# Webinar on Managing the Health Commons:
## An Interim Report on Conditions for Collaborative Stewardship


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# Research Collaborators

- **This presentation draws on results generated by all members of the Managing the Health Commons (MHC) research team at Indiana University , composed of myself and**
  - **Elinor Ostrom, Ph.D., Distinguished Professor, Political Science and Public and Environmental Affairs**
  - **Joan Pong Linton, Ph.D., Associate Professor, English**
  - **Claudia Brink, MBA, MPA, Ph.D. candidate in Public Policy, and Assistant Director, Workshop**
  - **Carrie Ann Lawrence, Ph.D. candidate in Health Behavior**
  - **Ryan Conway, Ph.D. candidate in Political Science**
- **We have also benefited greatly from our interactions with other research and research-action teams in the ReThink Health initiative (http://www.rethinkhealth.org/), funded by The Fannie E. Rippel Foundation (http://www.rippelfoundation.org/).**



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# A Regional Approach to Health Reform

- **Health and medical care are intrinsically local or regional.**
- Researchers have documented a **wide range of regional variation** in many measures of healthcare input measures (especially costs) and the overall quality of medical services within the U.S.
  - When we began examining health policy, we were introduced to officials from two of the communities which were recognized as having managed to achieve unusually high levels of quality in medical services at below average costs: **Grand Junction, Colorado** and **Cedar Rapids, Iowa.**
  - The general presumption was that ***they did something*** that contributed to these positive outcomes, specifically that they had developed ***informal mechanisms of collaborative stewardship at the community level***.
- We proposed a research project to learn more about the process of this regional-level stewardship.
  - At the same time, we began investigating **Bloomington, Indiana**, since we had an opportunity to dig even more deeply, here in our local region.



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# Capacity for Collective Action is the Focus of this Analysis

- For this **exploratory study,** we presume that better coordination at the local or regional level tends to generate positive health & healthcare outcomes.
- **We focus on understanding the factors that facilitate coordination**.
  - Since it is not based on a random sample of cases, this study by itself cannot substantiate conclusions about the **causal impact** of community collaboration on medical services or overall health outcomes.
- Because of our focus on collective action, **we do NOT draw explicit comparisons among specific measures of the quality of medical care** (such as readmission rates or declines in medical errors) **or in overall health outcomes** observed in these three communities.
  - Many professional consultants and other organizations work in these specialized areas; our niche lies in macro-level analysis of policy organizations.
- Our key analytical task is to identify the factors that affect **capacity for collective action** regarding the local/regional regulation of medical services.

# Collaboration With Study Communities & Future Projects

In each community we work with a **community advisory board** to identify interview subjects and to help us evaluate our findings.

- Our interview questions focus on eliciting their own positive and negative experiences with **multi-stakeholder collaborations**.
- Our cases are NOT a random sample, but instead a **convenience sample**, chosen because we had access to community leaders.

- We hope to develop the foundation for **two follow-on projects**:
  - A **community self-assessment tool**, for use in conjunction with community leadership teams, to help them identify potential issues for further cooperation and the resources they need to develop or enhance to accomplish those tasks.
  - Identification of variables to be included in a **rigorous test** of the effect of this capacity for collective action on the quality and costs of medical services in a randomized sample of communities in the United States.



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# Clarification: We Study Coordination of the Medical Services Industry as a Whole, not just Public Health

- Health is **not** a product that can be purchased from suppliers, instead health emerges from **co-production**, with individuals actively contributing to determining their own health.
  - Ultimately, a person's health is a product not just of the medical care he/she receives but primarily of his/her **decisions between healthy and unhealthy behavior**, within the constraints set by genetics, socio-economic status, and environmental factors.
  - These decisions can be influenced by the **built environment** within which individuals choose, and public health officials routinely consider how social structures and biophysical conditions affect health.
  - **Public health officials** already think in terms of understanding the system as a whole, and appreciate the need to act as responsible stewards of community resources.
- **But in the U.S., public health officials have no authority over the delivery of medical services**. That is where the costs of health care are determined, in decisions made by physicians, hospital administrators, insurance company officials, and employers.

# Markets & Common Resources in the Healthcare Industry

**Health care** (or medical services) can be seen 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** are typically inefficient in providing the optimal mix of services, for a variety of reasons, such as the difficulty of measuring quality, the technical complexity of evaluating alternative procedures, and a payment structure that make costs far from transparent to consumers and/or professional clinicians.
- In sum**, regulation** is especially important for healthcare markets.

- Other aspects of health care (especially medical insurance) have properties known in economic theory to create problems related to **overuse of services** or suffer from **adverse selection problems in the client pool** – both leading to an upward spiraling of insurance costs.
- Still other aspects are similar to **common-pool resources**, in which individuals extract resources without full payment, like ER services for a significant subset of the population.
- **Public health officials** routinely promote **population health,** which is widely recognized as a **public good (a good with positive externalities ),** where individuals may under-invest in health maintenance from the perspective of society.

**We argue that the overall system of health and the delivery of healthcare (medical) services is best understood as a commons that encompasses multiple types of resources and many types of goods and services.** Such a commons definitely requires some form of **stewardship**.

- Collaborative stewardship is effectively a form of **self-regulation of a commons.**



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# What is a Commons?

1. A resource or system of resources to which members of a group share **access**, and which they either (a) consume jointly or (b) use as a common pool from which they extract units for private consumption;
2. This common resource **can be exhausted or degraded by over-use** (of resources) **or under-investment** (in resource replenishment and/or contributions to public goods);
3. Efforts to **replenish or maintain** the relevant resources are **costly**;
4. And these costs will be paid only by someone with an **incentive to consider long-term consequences** of current actions.

**Examples:**

- **Natural resource commons** (fisheries, common grazing land, forests);
- **Constructed commons** (irrigation systems, technical infrastructures, information systems)

# Health as a Commons (In Need of Self-Regulation)

1. **Residents share access to local & regional resources for medical care:**
   1) trained healthcare professionals,
   2) hospitals, clinics & test facilities,
   3) financial support (insurance, government programs).
2. **Congestion can be common and service degradation can be severe because there is a limited number of clinicians, hospital beds, emergency rooms, insurance programs, etc.**
3. **These resources can be reallocated to achieve more efficient or equitable outcomes, but any significant reform will face resistance from entrenched interests.**
4. **Research of Lin Ostrom & others on Commons Theory suggests that key stakeholders can work together to craft, monitor, and enforce rules that ensure the continued viability of common resources.**
   - Who can act as **stewards** of common resources in health?



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# Key Local 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. **Public health officials**
6. **Community Service Organizations (CSOs)**
7. **Health Information Exchanges (HIEs)**

8. **Individual Citizens** (critical for overall health but limited influence over details of the medical services industry**)**

**Note: Other categories of relevant actors have been excluded to simplify initial analysis.**

# In This Project We Focus on Healthcare Professionals

- In the short term, **collaborative stewardship among professional stakeholders is critical to reducing costs and improving the quality of health care.**
  - Among the stakeholder groups we interview are leaders of **community organizations**, so the concerns of the general public are not totally overlooked in our analysis.
- **In the long run**, the **active participation of ordinary citizens** is critical for controlling costs and achieving better health outcomes
  - Especially their choices between healthy and unhealthy behaviors.
  - Health is not a product that can be purchased from suppliers, it emerges from **co-production**, in which individuals actively contribute to determining their own health.
- **In later stages of this project, and in subsequent projects**, we plan to expand coverage to citizen interviews, focus groups, and public forums. But we can't do everything at once.



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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 HEALTH 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.

# How often are these local resource allocation decisions guided by considerations of long-term effects or systemic stewardship?

**Allocation of human capital**
- Availability of primary care
- Physician training & recruitment
- Referral patterns (for specialty care)
- Hospital-physician relations
- Care transitions

**Healthcare facilities & physical capital**
- Coordination of emergency care
- Quality improvement and cost-cutting procedures (e.g., reducing medical errors)
- Facility construction
- Consolidation of hospital systems
- Market concentration; anti-trust

**Financial issues**
- Cost of chronic and end-of-life care
- Cost of care for uninsured patients
- Safety net for catastrophic bills
- Reimbursement and rates for care

**Public/population health**
- Emergency preparedness
- Preventive care
- Pre-natal care
- Dental care
- Mental health care
- Health promotion (tobacco, obesity, etc.)
- Improving the built environment

**Information systems**
- Quality monitoring
- Format for electronic records
- Privacy of personal health records
- Health information exchange networks

**Other issues**
- Employment & economic conditions
- Equity; urban/rural disparities
- Legal culture (malpractice, regulation)

# Understanding the Dynamics of Collaborative Stewardship

**The range of participation and cooperation will expand or contract as new issues come under consideration**

- Benefits of adding a new member, vs. higher transaction costs
- Costs of removing existing members, vs. lower transaction costs

**Once achieved, sustainability of cooperation is always at risk**

- Group members with access to a commons have conflicting interests in use of that resource, and differing capabilities in affecting outcomes.
- Individual participants will continue to pursue their own self-interests, even while they are cooperating on other matters.
- This tension never goes away.

**Sustainability of self-regulatory stewardship efforts requires supporting conditions from both structure and process.**

# To evaluate a community's capacity for collective action, we draw factors from four bodies of research/practice

1. **Commons Research on small-scale communities where**
   - » Individual survival is dependent on continued access to that resource;
   - » Family ties often generate concerns for long-term future sustainability,
   - » Social ties among users are typically dense and salient,
   - » Resource users are close to the action, facilitating monitoring and effectiveness of social sanctions.
2. **Collective Action Theory: "best practices" for forming teams of collaborators who are not so closely linked,**
3. **Inter-Organizational Relations: where participants are agents representing the interests of private, public and voluntary organizations as well as more informal groups.**
4. **Healthcare Policy: factors specific to this policy area.**



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# Design Principles for Sustainable Resource Management (Ostrom 1990)

**Background Conditions**

1. **A group of resource users in well-defined region**
2. **That has sufficient authority to manage available resources**

**Patterns of Interaction**

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,**

**Outcomes and Evaluation**

8. **And these rules and procedures are appropriate for local circumstances and distribute the costs and benefits of their collective action in an equitable manner.**

Notes: Current background conditions emerge from past interactions and outcomes.

# Examples from Collective Action Theory

**Generic process for collective action**

- **A group meets regularly to discuss their shared concerns and to**
- **Identify specific goals that they can accomplish together,**
- **Allocate tasks to members and follow up on implementation,**
- **Reassess the situation frequently and consider changes in plan,**
- **Enhance social ties and practices of effective communication within group,**
- **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**

# Examples from Inter-Organizational Relations

**Principles for Successful Public-Private-Nonprofit Collaboration in Governance Networks: from Bryson, Crosby, and Stone, "The Design and Implementation of Cross-Sector Collaborations," *Public Administration Review* 2006.**

- **Have committed sponsors and effective champions at many levels,**
- **Build leadership, legitimacy, and trust,**
- **Engage in deliberate planning but remain flexible and resilient,**
- **Use resources to cope with power imbalances, conflict, and shocks,**
- **Remain responsive to key stakeholders & build on distinctive competencies,**
- **Engage in regular reassessments, and**
- **Have an accountability system that uses a variety of methods to track and interpret data on inputs, processes, and outcomes.**

# Key Complications Related to Health and the Delivery of Medical Services

- **Preventive care is critical for health and for reduction of costs in the long term, but the medical care system focuses on treating people only after they become sick**
- **Third-party payers and bundled reimbursement policies separate cost considerations from patient and physician decisions, so having better information is critical for reform**
- **Technological innovation can result in higher costs if high-tech facilities and techniques are over-utilized**
- **There is no obvious institutional home for regulation of medical services at the local/regional level**
- **On the plus side: the unusually high prevalence of compassion as an influence on those who choose to enter the healthcare professions.**

# Lessons From Case Studies (Preliminary)

- A strong sense of community or physical isolation is not enough; **stewardship requires frequent, open, & confidential communication.**
- **Local autonomy** is not assured, and must be sought and protected.
- Best to **keep focused on a few critical factors**, and use multiple ways to address that issue (ex: Grand Junction & primary care shortages).
- **Avoid becoming an exclusive group**; need to recruit new participants.
- Collaboration 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.
- **Monitor performance** and share information widely.
- Teams must develop procedures through which partners who acted unilaterally on an earlier issue can be **welcomed back** into the fold.
- **Assessment tools** must be developed and applied, with regular re-evaluation of ongoing programs and future needs.



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# Dynamic Process for Collaborative Stewardship

1. Communicate
2. Prioritize and Focus Efforts
3. Build Confidence
4. Recruit Partners
5. Commit Resources
6. Monitor and Sanction
7. Build and Sustain Trust
8. Reevaluate



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# Practical Steps

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. **Commit Resources:** make tangible contributions; acknowledge contributions of others
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

# Conditions for Collaborative Stewardship

## Background Conditions

1. Relevant physical, human & social capital.
2. Multiple communication channels.
3. Local autonomy recognized & protected.
4. Community identity strong & expandable.

## Patterns of Interaction

1. Team defines core mission as stewardship.
2. Leaders maintain focus on specific goals.
3. Convener & coordinator roles filled.
4. Group learning generates innovation.
5. Shared norms support open discussion.
6. Routine monitoring & measurement.
7. Sanctions graduated and reversible.
8. Vital interests of all stakeholders protected.

## Outcomes & Results

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

# Format for a Community Self-Assessment Tool

**[1] Ask representatives of local stakeholder groups familiar with past or ongoing efforts of collaborative stewardship,**

**[2] whether or not their interactions on topical areas:**

1. **Healthcare facilities and physical capital**
2. **Allocation of human capital in delivery of care**
3. **Financial issues**
4. **Public/population health issues**

**[3] show evidence of the presence of these facilitating conditions:**

- **Background Conditions/ Structure**
- **Patterns of Interactions**
- **Outcomes & Results**

**[4] and use their answers to help them identify gaps in their capacity for collaborative stewardship of their local/regional health commons.**



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