Rethinking Health Care and Corporate Governance

Michael D. McGinnis, Ph.D.
Department of Political Science and
The Vincent and Elinor Ostrom Workshop in Political Theory and Public Policy,
Indiana University, Bloomington

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I'd like to start by explaining my title, which can be interpreted in two different ways.

The first and most obvious interpretation is that I will be considering possible changes in two related subjects: (1) health care and (2) corporate governance. This seems reasonable, since so much of health care is delivered by individuals working in and/or being paid by corporate entities, such as hospitals, physician practices, nursing homes, pharmacies, HMOs, ACOs, etc. And much of the behavior of these individuals is shaped by the rules and norms set by the governing bodies of those corporate entities, by their boards or executive leaders, just as much, or even more, than they are affected by regulations set by public officials and standards set by professional associations. Clearly, corporate governance has important effects on patterns of health care.

This is part of my topic, but I am primarily interested in exploring a second interpretation of this title, in which the word “governance” refers back to both (1) corporate entities and (2) health care. This interpretation may seem a bit peculiar, since it is not clear if health care systems are ever governed, in any meaningful sense. But I assert they are, and that we have been discussing proposed changes in health care governance throughout these last few days.

I need to explain that I am treating “governance” as the **processes** through which the rules, norms, and social expectations that guide the behavior of individuals and corporate entities in a given area of policy are established and reinforced, whether by formal or informal mechanisms. Governance is a broad activity that is undertaken by both public officials (in governments) and by non-governmental actors (such as the boards of nonprofit or for profit hospitals and other health care providers).

Generally, especially in the U.S. system, governance is a task undertaken by a complex combination of officials from multiple public agencies as well as by many other important policy actors. It seems like no one is in charge, but that’s to be expected in a political system designed to have lots of checks and balances and in which wide latitude is given to individual or corporate choice. Professional associations play important roles in setting professional standards and norms, and in virtually all policy areas standards are well-integrated into the governance of that sector. Government officials are often deeply dependent on the contributions made by those organizations most closely involved in those activities, dependent on them for information or expertise or recommendations, and especially for implementation of any new laws or regulations. This kind of interweaving of public and private is definitely the case for the governance of health care.

The topic of my talk is the relationship between two kinds of governance: the policies and procedures through with individual corporations operate, and more general and harder to identify sources of the policies and procedures through which health care is delivered to individuals in a geographic region. My focus is on health care governance at the regional level, and I will be making the case that improved regional coordination of health care resources (which I describe as stewardship), is critical for the long-term success of any significant reform of our current system of health and health care.[1] Changes in corporate governance are needed to realize and sustain these higher level policy changes, but my own area of expertise, as a political scientist, lies at the broader level of public governance.

My key point here is that health care governance is not something that "the Government" does to us, but instead governance is something we do to ourselves, and that we reenact and reinforce these process through our everyday behavior. We all shape the expectations we hold for each other's behavior, and new laws and regulations and standards won't have any impact, ultimately, unless

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[1] I make this argument in detail in a paper available at http://mypage.iu.edu/~mcginnis/lgh.pdf. But much of the content of that paper is not directly relevant to the remarks I plan on making during the June conference.

they are somehow incorporated into our mutually negotiated expectations of each other.

At this meeting we've been discussing various aspects of shared decision-making (SDM) or informed patient choice (IPC), which can be manifested in legal, corporate, professional, or more informal ways. New laws could be written that require completion of more elaborate forms, or professional associations could set new standards, but nothing much will happen until those in charge of corporate governance incorporate these procedures and expectations into the organizational culture of their own organizations and these behaviors become ingrained as standard routine for individual health care professionals, as well as becoming part of the expectations of individual consumer/patients.

This is a tall order, but, frankly, it's the only way any meaningful change ever takes place.

For the remainder of my time I'd like to cover two topics. The first is to further explore the challenges in making substantial changes in how our health care system is governed, by looking at the historical record of previous efforts to do so. Then I'd like to conclude with a discussion of another policy area (environmental policy, actually) where a remarkable transformation has been accomplished, and see if we can learn anything from that area that might be relevant for health care.

To put these efforts in historical context, I'd like to shift away from SDM or IPC per se to instead explore another really good idea that has been around for some time, and which also has not been accomplished very widely. There are several such ideas, all relating in some way to improving coordination among providers (either in the form of team-based care of individual patients or more efficient sharing of medical information) or between providers and patients (as in the SDM/IPC area or other means of getting individuals more engaged in managing their own health). The area of reform that I am particularly interested in concerns the higher-level problem of improving and facilitating collaboration among local health care providers, public health officials, and community leaders, to more effectively manage the local health care system as a whole, to steward their collective resources to deliver better care to more people at lower costs.

I emphasize the local context not only because most health care is itself local, but because that is where a considerable portion of the governance process takes place. Political arenas at the national and state level are dominated by partisan debates, but the rubber hits the road much closer to home. I'd venture that both supporters and critics of the ACA can agree that its consequence has been an increasing complexification of health care, by adding new reasons why the costs and quality of care is likely to differ among the states and localities.

Since we're meeting at the home of the Dartmouth Atlas, where the extent of regional variation in health care utilization, quality and cost has been so powerfully demonstrated, I don't need to belabor this point. But I do interpret this situation differently. Many analysts see this variation as a problem that could be solved by wider adherence to best practices by clinicians in all parts of the country. Perhaps, but to me this variation is also a demonstration of the fact that processes of health care governance operate in very different ways in different parts of the country. Part of this variation is due to different social-demographic conditions, but it also reflects the different cultures of practice, the different norms and expectations operating in different localities. In short, regional variation demonstrates the very real operation of governance processes operating in different ways in different parts of the country.

I first became interested in understanding the governance of health care when my colleague, Lin Ostrom, won a Nobel Prize in 2009. Her research attracted attention because she documented the feasibility of effective non-market and non-state solutions to problems of resource sustainability. When she was asked if her research on community-based management of a resource commons was at all relevant to the management of health care systems at the local level, we began a research project, on which I took the lead, and on which I continue to work. We have found some similarities between these two very different policy contexts, but also some differences, especially regarding the relative of identifying regional leadership or stewardship teams in health care hat have the right incentives and capacities to work together to steward their shared resources, while still satisfying their own corporation's core mission.

But today I'd like to focus instead on what I found when I started to look back into the history of previous efforts to establish a more systematic form of health care governance at the community or regional level. I was amazed to find that pretty much the same thing had been proposed, and actively pursued, in separate programs and in different ways, every 10 or 20 years, at least as far back as the

1930s. Different reports used different terminology to describe the problem of the absence of local coordination, and proposals differed in many specifics, but ultimately, it was pretty much the same diagnosis and failed treatment.

I would like to, very briefly, survey the most important previous efforts along these lines, and see if we might learn from their shortcomings how we might do a more effective job of linking improved coordination at many levels.

1. Let’s begin in 1932. A report from the Committee on the Costs of Medical Care made the case for improved coordination at all levels of health care, via such mechanisms as team-based care to group physician practices to regional coordination. But these efforts were too radical, even in the context of the New Deal, and health care coverage was not built into the original Social Security program. AMA concerns played a major role in preventing any implementation of this quite prescient report.

2. The Hill-Burton program (Hospital Survey and Construction Act) began in 1946, after World War II ended. This national program supported production of new hospitals, especially in rural areas, which were supposed to be guided by systematic planning about the level of need for hospital beds and other facilities. However, the planning aspect of this program was not very effective or long-lasting. Subsequent critics saw this program as a major contributor to over-production of hospitals, which led to rising costs in the long run. For me as a political scientist and policy analyst it looks like a perfect example of distributive politics, also known as the pork barrel.

Congress found it easy to spread this money around, because practically every district was getting a piece of the action. Access to basic health care was dramatically improved, but the system as a whole was not moved in a more cost-effective direction.

3. In urban areas community hospitals, often established and funded by local coalitions led by philanthropists, tended to receive the most support under this program. These patterns of Informal coordination led to the establishment of more formal regional health councils in several major metropolitan areas. In 1961 a joint committee of the APHA and AHA advocated an extensive program in Areawide Health Facilities Planning, and this ambition was incorporated into the public health departments in many places, but never fully institutionalized. Instead, community health programs continued to be organized by community coalitions that specialized in locating new sources of external grant funding.

4. These same themes continued to develop throughout the next few decades, although it's not easy to find references to these programs in more recently written overviews of health policy. In the Great Society war on poverty in the 1960s informal "Partnerships for health" proliferated under the Comprehensive Health Planning Act (1966), but these did not receive sufficient funding and lacked any enforcement authority, so they were severely limited by the range of local philanthropic programs. Federally-funded Neighborhood Health Centers were established in virtually all major communities, although the funding levels remained low

and uncertain. Presidential support for these programs crashed during the Nixon Administration, but some support for the follow-up program on Community Health Centers continued for some time. Ultimately, however, there was insufficient support at the national level, and only those centers which received significant support in their local communities continued to operate, as memory of this national program receded from memory.

5. In the 1974 HPRDA (Health Planning and Resource Development Act), more formal Health System Agencies (at both the state and community levels) were required, but again, these were unfunded mandates by Congress that did not last very long, even though, in works written at the time, this act was seen as a major integration of previous programs, including Hill-Burton and the CHP. They kind of faded away, and the best reason I can come up for is that this coalition supporting these diverse programs wasn't stable, and the constituency just wasn't there to support these HSAs. Another requirement was that there would be significant representation of citizens on the boards of these agencies. . But this representation left a lot to be desired, with elite community leaders or other easily co-opted by provider organizations not proving to be very effective advocates for disadvantaged communities. Similar problems of elite-based tokenism tend to occur in later programs with similar stipulations.

6. Starting with New York in 1964, several states began establishing Certificate of Need agencies that required prior approval for any significant expansion of hospitals or other health care facilities. This movement was a response

to the growing costs driven by excessive building, and in the 1974 law Congress mandated that all states set up a CON law. But in 1987 this mandate was rescinded and all federal funding cut off. This generated a pretty intensive debate, and some form of CON still exists in many states. Among the biggest concerns of CON-type procedures are that they require excessive paperwork and are being mired in bureaucratic minutiae, or that they have been captured by market incumbents, who used this requirement to protect their own interests in limiting the entry of new competitors. This is the common story of regulatory capture, which was one of the basic themes behind the deregulation movement of the 1980s and beyond.

7. Another line of reform focused on more market-directed efforts, such as the incentives, beginning in the 1970s, to start establishing HMOs, which grew in importance and especially in diversity of structure. However, these HMOs generated backlash from public, because managed care came to be seen as primarily or even solely interested in controlling costs, and not so much in providing higher-value care. So even the more market-based responses turned out to have significant flaws. Some ACO critics wonder if something similar might be in store for ACOs.

8. Now, in ACA, there are a few requirements to encourage coordination between hospitals and local community leaders, as in the regular reporting of community needs or asset assessments, but we'll have to see if that goes much beyond superficial kinds of information sharing. ACA also provides

funding for innovation programs, but few of these innovations prove easy to scale up to higher levels of operations, or even to be sustained in their original locations.

I’m confident a similar list of past efforts could be provided for antecedents of SDM or IPC, but I’ll leave that task to others. The broader point is that we need to learn from past failures. In each case at the advocates of these mechanisms were surprised by the way provider organizations reacted to these new regulations or new institutions. For a current example, consider the number of private employers who are lowering eliminating health benefits for their employees, or giving them money to buy plans on the new insurance exchanges.

As a policy analyst, I consider this an impressive litany of policy syndromes that suggest reasons why we should expect to see lots of coordination failures. Most of the usual suspects behind policy breakdowns are included, from the excesses of pork barrel allocations, regulatory capture, program chasing by nonprofits, paternalistic philanthropy, the impossibility of comprehensive planning, tokenism, symbolic enactment, unfunded mandates and corporate reaction to new regulations in ways that improve one’s market share.

But we now have enough understanding of public policy that we should be able to anticipate many of these syndromes or other strategic reactions to new regulations. So instead of offering programs of new regulations, or even ones that encourage the development of market options, policy advocates need to think more strategically themselves, and consider the interactions among public, private, and community organizations, as well as the reaction of the public as customers, and build programs that utilize the respective strengths of all of these stakeholders.

It turns out this kind of cross-sector collaboration is all the rage in public administration circles, especially at the regional level. But, somehow, this connection hasn't been made very clearly or convincing for the health care sector. Surprisingly, if you look at the health and health care system, and I mean really look at it, you will see an incredible tapestry of successful collective action, including many targeted programs in which specialists with diverse skills and interests come together to innovate new treatments, promote healthy behavior, or implement quality improvement programs. There already is a lot of multi-stakeholder collaboration in place in health care systems throughout the U.S., but somehow these efforts repeatedly fall short of realizing their full potential.

One way to improve the prospects that great ideas, such as SDM/IPC, or PCHM, or ACOs, or health promotion campaigns, or even improved coordination at the regional level, might succeed, is to go beyond focusing on only one of them at a time. This conference has focused on SDM/IPC, but for its potential to be fully realized, there need to be other supportive institutions in place. Any provider organization seeking to implement SDM needs to find a financially viable business place to make it feasible, and it has to be designed in ways that it actually provides something that the customers want. Physicians may need to be given incentives to participate in these programs, and additional regulations building on an expanded understanding of informed consent can help encourage them to do so, but we can't presume that just by offering it the customers will rush to take advantage of this new and improved product.

It's here that Ostrom's commons perspective has, I think, a unique contribution to make. At one level her research can help us understand the conditions under which collaboration is more or less likely to succeed, but there are other sources for similar lessons, including team-building consultants and leadership gurus and public administration reformers. What's unique is that Ostrom helps us see all the many forms of collaboration all around us, and to focus on the missing steps, the missing links in the supporting mechanisms needed to sustain partial and otherwise temporary successes. Economists often talk of problems being due to missing markets, and advocate expansion of consumer choice into other areas. But I'd rather generalize this concern to cover all kinds of missing institutions.

One thing that missing in today's health system is a sense of ownership, of collective responsibility for the health care system as a whole. We can't delegate that responsibility to someone else, in the form of a health policy czar; nor can we assume that no such leadership is necessary, in hopes that market forces will invariably push us in the right direction. They won't, and no one planner can handle all of this complexity. We need to develop more of a sense of **shared responsibility** for stewardship of the many resources – physical, financial, professional, and social – relevant to health and health care. In any such efforts, all health care professionals, and all need to play an active and supportive role.

Return to my examples of failed efforts to require area-wide health facilities planning. Voluntary coordinating agencies lacked sufficient authority to insure compliance, and tended to search for new sources of funding. CON and other regulatory requirements tended to be captured by vested interests, and/or turned to their own purposes by creative exploitation of loopholes and other strategic responses. So we need something between, or other than, fully voluntary or compulsory policy instruments.

Fast forward to today. Most hospitals have programs of community outreach, and encourage physicians and other employees to volunteer in various community programs. One colleague mentioned to me that her hospital has a "Day of Caring" program once each year that corporate executives use to generate some positive publicity. But these are a sideshow, off the mainline of corporate activities. Meanwhile, regulatory efforts continue to proliferate, but tend to have unintended consequences, since private responses to regulatory requirements tend to focus on opportunities for increasing one's market share, but not with respect to original goals of regulators. Also, too often these regulations are implemented in a one-size fits all format, inappropriate for the local variation of community needs and preferences for health services.

Here I draw again on an analogy to Ostrom's research, which showed that resource-dependent communities don't have to rely on outside management or on market processes to achieve a sustainable regime for governing resource use and replenishment. This surprised a lot of academics, but not so much the people directly involved, from which we can all learn. Well, health care provider communities should be similarly suspicious of any effort to seek solution in better regulations, or in further commodification of their services to more closely approximate market templates. Instead, they should take on the **shared responsibility** of changing the conditions of their own employment. Doing so is by no means easy, but it's also not impossible.

To me these problems are manifestation of ubiquitous challenges preventing improved coordination in health, health care, and health policy. Shared decision-making, patient-centered medical homes, and accountable care organizations are all good ideas that advocate improved coordination between clinicians and patients on which procedures are truly necessary (SDM), between different types of clinicians coordinating care across the continuum of health services (PCMH), and between provider organizations and payers to shift focus to maintaining health rather than just reducing costs(ACO). Regional stewardship takes this logic of improved coordination to the next higher level above ACOs, which is the topic of Elliott's presentation immediately before mine.

None of these ideas (including the need for improved coordination at the regional level) are new, and all have been tried in different forms before, with varying levels of success. I will argue that each of these ideas works best when its implementation is supplemented with supporting changes in closed related institutions or practices, and that none of these improvements can be fully realized (nor long sustained) in isolation.

Let’s return to the core topic of this conference. As should be clear by now, to be successfully implemented and sustained, SDM requires that clinicians be given incentives to spend more time with patients, even if that results in lower utilization of some procedures. Much of the conference discussion can be interpreted as an effort to explore the possible inclusion of additional supports for SDM, specifically by making these procedures a routine part of the legally mandated process of informed consent. Not only would clinicians experience improved job satisfaction and gain materially by engaging in SDM, but they would also be legally required to so as a matter of course. This legal dimension is critical to encouraging corporate executives to integrate SDM procedures into the basic policies and procedures of their organizations. In case this point has been too subtle, we are considering a follow-up conference in 2016 on exactly this point, with a title of something like taking SDM to the C-suite.

I would like to use Elliott’s talk as a point of departure. He discussed the institutional supports needed for a successful ACO, including the point that the contracting parties need a clear understanding of the procedures for sharing of savings or risk. Also, regulations need to be in place that will encourage the formation of this kind of collaboration, by making it financially attractive for the providers to contract together for this purpose. Elliott examined whether ACOs can get members of the public more directly involved, which would be a major move in the direction of what would be needed for better local governance. To make that kind of move feasible, the corporate executives would have to incorporate mission objectives of community concern, beyond just financial considerations. If the ACO concept becomes identified in the public mind with cost-savings, then it is likely to suffer the same kind of backlash that HMOs faced. Elliot has higher aspirations for this concept, which he has championed from the very start.

But we can also learn from successes, even if we have to look for them in unrelated policy areas. How might we build a mutually-reinforcing path of movement to a new equilibrium for the health care sector of our public economy (and more specifically for improved realization of the goal of fully informed patient choice via shared decision making procedures)? Because you might have trouble seeing this as a plausible path, I'm going to first summarize how a similarly multi-faceted set of policy changes has manifested itself in the area of the environmental consequences of industrial production.

Look back a few decades and you'll see an economic system in which producers of all kinds routinely polluted the environment, with little or no consequences to themselves. Increasing concern on the part of the public (and by experts in environmental science) lead to the passage of laws assigning responsibility for pollution to corporate producers. In some states these movements were especially effective in encouraging state executives and legislatures to impose stricter environmental regulations that could be implemented at the national level. Given our complex system of diverse jurisdictions, this led to a race-to-the-bottom, in which poor states (or other countries) offered lower levels of environmental restrictions in hopes of attracting more industry to their areas.

Even so, these regulations established a floor below which environmental conditions were no longer allowed to fall.

But it wasn't just a question of interactions between corporations and government regulators. Non-profit groups acted to enhance public knowledge and concern about the production methods of different corporations, and a process of naming and shaming began. Consumers began to take this information into account in their purchasing decisions, or their broader brand loyalties. Some companies began to play to these emerging tastes by changing their own advertising campaigns. They began to compete over the relative greenness of their own corporate practices, and so we began to see instead a race to the top. Those corporations most effective at capturing this market opportunity did so by deeply institutionalizing green concerns within their corporate practices, not just through tangible incentives but also through nurturing a shift in their corporate culture. Changes in corporate governance were especially effective at reinforcing goals sought by the public and encouraged by public officials. Now many communities advertise themselves to potential employers or workers as being great places to work, thus furthering a competitive "race-to-the-top" in which environmental conditions just keep getting better.

Or course, we still have environmental problems, from the local to global levels, but we're much better off than we used to be, or than other countries are, which lack one or more of these changes. This improvement resulted from an inter-related array of changes by public officials, private corporations, voluntary associations, and individual consumers. It probably wasn't part of anybody's strategic plan from the start, but now that we've seen this process in action, those of us wanting to realize similar progress in the health sector can learn from their experience, and build these ideas into our strategy.

How might something similar look in health care, and how would reform ideas like SDM/IPC or regional stewardship fit into a similar picture? Frankly, the details are for you all to figure out, but here are some generic suggestions I'd like to make.

1. Health care and insurance regulators can set floors on acceptable policies, both in terms of quality control (such as not paying for unneeded surgeries or readmissions) or setting minimal essential benefits of health insurance policies. This is, of course, a major component of ACA. As we've been considering the last few days, one logical next step might be enhanced requirements for informed patient choice.

2. These regulations should include both legal minimal requirements but also incentive packages that encourage over-compliance, moving to even better levels of performance (which is how the ACO idea is supposed to work, by improving value while reducing costs, as well as the many other innovation programs supported by CMS). Some care providers, in some communities, will begin to experiment with the business model needs to sustain SDM programs, and researchers may contribute to making these procedures easier to replicate elsewhere.

3. These changes, by themselves, are unlikely to eliminate the pattern of unwarranted regional variation in utilization, cost and health outcomes, but this variation might become more widely realized.

4. Within any given region, individual consumers may begin to demand better value for their health care costs, both in terms of quality and in terms of better fit to their own true values. To do so they need better access to information, so someone (public officials and/or professional accrediting associations) has to require basic transparency in cost and performance measures, and some provider organizations need to start using their own record as the basis for marketing and increasing their market share. To be sustainable these efforts need to go beyond incentive changes to also implement changes in their organizational culture, or mission.

5. Once this kind of information becomes more widely available, those provider organizations that begin to effectively internalize quality control (reducing medical errors, etc.) and concern for patient engagement (SDM) will be best positioned to succeed in this competitive race to the top. (This is why the members of the steering committee for this conference is considering a follow-up conference in 2016 on the topic of bringing SDM into the C-suite.)

6. And the regional level enters in through the many ways health care providers interact with each other, through building a level of discussion and shared learning. Watched over by a public that expects results, and

that has access to information by which they can evaluate the performance of their local health care system, in comparison to past performance and to other communities,

7. And this information is incorporated into community efforts to attract new jobs and workers, as people seek to move to not just cleaner and safer areas, but also healthier ones.

All this lays out a comprehensive campaign with critical contributions from provider organizations, public officials, professional associations, community organizations, and individual consumer/citizens. SDMs, PCMHs, ACOs, and regional governance all play a role, as does increased transparency and a general emphasis on quality improvement and continual learning. Simultaneous progress on all these innovations are needed to reinforce each other, and some means has to be found to coordinate all this at a regional level, and especially to institutionalize these procedures within corporate structures of all the relevant stakeholders. I wish I could give you one magic bullet to fix the whole problem, or a simple slogan, but that's not the way the real world works.

Now I'll open it up for your questions or suggestions to share with your colleagues about what practical measures might prove to be most important for securing movement in all these directions at once. Thanks.