. To really reach out to Maine people, the advisory council and officials from the Governor's Office of Health Policy and Finance researched newer methods that focused on informed dialogue that encouraged open interchange of ideas and opinions.

Public engagement in the development process for the [biennial] health plan was…made an explicit goal in the 2004 one-year transitional plan.

A literature search and interviews with policymakers and practitioners pointed to several possible public-engagement strategies to accomplish this goal.[3] After an extensive review process, the Governor's Office of Health Policy and Finance, with guidance from the Advisory Council on Health Systems Development, selected the AmericaSpeaks "21st Century Town Meeting™" model because of its use of "deliberative democracy." This method had the potential of engaging a significant number of lay people in informed discussion and priority setting. The deliberative democracy model requires that a large number of people work collaboratively to understand the issues, engage in lively and informed dialogue, learn from each other, and come to understand differences in perspective. One additional feature of the "21st Century Town Meeting" was the ability to include participants from across the state through simultaneous linked videoconference. (See sidebar on page 28.)

In addition to the "Tough Choices" town meeting process, Maine people had a number of additional venues for input and participation in developing the state health plan, including the following:

- All meetings of the Advisory Council on Health Systems Development are open to the public and include time set aside for public comments.
- The Governor's Office of Health Policy and

AmericaSpeaks
21st CENTURY TOWN MEETING[4]

AmericaSpeaks has conducted more than 40 "21st Century Town Meetings" across the United States. It also has facilitated public discussion on the redevelopment of the World Trade Center site and on the future of Social Security.

The AmericaSpeaks process involves

- Engaged decision making by ensuring that the public is part of the process and that the public's input targets decisions that can be influenced;
- Diverse participation by setting demographic targets;
- Informed participation through the use of discussion guides that provide detailed background information;
- Facilitated discussion through the use of experienced facilitators at each table;
- Keypad polling, which lets each participant vote on questions and see the result of the voting instantly on a large display screen;
- Networked computers that serve as electronic flipcharts for recording ideas during the discussion;
- A "theme team," a trained group of people who identify ideas and priorities as they emerge from the discussions;
- Preliminary report summarizing the primary outcomes and given to participants at the end of the day.

Finance published a "data book" with regional-level information on health status, access, and costs, which was disseminated in print and on-line (Governor's Office of Health Policy and Finance 2005). Key findings from this report were presented at a series of public forums, called the "Health Care Listening Tour," held throughout the state during September 2005. The intent of the listening tour was to get further input from citizens about improving health and health care in Maine. The Advisory Council on Health Systems Development, along with representatives from the Governor's Office of Health Policy and Finance, participated in these sessions, which were held in Brewer, Presque Isle, Calais, Lewiston, Augusta, Portland, and Saco.

- Finally, with the release of the draft state health in November 2005, the GOPHF held formal public hearings to receive additional public comments.

"TOUGH CHOICES": METHOD AND PROCESS

Working with a planning team and the Advisory Council on Health Systems Development, the Governor's Office of Health Policy and Finance planned a "21st Century Town Meeting," which was scheduled as a three-site event (Brewer, Augusta, and South Portland) for March 12, 2005, with 1,000 to 1,200 projected participants. Unfortunately, on the eve of the event, a major snowstorm caused the "Tough Choices" meeting to be canceled. The process was rescheduled for May, but fiscal and facility limitations necessitated reconfiguring the event to be held at two sites (Orono and Biddeford), with close to 400 participants.

To ensure that "Tough Choices" would draw on the informed voices of Maine people, the AmericaSpeaks town meeting process involved recruiting a representative sample of Maine residents based on invitations to a random sample of Mainers, developing a participant discussion guide, recruiting and training facilitators and other volunteers, and developing the sites to be linked electronically. Funding for the project came from private philanthropic sources.[5]

Participant Recruitment and Demographic Characteristics

In the AmericaSpeaks model, recruitment efforts typically involve community leaders and others working through networks to achieve a demographically representative participant group. This model was modified at the request of officials in the Governor's Office of Health Policy and Finance; in a unique approach, Maine participants were recruited through a survey method designed to generate a demographically representative group from all across the state.

Planning team members designed a multi-step recruitment process. First, the planning team purchased a list of Maine addresses based on telephone directory listings from a national, reputable survey research firm. From this list, a random sample of 25,000 households was developed. The sample households received a communication from the governor explaining the town meeting process, along with a questionnaire. Interested participants returned the completed questionnaire, and provided basic demographic information on age, sex, ethnicity, education, and income, along with information on health care coverage (if any), and occupational category.

Next, the team matched key demographic characteristics to state benchmarks. Those meeting the demographic criteria received an invitation from the governor and program materials. Once the demographically representative group was recruited, other interested respondents were sent a letter from the governor explaining they were not selected at this time and inviting them to provide feedback in other ways.

As is the case nationwide, some groups, such as young adults, were more difficult to engage than others. The team used additional recruitment strategies to find more participants for categories that did not meet their targets, including mailings to additional randomly selected people, and repeat mailings to the existing candidate pool. These strategies, however, were not as successful as the team had hoped in reaching young people, particularly 18–24 year olds. Many young adults do not have "land-line" telephones, and often therefore are not included in survey sample lists. To recruit this age group, the project team sent targeted emails to groups representing a broad spectrum of young people, such as college students.

Through this process, the team identified a pool of 2,700 demographically eligible participants. Factoring in response rates and expected attrition, the team projected between 1,000 and 1,200 participants at the three sites. When the decision was made to reschedule the event, the same group of 2,700 was again invited to participate.

The resulting group of nearly 400 participants at the May 21st event was broadly representative of the state in terms of gender (49% female, 51% male) and race (93% Caucasian). Age categories varied somewhat, with some under-representation in the youngest and oldest categories. The age category of 35–44 year olds most closely matched the state's demographic. Young participants, particularly those under age 25, were substantially under-represented (only 3% of the participants were under age 25, compared with 10.7% in the state population). Income levels were reasonably close at all levels, except for those in the lowest category of household income (less than $14,900), who were substantially under-represented (9% of the participants compared with 18% in the state population).

Participant Discussion Guide

One of the key components of the AmericaSpeaks town meeting process is a background document that frames the issues. For "Tough Choices," this study guide outlined issues about the current health status of Maine people, their use of health care services, their participation in private or public insurance programs, and their own choices and behaviors with regard to health risks. The 27-page discussion guide laid out four elements of the state health plan and some of the "tough choices" and trade-offs to be considered: (1) improving health status, (2) reducing health care costs, (3) improving health care quality, and (4) increasing access to health insurance coverage. Each section included background, a discussion of the issues, and a set of options on which participants would vote.[6]

Participants received the guide ahead of time so they could review it. During the town meeting, participants spent most of the day in detailed discussion about the strategies and options described in the guide. If additional themes emerged from the participants during the meeting, they could be added to the list of options before the vote was taken.

Meeting Process

Based on more than 10 years of experience and experimentation in the design of "town meetings," AmericaSpeaks worked with the planning team to convert the discussion guide and its four main policy categories into a design for a six-hour process. Recognizing that the issues were complex and the time was limited, the organizers distilled the 27-page guide into a concise set of discussion points and alternatives.

Participants met each other, discussed core beliefs about health and health policy, and worked through

a series of exercises, addressing health status, cost, quality and access to health insurance in Maine. At both sites (the University of New England in Biddeford, and the University of Maine in Orono) during the May 21st meeting, participants sat at small tables with a trained facilitator at each table. During the day, two lead moderators presented questions for discussion via large-screen video teleconferencing set up at each site. Participants used the networked computers at each table to transmit their notes from the discussions to a "theme team" located in Augusta. The theme team members, each with some background in health and health policy, tracked the common elements and noted the divergence of opinion from all the tables and made periodic summary reports via the video screens to all participants. After each summary report, all participants responded to a series of options using individual handheld, wireless "keypad" voting devices. Polling data from both sites were combined and reported back to the groups via the large-screen video.

The planning team designed the flow of the day to include pre- and post-meeting questions to assess how participants' thinking evolved throughout the day. After a few exercises to familiarize participants with the voting technology, the meeting began with the pretest questions, followed by a discussion on values. Then, participants considered the four primary topics outlined in the discussion guide, and were polled on their relative support for the options under each. First-round polling results are shown in Tables 1-4.

In the second step, they selected the top two options from each of the four topics, including any additional options that had been proposed during the earlier discussion. At the end of the day, they reviewed the top alternatives as a group to see if they made sense as a whole and to try to integrate these alternatives.

RESULTS

The process generated open dialogue and both qualitative and quantitative data on values and strategies. Participants learned about and discussed health care issues and policy options. They wrestled with the complexity of priority setting. During the course of the day, participants generated additional options and participated in more than 40 rounds of substantive voting.

TABLE 1: **Results of Polling on Improving Health Status**

OPTION	For	Against
Encourage making good food choices and increase exercise at school	98%	2%
Require no cost (free) preventive care in all health insurance	80%	20%
Enact tougher seat belt and/or helmet laws	66%	34%
Tax unhealthy habits	59%	41%
Premium discounts for healthy living	50%	50%

Initial discussion generated general agreement on values that should guide policy development:

- Health care should be a right, not a consumer good;
- Everyone should have access to affordable health care;
- High-quality health care should be available to everyone.
- Health care should be affordable for employer and employee;
- Costs to individuals should be based on ability to pay;
- Funding prevention saves money and improves health;
- People need to take personal responsibility for their health;
- Health care should include mental health and substance abuse coverage.

As participants moved into discussions on improving the health status of Mainers, reducing health care costs, improving quality, and increasing access to health insurance, common agreement ebbed and waned, and participants frequently flexed their muscles, insisting on adding additional options. At one point, the exercise to balance priorities across the areas of access, cost, and quality nearly mired down until meeting organizers separated large-scale changes to the system from incremental changes within the existing system.

TABLE 2: **Results of Polling on Reducing Health Care Costs**

OPTIONS	For	Against
Regulate insurance premiums	64%	36%
Reduce or hold the line on insurance mandates	49%	51%
Cap costs of health care providers and insurers	37%	63%
Insurance coverage limits on prescription drugs, tests, and procedures	28%	72%
Reduce insurance regulation	26%	74%
Establish a high-risk pool	15%	85%

TABLE 3: **Results of Polling on Improving Health Care Quality**

OPTIONS	For	Against
Create report cards on quality of care for consumers	78%	22%
Create a statewide system to allow providers access to electronic medical information	73%	27%
Establish best practices and treatment guidelines	71%	29%
Place controls on the introduction of new medical technology	46%	54%
Require people with serious mental illness and/or substance abuse to get appropriate care	29%	71%

Improving Health Status

Participants discussed the five options to improve health status presented as examples in the discussion guide (Table 1). In first-round polling, a majority of the participants supported each of the options, with the strongest consistent support for *encourage making good food choices and increase exercise at school;* there was an even split for and against having *premium discounts for healthy living.* After individual table discussions, a sixth option was added by participants: *reduce cancer-causing chemicals in the environment.*

In the next round of polling, to select the top options for improving health status, the following options had the greatest support:

1st *Encourage making good food choices and increase exercise at school;*

2nd *Require no cost (free) preventive care in all health insurance.*

Reducing Health Care Costs

The discussion guide outlined six options to reduce health care costs (Table 2). Perhaps not surprisingly, participants did not endorse most of these cost-reduction strategies. The only strategy to gain significant participant support was to *regulate insurance premiums.* During the more in-depth follow-up discussion, participants added additional options to control costs: *cap insurance profits and executive salaries; get out of the private for-profit insurance paradigm.* A vocal minority also emerged that advocated *creating new options.* Meeting organizers challenged these participants to participate in subsequent focus groups to identify new options. Those focus groups were subsequently held in August. They did not yield radical new ideas, but did include thoughtful discussion of alternatives identified during the "Tough Choices" meetings themselves.

After multiple voting and re-discussion, the participants defined the top three options for reducing health care costs, one of which had not been presented in the guide, but was added by participants:

1st *Get out of the private for-profit insurance paradigm* (added by participants);

2nd *Regulate insurance premiums;*

3rd *Cap costs of health care providers and insurers.*

Improve Health Care Quality

The discussion guide offered five ways to improve the quality of health care in Maine (Table 3). Three of them generated significant support: *establish best practices and treatment guidelines; create a statewide system to allow providers access to electronic medical information; and create report cards on the quality of care for consumers.*

Participants also expressed a strong interest in preventive health care during discussion, but the meaning of that term varied considerably among participants. The Governor's Office of Health Policy and Finance must gain additional input through other

TABLE 4: **Results of Polling on Increasing Access to Health Insurance Coverage**

OPTIONS	For	Against
Expand the DirigoChoice Plan[a]	74%	26%
Expand MaineCare [Medicaid] coverage	69%	31%
Create a single-payer universal coverage system in Maine	64%	36%
Require all Mainers to have insurance coverage	29%	71%
Mandate employer contributions to insurance coverage	18%	82%

[a]The DirigoChoice Plan is the new health insurance plan established under the Dirigo Health legislation. It offers comprehensive coverage to small businesses, the self-employed, and individuals, and includes discounts based on income that decrease monthly rates and reduce deductibles. It is currently offered through Anthem Blue Cross and Blue Shield of Maine.

TABLE 5: **Final Polling Results**

SYSTEM-WIDE CHANGES	
Single-payer system	48%
Expand DirigoChoice and MaineCare *[a merging of two of the options in the Participant Guide]*	30%
Get out of private for-profit insurance paradigm	8%
None of the above	13%
Total system-wide changes	100%
INCREMENTAL STRATEGIES	
(Improve Health)	
Cover preventative services without consumer cost	16%
Encourage good food choices and increase exercise at school	13%
(Contain Costs)	
Regulate insurance premiums	6%
Cap costs of health care providers and insurers	6%
(Improve Quality)	
Improve public health infrastructure	50%
Establish best practices and create report cards	8%
Total incremental strategies	100%

mechanisms to better understand the implications of this concern for the state health plan.

In polling for top options for improving health care quality, two were tied for second after multiple rounds of voting:

1st *Place controls on the introduction of new medical technology;*

2nd *Establish best practices and treatment guidelines* (tie);

2nd *Create report cards on quality of care for consumers* (tie).

Increase Access to Health Insurance Coverage

The guide presented several options to improve access to health insurance (Table 4). Among these examples, participants strongly supported *expand MaineCare [Medicaid] coverage; expand the DirigoChoice plan;* and *create a single-payer universal coverage system for Maine.* Participants did not favor mandated employer contributions to insurance coverage or a requirement that all Mainers have health insurance. An additional option was proposed by participants to combine expanding MaineCare (Medicaid) coverage and expanding the DirigoChoice plan.

After much additional discussion, the participants selected two top choices for increasing access to health insurance:

1st *Create a single-payer universal coverage system in Maine;*

2nd *Combine the expansion of Medicaid with expanding DirigoChoice.*

Integrating Strategies

As the day came to a close, participants grappled with the complexities of clarifying and integrating strategies. A clear current of dissatisfaction with

Maine's present health care system persisted, yet the group could not reach closure until we separated options into two groups for polling purposes: large-scale changes to the system, such as shifting Maine to a single-payer system, and less dramatic incremental changes in the current system, such as improving food choices in schools. Participants were able to select options within each group, rather than having to support all the options together (Table 5). No single option in either system-wide change or incremental change within the existing system won an overwhelming majority.

DISCUSSION

The Governor's Office of Health Policy and Finance and the other agencies charged with developing the state health plan have used the information from the "Tough Choices" meeting to inform and to guide the creation of the upcoming biennial state health plan. The "Tough Choices" session indicates that there are several issues that need to be thoroughly explored, tested, and addressed.

Need for Systemic Change

Participants at the meeting expressed a significant interest in systemic change. Although no specific option received overwhelming majority support, it is important to note that the "Tough Choices" participants spontaneously added the option of promoting a single-payer health care system as one change that could advance costs savings and improve the quality of and access to health care. Clearly, this issue is worth exploring further in other forums and public hearings. Any process to develop the state health plan must include discussion of alternative systems, and the plan itself should make a clear, compelling case for the recommendations that it makes.

Incremental Improvements to the Existing System

The process for developing the state health plan should examine the strong interest of the participants in promoting prevention and in supporting some elements of Maine's public health system, specifically clinics.

Reducing Costs

Even though participants recognized the positive impact of reducing costs on the health care system (84.2% rated the need for cost reduction as high or very high), they were unenthusiastic about most of the cost-reduction strategies presented in the discussion guide. The top choices included regulating insurance premiums and capping the costs of health care providers. Participants insisted on adding a strategy to explore additional cost-reduction options.

LESSONS FROM "TOUGH CHOICES"

An overwhelming majority of participants (93.3%) believed that they learned something new during the session, and well over half (60.3%) indicated that their opinions had evolved during the day. The clear policy implication is that having public information on the complicated issue of health care cost, quality, and access is important and that people outside of the health care field are willing to engage in meaningful discussion about complex issues.

The "Tough Choices" process was a pioneering endeavor for Maine—and one with national implications. In pairing survey methodology with informed, facilitated discussion, Maine has developed a model of interest to other states and even to other countries. Observers at the meeting included representatives from the National Institutes of Health, the state of New Hampshire, and the national Citizen's Health Care Working Group (a 14-member group of citizens appointed by Congress to develop a roadmap for health care for the President and Congress). The Citizen's Health Care Working Group has engaged AmericaSpeaks to build on the Maine "Tough

…participants spontaneously added the option of promoting a single-payer health care system as one change that could advance costs savings and improve the quality of and access to health care.

Choices" process to frame a national discussion on how our nation's health care system should improve cost, quality, and access. In addition to national interest, a representative from Italy came to evaluate use of this methodology in a national discussion on youth.

Within the state, the process provided information on issues to be addressed in the state health plan and began a long-term dialogue on health care that includes the voice of citizens. Participant feedback indicates that the "Tough Choices" process is a valuable educational tool.

Hearing the voices of Maine people helps policy leaders define and plan a responsive health care system that will address the needs of all Maine residents. "Tough Choices," however, is only one element in the development of a state health plan. There must be an ongoing discussion with Maine citizens to make the real changes needed to achieve Maine's goal of becoming the healthiest state in the nation.

Clearly more work needs to be done on identifying realistic strategies and solutions to the challenges Maine is facing with regard to expanding access to health care, controlling health care costs, and improving health care quality. The state health plan is an important start, but ongoing public dialogue and engagement will be essential to deal successfully with the tough issues involved in setting health care policy.

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Tish Tanski is a private consultant, with an interest in the role of the consumer in health care. She is working with AmericaSpeaks and the National Citizens' Task Force on Health Care on a national dialog to be held in the winter of 2006 across the nation and is a member of the Maine Health Information Network Consumer Advisory Group. She recently was a senior policy analyst with the University of Maine's Margaret Chase Smith Policy Center. Previous experience included serving as executive director of the Schoodic Education and Research Center, director of institutional relations for The Jackson Laboratory, and director of the Maine Science and Technology Commission.

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ENDNOTES

1. Implementation of the Maine Rx program was delayed in the face of court challenges from the pharmaceutical industry, but there was an ultimate ruling in Maine's favor by the U.S. Supreme Court in May 2003. The updated version of the program, Maine Rx Plus, enacted in June 2003, was launched in January 2004. The Maine Rx Plus program provides significant discounts to Maine residents with incomes at or below 350% of the federal poverty level. James Carroll in an article published in *Maine Policy Review* (2003) provides an analysis of rising prescription drug costs and efforts by Maine and other states to control those costs.
2. For further details on the full provisions of the legislation and the structure and components of the Dirigo Health program, see an earlier article published in *Maine Policy Review* (Treat et al. 2003).
3. Initial funding for the planning to select a citizen input method was provided by the Maine Health Access Foundation. The Margaret Chase Smith Policy Center, University of Maine, coordinated the planning process. Three overall strategies for public engagement were identified, each advanced by a non-profit organization: The Study Circle Center, AmericaSpeaks, and Public Engagement Media. Each promotes citizen dialogue through neutral background materials to frame the issues.
4. Material presented in this sidebar is derived from the AmericaSpeaks Web site, http://www.americaspeaks.org/services/town_meetings/index.htm
5. The Maine Health Access Foundation provided significant funding for the effort. Other funders included Jane's Trust, the Betterment Fund, the Robert Wood Johnson Foundation and the Maine Community Foundation. The U.S. Department of Health and Human Services, Health Resources and Services Administration also provided funding through an ongoing project with the Muskie School at the University of Southern Maine. Unfortunately, with the cancellation of the originally scheduled event, there were considerable "sunk" costs that could not be recouped. The Maine Health Access Foundation agreed to fund the rescheduled event at two sites.
6. Lake, Snell, Perry and Associates, a national consulting firm with extensive experience in the field of health, worked with AmericaSpeaks and the planning team to draft the participant discussion guide, which was reviewed prior to publication by stakeholders, the state Advisory Council on Health Systems Development, and by citizen focus groups to assure that the concepts and policy choices were comprehensive and clearly presented. The Governor's Office of Health Policy and Finance convened the stakeholder meetings and University of Maine Cooperative Extension helped convene the citizen focus groups to beta-test and fine-tune the guide.

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