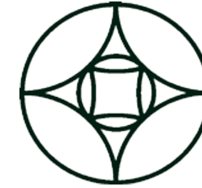

Ostrom Workshop

Towards Local Stewardship of a Health Commons

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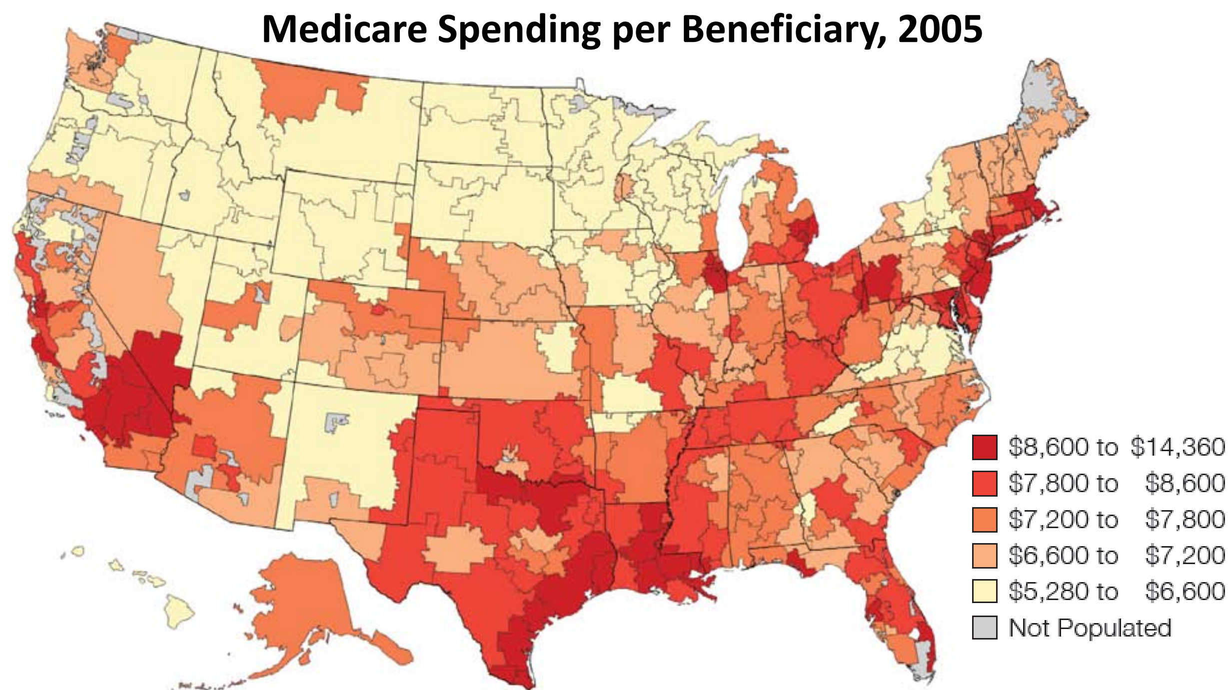
Health Care is Local



- **Wide range of regional variation in the USA on measures of costs, quality, access, and public health. (See March 2012 Local Scoreboard report by Commonwealth Fund,** http://www.commonwealthfund.org/Publications/Fund-Reports/2012/Mar/Local-Scorecard.aspx
- **Unusually successful communities have developed <u>informal mechanisms of collaboration at the regional level</u>.**

Source for Map: Wennberg, John E., Shannon Brownlee, Elliott S. Fisher, Jonathan S. Skinner and James N. Weinstein. 2008. Agenda for Change: Improving Quality and Curbing Health Care Spending: Opportunities for the Congress and the Obama Administration, A Dartmouth Atlas White Paper, December 2008.

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What is a Commons?

A <u>commons</u> is any resource to which members of some group share access. Examples include common grazing land, lakes, forests, or, as we argue, a community's resources for health care.

From Tragedy to Stewardship

- A **commons** is any resource to which members of some group share access. Typical examples include common grazing land, lakes, or forests.
- Individuals may extract resources for their private use, but if too many people extract too much in too short a period of time, resources may be degraded or destroyed in a "**tragedy of the commons**" (Hardin 1968)
- Tragedy can be avoided if someone takes responsibility for insuring the replenishment or maintenance of that resource. The question **is who will pay the costs for doing so**?
- Hardin identified two potential solutions: (1) division of the commons into parcels of private property, or (2) management by a public authority.
- **Elinor Ostrom** received the 2009 Nobel Memorial Prize in Economic Sciences for demonstrating that a third solution is possible: some communities of resource users can, under the right conditions ("**Design Principles**"), work together to manage critical resources over long periods of time by establishing, monitoring, and enforcing rules.
- "**Stewardship**" is the practice of managing common resources in a way that insures the continued availability of that resource to future users.

What is a Health Commons?

We define a *health commons* as the entire supply of financial, physical, human, and social resources available for use in the delivery of health care (or medical services) to a community (or local region)

a. Financial capital: Insurance, government programs
b. Physical capital: hospitals, clinics & test facilities,
c. Human capital: trained healthcare professionals,
d. Social capital: Time and energy for collaborative programs.

Unlike a simple commons, health care resources are rarely available equally to all members of the relevant group.

Specific forms of financial, physical, human or social capital are owned (or their use managed) by organizations or individuals, many of whom are primarily interested in pursuing their own personal goals.

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Shared Stewardship in a Health Commons

By <u>shared stewardship</u> we mean the collective management of a community's resources related to the delivery of health care so as to make the most effective use of those resources for the benefit of all members of that community.

In any community, these <u>resources are already being allocated</u>, by those stakeholder groups who have control over one or more types of capital.

<u>A stakeholder group</u> includes individuals and organizations who share a broadly similar approach to health and healthcare:

- **similar economic interests,**
- **similar capabilities to affect specific outcomes, and/or**
- **similar modes of thought, mental models, and value systems (as a consequence of professional training and practical experience).**

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Stakeholder Groups

1. **Physicians and Other Healthcare Professionals**
2. **Administrators of medical facilities**
3. **Insurers** (Private and Public)
4. **Employers** (primarily as purchasers of insurance)
5. **Local government officials (esp. public health officials)**
6. **Community Service Organizations (CSOs)**

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7. **Government Program Administrators**
8. **Regulatory Agencies or Professional Organizations**
9. **Technology Innovators and Producers**

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10. **Individuals**

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Key Decisions

1. Physician/Professional:

Primary Care

- Number/time of patients seen
- Threshold for ordering tests
- Independent or join association
- Oppose new entrants
- Use electronic records

Specialists

- Threshold for intervention
- Set up/join specialized clinic
- Partner with PCPs
- Expand areas of activities

2. Facility Administrators

- Legal status: profit, nonprofit
- Ties to training programs
- Independent or consolidated
- Relationship with physicians
- Build new facilities?
- Build specialized clinics or partner
- Participate in gov. programs

3. Insurers

- Reimbursement options
- Relationship with hospitals, IPAs, patients
- Monitor physician, facility performance

4. Employers

- Offer insurance to employees
- Self-insure or partner with plan

5. Public health officials

- Sanitation and related public goods
- Public information campaigns
- Design of built environment

6. Community Based Organizations

- Set up free clinics or focus on advocacy
- Disseminate comparative information

7. Government Administrators

- Breadth of coverage
- Compensation levels

8. Regulators

- Tax breaks (esp. local officials)
- Set safety standards (esp. state & prof. assoc.)
- Approve new facilities (if certificate of need)
- Anti-trust exemptions (national)
- Medical legal system (all levels)

9. Technology Innovators

- Focus of R&D projects
- Dissemination of products and information
- Marketing practices

10. Individual patients

- Active engagement with health info
- Healthy life-style
- Regular check-ups
- Compliance with advice
- Buy insurance

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External Constraints on Local Autonomy in Healthcare

1. **Technological innovation in medical testing, treatments, and drugs;**
2. **National policy initiatives (health insurance reform, ACO program details, changes in Medicare and Medicaid, drug approval, etc.);**
3. **State policy changes (esp. Medicaid reimbursement, but also changes in legal requirements and certification);**
4. **Professional standards and best practices, including limits on size of classes in medical or nursing schools;**
5. **Corporate decisions regarding advertising (esp. for new drugs) and location of and content of products in restaurants & grocery stores;**
6. **Consolidation and other trends within healthcare delivery, insurance, and related financial sectors;**
7. **Demographic and cultural changes;**
8. **Economic upturns and recessions.**

But Local Stakeholders are NOT Powerless.

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Important resource allocation decisions are made in local settings:

1. Recruitment of professionals in different specializations;
2. Corporate decisions to build new facilities or to consolidate;
3. Negotiations between hospitals, physician groups, and insurance plans regarding reimbursement levels and partnerships;
4. Procedures established within hospitals or physician groups (regarding quality control, reducing medical errors, hospitalists, etc.);
5. Consultations among medical professionals (especially how care is coordinated among physicians, nurses, pharmacists, therapists, etc.);
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. Location of parks, bike paths, food stores, and other aspects of the “built environment” that affect personal choices for healthy behavior;
9. Personal choices between healthy and unhealthy behaviors.

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17 Decision Points in Local/Regional Health Care

Source: Pictures taken from Jack Homer, System Dynamics Applications at the Federal Centers for Disease Control and Prevention (CDC), May 6, 2009, http://www.chronicdisease.org/files/public/2009Institute_SD_Track_JackHomer_SystemDynamicsApplications.ppt

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Who Participates in Decisions? Who Should Participate?

Topic	Typical Participants	Needed Participants
PHYSICAL FACILITIES: Consolidation, Construction of new facilities	Facility administrators Physicians & Professionals	Community Service Orgs Government Officials Employers Insurers
DELIVERY OF CARE: Care Transitions, Chronic care, E-records, Hospice, Mental health care, Primary care, Quality improvements	Facility administrators Physicians & Professionals	Community Service Orgs Government Officials Employers Insurers Individuals
FINANCIAL ASPECTS: Insurance coverage, Pay for performance, Wellness programs, Access to care	Insurers Employers Facility administrators	Physicians & Professionals Community Service Orgs Government Officials
PUBLIC HEALTH: Built environment, Emergency preparedness, Environmental safety, Food deserts	Government Officials Community Service Orgs Facility administrators Employers	Physicians & professionals Insurers Individuals

Overall lesson: Ultimately, all parties need to be involved in all issues.

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Moving Towards Stewardship

Resource allocation takes the form of stewardship only when the people making resource allocation decisions take explicit account of their effects on the system as a whole.

Indicators of effective stewardship in a health commons:

1. Cost-efficiency ("bending the cost curve")
2. Appropriate scale of facility construction
3. High quality of care ("evidence-based medicine")
4. Availability of primary care professionals and preventive care
5. Job satisfaction among health care professionals
6. Measures of patient-physician interactions ("experience of care")
7. Community capacity for collective action
8. Measures of public health outcomes

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Lessons for Shared Stewardship

What is needed to make this happen? We draw lessons from

1. **Commons Theory** (especially Ostrom's research on the Design Principles found in sustainable resource-dependent communities)
2. **Case studies** of different types of multi-stakeholder collaboration in health care at local/regional levels
3. **Theories of collective action and organizational learning** (especially team-building practices like the focus of this on-line course)
4. **Public administration** (especially the operation of cross-sector collaborations, that is, networks through which public, private, and voluntary organizations work together to solve public problems and realize collective aspirations)

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Design Principles for Sustainable Resource Management (*Governing the Commons*, Elinor Ostrom 1990)

1. In a region with clear boundaries, a group of resource users
2. Has sufficient autonomy to manage available resources, and
3. Does so by collectively crafting rules and procedures regarding levels and modes of resource extraction,
4. Sharing information generated through routine monitoring of user actions and resource outcomes,
5. Imposing graduated sanctions on rule-breakers,
6. Resolving disputes directly or with the help of intermediaries,
7. Forming sub-groups to focus on particular problems, and
8. These rules and procedures are appropriate for local circumstances and fair (distribute the costs and benefits of their collective action in an equitable manner).

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Do Similar Principles Apply to a Health Commons?

- Some design principles have close analogues in a health commons (monitoring, sanctioning), others do not (boundaries, autonomy)
- This is the wrong question. Better questions are:
  - HOW WERE THESE PRINCIPLES ESTABLISHED?
  - WHERE DID THEY COME FROM?
  - HOW CAN THEY BE ACHIEVED OR PROTECTED?
- We need to focus on the underlying processes that provide the foundation for the Design Principles
  - THEN IDENTIFY POTENTIAL CONTRIBUTORS TO SUCCESS RELEVANT TO YOUR OWN SETTING

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Foundations for Shared Stewardship in Small Resource-Dependent Communities

- **Shared dependence on a resource can enhance a strong sense of community and shared destiny.**
- **Concern for their children's future helps them consider the long-term consequences of their decisions.**
- **Autonomy is often conferred by default.**
- **Natural leaders emerge from dense social interactions.**
- **Resource users are close to the action, facilitating monitoring and application of sanctions.**
- **Social sanctions can be very powerful in these settings.**
- **Traditional forms of dispute resolution are already in place.**

NONE of these conditions holds for a health commons!

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Lessons from Case Studies of Health Commons Stewardship

1. A strong sense of community or physical isolation is not enough; **stewardship requires frequent, open, & confidential communication.**
2. **Local autonomy** is not assured, and must be sought and protected. It's not obvious who has the authority to serve as **convenor**.
3. **It's critical to monitor performance** and share information widely.
4. **Choose priorities strategically**: keep focused on a few critical factors, and use multiple ways to address that issue.
5. Externally funded collaborations on **health promotion campaigns** (such as anti-smoking or anti-obesity) are useful to develop trust and habits of cooperation, but eventually community leaders **need to address more difficult issues** of facility construction, physician payment, and coverage for uninsured.
6. **Avoid becoming an exclusive group**; be open to new participants.
7. Teams must develop procedures through which partners who acted unilaterally on an earlier issue can be **welcomed back** into the fold.
8. **Assessment tools** must be developed and applied, with regular re-evaluation of ongoing programs and future needs.

Lessons from Collective Action Theory

Team-building for collective action

- Spend time learning to know each other and to identify shared concerns
- Translate concerns into specific goals that can be accomplished together,
- Build trust and mutual respect by strengthening social ties and practices of effective communication within group,
- Allocate tasks to sub-groups and follow up on implementation,
- Reassess the situation frequently and remain open to changes,
- Inspire and nurture leaders from within the group to sustain these efforts.

Specific example: Relational Coordination in multi-speciality teams in patient-centered care, from Jody Gittell, *High-Performance Healthcare*, 2009.

- Communication is frequent and problem-focused,
- Participants have Shared Goals, Shared Knowledge, and Mutual Respect

Lessons from Public Administration:
Cross-sector collaboration is more likely to be successful when*

- **<u>linking mechanisms</u>**, such as powerful sponsors, general agreement on the problem, or existing networks, are in place at the time of initial formation.
- they have **<u>committed sponsors and effective champions</u>** at many levels who provide formal and informal **<u>leadership</u>**.
- they establish — with both internal and external stakeholders — the **<u>legitimacy</u>** of collaboration as a form of organizing, as a separate entity, and as a source of trusted interaction among members.
- **<u>trust-building activities</u>** (such as nurturing cross-sectoral and cross-cultural understanding) **<u>are continuous</u>**.
- partners use resources and tactics to **<u>equalize power and manage conflict</u>**
- they combine **<u>deliberate and emergent planning</u>**.
- they [use] resources and tactics [to **<u>deal] with power imbalances and shocks</u>**.
- they have an **<u>accountability system</u>** that tracks inputs, processes, and outcomes; use a variety of methods for gathering, interpreting, and using data; and use a results management system that is built on strong relationships with key political and professional constituencies.

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Challenges in Building a "Regional Authority" for Healthcare Collaboration

- **Accountability** is a particularly complex issue for collaborations because it is not often clear whom the collaborative is accountable to and for what.
- **Competing institutional logics** are likely within cross-sector collaborations and may significantly influence the extent to which collaborations can agree on essential elements of process, structure, governance, and outcomes.
- **Collaborative structure is likely to change over time** because of ambiguity of membership and complexity in local environments.
- **The normal expectation ought to be that success will be very difficult to achieve in cross-sector collaborations.**

*Source: John M. Bryson, Barbara C. Crosby, and Melissa Middleton Stone. 2006.
"The Design and Implementation of Cross-Sector Collaborations: Propositions from the Literature,"
Public Administration Review, 66 (s1), December 2006, pp. 44-55.

Dynamic Process for Shared Stewardship

1. **Communicate:** build multiple social ties and channels of communication; fill convener and coordinator roles
2. **Prioritize and Focus Efforts:** develop a common understanding of system; select specific & achievable goals
3. **Build Confidence:** begin with programs that can show results quickly; take ownership by asserting autonomy
4. **Recruit Partners:** seek external funding but maintain focus on mission; welcome new partners when needed
5. **Implementation:** commit resources as promised and carry out plans; maintain coordination while doing so
6. **Monitor and Sanction:** gather and share information; graduated sanctions on those who violate agreements
7. **Build and Sustain Trust:** protect vital interests of all parties; allow those sanctioned to restore position
8. **Reevaluate:** take time needed to evaluate programs; base innovations on local knowledge

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Conditions That Help Sustain Shared Stewardship

Pre-Requisites

1. Sufficient physical, human & social capital.
2. Multiple communication channels.
3. Assert local autonomy & protect it.
4. Community identity strong & expandable.

Support

Processes

1. Fill convener & leadership roles.
2. Define core mission as stewardship.
3. Prioritize specific & attainable goals.
4. Group learning generates innovation.
5. Shared norms support open discussion.
6. Routine monitoring & measurement.
7. Sanctions graduated and forgiving.
8. Protect vital interests of stakeholders.

Enable

Results

1. Build success cumulatively.
2. Develop trust & reinforce it.
3. Teams craft rules that fit local conditions.
4. Rules distribute costs & benefits fairly.

Reinforce

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Steps in a Community Self-Assessment Process

1. **Members of local stakeholder groups should evaluate past or ongoing efforts at shared stewardship**
2. **Of common resources relevant to one or more key decision points or topical areas,**
3. **And ask themselves how many of the facilitating conditions (pre-requisites, processes, results) have been satisfied in those examples.**
4. **Then use these answers to identify missing ingredients, or gaps in their preparation for the even more difficult tasks ahead.**

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Supplemental Slides

Health and Healthcare as a Complex System of Public Policy

Public policy sets rules that govern the production and distribution of all types of goods and services: public, private, toll, and common pool resources.

- **Public health officials routinely promote community health, which is widely recognized as a public good.**
- **Health care (or medical services) is typically understood as a private good, involving service transactions between patients and healthcare professionals.**
  - **But these are not merely private goods, given the need for consumers to be actively engaged in producing their own health outcomes (co-production).**
  - **And healthcare markets rarely reach efficiency because of the difficulty of measuring quality, the technical complexity of evaluating alternative procedures, and pricing structures that make costs far from transparent to consumers.**
  - **In sum, regulation and oversight are especially important for healthcare markets.**
- **Other aspects of health care are toll, or club, goods, like insurance.**
- **Still other aspects are common-pool resources, in which individuals extract resources from a common pool for their own use, like ER services.**

We argue that the overall system of health and the healthcare services is best understood as a <u>complexly inter-related commons</u>.

Different Types of Goods in a Health Commons

Rival **_Consumption_** *Nonrival*

Low **_Costs of Exclusion_** *High*

Private Goods/Services	Toll Goods/Services
•Consultation with clinicians •Drugs and medical procedures •Elective medical services •Commercial health insurance •Malpractice insurance •Professional training •Individual health (requires co-production)	•Certification programs •Employer-funded insurance plans •Healthcare cooperative •"Cadillac plans" covering a wide range of medical procedures • Membership in Y or similar organizations •Management services for members of IPAs
Common Pool Resources* •Time for physician consultations •Access to emergency services •Money in budgets for social insurance programs •Beds or testing facilities in existing hospitals or clinics •Organs for transplantation [*Consumption is rival because of scarcity; exclusion costly because of professional norms of compassion and care for all]	**Public Goods/Services** •Community Health •Membership in social insurance plans •Legal protection for access to emergency care •Requirements for charity care •Workplace safety regulations •Legal system for determining liability •Health promotion programs •Vaccination and disease control •Emergency preparedness •Parks and recreational facilities •Medical R&D and scientific knowledge •Mayo Clinic website (& other health info)

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Shared Stewardship and Polycentricity

Shared (or collaborative) stewardship is a generalization of collaborative governance:

- a term used in public administration to designate situations in which public officials routinely confer with private firms and voluntary organizations in the formation and delivery of public services.

Both terms are specific instances of polycentric governance:

- **a technical term from institutional analysis (Ostrom, Tiebout, and Warren 1961) designating a complex political system in which**
  - multiple public authorities from overlapping jurisdictions
  - and agents of relevant private, voluntary, and community-based organizations
  - govern themselves and all relevant individuals (who may be participating as constituents, managers, employees, volunteers, members, visitors, and/or citizens)
  - through an ongoing process of *mutual adjustment*,
  - within the constraints of general rules and cultural norms.
- **Polycentric governance provides plenty of opportunities for all interested parties to participate in policy-making and implementation, and facilitates the fine-tuning of rules and procedures to fit distinctive characteristics of local situations.**
- **Polycentricity has been the central focus of research conducted by scholars affiliated with the Workshop in Political Theory and Policy Analysis.**

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