



Summary of CitiZing Online Activity

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Process and Participation Overview: Citizen Solutions is supported by the Bush Foundation with InCommons, in partnership with the Citizens League and a broad and growing coalition that understand the need for a new, citizen-led perspective to inform the state's future health policy. Citizen Solutions hosted five weeks of dialogue online, aimed at bringing diverse perspectives to the Citizen Solutions conversations. Online participation was encouraged at each in-person workshop and publicized by the Citizens League and our Citizen Solutions partners over the course of the project.

Overview: There were five major components to CitiZing.

- Meeting Summaries & Videos: summaries of each in-person workshop;
- Bi-Weekly Discussion: a bi-weekly discussion question;
- Your Stories: a place where people could share their health care stories;
- Open Discussion: discussions started by CitiZing visitors, which could be about any aspect of the health care system on their minds; and
- Resources: health care resources (data, news articles, etc.).

Meeting Summaries: & Videos Summaries of each in-person workshop were completed (approximately 40 in total), providing a summary of the workshop discussion, polling, or “clicker,” data and participant comments.

Four videos, featuring workshop participants, were also featured. These videos were short pieces in which participants: defined health; engaged in a trade-off exercise involving health care rights and responsibilities; and shared their health care experiences.

Bi-Weekly Discussion: Five discussion questions were featured on CitiZing. For each question there was a bi-weekly question-asker who was an individual affiliated with the health care system in Minnesota. In addition, there were seven paid panelists who responded to our discussion questions. The Citizens League identified the question-askers and the panelists.

Your Stories: Seven videos and a few text posts were featured in which workshop participants shared their stories about health and health care in Minnesota. These videos and stories covered topics such as: defining health, trade-offs, healthy lifestyles and wellness; whether health care is a right or a privilege; pre-existing conditions; and the large and inconsistent costs of health care, among others.

Open Discussion: In the Open Discussion section, visitors were allowed to star their own discussion forum, a round a health care topic of their choosing. This space was provide to give visitors a chance to talk about what was on their minds. Seven separate forums were initiated and addressed topics such as: medical tourism; health care advocates; personal observations/experiences; and the ideal definition of “health care.”

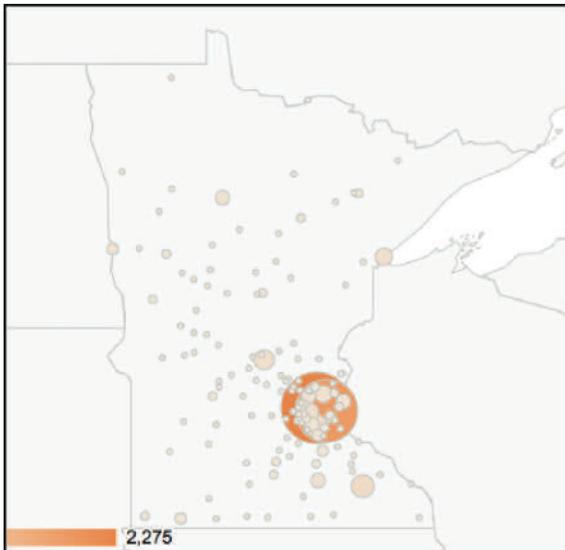
Resources: The Resources section featured all of the data cited in the workshop presentation, along with other articles related to health and health care.

1. In total there were six weeks on CitiZing. The final week, week 6, is not included in this report because of the timing of the discussions, which ran from July 25-August 7.
2. Not all of these panelists were able to respond each week. Discussion questions had between four and six responses from panelists.

Bi-Weekly Discussion Summary: The bi-weekly discussion was the primary focus of CitiZing activities. Every other week, to coincide with the start of a new discussion question individuals who had joined the Citizens Solutions project on CitiZing, as well as those who attended an in-person workshop in the prior two weeks, were sent an email alerting them to the new discussion and encouraging their participation. The site's web address was also provide to everyone at the in-person workshops, through the final slide of the presentation and also on cards which were placed at each table.

Participation Statistics: The Citizens Solutions website had 7,100 visits by 3,550 unique visitors. There were over 700 individuals registered on the project site. (Some of the online participants also attended the workshops, so these totals may contain duplicates.) It should be noted that the project website has a much broader reach than the number who registered—it had 7,100 visits by 3,550 unique visitors. About 88% of the site's visitors were from Minnesota. There were 30,000 total page views, the average number of page views per visit was 4.24 and the average time spent on the site was 5 minutes.

This map represents the geographic location of website's instate visitors (the bigger the dot, the greater the number of visitors):



Summaries of Five Bi-Weekly Discussions

Question #1: Ellen Benavides, assistant commissioner for the Minnesota Department of Health, asked:

Would you support shifting how we pay for health care to spend more on prevention and community health initiatives? What sorts of prevention activities and investments do you think would be most effective in your community?

Everyone who responded to this question said yes, more money should be spent on prevention. There was less agreement on what, specific, prevention activities should be funded, but many respondents said that access to healthy food and exercise were critical components. In addition, many respondents indicated the importance of culture when designing preventive initiatives.

A few comments from the discussion:

"[Prevention] may not always be the most cost effective thing for our healthcare system. While some preventive health initiatives improve our health while saving overall costs, others improve our health while ultimately costing the healthcare system more in the end. Keep in mind, the greatest cost savings for the healthcare system would be if we all just died immediately, but that's obviously no way to think about healthcare costs." – Dave

"I think we should start giving PRESCRIPTIONS FOR FOOD as a preventative. All schools should be educating students and families of healthy eating. All businesses should be having shared walk breaks instead of unhealthy snack food breaks...And we need to learn how to FACE OUR MORTALITY ... it [will] prevent us from over spending on trying to become immortal to learning how to respect and understand death." - Harry

“Prevention’ methods should relate to the realities and methods of persuasion that are designed for the “culture” (i.e. class or ethnicity) most at risk. Focus groups are a good way to go ... Some people can change behaviors way easier than others, because of their circumstances and their sense of self efficacy.” – Carol

“There needs to be accessible information for people to learn how to cook healthy meals on low budgets.” – Dana

“Prevention activities need to be intentionally created around social determinants of health ... the circumstances in which people are born, grow up, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.” – Monica

Question #2: Lisa Nilles, MD, Vice-Chair of Health Care for All Minnesota, asked:

When you think of a “single-payer” system, what comes to mind? Under what conditions, if any, could you support a single-payer system? If none, where do you think a single-payer system misses the mark?

This question, without a doubt, generated the most participation and discussion of all our discussion questions. The majority of respondents supported single-payer, but a few were against it. The majority of people who supported said it would allow for greater access and make health care more affordable. Many of those against a single-payer system questioned how it would be financed, citing concerns over Medicare viability.

A few comments from the discussion:

“Under no conditions could I support a single-payer system. I think it misses the mark in a couple ways: [it doesn’t address] costs, [it builds in] rationing, [it would/could decrease the] quality of care, and [inhibit] medical innovations.” – Cliff

“Our present doctor and consumer relationship encourages doctors to see more people per day. ... The more [patients] seen per day, the more productive is the doctor. Single payer changes the relationship to doctor and patient, giving the doctor time to understand the whole person and see the factors that contribute to the patient’s health.” – Steve

“If you have a single payer buying medicines, that payer could, and should, be able to ensure that everyone gets their needed medication at a price they can afford. The current prohibition on Medicare’s ability to negotiate drug prices for recipients is an obscenity. Every other civilized nation does it, why not ours?” - William

“Regarding the [recent Lewin Group report recommending a single payer health care system in Minnesota], I am concerned by the lack of knowledge of the Minnesota market by its authors. We have been hard at work at both care transformation and payment reform in this state, far ahead of most of the rest of the country, for years. Our cost problems are mostly from the 80-85% of the health care dollar, the care delivery side.” – Linda

“We should not allow our discussion to consider only one payer. The single payer concept can be expanded to a unified buyer system.” – Arthur

“As one looks around the world, some form of a single-payer system is the only way that countries have been able to provide universal access to health care in an affordable way. The U.S. has tried a variety of other ways and continues to fail in both access and affordability. It’s time to accept the inevitable and get it done in the right way. My sense is that a state-based approach with federal guidelines will work best for our large and diverse country.” - Jim

Question #3: Peter Nelson, Director of Public Policy for the Center for the American Experiment, asked:

Would price information on health care help you make better informed choices? What else would be necessary in order for price information to make a difference for you? Do you think this sort of information would slow the pace of rising health care spending?

The majority of respondents felt that transparency in prices would be helpful. However, respondents understood the complications associated with calls for greater transparency in health care pricing. Many indicated the information must not only be transparent, but be paired with information on quality. Many respondents wrote about personal experiences with the health care system they found bizarre or confusing and weren’t sure transparency in prices would make things simpler in the end.

A few comments from the discussion:

“Yes, I believe price information on health care would help us make better choices. However, in our “information and choice overload” society, I don’t think information alone is sufficient ... the information [needs to be] reliable, quickly-accessible, easy-to-use, and we understand our net benefit for doing so ... Besides providing information, we need to share the cost variation so that we are rewarded for shopping for the best quality and price.” – Lance

“...As a health care scholar and teacher, I’m most interested in why such a system exists. Why is the financial relationship between providers, health plans, purchasers, and patients so convoluted?” - Dave

“I believe price information on health care would absolutely help me make better informed choices ... When a person has direct responsibility for costs of some of their medical services that person gets more serious about managing cost. Getting rid of co-pay insurance plans and implementing insurance deductibles would be a big step in making all of us more aware of medical costs and get us motivated to manage those costs. [We also need] better access to cost comparison tools...” – Cliff

“The cost of health care should be transparent, I should be able to find out up front what the cost of a test or procedure is projected to be. However, the cost of some things can never be known--like how would you price open heart surgery? With and without complications? This is not the airline industry where you know the cost ... of flying from point A to point B with two pieces of luggage. And by the way we don’t complain about airlines when they charge passengers vastly different rates for the exact same flight. Why are we outraged when it happens in health care? The problem is the lack transparency not the difference in prices.” – Janis

“The short answer is no... In our fragmented multi-payer system there is no one price... The so called “list price” isn’t the price paid. Unless we had administratively set prices as they do in all other industrialized countries- the question of shopping by price is moot. If one believes that price sensitivity is important, than one should support administratively set/negotiated prices leading to all-payer rates.” - Amy

Question #4: Sanne Magnan, a medical doctor and President and CEO of the Institute for Clinical Systems Improvement, asked:

If you had to divide \$100 among four buckets – health care, healthy behaviors, socio-economic conditions and environment – how would you allocate your money? Why did you choose that allocation? Any specific activities/programs/items you would implement?

Respondents were generally in agreement about a relatively even split between the buckets. However, there were a few respondents who allocated their \$100 more unevenly. Health care was the only bucket everyone allocated money to. Respondents most often awarded their largest allocation to Bucket #1, healthy behaviors. The average contribution and ranges for each of the buckets were as follows:

- Bucket 1: Health care. Average: \$36. Range: \$10-\$80**
- Bucket 2: Healthy behaviors. Average: \$28. Range: \$0-\$100**
- Bucket 3: Socio-economic conditions. Average: \$30. Range: \$0-\$40**
- Bucket 4: Environment. Average: \$12. Range: \$0-\$20**

Question #5: Jenny Peterson, Executive Director for both Generations Health Care Initiatives and HealthShare, Inc. Generations, asked:

What does “affordable” health care mean? What dollar amount would signify an “affordable” monthly or annual cost for health care for you and your family (include the price of an insurance policy and out-of-pocket cost)? What health services are most important to include in an “affordable” health insurance benefit plan?

There was no agreement on what “affordable” should mean, with many saying it was based on income and wealth, among other variables. However, almost everyone mentioned some sort of “sliding scale” or income-based system whereby people who made more money, paid more money and vice versa. Many respondents mentioned preventive services as essential to an “affordable” plan.

A few comments from the discussion:

“I honestly don’t know what I would consider affordable. I am so used to being shielded from the true costs through an employer based insurance system, that I suspect whatever number I’d call affordable, probably isn’t nearly enough to buy the type of healthcare coverage and the level of service I’ve come to expect.” – Dave

“A single person with an income of \$22,000 and little or no savings cannot afford the same for health care as a family with a \$150,000 household income with substantial savings in the bank ... Regarding health services to include in an affordable benefit plan - I’d suggest that a person could choose from a number of currently available plans.” – Cliff

“The health services that are most important to include in an affordable health insurance benefit plan would be annual physicals and doctor visits, any preventive care, basic dental care, prescription coverage, and possible surgery needs.”
- Dana

3. One respondent allocated his \$100 entirely to healthy behaviors saying access and affordability issues could only be solved, in his opinion, at the national level. He argued, then, that – at the state level – he’d allocate the \$100 to healthy behaviors. It could be argued he interpreted the question differently than intended.
4. Four respondents allocated the most money or it tied for their largest allocation to healthy behaviors. Three allocated the most, or an amount tied for the largest allocation, to health care. Two people allocated the largest amount to socio-economic conditions. No one gave their greatest allocation to Bucket \$3, environment.