**Managing the Health Commons**

**Planning Document**

Version 2.1

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**Workshop in Political Theory and Policy Analysis, Indiana University**

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**Overview**

The **Workshop in Political Theory and Policy Analysis** at **Indiana University** (<http://www.indiana.edu/~workshop/>) has partnered with the **Fannie E. Rippel Foundation** ([www.rippelfoundation.org](http://www.rippelfoundation.org)) to undertake an eighteen month action-research project. Our goal is to develop analytic and self-assessment tools built on the foundation of the research on community-based resource management for which Elinor (Lin) Ostrom won the 2009 Nobel Prize in Economics. This project is being conducted in collaboration with other research and community action teams participating in the ReThink Health initiative ([www.rethinkhealth.org](http://www.rethinkhealth.org)), also supported by the Rippel Foundation. This initiative contributes towards the broader goal of helping to create conditions under which Americans can become healthier while paying lower, and more sustainable, costs for high quality healthcare.

Although established theory predicted that users of common pool resources were doomed to suffer a **tragedy of the commons**, Professor Ostrom demonstrated that conditions found in many real-world communities made it possible for them to work together and avoid a tragic fate. In *Governing the Commons* (1990) and many other publications, Professor Ostrom used examples from throughout the world to demonstrate how local communities develop and sustain habits of collaboration that enable them to effectively manage resources critical to their own survival. Ostrom identified eight **design principles** (or design features) commonly found in successful examples of long-lasting institutions of resource management. Briefly, key stakeholders must have sufficient autonomy to devise and enforce their own rules, as well as easy access to shared means of modifying these rules as conditions change.

In this research action project we will investigate whether similar principles of community-based, collaborative management can be effectively applied to the resources most critically involved in health and healthcare. The U.S. health system is complex, encompassing public officials at the local, state, and national levels, and a wide array of professionals working in for-profit and not-for-profit organizations, as well as a myriad of financial sources and motivations. Within this context, the Workshop’s perspective on multi-level and polycentric governance of public service industries can bring important new insights on these difficult policy and system challenges.

We define the **health commons** as a composite of three critical pools of common resources (or capital stocks) and two closely related public goods. The public goods are **population health** and **health information exchanges** (through which medical information can be shared). The resource pools are:

* **Human capital** of physicians and other health care professionals;
* **Physical capital** of health care facilities and their corporate structures; and
* **Financial capital** available for the diverse activities included in health care delivery.

Each of these resource pools exhibits a unique combination of (1) **resource units** that are extracted and used for various purposes, (2) **groups of appropriators** who are engaged in processes of extraction and utilization, (3) **processes of replenishment and maintenance** of relevant resources and infrastructures, (4) **managers** who determine rules regarding access and distribution of rights, and (5) participants who regularly **monitor** the behavior of all relevant actors and determine when **sanctions** should be applied to rule violators. With respect to the public good aspects, since individuals face incentives to free ride on the contributions of others, many will take actions that undermine the overall health of the community or that make it difficult to share critical information. Our research will focus on understanding how efforts to collectively manage challenges in any one resource pool or public good aspect of the health commons can complicate or facilitate collaborative management of other aspects.

**A Regional Approach to Healthcare Reform**

Our analysis is predicated on the presumption that conditions relevant to health and healthcare vary widely across the United States. Although policy debates tend to focus on issues located at the national level, it seems obvious to us that healthcare is an intrinsically local affair. Patients typically go to doctors and hospital facilities close to where they live, except for unusual situations requiring the services of highly specialized physicians. Also, healthcare practitioners within a given community interact with each other on a routine basis, and develop and maintain regional cultures of care that differ significantly across the country. To some extent, this diversity reflects the continuing influence of the federal nature of the U.S. political system. For example, responsibility for the regulation of insurance and of healthcare professions tends to be concentrated at the level of state agencies. National programs and medical technology links all regions together into a common system, but the most fundamental interactions critical to this area of public service remain local and intensely personal.

In addition, health conditions vary widely across regions. We find especially useful the concept of the **Hospital Referral Regions** introduced by scholars associated with the Dartmouth Atlas project. They have “empirically defined 306 relatively separate, geographically defined Hospital Referral Regions (HRRs), where the resident population receives most of its care.” (Nolan 2010). HRRs are defined by examination of the zip codes of patients receiving care at hospitals located in a given community, based on Medicare data. Technically, a region is defined so that the majority of residents in an HRR get the majority of their care at one or more hospitals within that region. Overall, “80% of the US population lives in HRRs in which more than 85% of care is delivered by providers within that HRR.” (Nolan 2010). In effect, then, a Hospital Referral Region can be treated as an approximate representation of natural health care markets.

These regions have proven so useful for analysis because of the surprisingly wide range of variation in many measures of healthcare input measures and overall health outcomes (Fisher et al. 2003, Wennberg et al. 2008, Skinner and Fisher 2010). Of course, different regions face a diverse range of challenges set by demographic and economic conditions, and other scholars have pointed to demographic variation as a primary source of this variation (Hines and Joshi 2008, Gottlieb et al. 2010, Abelson and Harris 2010, Skinner and Fisher 2010). This remains a contentious issue within this field of study, and we take no position in these ongoing debates. Instead, we take this regional variation as a point of departure for our analysis.

Specifically, we presume that it is possible to learn from close examination of those regions which realize the best outcomes, in terms of overall population health, high quality care, lower cost, wider access. This regional approach fits very well with the findings of previous research projects associated with the Indiana University Workshop in Political Theory and Policy Analysis, as will be explained in more detail below.

**Project Design**

The project’s focus in the initial time period (January 2011-June 2012) will be on understanding patterns of community-level collaboration in four communities: **Grand Junction (Colorado), Cedar Rapids (Iowa),** and **Bloomington** and **Bedford (Indiana)**. Each of these communities has distinctive characteristics and challenges, and we are interested in learning the ways in which healthcare professionals in each community collaborate with each other in order to resolve community-level problems of coordination, as well as identifying remaining challenges to further collaboration. These regions do NOT constitute a representative sample of American communities. Instead, they were selected for analysis because our contacts with thought leaders in each community have given us a unique opportunity to learn from extensive discussions with professionals in diverse contexts.

For each component of the health commons, the project team will identify key stakeholders in the study communities and determine what types of collaborative behavior have already been implemented there. Field researchers will visit each community for an extended period of time and will interview a wide spectrum of stakeholders. This will enable us to trace critical linkages between public, private, and nonprofit organizations engaged in the production, distribution, and financing of the key public and private goods associated with health and healthcare.

This research will be guided by consultations with **community advisory boards** including members from major stakeholder groups – service providers, facility administrators, public officials, private employers, insurance plans, community activists, and consumers. Researchers will be in regular contact with these advisory boards before, during and after the field work with each community, and we will share research results with each community board. An **academic advisory board** will also help shape our research methodology and review our findings over the 18-month period.

Discussions with leaders and residents in each of these communities will be used to develop a **practical tool for self-assessment** that health and community leaders can administer to identify areas of potential improvement in community or regional level coordination. Interview schedules and other measurement instruments developed for these studies will be used to develop a **research protocol** for a follow-up project on a randomized sample of communities in the United States. Conclusions will be summarized in **articles** to be published in refereed journals and in **reports** addressed to more general audiences. Finally, we hope to build the foundation for **long-lasting partnerships** between Workshop researchers and health, government, and community professionals to encourage the effective redesign and sustainable implementation of health promotion and healthcare activities at the community level.

Appendix B provides a single-page overview of the key steps involved in our research project. Briefly, we propose to use the analytical tools of **institutional analysis** to understand health and healthcare policy in particular communities. Our empirical research will focus on learning about patterns of community coordination in two unusually successful communities (**Grand Junction, Cedar Rapids**) and in two communities close to IU (**Bloomington and Bedford, Indiana**)**.** These communities are by no means meant to be a random sample; instead they were chosen because we have access to top administrators in each community. **Field Researchers** will map networks of coordination and competition among key stakeholder groups by interviewing representatives from key stakeholder groups. These interviews will ask the subjects to discuss their experiences with coordination across stakeholder groups. In what ways have they been able to develop cooperative institutional arrangements? What challenges do they face in sustaining these arrangements? Researchers will then apply measures of centrality and cliques to these **networks,** and examine all of this data in light of our theoretical knowledge concerning what works in CPR situations and in public industries more generally. Throughout the process we will maintain a close dialogue with subject communities throughout process, especially through regular **accountability sessions** withthe advisory boards set up for each community.

**Analytical Background**

In the 1970s there was a strong push to consolidate police departments in large metropolitan areas in the United States. Armed with little evidence but with a strong belief in the benefits of economies of scale, elected officials and administrators began to close small neighborhood police stations. At that time a curious professor, who had learned from her Ph.D. dissertation on water systems in Los Angeles how community groups can effectively organize themselves for collective action, began to study police departments and continued to do so for the next 15 years. Her work did not take place in a library, but rather in patrol cars riding with police officers for one eight hour shift after another. Eventually similar research was conducted in 80 cities. One important conclusion of this research was that citizen satisfaction with the quality of police services was highest when they felt comfortable working with police (especially “their” beat cop who often lived in their neighborhood) to “co-produce” community safety. Large police forces found it difficult to deliver a comparable level of service quality, even though they had access to considerably more resources.

Years later this same professor, Elinor Ostrom, was awarded the Nobel Prize in Economics for what might seem to be an entirely different body of work, specifically, her later research on “economic governance, especially the commons.” In *Governing the Commons* (1990) and many other publications, Professor Ostrom drew upon examples from countries throughout the world to demonstrate how local communities develop and sustain habits of collaboration that enable them to effectively manage resources critical to their own survival. Despite the dire prediction that such communities were doomed to suffer a “tragedy of the commons” (Hardin 1968), Ostrom concluded that conditions found in many communities made it possible for them to work together and avoid a tragic fate.

Even before this prize was announced in the fall of 2009, a few health experts had contacted Ostrom expressing interest in applying her ground-breaking research on commons management to the area of health policy. In a plenary address, Dr. Donald Berwick (2009) pointed to the cases of Cedar Rapids, Iowa, and Grand Junction, Colorado, as being exemplary instances of the delivery of higher than average quality health care at substantially lower than average costs. He suggested that leading stakeholders in these communities had established collaborative management practices that satisfy many of the conditions specified in Ostrom’s research on the commons, and that these lessons might be reproduced elsewhere. Similar claims were advanced by others, including **Jane Brock, MD, MSPH,** Chief Medical Officer, Colorado Foundation for Medical Care (see Lynn and Brock 2010).

Ostrom welcomed this opportunity to explore what was for her a new area of public policy, and by May 2010, a Health Commons Working Group began meeting on a regular basis on the Bloomington campus of Indiana University, with several members participating via video-conferencing technology. This self-selected multi-disciplinary group includes local physicians, national leaders in health policy and administration, health improvement professionals, health information consultants, a hospital CEO, a chief medical officer of a medical foundation, social entrepreneurs, and academics in the fields of political science, allied health, psychology and the humanities, as well the President and CEO of the Fannie E. Rippel Foundation.

From the first meeting of this group, Ostrom saw close parallels with her earlier research on police services. She argued that even more critical insights might be available if this group also considered this earlier, ground-establishing research. This is what we propose to do in this research project, to apply the analytical lens of institutional analysis, as developed by Professors Vincent and Elinor Ostrom and their many colleagues and collaborators, to the common resource pools most critically involved in the public service industry of health care.

Our hope is that this analysis can help Americans become healthier while paying lower, and more sustainable, costs for high quality health care. U.S. health policy is an incredibly complex subject, encompassing the behavior of public officials at the local, state, and national levels, as well as a wide array of professionals working in for-profit and not-for-profit organizations. We are confident that our perspective on the management of common pool resources and the polycentric governance of public service industries can bring important new insights on these difficult policy challenges.

We propose to utilize the breadth and experience of this working group, along with the guidance of the ReThink Health Advisory Council, and our research team’s more than 80 years of research experience to engage in a systematic application of institutional analysis to the delivery of health care in the United States. This research project begins with in-depth studies of two of the unusually successful cases of community level coordination mentioned by Berwick, Cedar Rapids and Grand Junction, in order to ascertain factors common to these two cases. Surveys and other measurement instruments developed in those studies will then be applied to two communities located close to the campus of Indiana University. The case of Bloomington is of particular interest. Bloomington has an impressive degree of community-wide collaboration on many local policy issues, and yet its health care results, based on national statistics, are closer to average in performance. Quality of care is relatively high, but at the same time the costs are higher than average. Bedford is a neighboring community that faces even more difficult challenges, given its high level of unemployment and poverty.

This project will be fully collaborative, with direct participation by several health care professionals in each of these communities. We will institute a regular process of consultation with the subjects of our case studies, and will communicate our initial findings and final conclusions to them on an iterative basis.

**Principles of Commons Management and Polycentric Governance in Health Care Policy**

This long section outlines the key theoretical concepts and analytical steps to be undertaken in this research. It begins by defining a common-pool resource and summarizes the design principles identified by Ostrom (1990) as being critical for long-term sustainability of such resources. The particular resource components of the health commons are then detailed, and the many policy dilemmas most commonly associated with each of these components are briefly introduced. Next, the multiple levels and arenas of management particularly relevant to the study of healthcare as a public service industry are discussed. Lists of critical governance functions, key stakeholder groups, and the relevant variants of direct and intermediate services are provided as a foundation for our future analysis. After all this, the following section moves to our specific plans to apply these conceptual frameworks and analytical tools to the empirical study of particular communities.

A common-pool resource (CPR) combines aspects of private and public goods in a particular manner. Although the resource pool may be available to all, once specific resource units have been extracted from the common pool those particular units are no longer available to anyone else. At the same time, it is costly to exclude others from extracting these same resources. This combination of subtractability (or rivalness) of consumption and high exclusion costs differentiates CPRs from other types of goods (private, public, and toll goods)

Users whose livelihood relies on continued extraction from a common resource pool share a common fate, in the sense that all will suffer if that resource pool is depleted from over-exploitation or degraded by inadequate management. Yet as an individual, each user also faces an incentive to draw as many resource units as possible. If users ignore the long-term consequences of high levels of resource extraction, then destruction of that resource is inevitable.

The complex nature of common pool resources poses subtle problems for policy analysts. According to a still-classic work by Hardin (1968), a tragedy of the commons can be resolved in only two ways: (1) division into private property units or (2) collective management by some external authority. The former solution is especially appropriate for the production and distribution of private goods, and the latter is a common means towards securing the production of public goods. Although each of these policy responses is sometimes appropriate for the management of a particular CPR, in many cases each option is incomplete, ineffective, or even infeasible.

As demonstrated by Elinor Ostrom and many other researchers, another option also exists, in which the users of a CPR may devise and enforce their own rules in order to govern that resource in a sustainable manner. Ostrom (1990) summarizes this research by identifying eight design principles that are common to examples of long-lasting regimes of resource management. In the following list, these principles (or design features) are tentatively re-stated for potential application to policy areas in general.

1. **Participatory Rulemaking.** Members of an identifiable group of **primary** **stakeholders** take effective “ownership” of this policy area through joint participation in crafting the **rules** under which they agree to be bound.
2. **Responsible Monitoring**. Since rules are rarely followed automatically, it is essential to have some kind of **monitoring** procedures, and monitoring tends to be especially effective when the **primary stakeholders** are either directly involved or have close supervision over those doing the monitoring.
3. **Recognized Autonomy.** Higher level political **authorities** must **recognize** (even if only implicitly) the rights of this group of **stakeholders** to organize themselves and to exercise **autonomy** in their actions regarding this policy area.
4. **Rule Congruence.** Rules relating to appropriation and distribution of benefits should be **realistic** in terms of matching up with bio-physical, economic, and legal conditions, and the processes and procedures these rules define must be seen as **fair** by as many stakeholders as possible.
5. **Graduated Sanctions.** Once violators are identified, a **graduated series of sanctions** of increasing severity should be available, in hopes of encouraging rule violators to limit their infractions and to discourage frequent appeals to power-holders outside of this network of primary stakeholders.
6. **Dispute Resolution.** Stakeholders should have access to low-cost **dispute resolution mechanisms**, since some disputes may not be easy to resolve within the group of primary stakeholders.
7. **Scope Boundaries.** Identifiable **boundaries** around the scope of this policy area and the identity of legitimate stakeholders are either widely recognized or can be constructed by primary stakeholders in a way that avoids interference from excluded parties.
8. **Nested Organizations.** When needed, stakeholders **establish organizations at multiple levels of aggregation** to deal with specific aspects of this policy process, such as production, distribution, financing, rule-making, monitoring, dispute resolution, or other tasks critical in this policy area.

This may sound like a tall order, and these design principles are by no means satisfied in all circumstances. The more conditions that do hold, the more likely it is that the corresponding group will be able to manage their shared resources in a collaborative fashion. Even then success is never automatic. Patterns of cooperation are especially vulnerable to disruption when external actors enter the fray, especially multinational corporations and national level political authorities. The United States federal system presents a supportive environment for local self-governance, but even here local arrangements can be disturbed by interference from state or national level authorities (V. Ostrom 2008). For example, collaboration between the leaders of hospitals in a community can be stopped in its tracks if regulators interpret this as narrowing consumers’ choices or limiting competition.

Any common resource pool exhibits a unique combination of:

1. Resource units that are extracted and used for various purposes,
2. Groups of appropriators who are engaged in processes of extraction and utilization,
3. Processes of replenishment and maintenance of relevant infrastructures,
4. Managers who determine rules regarding access and distribution of rights, and
5. Those who monitor the behavior of all relevant actors and determine whether sanctions should be applied to rule violators.

In *Governing* *the Commons* Elinor Ostrom focuses on examples of natural resources managed and maintained by communities of appropriators whose very survival depends on continued access to that resource. Yet the fact that she was awarded a Nobel Prize in Economic Sciences for this research strongly suggests that these same principles are applicable to a much broader range of policy areas.

There are multiple resource pools relevant to health policy, and multiple levels and arenas of management that need to be considered. This research project will focus on identifying the critical characteristics of the major resource pools related to health policy, and evaluating the performance of cases with respect to the standards set by these design principles. At this early point in the project we cannot specify our conclusions, but we can suggest the following initial observations, which we use as a point of departure for more detailed investigations during the research period.

*Multiple Resource Pools*

For this proposed research, we assume the existence of three resource pools of particular relevance to health policy, specifically the following critical stocks of capital.

* **Human capital** of physicians and other health care professionals, as distributed across relevant specializations.
* **Physical capital** of health care facilities (hospitals, emergency rooms, clinics, test facilities).
* **Financial capital** available for allocation to all the diverse activities included in health care delivery.

One critical nexus of health policy concerns direct interpersonal interactions between patients and professional caregivers. At any one time there are only so many trained physicians, surgeons, nurses, pharmacists, technicians, and other specialists in related health professions, but an endless supply of actual or potential patients. How the time of health professionals is allocated is one essential aspect of resource appropriation in the health commons. A critical replenishment issue in this aspect of the health commons may concern the number, composition and distribution of primary care providers compared to more lucrative and prestigious specializations.

Overall costs could be significantly reduced if preventive care was given a higher priority in the system as a whole, but for most physicians the fee-for-service based system creates a need to see a large number of patients in order to pay their own steadily increasing bills. An emphasis on preventive care would also help patients realize that personal health is not a product that can be purchased like most private goods, but that health is instead a process of co-production in which patients are active participants in the process. (As noted in the opening paragraph of this proposal, neighborhood safety is a local public good that can be co-produced by citizens and police working together.)

Economic incentives also generate concerns with respect to health-related physical facilities. One common manifestation of competition between hospital systems, as well as between hospital systems and provider groups, is over-construction of high-technology services and test facilities. Under conditions of intense competition for increased market share, each system may feel the need to obtain the latest and most expensive equipment, even if it would make more economic sense to have only one unit in that metropolitan area. In this case the appropriators are the health professionals sending patients to make use of this equipment, perhaps after being encouraged to do so by top administrators who decided to purchase this equipment in the first place. This duplication of effort is a clear example of over-exploitation of this aspect of the health commons. Indeed, many critics have noted the extent to which the use of advanced facilities is supply-driven rather than by consumer demand. If hospital administrators within a community could instead coordinate their equipment purchases and subsequent utilization, then fewer unnecessary tests would be conducted, with savings all around.

New drug treatments are another important part of health-related physical capital. Concerns have often been raised about the reluctance of major drug manufacturers to invest money in the development of drugs for medical problems that afflict mostly poor people, since they would be unlikely to have sufficient funds to pay for these new drugs. In effect, drug researchers are the appropriators extracting from the existing stock of scientific knowledge to create new products that can be patented and sold for a significant profit, at least until generic versions become available. Private actors like the Gates Foundation may intervene to improve the chances that low-cost vaccines against diseases that occur mainly in poor countries, by guaranteeing a certain level of compensation for development of these vaccines.

Health is already a significant sector of the U.S. economy, and concerns have been raised that the rapidly increasing expense of health care could potentially weaken the health of the economy as a whole (Berwick 2009). There is only so much money that can be devoted to health care, whether the funds come from government sources, consumers, corporations, or from private insurance companies. Replenishment of resources in this financial commons must come from future economic growth, the prospect of which may be undermined if too many resources are devoted to health care in the near term.

The health commons connects these three resource pools in complex ways. For example, since Medicaid payments are often slow in coming and substantially lower than that of other payers, many physicians refuse to accept patients supported by Medicaid except for emergency treatment. As a consequence, many poor patients are unable to develop a long-term relationship with a primary care provider and instead rely on emergency rooms for basic health care. But since such facilities are necessarily finite, this practice adds to congestion problems in emergency services.

In unusually successful cases, such as Grand Junction, Colorado, and Cedar Rapids, Iowa, patterns of community-level collaboration have been established that offset problems typically associated with each of these forms of capital stocks. (Our evaluation of the Grand Junction case has been especially influenced by the following sources: Nichols et al. 2009, Bodenheimer and West 2010, Thorson et al. 2010.) Our initial impression is that health professionals in these communities have adopted procedures that resemble the conditions identified by Elinor Ostrom as being conducive to sustainable management of a common-pool resource. As discussed below, like other successful examples they also face continuous challenges to sustaining these conditions and behaviors.

For each of these resource pools in each of our test communities, we will identify key stakeholders and determine what types of behavior would be related to each of the design principles described above. Then, we will use interviews to help obtain answers to the following questions:

* What incentives do stakeholders face regarding extraction of resources and contributing towards maintenance of the available stock of resources?
  + For example, many physicians are members of for-profit corporations. As most are currently paid under a fee-for-service model, they are financially rewarded for performing more services – even when those services may be duplicative or when a less expensive but equally effective alternative may exist.
* What forms of coordination have been effective in changing these incentives and encouraging stakeholders to adopt a longer-term and more collaborative perspective?
  + To begin to address this question we will study carefully how health care providers in Grand Junction, Colorado have, since 1896, followed a mission “to improve ‘the health of the individuals and communities we serve, especially those who are poor or vulnerable.’”
* How does behavior with respect to one resource pool affect behavior associated with the other pools?
  + We will be looking at how the ratio of primary care physicians to specialists in a community may be leading to increased health care costs as well as the building of additional clinics and test facilities that support these specialists.

We are especially concerned with identifying potential challenges to the continued success of these arrangements. For example, what happens when a group of physicians builds a specialized outpatient facility that duplicates facilities already existing in a community hospital? Or what happens to traditions of community cooperation when a formerly independent hospital affiliates with a major hospital chain? Community-level practices of collaborative management must be deeply ingrained in the local professional culture to survive these kinds of challenges.

*Multiple Levels and Arenas of Management*

Commons management needs to be located within the broader context of governance of a public service industryas a whole. We use the term **public service industry** to cover all organizations actively engaged in some identifiable area of public policy, including the provision or production of public or toll goods or the management of common-pool resources.

It is standard practice to consider different substantive sectors of the economy as being relatively separate from each other. However, specific markets are always embedded within the context of overarching social and political processes. To truly understand market dynamics one also needs to understand the regulatory context constructed by political authorities. The role of nonprofit professional associations (like the AMA or the Joint Commission on Accreditation of Healthcare Organizations) are frequently important, especially in setting standards of good practice or certification schemes.

It is here that the term **polycentricity** comes into play. Given the diversity of stakeholder organizations involved in any public service industry as a whole, it is not appropriate to treat “the government” as a single entity that stands outside policy networks. Instead, public agencies from the local, state, and national levels, and with different responsibilities and often overlapping areas of jurisdiction, are engaged in close relationships with these stakeholders.

In a word, governance is polycentric, in that authorities from various centers of public and private authority interact to determine the conditions under which these authorities, as well as the citizens subject to these jurisdictional units, are authorized to act as well as the constraints put upon their activities for public purposes. And, as noted above, it is especially important that groups be given the autonomy to form organizations meant to pursue their shared goals, in the form of economic corporations, community groups, or special districts (such as school boards or water associations).

The polycentric nature of policing as a public service was amply demonstrated by the Workshop research from the 1970s discussed at the beginning of this proposal. At that time the general presumption was that consolidating all police services in a metropolitan area would result in substantial economies of scale, allowing taxes to be reduced and service improved. After all, how could a small- to medium-sized police department (with officers in the 25-50 range) possibly do a good job running its own crime lab? After studying how police services were delivered in 80 metropolitan areas, it became clear that police departments had already figured that out and had developed innovative ways to cooperate. In many cases small police departments had made an arrangement to pay a local hospital some modest fees to conduct laboratory investigations of samples obtained from a crime scene. After all, these hospitals had already purchased expensive equipment and trained staff to conduct a wide array of technical studies related to the analysis of blood samples.

This research on police service delivery demonstrated that both small and large scale organizations have critical roles to play in this particular area of public policy. Although it is difficult to directly measure the impact of this work, this research has often been cited when consolidation plans are being considered. It is also worth noting that the consolidation wave did not exactly overwhelm all opposition, since the current number of police departments in the U.S. remains very close to the number in existence when this research project was begun. Since then, serious scholars of metropolitan organization and service delivery have recommended various ways that large departments could increase the community patrol aspects of their officers so as to increase contact between officers and citizens.

Finding the right scale for the production of different aspects of public services is a critical challenge in any area of public policy. Recent years have seen a significant growth in consolidation of hospital facilities in different communities, with most consolidations remaining within the borders of a single state (because of the continuing importance of state health departments in certifying and inspecting medical facilities, as well as rate financing and reporting). Similarly, health insurance is regulated at the state level. Meanwhile, Medicare funding is national in scope and Medicaid combines support from national and state agencies. We suspect that small local organizations continue to play critical roles in health care delivery in all major markets, despite national trends towards consolidation. Evidence exists that concentrated “centers of excellence” have not found favor with consumers in many instances.

Unlike many policy analysts, we do not begin by presuming that increased consolidation is either good or bad on ideological grounds. Instead, we first identify the nature of the relevant goods and services that need to be produced in this policy area, and then evaluate the scale of operation at which production can be most efficiently organized. Any viable system of health care delivery will require contributions from organizations of many different scales of operation. Each relevant good and service needs to be examined on its own grounds.

Resources extracted from the three critical resource pools identified earlier can be used to construct an array of private, public, and toll goods, which are managed by a diverse range of private, public, and nonprofit organizations. An important part of our research program will be to identify the fundamental types of goods and services involved in the health service industry. At this point we can only suggest examples of each type of goods that we expect to play important roles in our subsequent analysis.

For purposes of analysis, a patient’s ability to consult directly with a health care provider of his or her choice is effectively a private good. Other private goods include the out-of-pocket purchase of specialized services like cosmetic surgery that are not covered by their insurance plan. However, individual health cannot be interpreted as a simple private good. Instead, it is better seen as resulting from a process of co-production, in which individual consumers actively participate in the production of that good or service. Because of this need for active engagement of the consumer in the process of co-production, no process of market exchange can adequately capture the full marginal cost or benefit of medical services.

Relevant public goods include the overall health of the community, which is affected by a broad array of factors beyond the health care industry per se. Publicly-available Information can also be considered to be a public good, although access to that information may not be equally shared by all segments of the population.

Toll (also known as club) goods include participation in specialized health care insurance coverage and certification by professional associations. Access to networks of information exchange can also be treated as toll goods, if access is restricted to those facilities willing to contribute towards the operation of that exchange.

These processes of production need to be separated from **provision**, which involves the selection of the bundles of public goods and services to which any collective consumption unit has access. Medical referral regions serviced by hospitals in a given municipality can be considered as one form of collective consumption unit. The population of patients can also be divided into groups depending on the level of care they require (acute care, generally healthy patients, those with chronic conditions, end-of-life care, etc.) In the health care public service industry, different forms of insurance coverage effectively divide the population into distinct groups (those covered by Medicare, Medicaid, private insurance plans, and the uninsured). Reliance on third-party financing of medical insurance breaks the direct link between consumption and willingness to pay that is essential for the smooth operation of efficient processes of market exchange. From the perspective of polycentric governance, however, this level of complexity is not that unusual.

Each of the following functions needs to be addressed, in some fashion or another, in any effective system of governance:

1. **Establishment** of collective entities, including collective consumption units
2. **Selection and Motivation** of stakeholder representatives or agents
3. **Provision** (or Procurement): Selection of the bundle of public goods/services for a collective consumption unit
4. **Production**: Physical process of constructing a good or service (steps from appropriation to transformation to distribution)
5. **Financing** (may combine multiple sources)
6. **Rule-Making** (and related collective choices)
7. **Monitoring** (and other information generation)
8. **Sanctioning** (based on information from monitoring)
9. **Dispute Resolution** (including appeals)
10. **Coordination** (and related management tasks)

For this part of this project we will draw upon concepts and resource protocols developed by Workshop researchers who studied the structure of policing in metropolitan areas in the United States, in research dating back to the 1970s and 1980s (McGinnis 1999, Oakerson 1999). We will, of course, need to prepare data structures directly relevant for application to health policy. This will involve such tasks as:

* Identifying private, public, and toll types of goods and services that are especially important in related areas of health policy. (For examples, see above.)
* Specifying the critical arenas of direct and indirect services through which these goods and services are produced, distributed, and financed.
* Identifying the types of individuals and organizations that are involved in the production, provision, and financing activities for each of the major categories of direct and indirect services.

In earlier analyses of policing service delivery, it proved useful to separate direct and intermediate services. Direct services are those consumed by members of the public directly, whereas intermediate services typically involve coordination among professionals.

Initially, we have identified the following direct services:

1. **Primary care:** consultation with preferred health care provider (from family physician to nurse practitioner to chiropractor to school nurse, etc.), simple tests, initial diagnosis, referral to specialists, care coordination, etc.
2. **Secondary or specialist care:** tests, surgery, therapy, etc.
3. **Emergency or urgent care:** time-sensitive services
4. **Chronic care:** maintenance in cases of long-lasting medical conditions
5. **Palliative care:** nursing homes, hospice, home health
6. **Preventive care:** promotion of public health, health information, behavior change, healthy communities
7. **Household based co-production:** parents’ administering over the counter medications to children and provision of nutritious meals

We do not list practitioners of **alternative** **medicine** (chiropractors, acupuncture) as a separate category, even though we realize that such individuals play important roles in the informal support structures that many people depend upon. However, the services provided by alternative medical specialists may fall into any of these direct service categories, especially primary, chronic, palliative, and preventive.

Among the most important intermediate services are

1. **Testing and lab services:** implementation and interpretation of results
2. **Facility management and support operations**: management services, etc.
3. **Information systems:** health information exchange, electronic medical records, performance monitoring systems, consumer information
4. **Research and development:** drugs, devices, diagnostic technology, quality improvement methodologies
5. **Provision of financing:** Private insurance, Medicare, Medicaid, self-insurance, self-payment, etc.
6. **Facility construction:** hospitals, clinics, emergency facilities, testing centers
7. **Regulation of health care industries:** government agencies, professional organizations, certification agencies
8. **Lobbying and advocacy**
9. **Professional training:** medical, nursing, dental, osteopathic, chiropractic schools as well as training for radiology technicians, nursing assistants, etc).
10. **Community level coordination:** burden-sharing agreements, emergency planning

For this part of the project we will draw upon standard lists of the types of organizations involved in health policy, and identify the relevant examples in each of our study communities.

1. **Individual Patients and Households**
2. **Physicians and Other Healthcare Professionals** 
   1. **Primary care professionals**
   2. **Specialists in secondary or tertiary care**
   3. **Other health professions (nurses, pharmacists, technicians, etc.)**
   4. **Management and other support companies**
3. **Administrators of facilities from the following categories:** 
   1. **Specialized clinics and general-purpose hospitals**
   2. **For-Profit and Non-Profit**
   3. **Academic and Community and Government-Owned**
   4. **Stand-alone or Consolidated Hospital Systems**
4. **Insurers (Private and Public)**
5. **Employers (as purchasers of insurance)**
6. **Administrators of government-run programs**
7. **Public health officials**
8. **Government Regulators and officials of certification organizations**
9. **Health Information Exchanges (HIEs) and other information services**
10. **Community Service Organizations (CSOs)**

Clearly, some individuals will fall into more than one of these stakeholder categories. Even so, we are convinced that these categories provide a useful point of departure, since each of these categories represents a unique configuration of professional norms and economic interests.

For each of the case studies we will construct a series of matrices to represent the network ties among producer, provider, and financing units engaged in each of these forms of services. This will enable us to represent the overall structure of inter-connections among stakeholder organizations, governance functions, and output measures and to develop quantitative measures of industry structure. (For an example of how similar research techniques were applied to the study of police services, see Ostrom et al., 1974.)

To illustrate the types of issues with which the research team is likely to be concerned, consider the following set of problems that typically arise with any commons: over-harvesting, under-investment, inequitable access, unbalanced allocations, building trust. Table 1 lists examples of each of these dilemmas related to each of the three components of the health commons**.**

These entries are meant to be illustrative only, and we will need to flesh out the specific manifestations of each dilemma that are most relevant for each of our case studies. We expect such problems to have emerged in one form or another in each of the communities, and we will need to learn what responses community leaders chose in each instance.

As noted above, CPR and public good aspects of the health commons are closely related, and interact to generate more complex dilemmas.

In our analysis we will differentiate between direct services (to individual patients) and intermediate services (to physicians and other medical professionals). Table 2 summarizes the types of issues likely to arise in these mostly separate arenas of interaction. Again, this is only a very preliminary list, but it does suffice to suggest the scope of the difficulties inherent in any effort to cooperatively manage a community’s healthcare delivery.

**Empirical Investigation of Study Communities**

We have begun exploratory research on this topic. A working group including faculty, graduate students, and health care professionals has been meeting for several months now, and our initial meetings have focused on developing a common vocabulary for discussion among individuals coming from very different backgrounds.

During Fall 2010, graduate and undergraduate students at Indiana University were involved in a preliminary study of citizen attitudes towards health, specifically in the community of Bedford, Indiana, which is located some 20 miles south of the campus of Indiana University. Graduate students in Kathy Gilbert’s qualitative methods course pair up with undergraduates in Joan Pong Linton’s service writing course to make contacts with health care organizations in southern Indiana (examples: Volunteers in Medicine, contact through Rob Stone, and interviews with community members and health professionals in Bedford). Focus will be on an informal inventory of the activities conducted by health care organizations of various types (with categories as used in the report on the Grand Junction case study). This study will help participants appreciate community perceptions of health care. However, the research project as a whole will focus instead on interviews with health professionals.

A planning session was held in Bloomington, Indiana, on November 10-12, 2010. Participants included key researchers in Bloomington, members of the ReThink Health Advisory Board, and representatives of the pilot communities. Funding, planning, and implementation of this session will be covered by the Rippel Foundation, with local assistance of Workshop staff. One of primary goals of this planning session will be to use this proposal to further refine the focus of this research to enable the greatest amount of understanding about the challenges to completing the products anticipated from this project. In addition we will be developing the framework for an iterative process for refining the focus of this research during the term of this project.

The core members of the research team will meet on a weekly basis during the Spring 2011 semester to read and discuss background material as well as prepare preliminary lists of potential measuring instruments. These deliberations will be guided by advice from members of a theory and measurement based advisory board consisting primarily of participants from the Nov. meeting in Bloomington. Initial drafts of survey instruments will be used to obtain approval from our Institutional Review Board, which reviews all research involving human subjects.

Our measuring instruments will be used to identify the relevant stakeholder organizations in each of our study sites, and more specifically to identify candidates for interviews. Interviews will be conducted by the project’s researchers who will live in each community for a few months. This research will begin in earnest during the summer of 2011.

Regional advisory councils will be established to help guide the field research in each community. These councils will include local professionals, several of whom have been involved in preliminary discussions of this research approach. These regional councils will be especially important sources for contacts with our initial interview subjects in each community.

Field researchers will be in regular contact with study subjects, and have specified two accountability meetings, at which the initial observations of the field researchers can be compared with those of the leaders of that community. Working group participants will prepare reports for the subjects of our case study, and will visit the relevant communities to discuss our findings with members of those communities. Their reactions and suggestions will be incorporated into revised reports.

We have developed a preliminary set of interview questions (see Appendix A). We are pre-testing this interview schedule and will be shortly submitting a revised version for approval by our Institutional Review Board.

We have begun the process of setting up each of the community advisory boards:

* Grand Junction: initial kickoff meeting scheduled for June 10.
* Cedar Rapids: initial kickoff meeting scheduled for July 12.
* Bloomington: Kickoff meeting scheduled for May 31.
* Bedford: still in planning stages

A meeting of our measures and outcomes advisory board has been arranged for April 28 in Bloomington, Indiana.

At the kickoff meetings we will meet with the board as a whole and discuss with them our plans for this research project. We will ask their advice concerning what matters we should pay particular attention to in our research on their community, as well as what sensitive issues we might want to avoid or handle gingerly. We hope to meet with each of the members individually, and ask them who else we should interview. We will endeavor to maintain contact with these community boards throughout the period of our research. Their input will be especially useful in making sure that our conclusions are couched in terms that will be understandable to practitioners. We do not see this as a purely academic exercise.

For each of these case studies, project investigators will be seeking answers to the following questions:

* Who are the key actors involved in each of the direct and indirect service sectors of this public service industry in these communities?
* What efforts have been made to coordinate on the management of the critical resource pools?
* What challenges are these communities facing in achieving or sustaining effective patterns of cooperation and coordination?

These questions can be addressed during the interviews. We will also be asking interview subjects to identify other individuals we should also interview. After evaluating their responses, and gathering other relevant data on network connections, project investigators will try to answer such question as:

* How closely do these modes of collaborative management satisfy the criteria specified in the Ostrom Design Principles?
* How can the network structure of cross-specialization best be described (based on relevant network measures)?

Our exploratory study of these four cases should give us a sufficient basis for preparing a report comparing instances of successful and unsuccessful efforts at community-level management of health care related resource pools. We will share our initial findings with the ReThink Health Advisory Board at a second meeting in November 2011.

**Initial Reactions and Preliminary Findings**

Our initial impression is that many different forms of coordination have already been tried (consolidated hospital systems, independent physician associations, HMOs, insurance plans, integrated organizations). Recent innovations include accountable care organizations (ACOs) and patient-centered medical homes (PCMHs). Experimentation by stakeholders provides a range of institutional alternatives from which to build comprehensive networks.

In short, there is plenty of institutional diversity in health care public service industry. It seems clear that these difficult problems are not amenable to solution by direct application of standard market or state-based solutions. National level solutions are difficult in principle because of the wide variability in conditions and outcomes in diverse regional settings. Although maintaining a meaningful range of choice on the part of consumers is critical, health policy is not an area in which we can reasonably expect competitive markets to work their ordinary magic. There are several ways in which this particular type of product diverges from situations for which markets are ideally suited.

* Market exchanges works best for private goods that can be divided and consumed by individual or households with minimal impact on the consumption of others. It is also easiest if the production and consumption processes can be clearly demarcated, with the exchange of economic resources serving as the critical link between producers and consumers. However, co-production is critical to “health,” in the sense that individuals who are not actively involved in changing their own behavior are unlikely to obtain results as positive as those less inclined to see health as a product that can be purchased from healthcare professionals. In this sense, health is even more problematic to effectively marketize than most post-experience goods.
* Markets work most efficiently when both quality and costs can be easily measured, both by producers and by consumers. In the case of healthcare, consumers suffer substantial information asymmetries, especially regarding quality of & need for procedures. Also, the costs they far for healthcare are far from transparent. Third-party payers separate consumers from realizing total costs. Uncoordinated billing further mystifies total cost, even service providers may not realize actual cost of procedures. A further complication is that reimbursement rates vary widely depending on insurance plan or its coverage.
* Healthcare markets are often said to be characterized by supply-driven demand, especially relating to the overuse of high tech test facilities. In many cases, excessive tests are given in order to protect healthcare providers from malpractice liability concerns. Given the high-tech nature of today’s healthcare industry, competition often takes the form of excessive building of high-tech facilities, which may have the perverse tendency of increasing costs. In situations where competitive markets are most appropriate, competition would lower costs rather than helping to raise costs.
* Consolidation of health care providers within a given region can result in local monopoly power, and vertical integration across different service sectors may tend to aggravate the perverse effects discussed above.
* Also, insurance coverage is often determined by factors remote from health care needs (i.e., employment), thus further de-coupling choices regarding insurance coverage and the actual benefits or costs of those packages.
* Finally, choices regarding one’s own healthcare are often intensely emotional and fear-driven, which is hardly the purely rational context typically presumed to characterize efficient market exchange.

Because of the increasing realization that standard market and national level solutions are not feasible in this policy area, considerable attention is being paid to regional networks such as Hospital Referral Regions. Not many formal organizations coordinate operations at this level, but informal coordination can be effective, if sustained by a shared trust.

As part of our initial preparation, officials at the Ripple Foundation asked us to prepare an outline of the “logic model” that summarizes our expectations concerning the process of change that we expect to observe in our cases. Of course, this model remains to be tested against the historical experience of our study communities, but it seems worth summarizing this process or logic model at this early point in our analysis. Figure 1 illustrates this process as a whole, which can be described in words as follows:

1. There are several dimensions of measures that are relevant to important actors in the area of health and healthcare, specifically relating to the overall health of a population, the quality of health care, access to care, and the costs of care.
2. Positive outcomes on these dimensions do NOT naturally trend together. For example, if a new technology enables the quality of healthcare to increase in a given situation, it is likely that the cost of that care will increase and/or access to that care will be more restricted. In the absence of carefully coordinated actions, the natural tendency is that any improvement on one dimension tends to be associated with decreased performance on one or more of the other dimensions.
3. An individual actor (or organizational type) may be able to obtain favorable outcomes on one or more dimensions, especially in the short-term. However, these gains are unlikely to be sustainable in the long term, because of point 2. Dissatisfaction with these other outcomes may lead to a sense of crisis and a widespread realization that something else needs to be done.
4. If actors respond to their concerns by agreeing to jointly coordinate their actions, that group as a whole may be able to achieve outcomes that are mutually satisfactory to the members (at least in the short term), with the following caveats.
   1. Successful coordination typically requires one or more members of this “coalition” or “partnership” to give up opportunities for personal gains, and there will always be some members who will renege on their agreements.
   2. Coordination will be most likely to be effective and sustainable if the parties are engaged in active monitoring and are willing to apply graduated sanctions to rule violators. More generally, the more closely the partnership’s internal decision-making processes satisfy the “design principles” of commons management identified by Elinor Ostrom and her colleagues, the more effective that group will be at obtaining its shared goals.
5. If the extent of mutual coordination remains narrow (in the sense that important types of actors are not included in the process), then any successes achieved under step 4 are NOT likely to be sustainable. Any partial partnership is likely to experience pressure from at least three sources:
   1. Some members will seek to expand the breadth of coordination by including other types of actors, in hopes of realizing even better results.
   2. Some members will resist any expansion of the partnership, in order to protect their existing gains.
   3. Some members will renege on their commitments, for reasons described in 4a. If such violations are not detected and sanctioned appropriately, then that group may no longer be able to maintain its existing level of coordination.
6. Even the broadest pattern of coordination will remain susceptible to being undermined by external shocks or internal disagreements. However, regular monitoring, graduated sanctions, low-cost dispute resolution mechanisms, and inclusion of all relevant parties in rule-making (e.g., the design principles) will improve the chances that positive outcomes can be sustainable, even in the presence of external shocks.

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**Table 1.** **Potential Dilemmas in Each Component of the Health Commons**

|  |  |  |  |
| --- | --- | --- | --- |
| *Dilemma Type* | **Human Capital (Professionals)** | **Physical Capital (Facilities and Managers)** | **Financial Capital (Budgets)** |
| *Over-harvesting* | Pressure to see more patients, shorter consultations | Competitive pressures to build duplicate facilities | Increasing health care costs may undermine economic growth |
| *Under-investment in infrastructure* | Training lacks attention to team-building skills | Fears of anti-trust investigations may discourage coordination | Future patients tend to avoid preventive care |
| *Inequitable distributions* | Uneven access to primary care physicians | Uninsured patients may not have access to diagnostic tests | Inadequate reimbursement from Medicaid and Medicare |
| *Unbalanced allocations* | Medical students face incentives to select high-status specializations | Drug research may be directed towards diseases with high expected profits | High proportion of health spending on end-of-life care |
| *Establishing & Maintaining Trust* | Fears about continued viability of professional autonomy | Competitive pressures undermine efforts at collaboration | Doubts about long-term viability of Medicare |

**Table 2.**

**Examples of Potential Challenges in the Management of**

**Direct and Intermediate Resource Pools and Goods/Services**

**(a) Common Resource Pool Components of the Health Commons**

|  |  |  |
| --- | --- | --- |
|  | **Direct Consumption** | **Intermediate Organizations** |
| *Human capital of health care professionals* | Perception of too short visits with physicians | Incentives to see more patients for shorter time periods |
|  | Uneven access to primary care physicians (especially uninsured or Medicaid patients) | Medical students face strong economic incentives to choose a high-status specialization rather than primary care |
|  | Shortage of physicians in rural areas | Training programs emphasize individual decision-making skills with little attention to teamwork |
| *Physical capital of health care facilities* | Incentives for excessive tests | Competitive pressure to build duplicate facilities and implement aggressive testing (supply-driven markets) |
|  | Uninsured patients may not have access to diagnostic tests | Costs of coordination, including possibility of triggering FTC anti-trust investigations |
|  | Influence of drug ads and internet on consumers | Incentives to focus drug research on selected diseases |
| *Financial capital available for health expenses* | High cost of end-of-life care | Effects on economy as proportion of public budgets and GDP continues to increase, and high costs to employers |
|  | High cost of care for chronic conditions | Inadequate reimbursements from Medicaid & Medicare |
|  | Uninsured (by choice or necessity) | Emergency care required for charity cases,, with little compensation |
|  | Avoidance of preventive care (reliance on sickness care services) | Concentration of market power in consolidated health systems, physician associations, or insurance plans |
|  |  | Costs of medical errors and malpractice suits |

**(b) Public Goods/Services Components of the Health Commons**

|  |  |  |
| --- | --- | --- |
|  | **Direct Services**  **(Co-Production)** | **Intermediate (or Indirect) Services** |
| *Public health* | Collective action to improve community health | Planning for development of healthy communities |
|  | Costs of changing unhealthy habits, tendencies | Emergency preparedness |
|  | Non-compliance (with medication as prescribed) | Public information campaigns |
|  |  | Vaccination programs |
| *Health information* | Evaluating publicly-available health information | Development of new scientific knowledge |
|  | Who owns Personal Health Records (electronic)? | Establishing, maintaining Health Information Exchanges |

**Figure 1**



**Appendix A**

**IRB STUDY #1105005277**

**INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR**

**Managing the Health Commons**

You are invited to participate in a research study of how health care is coordinated in communities. You were selected as a possible subject because of your role as a decision maker in health care and/or in your overall community. We ask that you read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Professors Elinor Ostrom and Michael McGinnis in the Workshop in Political Theory and Policy Analysis at Indiana University. This study is being funded the Fannie E. Rippel Foundation.

**STUDY PURPOSE**

The purpose of this study is to understand how individuals in decision making positions in health, health care and general community organizations have coordinated their efforts with other organizations. We are also interested in learning about how these coordinated efforts have succeeded and why they have succeeded to a greater to lesser degree.

**PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will do the following:

Answer about ten questions related to coordinated efforts during an interview that is estimated to last one hour.

**CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. Your identity will be held in confidence in reports in which the study may be published and any databases in which results may be stored. If you give permission to record this interview, the transcripts of this interview will not contain your name and the recordings of the interview will be destroyed at the end of this study which is June 30, 2012.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and his/her research associates, the Indiana University Institutional Review Board or its designees and (as allowed by law) state or federal agencies, specifically the Office for Human Research Protections.

**PAYMENT**

You will not receive payment for taking part in this study.

**CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study, contact the researcher Professor Michael McGinnis at (812) 855-0441.

For questions about your rights as a research participant or to discuss problems, complaints or concerns about a research study, or to obtain information, or offer input, contact the IU Human Subjects Office at (317) 278-3458 or [for Indianapolis] or (812) 856-4242 [for Bloomington] or (800) 696-2949.

**VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relations with the Workshop in Political Theory and Policy Analysis at Indiana University.

**IRB Study Number: Title of Study:** Managing the Health Commons

**Sample Interview Questions Principal Investigator:** Michael McGinnis

**Introduction**

The Workshop in Political Theory and Policy Analysis at Indiana University Bloomington is working with the Fannie E. Rippel Foundation on a research project. Here is a one-page description of our study. If you’d like more information on this study you can contact the researcher listed at the bottom of this sheet.

Over the coming months, we will be talking with individuals in four communities in the US (in Colorado, Iowa and Indiana) to learn whether community-level coordination around healthcare can produce better care and better health for Americans while maintaining or decreasing the cost of that care. We also recognize that coordination efforts can be difficult to achieve and we want to understand any problems that have occurred in your community.

We are very interested in learning about your experiences in this community.

1. What do you see as your primary role in this community?
   1. Prompt: healthcare role?
2. What are your responsibilities in this role?
3. Please describe the organization in which you fulfill these responsibilities.
   1. Is this organization:
      1. For profit? Not for profit? Non-profit?
      2. Headquarters?
      3. General mission?
      4. How old? How was it established?
      5. About how many employees?
4. Tell me about who you interact with on a regular basis, outside of your own organization, in order to carry out your responsibilities?
   1. What tasks do you work on with other organizations?
   2. What topics do you discuss with other organizations?
5. Can you tell me about an example of cross-organization cooperation that you have participated in and that you found especially useful or successful.
   1. What do you think made this effort successful?
   2. Who or with what organizations did you work with on this effort?
   3. Did you know these people or these organizations before?
   4. How did you meet or become involved with these organizations?
      1. In a professional, community or social capacity?
   5. Were there any people in the group who were closer to one another?
      1. Who were they?
      2. Which groups of people contributed the most – resources, times or information?
      3. How did you identify the groups that contributed the most?
      4. Were there some groups that didn’t seem to be working together as well?
         1. How were the people in these groups encouraged to work together?
         2. How did the overall group deal with smaller groups or with individuals who weren’t fulfilling their responsibilities to the group?
      5. Were there any conflicts in these groups of people or between groups?
         1. Were these conflicts resolved?
         2. How were these conflicts resolved?
      6. In this project, how did you work together or depend on each other?
6. Have you had another experience that was less positive?
   1. Please tell us why you think this effort was less positive.
   2. Potentially follow the prompts under question 5.
7. What challenges do you think were most difficult to address in that case?
   1. Were these challenges related to:
      1. Money – financing or facilities
      2. Personalities
      3. Politics (internal or external)
      4. Accountability of diverse participants
      5. External actors or organizations trying to influence the group’s direction?
8. Thinking more broadly, what types of issues arise in your community that you think need to be addressed?
9. Does your community have any organizations or associations to facilitate coordination around these issues?
10. Are there barriers in your community that make it difficult to resolve these issues?
11. Do the participants in coordinated activities follow the actions of other participants to increase the likelihood of everyone pitching in?
    * 1. What happens if there is some doubt about everyone following agreements?
12. Are there other aspects of the local health care system in your community that you would like to discuss?
13. Are there any major changes that you think are most important to be made in your community regarding health care?

I have finished asking questions. I would like to thank you for participating in this project, and would like to know if you have any questions for me at this time.

* 1. Would you be willing to be contacted again, if we need additional information?
  2. Do you have any suggestions of other persons in your community that we should talk with about these questions?
  3. Would you like a copy of our results?
     1. If yes, obtain best address to receive our report.

**Appendix B**

