Health System Scenarios

Possible Futures for Health and Health Equity in the USA, 2017–2030

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Scenarios

User Guide

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Foreword

from the Robert Wood Johnson Foundation

In the United States, entrenched inequity leads to great disparities in health outcomes across population groups. Depending on ethnic background, socioeconomic status, gender, sexual orientation, legal status, or mental and physical capabilities, one individual is more or less likely to die of certain diseases, have a shorter life expectancy, and be vulnerable to serious physical and emotional harm than another. These differences stem from affordable housing, public safety, and transportation. Because so many people are unable to live the healthiest lives possible, the well-being and prosperity of entire communities are threatened.

Systems are often inequitable and can exacerbate these health inequities, so it's crucial to examine the ways in which systems and institutions work. To make a difference, this inquiry must happen within and across all the systems that influence health.

To this end, the Robert Wood Johnson Foundation supported Reos Partners in convening a multi-stakeholder team of system leaders to examine the systems and relationships that produce individual and community health and illness. The purpose was to catalyze open and reflective strategic thinking and conversation about the possible futures of health and health equity, and the opportunities, risks, and choices these futures present. In turn, seeing these possible futures more clearly can stimulate individual and collective actions to adapt to and influence these futures.

While the scenarios do not necessarily reflect the views of the Foundation, our hope is that the three scenarios presented in this report will enable you and other system leaders from across disciplines to devise and implement robust, boundary-spanning solutions that produce meaningful and sustained improvements in the lives of individuals and communities.

What Scenarios Are

The Health System Scenarios are stories about what could happen in the future—not what ***will*** happen (forecasts) or what ***should*** happen (policy recommendations), but what ***could*** happen over the coming years in terms of the system that produces individual and community health and illness, based on current trends and taking account of relevant political, economic, social, and cultural dynamics.

These three scenarios were constructed by a team of system leaders from the fields of public health, public policy, education, rural health, Native American health, the arts, philanthropy, healthcare, and community organizing who gathered for nine days of in-depth meetings.

The three stories are relevant, challenging, plausible, and clear. The purpose of the scenarios is to provide a common framework and language to support dialogue, debate, and decision-making among all actors working in the systems that enhance or inhibit the opportunity for people to achieve health and well-being. They are intended to support an open and constructive search for answers to core questions of how to bring about health and health equity: What opportunities and challenges are we facing now, and what might we be facing in the future? What are our options for taking action and bringing about change?

Scenarios play a unique role in strategic planning. Because they are fictional, and because they come in sets of two or more different, plausible stories, they offer the advantage of supporting informed debate without committing anyone to any particular policy position. Although we cannot predict or control the future, scenarios show us that we can work with and influence it.

More specifically, these stories support the formation of policy and strategy through the use of scenario-based dialogues. The purpose of such dialogues is not to redo the construction of the scenarios, but rather to use the scenarios as they are written to discover what can and must be done. The most fruitful dialogues of this kind involve a representative group of interested and influential actors from across the whole system in question. (This system can be a government, city, sector, community, or region, for example.) Diversity is important—the group can include not just friends and colleagues, but also strangers and opponents.

There are ***four key steps*** for this kind of scenario-based dialogue.

1. First, the scenarios are presented through text, slide presentation, or storytelling.

2. Second, for each scenario the group addresses the question, "If this scenario occurred, what would it mean for us?" and works out the opportunities and challenges the scenario poses.

3. Third, the group focuses on the question, "If this scenario occurred, what could we do? What options do we have?"

4. Finally, the group steps back to the present and considers the question, "Given these possible futures, what should we do next?"

The Current Situation

The United States faces a health crisis. The country spends almost one-fifth of its GDP on healthcare, yet has poorer health outcomes than other nations that spend much less. It spends more on healthcare per person than any other country but is at or near the bottom in rankings of industrialized countries for health indicators such as infant mortality and life expectancy.

The United States also ranks poorly on health equity, with significant disparities in morbidity and mortality by race, income, and geography. The root causes of many of these disparities can be traced back to differences in healthcare access, behavioral risk factors, exposure to environmental hazards, and the social determinants of health.

Cumulatively, these risk factors have contributed to making preventable chronic diseases the leading cause of early death and disability in the United States. As a result, there has been a decline in the number of years people live in overall good health. Better outcomes would require a significant change to how the United States views and addresses health—not only in how health insurance and clinical care are provided, but in the multiple social, economic, and environmental determinants of health as well.

How will the United States respond to this mounting pressure to improve health outcomes? Will it reduce the role of government and rely on the ***Marketplace***? Will it bring national stakeholders together in the ***Conference Room***? Or will it organize change from the bottom up, at the ***Kitchen Table***? These scenarios explore three possible directions for how the health system in the United States could evolve and what each path would mean for health and health equity.

Definition of Health Equity

Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

Source

http://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html

The Social Determinants of Health

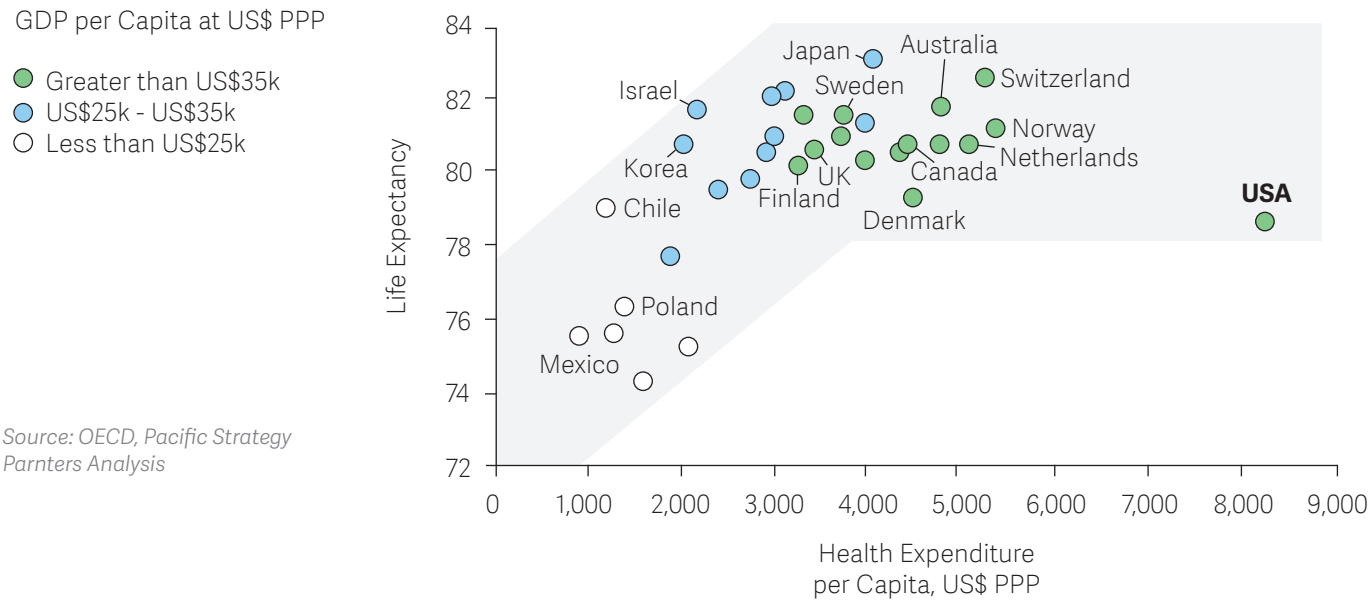
The social determinants of health are the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. This includes education, employment, health systems and services, housing, income and wealth, the physical environment, public safety, the social environment, and transportation.

Source

https://www.nap.edu/read/24624/chapter/1#xxiii

Life Expectancy vs. Health Expenditure (2010)

Health expenditure does not necessarily lead to improved health outcomes



Source: OECD, Pacific Strategy Parnters Analysis

The Scenarios

Marketplace

Conference
Room

Kitchen
Table


SALE
FRESH &
ORGANIC
meats
Menu

Marketplace

In ***Marketplace***, a new federal framework for regulating and funding healthcare markets is enacted by Congress. Changes to Medicare and Medicaid narrow eligibility and reduce the extent of coverage. Small and medium-size businesses reduce or eliminate the healthcare benefits their employees receive. Consequently, medical debt and bankruptcies rise while safety net hospitals and other essential community providers experience increases in uncompensated care and in the number of people using their services. At the same time, the use of healthcare products and services by those who can afford them grows.

The primary force driving change
The federal government reduces its role in funding and regulating healthcare

Whose needs drive change
People concerned with high costs and government interference in healthcare

The thinking that drives change
Healthcare can and should be provided by markets

Who drives change
Federal elected politicians and healthcare companies

How change is effected
Transfer of funds and authority to state and local governments and to private companies

The risks of these changes
Markets deliver health only for those with money

The results of these changes: the state of health and health equity in 2030
Pockets of market-driven innovation but growing gaps between haves and have-nots

The federal government changes its regulatory and funding role

In this scenario, the federal government replaces the regulatory framework established by the Affordable Care Act (ACA) with a new arrangement, which reduces the federal government's function as a regulator of healthcare markets and cuts federal expenditure for public health insurance programs. Actions taken by Congress and presidential administrations eliminate requirements for private health insurance, including those for minimum health benefits, coverage of pre-existing conditions, and health provider network adequacy. Federal tax credits and subsidies for the purchase of private health insurance by lower-income Americans are eliminated; cost-sharing subsidies that had reduced co-pays and deductibles for those with lower incomes are also reduced or eliminated.

By 2020, the federal government transitions Medicare from an entitlement program to a fixed-subsidy voucher program. Medicare enrollees must use vouchers to purchase health coverage plans offered by private insurers. For those who can afford them, some plans provide comprehensive coverage. Other plans provide more limited coverage than was previously available and require increased cost-sharing by consumers with no adjustment for lower-income enrollees. This leads to reduced utilization of health services by those with limited means.

At the same time, the federal government transitions Medicaid to a capitated state block grant program. This caps the amount of federal funding provided to states for each Medicaid enrollee. States have more flexibility in the administration of Medicaid, but over time the federal contribution meets a smaller percentage of total program costs. The higher federal share of payment for participants added under the ACA Medicaid expansion is reduced. As states become responsible for the reduced federal share, they begin to reduce Medicaid coverage and eligibility. States seek to limit their financial risk by expanding their capitated contracts with private Medicaid managed care organizations.

As changes to Medicaid continue, priority is given to low-income seniors in long-term care, people with disabilities, and pregnant mothers and children. This results in stricter eligibility requirements for other populations. For example, states attach work requirements to eligibility requirements and lifetime participation limits. Consequently, it becomes increasingly difficult to access Medicaid coverage. Those who do maintain their coverage experience an increase in cost-sharing, including for emergency room use.

Arizona Medicaid Enrollment Freeze

When the Great Recession hit, Arizona, like many other states, had to make painful decisions about Medicaid, including whether to maintain coverage for low-income adults.

Arizona chose to freeze enrollment for low-income adults enrolled in its waiver beginning in July 2011. It stopped accepting new enrollees and continued coverage for existing enrollees only as long as their income remained below the poverty line; people who rose above poverty but then fell back below it could not re-enroll.

The federal Centers for Medicare & Medicaid Services required Arizona to implement some coverage safeguards, such as notifying all low-income adults about the freeze and checking whether adults about to lose coverage were eligible for other Medicaid coverage groups, such as low-income parents or pregnant women, before disenrolling them. Despite these safeguards, enrollment fell dramatically—by nearly 45 percent within a year and by almost 70 percent by December 2013, two and a half years after the freeze took effect.

The ACA's Medicaid expansion allowed Arizona to lift its freeze, and the state quickly saw a 40 percent increase in enrollment by January 2014, the first month the program reopened for new enrollees.

Arizona's experience is consistent with the 2011 study *Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*, which showed that fewer than half of low-income adults are continuously eligible for Medicaid over the course of one year. Findings from two other studies *(Improving Medicaid's Continuity of Coverage and Quality Care and Loss of Health Insurance Among Non-Elderly Adults in Medicaid)* suggest that most of the current expansion population would become ineligible for the enhanced match in less than two years, so states could continue covering them only by picking up a much higher share of the cost.

Because the states wouldn't likely find the money to pay those higher costs, losing the enhanced match ultimately would mean losing the expansion itself.

Sources

http://www.cbpp.org/blog/arizona-shows-why-house-gop-plan-would-likely-end-medicaid-expansion

http://hsrc.himmelfarb.gwu.edu/cgi/viewcontent.cgi?article=1247&context=sphhs_policy_facpubs

https://www.ncbi.nlm.nih.gov/pubmed/18810555

In 2021, the Centers for Medicare & Medicaid Services reports that because of these changes, as many as 30 percent of adults nationwide are uninsured or underinsured to the point that they cannot functionally access health services. Some are no longer eligible, while others cannot afford the increases in cost-sharing. Those affected increasingly defer use of health services until their health condition is urgent. As a result, health problems that might have been prevented by early intervention become more serious and require more costly responses for both the patient and the healthcare system.

Healthcare benefits for employees vary according to the type of employer they have

Large employers continue to offer healthcare benefits, but the new federal healthcare framework sparks changes in how small and medium-size employers provide these benefits. With the elimination of the employer coverage mandate, many small and medium-size employers cease to offer health coverage to their employees and their families. Employees of these companies, as well as low-wage and part-time workers, must now purchase healthcare insurance independently should they decide they need it.

Small and medium-size employers that do continue to offer coverage provide a set amount of benefit dollars that employees can use to purchase the coverage they want. Other employers provide insurance options with a narrower range of covered services and increase the costs employees incur via a higher share of insurance premiums and higher health service co-pays and deductibles.

As costs increase for independent consumers and employees, people are more likely to postpone access to care. In 2022, the Office of Disease Prevention and Health Promotion reports a 20 percent decline in the use of preventive services, such as mammography and colonoscopy, especially among lower-income workers, and by 2023, healthcare expenditures for consumers have increased by 25 percent.

The use of safety net hospitals and other essential community providers by uninsured and underinsured increases

By 2024, the Congressional Budget Office estimates that 35 million people have become uninsured or underinsured due to the changes in the public and private health insurance markets. This affects not only Americans who live near or below the poverty line with little to no disposable income, but increasingly also middle-income Americans. Americans continue to access healthcare services only when their health condition is urgent and after repeated attempts at providing their own care have failed. The delay in seeking care is costlier for patients, such that by 2025 an association of bankruptcy professionals reports that health-related indebtedness and bankruptcies have increased by 10 percent.

Consequently, uninsured and underinsured Americans increasingly rely on healthcare services provided by safety net hospitals and other essential community providers, including those operated by local government, charities, and faith-based organizations. Increased usage of these services strains the capacity of the sector, and a significant number of these health service providers, particularly in rural areas, are unable to survive. As a result, the burden of providing care increases for the remaining providers.

Freestanding Emergency Rooms

Freestanding Emergency Departments (FSEDs) are facilities that are not physically attached to a hospital and that provide emergency care. They were created to respond to the healthcare service needs of rural, underserved, and higher population areas. There are two types of FSEDs: hospital outpatient departments (HOPDs), also referred to as off-site hospital-based or satellite emergency departments, and independent freestanding emergency centers (IFECs), usually operated by non-hospital for-profit entities. According to a study reported in the *Annals of Emergency Medicine*, FSEDs are an innovative model of acute care delivery with the potential to reshape the market for emergency care. However, the study cautioned that further research is needed to determine how the growth of FSEDs will affect the quality and cost of emergency care, as well as access to it.

IFECs are concentrated in a handful of states, primarily Texas, Colorado, Ohio, and Arizona. This is likely due to several factors, including state regulation of FSEDs and economics. In Texas and Colorado, the regulatory requirements to open an FSED are minimal, usually just an application form and payment of a fee. In some other states a certificate of need (entailing a formal regulatory process demonstrating that there is need in the market for the healthcare services) must be obtained before opening an FSED. Some states, including California, effectively ban FSEDs by requiring that any facility using the term "emergency" must provide intensive care, laboratory, radiology, surgical, post-anesthesia, and blood bank services.

The IFEC business model focuses on the patient as consumer, offering more healthcare service options than where restrictive markets exist. However, given that the majority of FSEDs are located in affluent, private-payer, suburban areas—places they were not intended for—there is concern that they fail to provide services in the areas that may need access the most.

Sources

https://www.acep.org/Clinical---Practice-Management/Freestanding-Emergency-Departments/

https://scholar.harvard.edu/files/cutler/files/1-s2.0-s0196064416301998-main.pdf

Health products and services expand

As the federal health framework changes, a market that is responsive mostly to the needs, preferences, habits, lifestyles, and spending patterns of wealthy and insured consumers emerges. This results in an expansion in products and services for critical clinical health needs, as well as for elective health wants. For example, across the United States there is a 30 percent increase in the number of private sector clinics that allow people to pay monthly fees for access to primary care.

There is also an increase in the use of personalized medicine, where doctors have access to their patients' genetic information, lifestyle, and environmental risk factors for disease. With this information, physicians screen and diagnose health problems earlier and tailor individualized treatment plans to the specific needs of each patient. In 2026, research conducted by the US Food and Drug Administration indicates that personalized medicine has contributed to a 20 percent increase in survival rates for diseases such as breast and prostate cancer for those who can afford this care.

Moreover, entrepreneurs seize opportunities to start businesses that focus on preventive care. This includes personal health coaching and online subscription platforms that support comprehensive lifestyle changes to avoid developing chronic disease. As the market continues to expand, health and well-being as indicated by length of life and quality of life increase for higher-income individuals with purchasing power.

Private sector actors also seek to meet the needs of lower-income consumers. Some companies experiment with business models for pharmacy-based clinics that provide low-cost primary care, while others develop low-cost medical devices made by 3D printers. These products and services result in a small increase in access to care by those living on low incomes; however, for the most part these businesses struggle to be profitable because of the limited discretionary spending of their target market.

Pharmacies Selling Fresh Fruits and Vegetables

According to the 2010 census, 23.5 million Americans live in "food deserts"—low-income neighborhoods in urban or rural areas in which access to fresh fruits, vegetables, and other healthful foods is nonexistent or severely restricted because there are few, if any, supermarkets.

Recognizing an unmet need in the market, several supermarket chains have attempted to respond. Approaches have varied, as have their initial successes. For example:

- Kroger—One of the nation's largest food retailers is piloting a chain of no-frills stores in the Midwest. The pilot has not proven itself profitable; CEO Richard McMullen notes, "We're still trying to understand the economics of the model to get to where it actually performs at [a return on investment] that we're happy with."
- FreshDirect—An online delivery service most associated with affluent urban consumers piloted delivery service in two poor communities in New York's Bronx borough. Vice President Larry Scott Blackmon notes that the company is collecting data to determine the effectiveness of the pilot.
- Walgreens—A non-food retailer committed in 2010 to creating 1,000 "food oasis" stores by 2016; as of 2013 (most recent data available), Walgreens had converted or built only 100 stores, which suggests that the concept has not yet been profitable.

Sources

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http://www.time.com/time/magazine/article/0,9171,1813984,00.html

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By 2030, health inequities have continued to rise, as indicated by disproportionate mortality and morbidity measures between racial, ethnic, and socioeconomic groups. Pockets of innovation have led to advancements in health and healthcare, but these are unable to be scaled beyond those with purchasing power. Wealthy people are getting healthier, but people who are living on lower income and without adequate health insurance are ill more often and unable to get out of debt. Overall, increasing health inequity is threatening the health of all Americans, as indicated by the country's overall declining life expectancy rate.

Confessions from the Marketplace

Poem by Tassiana Willis

1 Jane said,
"the marketplace to me feels like a small box
Caving in from all us poor folk reaching for the top
The top medicine the top docs
And isn't that strange
I mean they talked about how the market would
provide all these options for everyone
But no one I know won

Supply and demand they say
I mean I thought I would never see the day
I'd have to bid for my daughter's doctor appointment
Almost everyone on this side of the tracks lost their benefits
For a raise of 99¢
So much suicide
People thinking death is as good as it gets

What about my daughter?
What Spina Bifida did to her
It took 5 years of trying
For a doctor to tell me that unless she qualifies for a miracle
She'd be better off dying
And I can't sue him for that
For these private practice doctors
who charge an arm and limb
I'm sure they'll start taxing laughter too
Saying it the way thinking about this marketplace
makes joy leave the room"

2 David said,
"I think it's great you know? This 'marketplace'
I work from sunrise to sunset because that is what it takes
I can remember daydreaming in medical school where
I envisioned this
More money in my pocket than I know what to do with
This is the best time of my life
Providing for my husband and my family is right
I save lives what's so wrong with me charging a price?
I say a fee and my patients never-ever blink twice
Now there are people who can't afford to see a doctor like me
And that's because of their own personal choices
Nothing at all to do with me

The way I see it
The largest issue with healthcare was access
This allows everyone at least to have the option of the best
Listen my services are complex, top-notch, effective
To do what I do for free would be reckless
I mean that's what I love about this system
The marketplace rewards innovation, efficiency
This a business solution for health
Not equity"

3 James cried
Her wedding was beautiful
My sister looked like an angel
We all cried a little when my father danced with her
I'm sure tears of joy and tears of shame
James laughs

I'm healthy
Never needed anything from a doctor but a check-up
And with the money I make I just have good luck
I can afford the little things

But my father...
See, my father would've never been able
to walk her down the aisle
And we would have found ourselves in a church
for another reason
He is only here because of the preexisting condition
clause of ACA
I'm afraid that the marketplace will take him from me.
His pre-existing conditions costs more than
my sister and I's college loans
Two times over
Blood transfusions at least twice a year

They say stress and fear
Is bad for your health
And I guess so is being sick
He coughs

4 You
You may not be Jane, or David, or even James
But soon enough you could live in this marketplace
According to recent polls and conditions of the state
Of all the decisions,
This is the one America is most likely to make
You will have options,
You will have freedom,
Nevertheless, you will have a responsibility too
Not just to you,
Because even if you aren't them, you might work with
them, go to the same grocery store as them,
get coffee every morning with them.
And what happens when they no longer
can stand in line with you?

Conference Room

In ***Conference Room***, the combination of an unhealthy population and the rising cost of care is contributing to a slumping American economy. Corporate leaders and insurance companies, in partnership with health professionals, demand that politicians implement regulations and policies that reduce healthcare costs by incentivizing holistic approaches to health and well-being. As chronic illnesses continue to rise, influential stakeholders around the country experiment with approaches to respond to the root causes of these illnesses.

The primary force driving change
Healthcare costs are uncompetitively high

Whose needs drive change
People concerned with the ability of the health system to deliver health

The thinking that drives change
Health can be obtained only through systemic perspectives, negotiations, and regulations

Who drives change
Large employers and public health officials, who influence federal and state legislators

How change is effected
Experimentation leading to interventions and investments in and regulation of the broader health system

The risks of these changes
Slow-moving health bureaucracy

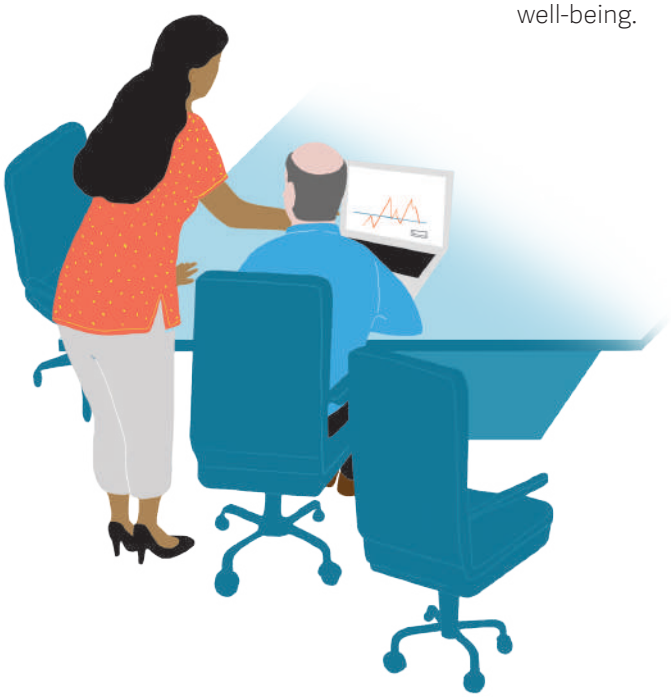
The results of these changes: the state of health and health equity in 2030
Nationally, both health outcomes and health equity are gradually improving

The high cost of illness is a drag on the economy

In this scenario, a weakening American economy is attributed, in part, to an increasingly unhealthy population and the associated high costs of care. For three years in a row, the US Bureau of Economic Analysis has reported a rise in employee absenteeism and declines in corporate profits and productivity measures.

As an example, research conducted by a national diabetes organization concludes that lost productivity associated with type 2 diabetes costs the American economy $69 billion annually. And a national mental health organization reports that serious mental illnesses, such as depression, post-traumatic stress disorder, and substance abuse disorders cost the economy $193 billion a year.

Worsening health is viewed as an urgent economic crisis impacting the country's competitiveness. After years of failed interventions, business leaders and legislators recognize that reforming federal regulations associated with health insurance and prescription drug costs alone will not bring about a healthier population. Instead, there is a growing understanding that attention must be paid to the social and environmental determinants of health. As an example, a national public health organization reports that cancers reports that cancers associated with environmental factors, such as lung cancer, are on the rise. In response to such evidence of preventable health problems, numerous new collaborations and coalitions form to bring about holistic interventions and investments in health and well-being.



Large employers lobby for new rules and regulations to drive down their costs

In 2023, as the federal government begins to formulate new laws and regulations for holistic approaches to health, the country's 20 largest employers create a coalition to influence how these changes will unfold. For example, the coalition advocates for measures that will stem the rising costs of providing healthcare benefits for employees. This includes impeding insurers from using fee-for-service reimbursement systems, and creating new models in which doctors, hospitals, and other providers are paid for the quality of care and health outcomes they deliver. They also demand structures for price transparency.

Further, large employers are concerned about the trend of consolidating health providers into expanding health systems, as identified by a national health systems change research organization. The coalition argues that this practice has created health system monopolies that are driving up the costs associated with providing healthcare benefits for employees. They negotiate with all stakeholders to regulate the amalgamation of medical practices to keep costs affordable for employers.

The coalition also stresses that the federal government must invest in efforts to reduce chronic illnesses that contribute to lost productivity. This includes expanding access to cancer screening and early detection, mental health counseling, and nutrition and weight loss education services.

Stakeholders experiment with holistic solutions to the root causes of illness

As rates of preventable chronic diseases continue to rise across the country, business and industry leaders expand their demands to include regulations for and investments into the root causes of these kinds of illnesses. In different parts of the country, various employers, industry representatives, and insurance companies collaborate to respond to the illnesses that cause employees to miss work. Local public health officials support these efforts by convening gatherings and providing content expertise.

For example, the rate of type 2 diabetes continues to rise in the "diabetes belt" (as identified by the Centers for Disease Control and Prevention), which includes Mississippi, Alabama, and Georgia. Employers, insurers, and legislators, in collaboration with public health departments in these states, work with the Federal Trade Commission to negotiate with large food and beverage companies to change laws that would require the percentage of daily value to be listed on the labels of all products containing sugar. A national education policy organization joins the partnership and advocates for increased funding for elementary and high schools. This allows schools to end sponsorship agreements with sugary drink companies on their campuses. Moreover, the national education policy organization demands that selling these products on school campuses be outlawed by 2026.

The Case of Tobacco

Once tobacco use was identified as the primary cause of lung cancer, chronic obstructive pulmonary disease, and cardiovascular disease, behavioral and social science research informed the smoking interventions that took place at an individual, community, state, and policy level. The result was a dramatic reduction in US tobacco use since its peak in the 1960s and an eventual decline in overall cancer death rates. The key driver was a dramatic reduction in male smoking rates from 54 percent at their peak in 1965 to 24 percent in 2008. In that time span, more than 46 million Americans stopped smoking. This is considered by many to be the most successful public health intervention in recorded history. Behavioral and social sciences (and not healthcare or biomedical research) accounted for much of the success in understanding the multiple determinants of smoking initiation and cessation. Numerous approaches have been undertaken, such as policy interventions and cessation and prevention programs, as well as communication of the risks associated with tobacco use. Of these, policy interventions (such as smoking bans and cigarette taxes) have been found to be among the most effective strategies for reducing smoking prevalence. Thanks to behavioral and social science research, tobacco use has been curtailed on a massive scale despite the highly addictive nature of nicotine.

The 1964 report of the US surgeon general, which linked smoking and lung cancer, was followed by multiple reports connecting active and passive smoking to myriad other diseases. Early antismoking advocates, initially isolated, became emboldened by the cascade of scientific evidence, especially with respect to the risk of exposure to secondhand smoke. Countermarketing—first in the 1960s and more recently by several states and the American Legacy Foundation's "truth" campaign—linked the creativity of Madison Avenue with messages about the duplicity of the tobacco industry to produce compelling antismoking messages. Laws, regulations, and litigation, particularly at the state and community levels, led to smoke-free public places and increases in the tax on cigarettes—two of the strongest evidence-based tobacco-control measures. In this regard, local governments have been far ahead of the federal government, and they have inspired European countries such as Ireland and the United Kingdom to make public places smoke-free.

Source

Institute of Medicine. 2007. Ending the Tobacco Problem: A Blueprint for the Nation. Washington, DC: National Academies Press. https://doi.org/10.17226/11795.

In the Appalachian region, employers are concerned about the impact that opioid use and overdoses are having on their businesses and on the health and well-being of their employees. State government attempts at various interventions, such as regulating opiate drug prescriptions, have proven largely ineffective, so local stakeholders experiment with approaches to deliver more effective and holistic interventions. In West Virginia, employers and local health departments partner to develop new harm reduction programs, while insurers agree to increase access to behavioral health counseling and treatment for the consequences of traumatic experiences.

Joint research between the Environmental Protection Agency, the National Criminal Justice Association, and the National Institutes of Health reports that a rise in chronic illnesses and antisocial behavior in adults and developmental delays in children can be attributed to lead poisoning. The problem is particularly urgent in low-income and minority urban and rural communities, where, for example, housing is situated near manufacturing plants and where lead paint has not been removed in lower-income housing stocks. A task force is convened by nonprofit environmental organizations and public health officials to respond to the crisis in states that are the most affected, including New Mexico and Nebraska. They work to develop customized interventions such as monitoring and reporting policies and standards for remediation of contaminated industrial zones before new housing developments can be built.

To get at the root causes of illnesses that emerge in adolescence and adulthood and keep employees away from work, such as mental health disorders, alliances nationwide call for funded initiatives that target early childhood development, particularly those focused on reducing adverse childhood experiences. They pool financial resources to try out approaches that target all forms of abuse and neglect. They also stress the need for programs that provide parents and caregivers with supports to provide safe and trauma-free environments for children—for example, child development and parenting classes to understand children's behavior, parent support groups to increase resilience, and timely access to resources such as food and clothing in emergencies.

State-Level Efforts to Address Health Disparities

The US Centers for Disease Control and Prevention and the Rhode Island Department of Health are collaborating in 10 Health Equity Zones (HEZs) across five counties in Rhode Island to support innovative approaches to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions of neighborhoods.

A HEZ is an economically disadvantaged, geographically defined area with documented health risks. A group of volunteer stakeholders, organized as a "HEZ Collaborative," works to achieve health equity for the residents of the HEZ by eliminating health disparities and using place-based strategies to promote healthy communities.

The work of each of the 10 HEZs is to be implemented over a three- to four-year period beginning in 2015, with year one devoted to community needs assessments. HEZ work plans, based on the needs identified and prioritized in year one, focus on the residents in neighborhoods that each HEZ serves. The HEZ work plans present ideas and approaches to invest in local communities and improve population health. Community engagement is a priority in reaching these public health goals.

To illustrate, the North Providence HEZ focuses on the neighborhood elementary school and middle school and the identified health needs of those students and their families. Another example is the Bristol HEZ, which focuses on improving nutrition and access to healthy food, promoting physical activity, facilitating community public health events, adopting Complete Streets policies, facilitating health literacy classes and health screenings, and offering a diabetes prevention program.

Source
http://rilisc.org/hez/

Comprehensive health legislation develops over time

In 2029, dozens of successful state and regional initiatives to regulate and invest in more holistic approaches to health are scaled up and adopted by the federal government in the form of new bills and regulations. Some coalitions are satisfied with these new laws and the influence they have had over them, while others continue to advocate for changes that align with their agenda. Public opinion on these laws and regulations is mixed. For example, new taxes to pay for federally provided health infrastructure are controversial. In addition, there is criticism that the government is overreaching into people's lives and personal freedoms by taxing unhealthy behaviors.

Coalitions and different levels of government recognize that implementation efforts are not perfect and that even with the best intentions and structures, some people still get left behind. As such, lawmakers are kept busy with constant attempts to refine policies and regulations through trial and error with ongoing multi-sector input and influence, all in an effort to improve the health of the public and drive down healthcare costs.

By 2030, a complex set of federal regulations and legislation exist that are designed to incentivize investments and behaviors that promote holistic health. New laws and regulations have been successfully implemented and show signs of contributing to the reduction in chronic diseases and gains in overall health among people who were most at risk. As such, healthcare costs have begun to stabilize or decline, depending on the region. Professionals who are working to drive down the costs of healthcare increasingly pay attention to the social determinants of health to make evidence-based policy decisions. Nationally, both health and health equity are gradually improving.

Inside the Conference Room

Poem by Tassiana Willis

This building has a constant revolving door where talking heads
come in and out
20 of the largest employers in the United States
Are all facing similar issues of employee sickness causing
retention rates to go down
All while health care costs go up
The scale tipping in no one's favor

Imagine a large table
With freshly pressed suits lining the edge of it
Steam from their ears dissipating
The room is hot
No one takes off their jacket
Too afraid of that *something up their sleeve* slipping out

Each of their companies a cord to America's economic lifeline
A draining mutuality of rules and regulations
There has been much conversation
Many words, spilling onto conference tables
And into the lap of those who were never taught to clean it up
Unfortunately, while they talk about the mess some are living in it

John, a once healthy guy recently underwent a leg amputation
He wonders what choices do you really have when fast food chains
All have you surrounded
When advertisements feel more like peer pressure and bullying
And a week off from work when you lose
your best friend to addiction
Doesn't seem like enough
And depression isn't covered in your health care
With the weight of the world on your shoulders
And only one limb to stand on
What can you do?
Who is responsible when a nation
Is too sick, too sad, too high to work?
When that nation's checks and balances continue to tip...toe
around the root causes of social determinants of illness

For years these companies have tried to tackle this issue
They are afraid that if they don't get to the root cause of major
health crises like type 2 diabetes and opioid abuse
America's largest industry will be death.
At least that is their plea to government.
Because if we don't
We will no longer be the land of prosperity and productivity
But the land of coffins and catch-up


REFUGEES
WELCOME
FUNDRAISER
BBQ
ANNOUNCEMENTS
BLACK
LIVES
MATTER
MISSING
Open garden!
FREE
CLASSES
IN THE
PARK

Kitchen Table

In ***Kitchen Table***, civil unrest and local grassroots activism are fueled by groups of marginalized and vulnerable people who are unable to access the resources they need to be healthy. Across the country, activists and community organizers experiment with different approaches to give voice to their concerns and to demand action. Multi-sector collaborations, led by local institutions, form to drive action at the local level.

The primary force driving change
Governments and corporations are not providing health, so people organize to do so themselves

Whose needs drive change
People who have been marginalized and ignored

The thinking that drives change
Health is a right that people must fight for

Who drives change
Community organizers and their allies

How change is effected
Local grassroots initiatives and regional coalitions

The risks of these changes
Confrontation and unrest

The results of these changes: the state of health and health equity in 2030
Health outcomes and especially health equity have improved but only in those regions with strong grassroots movements

Government action and inaction lead to civil unrest and grassroots activism

In this scenario, both action and inaction by government agencies and local authorities to address health inequities spark civil unrest and grassroots activism by those who have been historically marginalized as well as the white middle class. For example, in 2018 the federal government reduces the US Department of Housing and Urban Development's budget by 20 percent. This results in changes in Section 8 housing assistance and cuts to the housing choice voucher program benefit, which is reduced by as much as 50 percent. In addition, time limitations are introduced for the Veterans Affairs supportive housing program such that benefits are available for a maximum of three years.

Throughout 2018 and 2019, communities of color in St. Louis, Orlando, Los Angeles, and other large cities continue to experience highly disproportionate rates of police violence perpetrated against unarmed civilians. The US Department of Justice confirms that evidence of implicit bias and systemic violence within law enforcement agencies is largely unchanged. Already angry and exasperated, local communities and activists across the country are outraged at the death of an unarmed woman of color in Florida at the hands of police; the incident sparks large marches and demonstrations.

As several years pass without people in marginalized and vulnerable communities experiencing improvements in their health and well-being, the sense of frustration and hopelessness grows. A 2020 national values survey indicates indicates that Americans living at or below the poverty line, as well as those in the middle class, are increasingly pessimistic about their ability to access safe and affordable housing, secure good jobs, or complete their education. In the face of escalating tensions and violence, growing numbers of people and local institutions turn to community organizing to demand and effect change.

Activists experiment with different social change approaches

In different regions of the country, activists make use of a variety of approaches to develop solutions to the social, economic, and environmental causes of illness in their communities. Protests occur throughout the country, bringing together diverse groups of people and interests who see the connectedness of their struggle. For example, in California and Texas, rural farmers join labor unions to demand workplace health and safety regulations. In Georgia and Florida, people of different ethnic backgrounds, LGBTQ communities, and people with disabilities join to dismantle the structures that uphold the state-sanctioned violence that negatively impacts their lives.

Other community organizing efforts use social media as a platform to bring attention to their causes and encourage action on the part of residents. For example, in 2020 a nonprofit food center in Chicago launches a social media campaign to draw attention to the existence of food deserts in African American neighborhoods. They point to the fact that because there are no supermarkets in certain urban areas, residents are forced to do all their grocery shopping at convenience stores. As a result, they have limited food options, and sales of processed and frozen foods are disproportionately high in these communities. In an effort to increase access to healthier food, followers of the campaign are encouraged to write or call their local government demanding that they intervene and increase access to fresh fruits and vegetables at affordable prices.

2017 Women's March

On November 8, 2016, Teresa Shook took to Facebook and created an event to march for women's rights. She invited forty of her friends, but overnight 10,000 strangers RSVP'd to the event. Eventually somewhere between three and four million Americans all over the country participated in the march on January 21, 2017.

Notwithstanding the controversy the march raised due to competing ideologies among organizers, it did make a contribution to having marginalized voices heard. Marchers participated to advocate for legislation and policies regarding human rights and other issues, including women's rights, immigration reform, healthcare reform, reproductive rights, the environment, LGBTQ rights, freedom of religion, and workers' rights. According to organizers, the march was meant to "send a bold message to [the] new administration on their first day in office, and to the world, that women's rights are human rights." The march was streamed live on YouTube, Facebook, and Twitter.

Sources

https://www.washingtonpost.com/news/local/wp/2017/01/31/the-woman-who-started-the-womens-march-with-a-facebook-post-reflects-it-was-mind-boggling

https://en.wikipedia.org/wiki/2017_Women%27s_March

http://www.huffingtonpost.ca/entry/why-i-had-mixed-emotions-about-the-womens-march_us_588651a8e4b070d8cad4656e

Other organizers utilize storytelling events to create opportunities for collective healing in divided communities. The stories people tell reveal overlooked aspects of American history—how, for example, the legacy of slavery, displacement of Native American people, annexation of Mexico, Japanese internment, and the Chinese Exclusion Act all contributed to the current reality of poor health for many people in those communities. Community organizers partner with local mayors' offices to facilitate these events, which spark conversations across gender, racial, class, and geographic lines. Many report that after hearing these stories, they have a deeper understanding of the challenges people living in their community face. As a result, they advocate for city officials to invest in approaches designed to counter health inequities in their communities.

Welcome Tables

The Welcome Table is a process designed by the Winter Institute to help create relational trust, unity, teamwork, and cohesiveness in a group of community members who have expressed interest in improving racial relations and addressing other problems in their communities. The process shares with these community members better ways to communicate with each other and, by extension, with people from different ethnic groups in their communities as a whole.

New Orleans Mayor Mitch Landrieu has delivered on his promise to create opportunities for racial reconciliation and healing by engaging citizens throughout the city. From 2014 to 2016, the mayor's office hosted the Welcome Table New Orleans initiative. The project brought together diverse groups of New Orleanians to share experiences and stories, build relationships based on understanding and trust, and identify opportunities to collaborate to create a stronger city. By 2016, over 100 residents from eight neighborhood circles completed 22 reconciliation projects.

One result of the Welcome Table gatherings and related coordinated efforts was the adoption of the Equity New Orleans strategy in the spring of 2017. This initiative drives how city government seeks to understand and address equity in New Orleans in a data-driven, strategic manner in order to identify the best and most immediate opportunities for the city to demonstrate equity in policies, programs, and service delivery.

Sources
http://winterinstitute.org/
http://equityneworleans.org/

Multi-sector collaborations form to improve individual and community health

Meanwhile, the federal government remains unresponsive to the demands of citizens. As a result, multi-sector collaborations form to develop localized investments and approaches for improving individual and community health. Residents, community groups, schools, faith-based institutions, nonprofit organizations, local health systems, health departments, and anchor businesses all participate. Together, they identify urgent health needs that they can collaborate on addressing, such as teenage pregnancy, community safety, and tobacco use.

After several years of coordinated action, these collaborations contribute to an increase in trust and social capital among the people in these communities. Local leaders experiment with new approaches to deliver health. Some areas see the emergence of localized micro-health systems funded by philanthropic investments and pay-for-service revenue streams. Resident-owned health insurance cooperatives are established, which contribute to the accumulation of collective local wealth. In other places, residents form buying clubs for prescription medications. As a result, more Americans have access to healthcare services at the neighborhood level, as well as the social determinants of health. A level of self-sufficiency exists that is not dependent on the actions of the federal and state government.

ACT UP: AIDS Coalition to Unleash Power

ACT UP is an international direct-action advocacy group working to impact the lives of people with AIDS and the AIDS pandemic to bring about legislation, medical research, treatment, and policies to ultimately bring an end to the disease by mitigating loss of health and lives. The group is most closely associated with the life-or-death struggle associated with the HIV/AIDS epidemic in the 1980s, which engaged government and industry players in the creation of solutions to expedite the availability of medication for people with AIDS.

As the number of deaths due to HIV/AIDS mounted, men and women fought to save lives by demanding that public officials, religious leaders, and pharmaceutical companies create effective treatments and make the treatments widely available. Members of ACT UP achieved this by educating themselves and partnering with researchers, communication executives, and lobbyists to push for change. Thanks to the movement, HIV evolved from a fatal infection to a chronic disease that can be managed, thus prolonging the lives of more than 16 million people around the world. The LGBTQ community became a force to be reckoned with in politics and business.

Some 30 years after its founding, ACT UP's work has become a living example of the power of political activism. Their legacy includes:

- *Countering the power of fear and homophobia.* In the wake of the AIDS crisis, the very people who inform the masses and put laws in place chose to instill fear and homophobia rather than truth. Their uninformed opinions deterred advancements from being made in the field of AIDS research and likely caused countless unnecessary deaths.
- *Leveraging the power of knowledge.* With death as the ready-made option offered for people living with AIDS, the only way the HIV-infected community could reach for life was through self-education. They became scientists, learning the chemistry behind HIV, how it multiplies, how it divides, how it kills. They became politicians, learning the legal loopholes and political blockades that held up the necessary funding for research and kept drugs from being made available to those in dire need. Arming themselves with knowledge, members of the movement waged an unbeatable war.
- *Utilizing the power of political action.* Dr. Emilio Emini, a pioneer in the field of HIV vaccine research, was on the verge of quitting the movement time and time again. The going was tough, no advancements were being made, and there was seemingly no end to AIDS in sight. Then along came political activists with fire in their bellies and an undying will to fight until a cure was found—a cure made available to the general public through legal, fair means.

ACT UP's founder, Larry Kramer, has said, "Every single drug that's out there is because of ACT UP, I am convinced. It is the proudest achievement that the gay population of this world can ever claim."

Sources

https://en.wikipedia.org/wiki/ACT_UP

http://influencefilmclub.com/wp-content/uploads/2014/07/How-to-Survive-a-Plague-Discussion-Guide.pdf

Community organizing and collaborations produce mixed results across the country

In 2028, there are differences in how much local and regional activism has been able to succeed. In neighborhoods where the urgency of the health crisis is high, leaders have an easier job of sustaining their community's organizing efforts because there are large numbers of people who are determined and relentless. In some places, animosity grows between once-aligned activists and social change groups because they disagree with one another's approaches. The most successful change is rooted in places where multi-interest groups can successfully and consistently collaborate, political institutions are responsive, and the economic means are available to invest in responding to residents' demands.

By 2030, community organizers in some regions have successfully increased investments in and access to the social determinants of health for marginalized and vulnerable people, with successful multi-sector collaborations having reversed negative health trends on specific, urgent issues. Where local leadership and collaborations are effective, metrics of well-being adjusted life years improve, and health outcomes improve, especially health equity, indicated by more equal life expectancies between different groups. But in other places, citizen-led movements are unable to sustain themselves, and conditions worsen for the marginalized and vulnerable, and health outcomes continue to decline and health inequities increase.

At the Kitchen Table

Poem by Tassiana Willis

Terrisa is a first generation graduate with a double major in Anthropology and Business
She would have traded in Business for Black Studies but her grandmother fell ill in 2017 the same year she lost her Medical
Terrisa promised her she would take care of the family business if anything should happen
And it did
With stage 4 cancer and the stress of taking care of her family, and not having adequate health care Terrisa's grandmother found herself at an intersection very few could survive crossing

Her grandmother owned one of last few bakeries in her home town
The locals called her Peaches in honor of her making the best peach cobbler this side of heaven
Legend has it, she stole the recipe from G/d himself

Normally, at this time of night the bakery would be pitch black
But tonight it is filled with bodies, some wear suits, others in tank tops, dresses, high heels, boots, crocs, jeans
There is paint, stencils and cardboard all for tomorrow's protest
See, at this kitchen table, you must pass the politics and pastries
And cherish the smell of snickerdoodle cookies never leaving the air
Tonight they are fed up with the lies and pacifying
remarks from the administration
Here they are not waiting to be served, they are the ones creating the recipes for health

Mark, Peaches' former doctor, the one helping the young people make "What's our fate if we have no Section 8?" signs, donates his time one Friday a month to answering any questions people have about cancer.
Not every recipe is a family heirloom, some things must be pulled out of thin air because the circumstance calls for it.

Julie, who helps at the bakery, is a licensed dietician. She and Terrisa worked together to revamp her grandmother's recipes so that they could provide gluten free options. They also worked together to cut out half of the sugar and the loyal customers barely tasted the difference.

One of the ballet teachers offers her dance studio to healers so they can have free healing circles.
There is no pill for poverty, no pharmacy holds the answer to Post Traumatic Slave syndrome.

They all have learned together, that power is in the hands of the people.
That the government's one size fits all sick care system
seems to fit few, if any.
They have learned, that laughter lasts longer than most prescriptions and an aching side is the best side effect.
That it is less about who owns the table and more about who it is trying to serve.

And in moments like this, when the bakery becomes the beckon and backbone of the community, Terrisa wishes her grandmother could be there to see how one piece of peach cobbler could transform a community.

Comparison of the Scenarios

Marketplace

The primary force driving change	The federal government reduces its role in funding and regulating healthcare
Whose needs drive change	People concerned with high costs and government interference in healthcare
The thinking that drives change	The thinking that drives change Healthcare can and should be provided by markets
Who drives change	Federal elected politicians and health-care companies
How change is effected	Transfer of funds and authority to state and local governments and to private companies
The risks of these changes	Markets deliver health only for those with money
The results of these changes: the state of health and health equity in 2030	Pockets of market-driven innovation but growing gaps between haves and have-nots

Conference Room	Kitchen Table
Healthcare costs are uncompetitively high	Governments and corporations are not providing health, so people organize to do so themselves
People concerned with the ability of the health system to deliver health	People who have been marginalized and ignored
Health can be obtained only through systemic perspectives, negotiations, and regulations	Health is a right that people must fight for
Large employers and public health officials, who influence federal and state legislators	Community organizers and their allies
Experimentation leading to interventions and investments in and regulation of the broader health system	Local grassroots initiatives and regional coalitions
Slow-moving health bureaucracy	Confrontation and unrest
Nationally, both health outcomes and health equity are gradually improving	Health outcomes and especially health equity have improved but only in those regions with strong grassroots movements

Contributors

The Scenario Team is made up of people who are representative (but not representatives) of the whole system that produces individual and community health and illness in the United States. Individually, they are respected leaders of their own sectors; as a team, they have a range of backgrounds and perspectives (sectoral, ideological, professional, geographical) that enable them together to grasp the emerging system as a whole. Groups represented in the project include system leaders from public health, public policy, government, business, education, rural health, Native American health, the arts, philanthropy, healthcare, community organizing, and others.

Because these scenarios represent three different pathways forward, almost every scenario team member disagrees with elements in at least one of the scenarios. As a consequence, this list represents not a consensus on policy recommendations but the people themselves—a group of diverse, committed, and caring professionals who worked together in the hope that these scenarios might encourage a dialogue that will help the United States move toward achieving health and health equity.

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Health System Scenarios: Possible Futures for Health and Health Equity in the USA, 2017–2030

User Guide

About the Scenarios

What are the scenarios and why should I use them?

The *Health System Scenarios* are the collective creation of a group of 22 system leaders from across the country. This team worked together, in nine days of workshops, to identify key forces at play, ask burning questions, and create stories about what the future of the American health system—and consequences for health equity—might hold.

The group built three scenarios for how the health system could change in the United States:

Marketplace, in which change is driven by politicians, companies, and consumers who are concerned about excessive government regulation

Conference Room, in which change is driven by governments, employers, and other powerful stakeholders who are concerned about the high economic costs of illness

Kitchen Table, in which change is driven by activists from marginalized and vulnerable communities who are concerned about inequity

These scenarios are ***not predictions.***

They are ***not proposals.***

They are ***stories*** that describe possible pathways into the future to help us talk and think more deeply about our current reality.

The purpose of the exercise is to:

- Catalyze open and reflective *strategic thinking and conversation* among Americans about the possible futures of the system that produces individual and community health and illness and health equity, and about the opportunities, risks, and choices these futures present
- Stimulate individual and collective *strategic actions* to influence these futures

Success of a Scenario

The success of a scenario or set of scenarios is not evaluated by whether these situations occur in the future, but rather by whether they influence the strategies and choices of today. Sometimes the most significant scenario is, in hindsight, the one we manage to avoid.

In developing scenarios, we create a common language that allows us to talk about the challenges of the present and the future. Based on this conversation, we can make choices and form strategic alliances that allow us to promote the future reality that we desire.

Therefore, for the scenarios to be successful, it is essential for people to reflect on and talk about them. This reflection may be individual or collective, face-to-face or virtual. We encourage any concerned citizen to gather with others to talk about the different stories and their implications.

The purpose of structured reflection on the scenarios is not to arrive at a consensus about what *will* happen. It is to engage a diverse group of participants in a discussion about what *could* happen, using the scenarios to inform and inspire individual and collective strategies, illuminate possible pathways, and clarify next steps.

We suggest you familiarize yourself with the content of the three scenarios before using the tools in this booklet.

"The transformative scenario planning process enables politicians, civil servants, activists, businesspeople, trade unionists, academics, and leaders of other stakeholder groups to work together to construct a shared understanding of what is happening and what could happen in their system, and then to act on the basis of this understanding.

The focus of transformative scenario planning is the development, dissemination, and use of a set of two, three, or four scenarios (structured narratives or stories) about what is possible. A scenario is a story about what could happen: an internally consistent hypothesis about the future that is relevant, challenging, plausible, and clear.

Scenarios provide a shared framework and language for strategic conversations within and across stakeholder groups about the situation they are part of and what actions they can, must, and will take to address it. Transformative scenario planning thereby offers a way for social systems to get unstuck and to move forward."

— Adam Kahane
(Author of *Transformative Scenario Planning*)

Individual Reflection on the Scenarios

How do I personally reflect on the scenarios and discover my own role in influencing them?

The *Health System Scenarios* are relevant for every citizen and leader. Everyone has a role in determining the future, and everyone is affected by how that future plays out in the United States.

We offer here a set of questions and tools for individual reflection on the scenarios. We encourage you to engage with these questions personally, whether for five minutes or for several hours, to deepen your thinking about health and health equity in the United States and your role in it.

We invite you to share the results of your reflections, if you wish, with your peers, with partners and collaborators, and even with those you disagree with, through virtual or face-to-face interactions.

Questions for individual reflection

Each scenario

- What feelings does each scenario evoke in me?
- What most stands out for me about each scenario?
- If this scenario happened, what impact would it have on me, my family, my community, and my organization?
- What opportunities can I make the most of and what threats do I face in this scenario? What would I need to do to get by in this future world?
- What can I do today to prepare for this possible future?

The set of scenarios

- What feelings does the set of scenarios as a whole evoke in me?
- What do I see now that I didn't see before?

The future

- What worries me about the future?
- What excites me about the future?

My Role

- What is my sphere of influence?
- What role do I want to play?
- What can I do to influence these futures?
- What actions can I take?

Tools for individual reflection

Contemplating

Contemplation means observing and thinking about something without judgment. You may want to read the scenario narratives calmly and reflectively with the above questions in mind, spend some time in silence, and notice what insights and meaning emerge for you.

Journaling

Writing in a journal is a key tool for learning through experience, by noticing, reflecting on, and documenting how your ideas evolve. It is simply the practice of immediately writing what comes to mind rather than thinking through the ideas first, and involves writing for yourself rather than for others. Journaling is an opportunity to reflect on ourselves, on our context, and on what we are learning.

Drawing

Another useful tool for individual reflection on a set of scenarios is to draw freely. Try, for example, drawing each scenario with yourself in the picture. Or simply draw something that represents the feeling you have when you consider the scenarios.

Thinking with a partner

Together with a thought partner, you may want to express out loud what you are thinking. Have a friend ask you the reflection questions and listen to your answers, provoking you to deepen your thinking as the conversation evolves. Then turn the tables and ask your friend the questions, without expressing your own opinions.

Serenity Prayer

"God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference."

— Reinhold Niebuhr, 1941

Disseminating the Scenarios and Stimulating Public Conversation

How do I effectively present the scenarios to a group and stimulate conversation around them?

The *Health System Scenarios* offer an opportunity to engage many diverse voices across the country in drawing attention to the opportunities, risks, and choices we face regarding the future of health and health equity.

More than a product with a single message, the scenarios are a catalyst to spark reflection, discussion, and action relevant to the diverse social, political, and environmental contexts of different regions of the country.

We want to generate a buzz, repeated across the United States, through different voices and in different words, to provoke strategic actions and deepen the conversation around the future of health and health equity.

You can contribute to this effort by organizing presentations, conversations, meetings, and workshops and by spreading the word about the scenarios through the media and social networks.

You can contribute to the dissemination effort:

Responsively

- Take advantage of existing conferences and seminars you are participating in to mention the scenarios and their messages
- Comment on current events in the context of the scenarios

or

Proactively

- Organize a public event
- Schedule a briefing or discussion meeting for your colleagues, peers, or strategic partners
- Offer a webinar
- Contact the media
- Actively identify your target audience and reach out to them
- Write articles, blog posts, or tweets related to the scenarios and their messages

How to organize an event to present and discuss the scenarios

1. Define the objective of your event.

As the event promoter, you need to clearly articulate the objective. Use the overall scenario process objectives on page 42 as a starting point. You may want to tailor them for your event—for example, "Consider the implications of the scenarios for the xx sector."

2. Decide the date, time, and location.

Decide where and when the event will take place. For a public event, the location should be accessible to people with disabilities and by public transportation. It should be large enough for people to spread out and preferably be equipped with stacks of chairs, a projector, a computer, flipcharts, and markers. We suggest scheduling a minimum of two hours for the event.

3. Invite participants.

Create an invitation with the information on date, time, venue, and objectives. Create a participant list and send the invitation. It's important to extend personalized invitations to the people you most want to attend.

4. Clarify roles.

Define with your team who will facilitate the event, who will present the scenarios, and who will document the results and compile the attendee list.

5. Design the agenda.

See the suggestion on the next page.

6. Document the event and share lessons learned.

Take photos and make note of the key points discussed so you can share them. If using social media, use the hashtags **#PromoteHealthEquity** and **#CultureofHealth**.

Possible agenda for presentation events

0h00 Welcome and opening

The host welcomes the participants and shares the event's objectives. The facilitator explains how the event will work.

0h10 Introductions

Ask each participant to consider, "If you could speak to a clairvoyant, what question would you ask about the state of health and health equity in the United States in 2030?" If your group is smaller than 20 people, ask each person to say their name and their question. If it is larger than 30 people, ask participants to share with their neighbors and then request five or six of the questions to share in plenary.

0h30 Present the scenarios

Use the executive presentation available at www.reospartners.com/healthequity

1h00 Group discussion

Facilitate a discussion in plenary or at small tables followed by a plenary.

- What signs are we seeing in our country today that one or more of these scenarios might be emerging?
- What opportunities, risks, and choices do these scenarios present to us?

1h40 Final reflection

Ask some or all of the participants to share their response to the question, "What do I see now that I didn't see before?"

2h00 Close

Collective Reflection About the Scenarios

How do I facilitate a collective reflection about the scenarios?

Beyond disseminating the scenarios and provoking conversation, you may be looking for an in-depth way for a group to consider the scenarios together. For instance, you may want to host a collective reflection in a community, sector, group of peers, or diverse group of citizens who do not work together in their day-to-day activities.

The intention of your collective reflection may be to deepen the group's understanding of what is emerging or to brainstorm possible actions.

If you want to reach a deeper level of dialogue, we recommend scheduling sessions that are at least four hours long, so you have time to both grasp and internalize the content of the scenarios, and come to new insights about their meaning for the group.

This section offers you tools and ideas for hosting such dialogues.

Levels of Conversation

When preparing for a collective dialogue about the scenarios, be aware that there are different types of conversations. Each type has its place and usefulness, described below. Sharing this language with your group may help you consciously move into a reflective dialogue.

Downloading

Downloading is the mode of conversation in which we say what is habitual, polite, known, or expected. We are essentially outputting our brain's customary responswes as if we were a computer. While downloading may supply the "right" answer quickly and preserve the status quo, it is insufficient when dealing with complex changes in context or seeking to create something new.

Debating

Debating is different from downloading in that we speak our minds openly, even at the risk of generating conflict. The process of actively searching for additional facts, new perspectives, and alternative options represents a significant leap in the level of conversation. But in this mode, we are constantly judging whether we agree or disagree, and our primarily orientation is still seeking to be "right."

Dialoguing

A dialogue is a creative conversation, requiring empathy and self-reflection. In this mode, we listen with attention, speak with intention, and seek to understand and discover new meaning. A truly generative dialogue can help a group discover its shared purpose and develop collective understanding.

Tools for dialogue and collective reflection

Circle dialogue (for up to 30 participants)

Invite participants to sit on chairs in a circle, then present a question to the group. Ask each person to share their reflection on the question, moving around the circle or inviting them to speak as they are ready. The ideal is to hear each person's voice. Encourage participants to listen with attention and speak with intention.

Small-group conversations

Especially if your group is larger than 15 to 20 people, it is useful to break into small groups for parts of the conversation. You may give the groups a task, such as filling in the worksheet on page 57, generating their top three challenges and top three opportunities, or developing three ideas for transformative actions. At the end, come back into the whole group to share learnings.

Paired walks

We often underestimate the power of walking and talking. Most of our meetings are sitting meetings. By walking together, we can seek inspiration, generate energy and focus, connect with our natural impulse toward movement, and deepen our collective reflections. Even a 20-minute walk in pairs to reflect together around a guiding question can make a big difference to the productivity and collaborative capacity of a diverse group.

Sample questions for collective reflection

All the questions from the section on individual reflection (page 46) can also be applied to a process of collective reflection. By sharing our answers in a group, we may deepen them for ourselves.

In addition, there are other questions that are particularly useful for collective dialogue:

- What strikes us as interesting about the scenarios?
- What do we see as the most important forces influencing the future of health and health equity in our country?
- What do we see as the highest potential for health and health equity in our country in 2030?
- What ideas can we think of for actions that could influence the future of health and health equity in our country?
- What signs are we seeing that indicate one or more of these scenarios are realizing themselves?
- What are the most important levers for influencing the future of health and health equity in our country?
- What is the collective sphere of influence of this group?

> "Engaging with the future does not take place in the future; it takes place in the present. Having a future focus changes the way we see the present, so much so that we 're-perceive' that present and its strategic requirements. Learning from the future is exciting and challenging because it changes forever the way we engage with the present."
>
> — Oliver Freeman

Small group conversation worksheet	What opportunities does this scenario present us with?	What challenges does this scenario present us with?	What would we do to adapt this scenario?	What can we do to influence this scenario?
Marketplace 				
Conference Room 				
Kitchen Table 				

The Scenarios in Education Settings

How can I incorporate the scenarios material into an existing educational program?

The scenarios can be a stimulating element in academic programs on healthcare, public health, philosophy, politics, sociology, economics, business, public administration, or other disciplines.

Use the slide presentation provided on the website to prepare a lecture on the scenarios and/or assign the report as pre-reading before you hold a class discussion.

Another option is to organize an academic debate or seminar about the three scenarios, inviting participants to comment on the challenges and opportunities they see reflected in the scenarios and the policy or strategy implications.

Ideas for student assignments

- What signs do you see today of these scenarios emerging? Write an essay defending the plausibility of each scenario, using data on current trends.
- Which scenario do you consider to be the most relevant and challenging? Write an essay or prepare a presentation explaining your argument.
- What will the news media say in the future? Write a newspaper article, press release, or blog entry for each scenario from the perspective of the year 2030.
- Considering these scenarios, what forces do we most need to monitor? Write an essay in which you discuss the patterns and trends you see today.
- Rewrite one of the scenarios, maintaining its essential meaning but contextualizing it specifically for your region of the country.
- Create a role play or art piece reflecting the meaning of the three scenarios for you.

Strategy and Policy Development with the Scenarios

How can my organization or others use the scenarios to improve our strategy or policies?

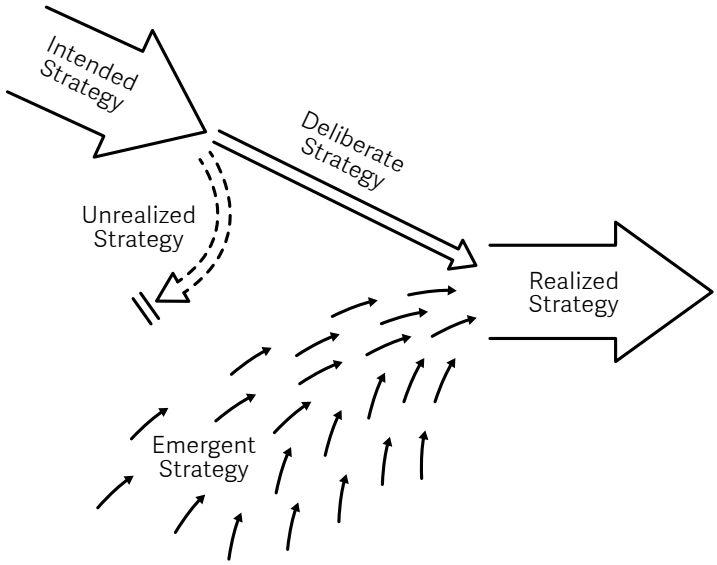
Scenarios are a useful tool for developing or rethinking an organization's or collective's strategy and for guiding the development of new policies.

When we work with scenarios, we are looking at the big picture and the long term. The scenarios do not directly provide the answer for what you should do tomorrow. But by reflecting on the implications of each scenario, you can consider what position you want your organization to be in, what forces you need to pay attention to, and where your effort is best spent in the unfolding future of health and health equity in the United States. The scenarios also create strategic clarity that will help you plan initiatives and actions.

You can customize these ideas, questions, and tools to meet your particular strategic planning needs.

Emergent strategy

In most situations, a group will already have strategies or policies in place, but strategy must be emergent and alive, because the context is always changing. This is particularly true for organizations working with topics as complex and dynamic as health and health equity in the United States.



Source
Henry Mintzberg

Based on the idea in the diagram above, scenarios can help you consciously develop and incorporate the emergent strategy into your realized strategy.

Objectives of a scenario-based strategic planning exercise

- To better understand the driving forces affecting health and health equity in the United States
- To identify the challenges and opportunities the scenarios present to the organization or collective
- To develop strategic direction and priority initiatives for the organization or collective
- To build participants' ability to see the big picture and the long term

Questions for strategy development

- What opportunities, risks, and challenges do these scenarios present for our organization or collective?
- Considering these three scenarios, how do our current strategies hold up?
- What forces, indicators, or warning signals in our context do we need to be paying attention to?
- In each scenario, what position would we want to be in?

- What is our desired reality?
- What strategies/policies do we want to pursue?
- What do we need to stop doing, what do we need to start doing, and what do we need to continue doing?
- What do we need to think about and what do we need to do now?

Tools for strategy development

SWOT

A SWOT analysis is commonly used for evaluating strengths, weaknesses, opportunities, and threats for a particular organization or initiative. Because it provides a framework for looking at both internal and external factors, it is a simple and interesting mapping tool to work with when exploring a set of scenarios.

	Helpful	Harmful
Internal	Strengths In light of these scenarios, what are our organization's strengths in being able to adapt to, or transform, the future of the health system in the United States?	Weaknesses In light of these scenarios, what are our organization's weaknesses that place us at a disadvantage in adapting to or transforming the future of the health system in the United States?
External	Opportunities In our specific context, what opportunities do the scenarios present us with?	Threats In our specific context, what threats do the scenarios present us with?

Work as a group to write examples of strengths, weaknesses, opportunities, and threats on sticky notes and place them on one or more flipcharts. The advantage of using sticky notes rather than writing directly on the flipcharts is flexibility: You can easily change the notes and move them between quadrants if, for example, something that was considered a threat can be rephrased as an opportunity.

The strategy session does not end here. The SWOT analysis is a mapping tool to contextualize the implications of the scenarios for your specific organization before moving on to defining your strategy in light of the scenarios.

Identifying leverage points

A leverage point is a place where you can take strategic action to address a given situation. It is *low leverage* if a small amount of force will lead to a small change. It is *high leverage* if a small amount of force can lead to a *large* change.

In dealing with complex social problems, high-leverage points are those that address root causes. One way to identify root causes is to continually ask "Why?"

> Identify an event that concerns you related to health equity in your context.
> Ask "Why did that happen?" and then ask of the answer, "Why is that?" Continue to ask "Why" until you believe you have reached a root cause.

Having identified the root causes of certain situations, think about your *sphere of influence.* Where do you have the resources and capacity to apply solutions? How can you expand your sphere of influence through partnering?

Next, consider where your organization could invest its energy and resources to achieve the highest impact for the effort invested. Consider, "Where is our power?"

Visioning

In this activity, each participant draws a picture of their desired reality. They should include themselves and the organization in the picture. For inspiration, you may want to consider what is happening in your desired reality for each of the seven differentiators that distinguish the three scenarios from each other. In the comparative table of the scenarios available in the scenarios report, you will see that these differentiators are:

> The primary force driving change
> Whose needs drive change
> The thinking that drives change
> Who drives change
> How change is effected
> The risks of these changes
> The results of these changes: the state of health and health equity in 2030

After drawing the vision, consider:

> What would have to happen for this reality to be true?

> How could this reality come to pass, given the strengths, weaknesses, opportunities, and threats we identified?

Defining your strategic intent

Strategic intent is a clear and easily understandable statement of the actions the organization will take. Based on your SWOT analysis, your leverage points, and your vision, follow these steps to clarify your organization's specific strategic intent:

1. Ask each team member to try phrasing a strategic intent statement.

2. Identify as a group how these statements are similar or different.

3. Seek agreement on a collective statement.

> "Fear and discomfort are an essential part of strategy making...true strategy is about placing bets and making hard choices."
>
> — Roger L. Martin

Brainstorming options and actions

Once you have clarified your higher-level strategic intent, you may want to brainstorm your short-term options and actions.

Start the brainstorm session with this question: "What actions can we take in the next year to help us achieve our strategic intent?"

Ask the group to generate ideas for actions on sticky notes, then briefly read them out one by one.

Guidelines:

> Don't dismiss or debate any ideas during the brainstorm.
> Listen to other people's ideas and see if they spark ideas for you.
> Allow for wild ideas.
> Generate as many ideas as possible.
> Stay focused.
> Be visual—include sketches and diagrams.

As a group, choose the ideas you think deserve further examination. Consider the potential implications and impacts of the scenarios on the identified options.

Prototyping strategic actions

Prototyping is a way to build, test, and refine a strategic action before investing considerable resources in it. It's the process of deploying a series of small-scale experiments to quickly assess the strength of the idea, and then adapting the idea based on what you have learned.

Though prototyping, you take an unproven idea and turn it into one supported by feedback, data, and observation.

Steps in prototyping:

1. Build a model of your idea (this may be a drawing or a 3D model using modeling materials).
2. Invite colleagues to give you feedback.
3. Rebuild the model, taking the feedback into account.
4. Test the initiative at a small scale and closely observe the results.
5. Incorporate lessons learned and further refine the idea.

Prototyping is a learning process. It's crucial to keep a record of the information, insights, and feedback gained as the idea being prototyped evolves. Through iteration, the idea can evolve into something worthy of implementing on a large scale.

Considering internal implications for your organization

Your strategy not only guides what actions you want to take in the world outside, but also reveals how your organization may need to adapt its own culture, capacity, structure, and way of operating.

Consider:

- What organization do we need to become by 2030 to respond to these possible futures?
- What capacities do we need to learn and embody to stay alert and make sense of a fast-changing world and not get stuck in "business as usual"?
- What steps could we take today to become such an organization?

Invite your team to create statements related to what the organization could become. Write each statement on a flipchart.

Ask group members to vote with their thumbs on the statements. A "thumbs-up" means "I agree." A "thumbs-down" means "I disagree." A horizontal thumb means "I am unsure" or "I have a question." Ask those with horizontal thumbs to pose their questions so you can provide any needed clarification. Then ask those with thumbs-down what they would propose instead. Keep the process going until you have a set of five or six high-level statements that most team members agree on and are inspired by.

Then discuss:

- What will help us move forward from here?
- How are we going to drive this process? Who will lead it? If possible, identify a steward for each statement.

The Transformative Scenario Planning exercise on the future of health and health equity in the United States was implemented by Reos Partners with support from the Robert Wood Johnson Foundation.

All the materials produced can be freely used and are available at the Reos Partners website: www.reospartners.com/healthequity

If you have other ideas for how to use the scenarios, please let us know: healthequity@reospartners.com

ReosPartners

Reos Partners is an international social enterprise that helps people move forward together on their most important and intractable issues.

We design, facilitate, and guide processes that enable teams of stakeholders—even those who don't understand or agree with or trust one another—to make progress on their toughest challenges. Our approach is systemic, collaborative, and creative.

We partner with governments, corporations, and civil society organizations on challenges such as education, health, food, energy, environment, development, justice, security, and peace. Our work is pragmatic, professional, and tailored to the needs of the specific situation.

Our name comes from the Greek "rheos," which means "flow."

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