ReThink Health

Health Care Policy & the Bloomington School of Institutional Analysis:
Opportunities and Challenges of a Regional Approach to Reform

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Comments Welcomed mcginnis@indiana.edu

Topics

- **Linking Health Care and Commons Research**
  - For more details on this topic, see "Caring for the Health Commons: What It Is and Who's Responsible for It" http://php.indiana.edu/~mcginnis/chc.pdf)

- **Implications of the Bloomington School of Institutional Analysis**
  - Health
  - Health Care
  - Health Policy

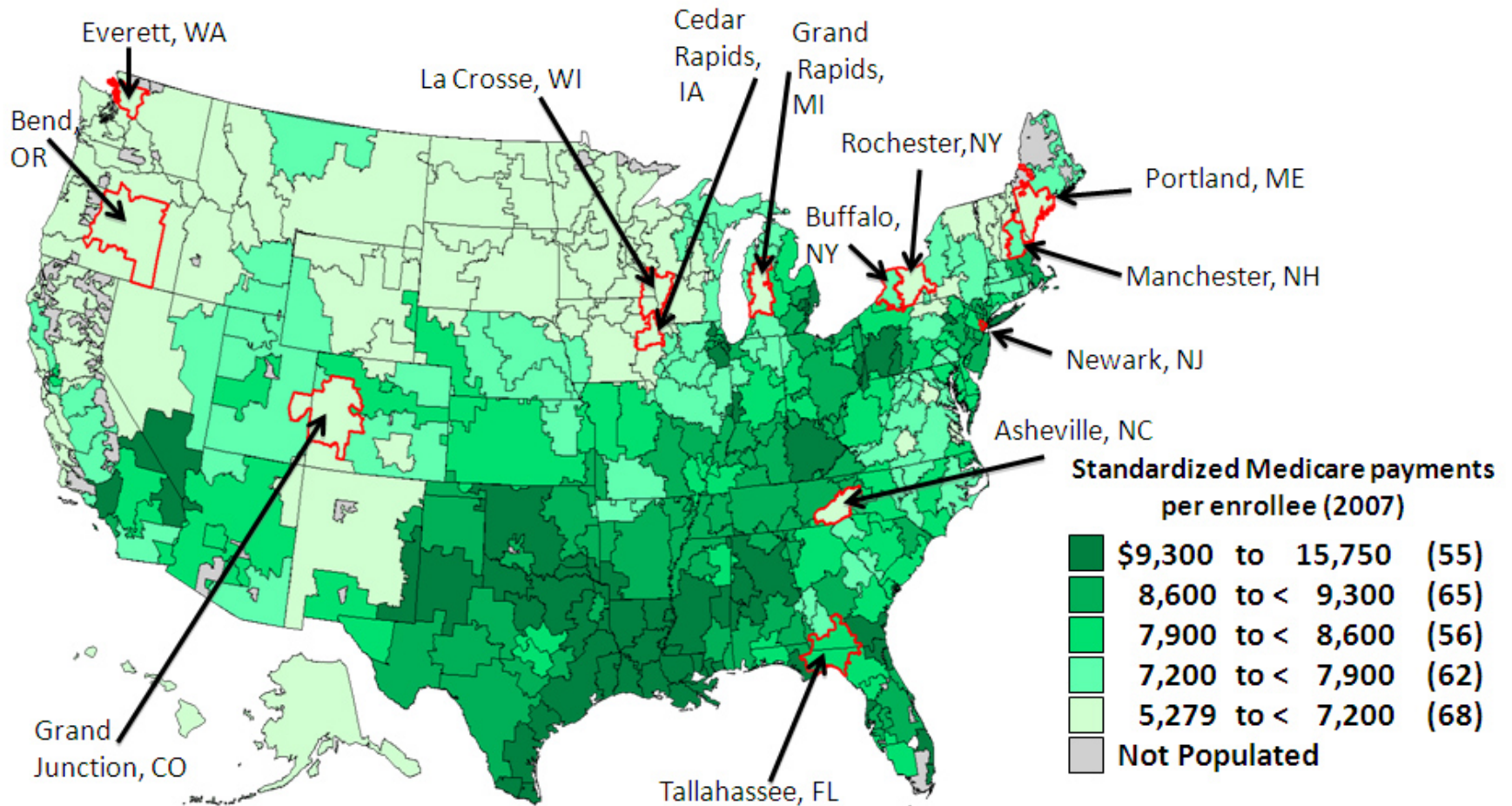- **Alternative Models of Health Stewardship**

- **Alternative Visions**

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Linking Health Care & Commons Research

- **Don Berwick – a tragedy of the commons in health care?**

- **Dartmouth Atlas – why regional variation?**

- **Any relevance of Design Principles to "positive deviants" with multi-stakeholder coordination? – Case study of Grand Junction, CO**

- **Action-research with ReThink Health team/alliance (http://www.rethinkhealth.org/): Upper Valley, NH/VT**

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How Will We Do That?
Participating Hospital Referral Regions

Everett, WA

Bend, OR

La Crosse, WI

Cedar Rapids, IA

Grand Rapids, MI

Rochester, NY

Buffalo, NY

Portland, ME

Manchester, NH

Newark, NJ

Asheville, NC

Grand Junction, CO

Tallahassee, FL

Standardized Medicare payments per enrollee (2007)

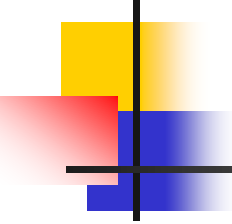|		
	$9,300 to 15,750	(55)
	8,600 to < 9,300	(65)
	7,900 to < 8,600	(56)
	7,200 to < 7,900	(62)
	5,279 to < 7,200	(68)
	Not Populated	

Why Institutional Analysis?

- Might help unite currently separate discourses in disciplines studying pubic health, health care, health policy
- **Help us understand why system is so Fragmented?**
  - Insurance coverage segments population in strange ways
  - Diverse professions, little training in teamwork
  - Many different kinds of hospitals, clinics, physician associations, hybrid consolidations
  - Wide regional variation in cost and utilization of care, and in health outcomes
  - Many different governmental agencies involved, but no policy network for health sector as a whole?
  - No obvious convener for comprehensive planning
- **IAD framework** should be relevant to all these areas

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Bloomington School of Institutional Analysis

- **Vincent and Elinor Ostrom established the Workshop in Political Theory and Policy Analysis, at Indiana University in 1973, and worked there until 2012**

- The **Ostrom Workshop** is an inter-disciplinary research and teaching center where faculty, students, and visiting scholars and practitioners focus on understanding how self-governing groups work to solve their own collective problems and realize their shared aspirations

- The "**Bloomington School**" encompasses their work and that of a large number of their students, collaborators, and colleagues

- **Unusual emphasis on** informal institutions, integration of multiple methods of multi-disciplinary analysis, and on both analytical rigor and policy relevance

- **Series of studies** on police, metropolitan systems, development assistance, resource management, constitutional order, and other topics as they emerge (including my research on health, health care, and health policy in the U.S.)

- **IAD framework** (http://php.indiana.edu/~mcginnis/iad_guide.pdf)

Institutional Analysis and Development (IAD) Framework

- **Institutions** are rules, norms, and other shared understandings that constrain and enable collective action; **analysis** breaks institutions up into their component parts, **development** shows how they change

- IAD emerged during long Workshop discussions and collaborations, intended and used to facilitate communication across disciplines,

- Has become the centerpiece of one of the most influential approaches to the study of public policy in political science and political economy

- Locates **action situations** (choice processes at **inter-locking levels of analysis**: operational, collective, and constitutional) within **institutional context** set by nature of goods/biophysical conditions, attributes of the community, and rules-in-use, with these contextual factors **endogenously determined** by other action situations, especially processes of **evaluation and learning**

How Is IAD Appropriate for this Project?

- **IAD highlights the configural nature of relationships**, since the effects of specific changes are filtered through complex institutional systems.
  - *A key unanswered question is how much value is added (to the now standard repertoire of realized or proposed program improvements) by coordination among regional stakeholders.*
  - *An open question: can IAD handle the requisite level of complexity in health care?*
- **IAD forces policy analysts to dig deeper** into the underlying nature of the problem.
  - *If you change one aspect of a system in hopes of realizing an improvement, you need to learn what deeper forces led to that aspect being in place. Unless you also make changes at deeper levels that divert those forces into supportive results, the status quo will reassert itself, and sabotage your intervention.*
  - *Many good ideas have been tried in health policy, but what's missing is a more comprehensive program of mutually supporting changes at all levels of analysis.*
- **IAD is especially effective when applied to situations in which individuals and groups are able to change the conditions under which they interact**.
  - *This is the crux of the ReThink Health initiative, that local leaders can, collectively, make and sustain the changes needed for a fundamental transformation to a "healthy" and sustainable system of health care in the U.S.*

Implications of Bloomington School of Institutional Analysis

Health

Co-Production

Health Care

Sustainability of Micro-Commons

Health Policy

Regional Stewardship

1. HEALTH

- **Dominance of social & behavioral determinants of health outcomes**
  - Yet little professional contact between public health officials and care providers
  - Reform efforts focus on system of care ("downstream")
- We have built a very expensive system of "**illness care**"
  - Over-utilization is rampant (supply-induced demand)
  - Should focus instead on preventive care
- Ostrom Workshop adopted an early emphasis on **Co-production** and active engagement of citizens
  - Patients need to be more than passive consumers
  - **Shared decision-making** leads to less utilization

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2. HEALTH CARE

Sources of Fragmentation in U.S. health care

- **Federalism**
  - State Insurance regulation, lots of federal regulation and programs.
  - Some local officials manage community hospitals or clinics.
  - Government programs & technology link local, state, national, global.
- **Health care is local and personal**
  - Patients typically go to doctors and hospitals close to home or work.
  - Providers interact with others in that community and neighboring regions.
- **Challenges and conditions vary in a big country.**
  - Diverse challenges set by demographic and economic conditions
  - Many regional "healthsheds" cross state borders, vary widely
  - But clinicians are suspicious of regional variation, tend to see as mistakes, as deviation from "best practices"
- **Professional training and innovations in technology and institutional design**

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Fragmentation as Basis for Transformation?

- **Fragmentation** is evidence of lots of **collective action**.
- Each community has experience with many programs for
  - Clinical care,
  - Insurance coverage,
  - Quality Improvement,
  - Health promotion
- A **micro-commons** designates a **program** (i.e., resources and procedures) developed and operated jointly by different types of health care professionals and other stakeholders.
  - **Each program established for a specific purpose, has rules on access to** prevent overuse and degradation.
  - **Each is a form of common property** (and thus a subject of both cooperation and conflict).
- The **health care system as a whole** consists of the macro-level aggregation of all these programs, and other relevant resources.

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Important Examples of Micro-Commons in Grand Junction

- **B4 Babies and Beyond** (pre-natal and infant care)

- **Marillac Clinic** (for uninsured patients)

- **PCP** (Primary Care Physician) recruitment

- **Financial Pool** to equalize reimbursement across insurance categories

- **Monitor** physician performance to reward excellence and encourage improvement

- **Quality Health Partners**: Health Information Technology

Sustainability of Micro-Commons

- **Micro-commons are not automatically sustainable**
  - Requires careful attention and hard work

- **Is sustainability even a concern here?   YES!!**
  - The underlying problem is unlikely to be eliminated.
  - Solutions to new challenges build on past successes.

- As instances of common property, **Ostrom's design principles** are, at least potentially, relevant as foundation for sustainable operation
  - Need a careful translation of context and interpretation from natural resources to health care context

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Translation of Terms to a Health Micro-Commons

Natural Resources	Health Micro-Commons
CPR = Common Pool Resource (Example: population of fish)	Program (Health Promotion or Quality Improvement)
Resource Unit (example: a fish once it has been caught)	Episode of care for an individual
Appropriation (extraction of resource unit from resource pool)	Benefits received from program
Actors: Appropriators and Providers may be from same group	Individuals appropriate resource units & providers are stakeholder organizations
Provision: replenish resource or construct and maintain infrastructure	Providers make different contributions to program
Appropriation Rules may restrict time, place, quantity, and technology of resource extraction	Rules define eligibility for beneficiaries
Provision Rules specify contributions to replenishment of resource or maintenance of infrastructure	Rules specify which providers are responsible for which services
Rule-making activities by community or by user group	Contracts among providers to deliver services, and insurance coverage to individual or groups
Higher level public authorities may restrict ability of local users to set or enforce own rules	Programs and regulations set by local, state, and national authorities, and by certification organizations
Tragedy of the Commons: degradation or destruction of the resource	Demand for the program's services tends to overwhelm supply capacity
Goal of **Sustainability** (ensure future access to resource)	Financial viability (avoid dependence on grants) **Initial problem is not likely to be eliminated**
Common property (joint ownership)	Jointly operated program

Conditions Facilitating Sustainability in Resource Commons

Design Principles	Facilitating Conditions
Clear Boundaries	Boundaries (on a group's access to resources) set by history of inter-group competition
Long-Term Horizon	Long-term concern implied by users' dependence on access to resource
Wide Participation	Close-knit community insures regular opportunities for communication
Trusted Leaders	Leaders likely to be well-known as members of community
Recognized Autonomy	Autonomy may be recognized by default (esp. for remote regions)
Congruence to Conditions & Values	Local knowledge based on traditions that worked, and reciprocity is critical for survival
Monitoring	Monitoring easy if users remain close to the action and are highly motivated
Graduated Sanctions	Social sanctions can be powerful, and are often finely nuanced
Dispute Resolution	If resolved via traditional methods, disputes can reinforce community ties
Nested Enterprises	Nested enterprises accumulate over time, cover a wide range of situations

*Principles not included in Ostrom's original list, but implicit in her analysis.

These same 10 Design Principles are relevant to health care micro-commons, with some modifications.

Responses to Sustainability Challenges (Grand Junction)

DPs	Challenges to Sustainability	Responses from GJ Micro-Commons
Clear Boundaries	Providers may participate in many programs; beneficiaries may qualify for several programs.	Financial pool established by Rocky and Mesa Co. Professional Independent Physicians Association (MCPIPA)
Long-Term Horizon	Long term commitment may be lacking if successful program reduces the problem	B4 Babies reduced infant mortality rates and achieved significant cost reductions; Multiple efforts to recruit PCPs.
Wide Participation	If program implementation doesn't require close consultation, providers may not feel like a team; Beneficiaries may be passive recipients.	Equalization of payment across insurance categories, coupled with incentive plans, nurtured a sense of community among providers.
Trusted Leaders	Program leaders may not benefit professionally from program success.	Long tradition of collaborative leaders
Recognized Autonomy	Not clear who has authority to initiate new programs.	Long tradition of setting up multi-stakeholder cooperation; no challenges from within region?
Congruence to Conditions & Values	Demand for programs may exceed supply; Information-sharing difficult across organizations.	Exempted physicians close to retirement from required participation in QHP HIT
Responsible Monitoring	Program-specific reporting often lacks comparative context; Consumer opinions are difficult to measure.	Performance data used for bonuses; Consumer use of comparative data.
Graduated Sanctions	Sanctions for low contributions may be toothless, if program is not central to core mission.	Informal sanctions , especially on new physicians.
Dispute Resolution	Program contracts may not specify procedures to resolve disputes.	Informal
Nested Enterprises	Each program may have multiple moving parts; coordination an on-going challenge.	Tradition of discussing programs openly.

Moving to the Macro-Level

In a regional system of the delivery of health care, many micro-commons operate simultaneously

- Each program was established for specific reason, but may later experience mission drift
- Some programs complement or reinforce each other,
- Other programs compete for funding, or undermine each other's effectiveness
- Many gaps will remain uncovered, since they lack some ingredients for getting a program started
- Funding agencies and government programs change priorities often, and often capriciously

If, as is usual, no one is in charge at this level, we should expect to see only more fragmentation.

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3. HEALTH POLICY

- **Health policy** tends to be **seen as something that happens _TO_ citizens and providers**, and not something under their control – remarkable lack of efficacy

- I see major relevance of public administration literature: public officials embedded within cross-sector networks

- Core problem: **missing institutions** !!
  - No one's in charge, at any level
  - Spillovers from other policy sectors, and many effects of health on other sectors; no mechanism to deal with this
  - Spotty record of entrepreneurship, falls well short of a full-fledged "ecosystem of innovation"
    - Even an ecosystem often needs some kind of governance

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Why We Call it Stewardship

- To me this is a problem of governance, but I'm been advised to avoid that word (because it's too close to government)
- Stewardship more appealing, but not ideal either;
  - **Governance**: my definition: the processes through which collective decisions are made, implemented, interpreted, and reformed for some group – processes that are shaped not only by formal government officials but also by private individuals, corporations, and a diverse array of professional associations, community-based organizations, and voluntary/non-profit/non-governmental organizations.
  - **Stewardship**: "the conducting, supervising, or managing of something; especially: the careful and responsible management of something entrusted to one's care." (Merriam-Webster on-line dictionary). Tends to be most easily understood by religious groups or by environmentalists.
- Example of effective stewardship (or good governance?): Grand Junction, CO

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Mesa County Health Leadership Consortium

Health Plan
- **Rocky Mountain Health Plans**

Physicians
- **Mesa County Independent Physicians Association**
- **Primary Care Partners**

Hospitals
- **Family Health West**
- **Community Hospital**
- **St. Mary's Hospital & Regional Medical Center**

Hospice
- **Hospice & Palliative Care of Western Colorado**

Home Health
- **Home Care of the Grand Valley**

Public Health
- **Mesa County Health Department**

Behavioral Health
- **Colorado West, Inc.**

Health IT
- **Quality Health Network**

Underserved Populations
- **Mesa County Human Services**
- **Marillac Clinic**
- **Hilltop Community Resources**
- **Mesa Developmental Services**

Business
- **Grand Junction Area Chamber of Commerce**
- **City of Grand Junction**

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What Do They Talk About In MCLHC Meetings?

- **Issues related to existing programs** that they run collaboratively;
- **Tensions & Externalities:** The costs that one program has imposed on others, and how those costs might be reduced;
- **Gaps** in coverage that remain in their system, and potential new programs to fill those gaps;
- **Opportunities** for external funding of new programs (and the risks of undermining existing programs);
- **Learning** from the experience of colleagues in other regions or areas of work;
- **Reminders of shared vision and overall strategy;**
- **And lots of good-natured banter.**

My conclusion: The MCHLC is a fine example of **good governance** in practice, even though the MCHLC is definitely NOT an official **government** body.

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The Grand Junction "Model" Or Path to Regional Stewardship

<u>Step 1</u>: They assigned priorities to some programs (see earlier slide) and made top priority programs sustainable.

<u>Step 2</u>: They slowly expanded the coverage of these programs, added new programs, and built habits of regular consultation and collaboration

- **Share plans & listen** to concerns of other stakeholders
- **Align organizational goals to community interests**
- **Build capacity** to cope with remaining gaps, in ways that do not result in increased competitive pressures

They built a system of shared stewardship.

Took a long time to establish -- not widely replicable.

- Geographic isolation, sense of community, major providers are nonprofits, dominant payer also nonprofit (Rocky)

Alternative Models of Health Stewardship

Stakeholder Groups and Other Actors

Principles of Design – Commons Theory

Exploring Other Paths to Regional Stewardship

The "Usual Suspects" for Participation in a Regional Stewardship Team

1. **Physicians and other healthcare professionals**
2. **Administrators of medical facilities** (hospitals, clinics, etc.)
3. **Insurers** (commercial and non-profit)
4. **Employers** (health-related and other)
5. **Local government officials** (esp. public health officials)
6. **Community Service Organizations** (public & non-profits)
7. **Professional Associations** (health-related or other)
8. **Individual Citizens** (often as groups with specific characteristics)

Note: This is a highly simplified classification of the relevant actors.

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Who Else Might Want to be Involved (And Who Can Make Important Contributions)?

- Schools, libraries, and educators
- Social workers and therapists
- Exercise and recreational facilities
- Food producers, merchants, and cooperatives
- Local cooperatives and other community enterprises
- Groceries and pharmacies
- Senior citizens (including retired professionals and community leaders)
- Friends and families of patients (including those living elsewhere)
- External investors (especially in social impact bond markets)
- Information technology experts

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Translation of Commons Theory to Regional Health Commons

Natural Resources	Regional Health Commons
CPR = Common Pool Resource (Example: population of fish)	Overall stock of physical, financial, human, and social capital in region
Resource Unit (example: a fish once it has been caught)	Costs of care for individuals in an identifiable population segment
Appropriation (extraction of resource unit from resource pool)	Utilization, total health care costs
Actors: Appropriators and Providers may be from same group	Stewardship Team acting on behalf of population as a whole
Provision: replenish resource or construct and maintain infrastructure	Providers may establish an innovation fund, and agree to reinvest savings
Appropriation Rules may restrict time, place, quantity, and technology of resource extraction	Rules may limit construction of new facilities that duplicate existing services
Provision Rules specify contributions to replenishment of resource or maintenance of infrastructure	Limitations on how parties can spend savings from programs, or what initiatives they should undertake
Rule-making activities by community or by user group	Stewardship team sets priorities for program support and gaps that need filling.
Higher level public authorities may restrict ability of local users to set or enforce own rules	Anti-trust regulations and other restraints on cross-stakeholder collaboration
Tragedy of the Commons: degradation or destruction of the resource	Rising health care costs reduce overall economic productivity
Goal of **Sustainability** (ensure future access to resource)	**Quintuple Aim**: Triple Aim (better health, high-quality care at lower costs), plus Equity and Productivity
Common property (joint ownership)	Stewardship of regional resources

A Strategy for Shared Stewardship of a Health Commons

Design Principles	Guidelines for Stewardship
Clear Boundaries	**Think Systemically**
*Long-Term Horizon	**Align Plans to Community Values**
Wide Participation	**Build Momentum**
*Trusted Leaders	**Find a Trusted Convener**
Recognized Autonomy	**Establish Shared Priorities**
Congruence to Conditions & Values	**Recognize Inequities**
Responsible Monitoring	**Gather and Share Information**
Graduated Sanctions	**Hold Each Other Accountable**
Dispute Resolution	**Address Disputes Honestly**
Nested Enterprises	**Nurture Innovation**

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Two Contexts for Sustainable Stewardship

Guidelines	Informal (Grand Junction)	More Formal Options
Think Systematically	Physical barriers helped create sense of shared community, collective self-reliance west of the Rockies; Rocky and MCPIPA built pool for equal reimbursement	Recognizing systemic dynamics is more important than drawing artificially clear geographic boundaries; Recruit new partners when needed
Align Plans to Community Values	Strong sense of community; Public health concerns becoming more central	Community values need to be clearly articulated, and shared priorities defined and followed
Build Momentum	Monthly MCHLC meetings with explicit agendas, notes; Open discussion of plans and initiatives and unmet needs	Set norms of open discussion, safe harbor; May define complex voting rules
Find a Trusted Convener	Initial leadership from physicians, Rocky (insurance plan) serves as MCHLC convener (and in dominant position local market)	Convener & sponsors need moral authority, with details depending on local context; Public health should play important role
Establish Shared Priorities	Set priorities on B4Babies, primary care, QHN, etc. FTC consent decree in 1988 (but still source of sensitivity)	Priorities can be community "game plan" or more formal statement of priority programs; Anti-trust remains sensitive issue
Recognize Inequities	Limit number of facilities to efficiencies of scale; Allowed older physicians to opt out of HIT upgrades	Confront negative externalities explicitly; Capture & reinvest savings may be effective tool (if targets are clearly stated and measurable)
Gather & Share Information	Locally developed system for patient health information Peer evaluation for physicians Local clinician training	Track changes in community needs & capabilities; Embed measurement in all programs
Hold Each Other Accountable	Informal (esp. lack of patient referral); Common pool for quality performance incentives	Formal specification may be problematic, but informal norms can be powerful
Address Disputes Honestly	Informal committee of local physicians and other healthcare professionals resolve disputes	Mediation options may need to be specified
Nurture Innovation	Shared funding for Marillac Clinic, hospice Reward primary care physicians for hospital visits	Build and sustain effective micro-commons, Monitor regional consequences and fill gaps

General Principles of Design for Regional Systems of Health Care Delivery

Design principles/guidelines for stewardship need to be grounded in and supported by enabling conditions at several levels:

- Characteristics of **individual leaders**: collaborative, innovative, systems thinking
- Processes within **leadership teams** (openness of communication, shared understanding) and
- **Stakeholders** with interests aligned to community values
- Enabling conditions at regional and national levels, esp. **sufficient resources** and **room for local autonomy**

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Institutional Diversity in (More-or-Less) Integrated Regional Systems of Health Care Delivery

- **No regular discussions among all key stakeholders** (Bloomington, IN)
- **Informal consortium of community leaders** (Grand Junction, CO)
- **Bottom-up initiatives** building towards broader discussions (South Carolina RTH group)
- **Regular meetings sponsored by a non-profit organization** (Network of Regional Health Improvement Collaboratives)
- **Multi-Stakeholder Cooperative** (Health Partners, MN)
- **Accountable Care Community** (Akron, Whatcom County)
- **Fully integrated system** (Kaiser Permanente, Geisinger)
- **Association of Diverse Collaboratives** (High Value Health Collaborative)

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Summary of Four Alternative **Models** for Regional Health Governance, McGinnis-Wageman,

Model and Illustrative Example	Who are members (and are Citizen Groups, Public Health, Education, typically included)?	How governing bodies are composed	Scope of authority to allocate resources	Decision making process	Degree of formality, legal status, con-straints	Financial process	Can it cross state lines?	Expand-ability	Anti-trust impli-cations	Impli-cations for care inte-gration
ACC: Accountable Care Community, (example Akron, Ohio)	partnership of community health programs, Public Health is key partner; education and social services, business leaders	ABIA founding partner structure: PH, providers, community organizations	Full range of health care and health promotion; priority setting, integrating initiatives (voluntary by partners)	ABIA builds operational infrastructure to enable targeted multi-party inter-ventions	Coalition	Varies. Outside grants to initiatives; some experiments with PPPM payment	Yes	Easy	None obvious. Consumers are included in decision making	Critical focus of model
MSC: Multi-Stakeholder Cooperative; (example Health Partners, MN)	Consumer groups, providers, insurers, and other relevant groups; Employers, & schools should be easy to include	Represen-tatives of each stakeholder group	Depends on state regulation; could be very broad	Complex voting rules are typical	Varies by state regulation of coops	* Savings can be distributed to members	Possibly, depends on state laws	May require complex renegoti-ation	Unclear, should be OK if consumers included	Depends on priorities of MSC
501(c)3 Non-Profit Organization (Example: Network of Regional Health Improvement Collaboratives)	Donors, volunteers, staff, recipients of services Very easy to include all kinds of groups	Board of Directors (as mandated by state laws)	Can award funds to applicants	Board and Staff	Highly regulated	Members pay yearly dues, but should be tax-deductible	Yes, this should be easy	Easy	None	Indirect, only through grant recipients
Informal collaboration (example: Grand Junction, CO)	Individual leaders as informal representatives of key stakeholder organizations	Mesa Co. Health Leadership Consortium	No direct authority, encourage members to follow "game plan"	Consensus, some voting	Very informal, weak legal status	^ No direct control over any budget	Easy (if near state border!)	Difficult, need common sense of belonging	Sensitive issue, so they avoid too much detail in agreements	Indirect, through many specific programs

Minimal Requirements for Stewardship

To be effective, in any setting, stewards need to

1. **meet regularly,**
2. **set priorities**,
3. **allocate resources** to keep achieving these priorities, and
4. **monitor effects** on the region as a whole.

And a **shared vision** can be a critical foundation

Alternative Visions:

Patient-Centered Care
Progressive Contact
Polycentric Care

Patient-Centered Care

- Critical to **Patient-Centered Medical Home**
  - **PCMH**: "a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety." http://www.pcpcc.net/about/medical-home
    - But individual patients are always in social contexts
    - Some information is too technical, and clinical coordination is beyond their control
    - Patients often need advocate or translator
- **Accountable Care Organizations** take to higher level
  - **ACO**: "*Accountable care organizations* are networks of providers with unified governance that assume risk for the quality and total cost of the care they deliver." (Burns and Pauly, *Health Affairs,* Nov. 2012)
  - But governance requires community-level perspective

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Progressive Contact (an Upper Valley possibility)

System of options across entire continuum of care

- **When healthy**: easy access to health information & preventive health (workplace, pharmacies, schools, etc.)
- **When need 1st contact**: 24/7 access (virtual & urgent care)
- **Primary care options**: physicians, PCMH teams, nurse practitioners, iphone doctors)
- **Acute care**: comparative data, shared decision-making
- **Chronic care**: multiple clinics, in-home monitoring
- **Palliative care**: nursing homes, hospice, home care
- **Community discussion and stewardship**: public forums, web portals, and leadership meetings

Combines virtual and personal contact in each context

Involves many others beyond usual suspects

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Polycentric Care (my favorite!)

- **System of health care governance is fragmented,** and plenty of **institutional diversity**, but it is **NOT a fully polycentric system**
    - **Efficiencies of scale** not fully realized, many missing institutions
    - **Too little coordination** of programs to be a polycentric system
    - Lots of **cost-shifting**, not acceptable on normative grounds
- "A **polycentric organization** has been defined as a pattern of organization where **many independent elements** are capable of **mutual adjustment** for ordering their relationships with one another **within a general system of rules**." (V. Ostrom 1972, in McGinnis 199b, p. 73; emphasis added)
- "The **efficiency of any particular polycentric system** would depend upon … (1) the correspondence of different units of government to the **scales of effects** for diverse public goods; (2) the development of cooperative arrangements among government units to undertake **joint activities** of mutual benefit; and (3) the availability of other decision-making arrangements for **processing and resolving conflicts** among units of government." (V. Ostrom 1972, in McGinnis 1999b, p. 53, emphasis added)

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Challenges of Realizing Polycentric Care

- Information and time requirements
- Coordination costs
- How can partisan entanglement be reduced, given
  - Medicare benefits are big contributor to federal deficit
  - Medicaid is key contributor to state financial problems
  - State insurance exchanges, but will lack of full adoption lead to national exchange?
- Need an inspiring public articulation of normative basis
  - Combination of choice, individual responsibility, local autonomy, equity, free enterprise, professional ethics, innovation, and basic human decency.
- Improve sense of efficacy

Our main lesson is this:

Healthcare professionals and community leaders

CAN and SHOULD

assert ownership of their health commons at the regional level.

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Many important <u>decisions</u> ARE made in <u>local</u> settings:

1. **Recruitment** of professionals in different specializations;
2. Corporate decisions to **build new facilities or to consolidate**;
3. Negotiations among hospitals, physician groups, and insurance plans regarding **reimbursement**;
4. Procedures established within hospitals or physician groups (regarding **quality control**, reducing medical errors, hospitalists, etc.);
5. **Communication among different types of medical professionals**
6. Interactions between individual **patients and clinicians** (especially regarding referrals to specialists or testing facilities);
7. Interactions between **patients and employers** or government agencies offering health insurance coverage or wellness plans;
8. **<u>Sharing of values, goals, plans, and information among providers and with public</u>**
9. Location of parks, bike paths, food stores, and other aspects of the **"built environment"** that affect personal choices for healthy behavior;
10. **<u>Personal choices between healthy and unhealthy behaviors</u>**.

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