Health as a Commons: Talking Points

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1. Political debates on health policy reform have focused at the national level, but **health care is an intrinsically local (or regional) affair.** Individual patients typically seek care from local physicians and healthcare professionals in a community interact with each other on a regular basis.

2. Researchers have found a **wide range of variation at the regional level** in healthcare input measures and health outcomes. Bio-physical, socio-demographic and political-economic conditions pose substantially different challenges for communities, and more research is needed to fully understand the reasons for this variation in healthcare costs and health outcomes.

3. The complex system of health and healthcare services constitutes a **commons**, in the sense that **individuals in a community benefit from the continued availability of these shared resourc**es:
   a. Physical facilities (emergency rooms, hospitals, clinics, testing facilities)
   b. Financial resources (publicly funded programs, private employers, insurance companies)
   c. Human capital (health professionals and health-conscious citizens)
   d. Social capital (trust among health professionals, community leaders, and citizens)

4. **Since NONE of these common resources are limitless or automatically replenished, profound dilemmas of collective action will arise from the reality of resource scarcity**.
   a. In a "**tragedy of the commons**," common resources are depleted when individuals exploit them for personal gain and no one takes responsibility for managing the resource base as a whole.
   b. In **collaborative stewardship** of a commons, those stakeholders most directly concerned with the long-term sustainability of these resources take _ownership_ of the problem, and work out ways to _coordinate their resource usage and replenishment activities_.
   c. Effective **stewardship** of a commons requires that someone can see the **system as a whole**, and make decisions based on a long-term perspective.

5. Initial analyses of communities which have managed to combine high quality of health care with below-average costs suggest that they have developed _**informal mechanisms of collaborative stewardship**_. Each does so in different ways, and research is needed to identify the common principles underlying these different paths to success.

6. In research on the **management of biophysical commons** (fisheries, forests, and irrigation systems), Nobel laureate Elinor Ostrom identified **8 design principles** that are satisfied, in varying forms, in cases of sustainable resource management (see Appendix for details). Briefly, they require that
   a. an identifiable stewardship group routinely collaborates in making and enforcing rules,
   b. local stakeholders actively participate in monitoring, sanctioning, and resolving disputes, and
   c. higher authorities recognize local autonomy or refrain from undermining local efforts.

7. Our **working hypothesis** is that a similar set of design principles and supportive processes will prove to be critical for effective stewardship of the resources most relevant to health and healthcare. Specifically, we expect to find that **communities where the full array of relevant stakeholder groups manage to coordinate on a regular basis** will tend to experience <u>better health outcomes and a higher quality of care delivered at a lower-cost to a wider segment of their community</u>.

8. This connection between natural resource commons and health policy requires some explanation:
    a. **We interpret the term "commons" broadly to include public goods**, including conditions required for the efficient operation of markets. Since many public goods are financed through taxes, **free riding** on the contributions of others is a form of resource exploitation.
    b. Among the public goods most relevant to a **health commons** are legal protection for access to care, safety regulations, emergency preparedness, and health promotion activities.
    c. <u>We do NOT assume that design principles from commons research automatically **scale up** to cover more complex policy arenas</u>, like the U.S. healthcare system. As a consequence, we must cast our analytical net more widely.

9. In our list of factors facilitating sustainability of collaborative stewardship of a health commons , we **combine lessons from four bodies of research/practice**:

    a. **Commons Research** focused on small-scale communities whose survival depends on the continued availability of a natural resource (as summarized above and in the appendix).

    b. **Collective Action Theory** in general, especially regarding the challenges facing teams of individuals who are NOT members of a close-knit community. Such teams need to develop
        i. <u>regular channels of communication</u> and easily accessible forums for discussion,
        ii. a <u>shared understanding</u> of the nature of the system they are managing,
        iii. a shared sense of <u>trust</u> in each other's reliability,
        iv. and <u>norms and procedures</u> which to support productive discussion and reflection.

    c. **Inter-Organizational Relations**, since the relevant participants in collective action are agents representing the interests of formal organizations or informal groups. This requires
        i. <u>strong leaders</u> who are able to maintain the support of their home organizations,
        ii. an agenda focused on <u>achieving specific goals</u> or resolving particular issues,
        iii. <u>sensitivity to the vital interests and core competencies</u> of member organizations,
        iv. and a <u>willingness to expand</u> the team to include previously unrepresented groups.

    d. **Healthcare Policy,** incorporating factors specific to this policy area, especially the identity of key stakeholder groups.

10. To identify the key actors who need to be involved in collaborative stewardship of a Health Commons, we **define a stakeholder group** as including those individuals and organizations who share a broadly similar approach to health and healthcare, more specifically,
    a. similar economic interests,
    b. similar capabilities to affect specific outcomes, and/or
    c. similar modes of thought, mental models, and value systems (as a consequence of professional training and practical experience).

11. For analytical purposes we arrange the large number of types of individuals and organizations actively engaged in health and healthcare into a short **list of stakeholder groups:**

> 1. **Physicians and Other Healthcare Professionals**
> 2. **Facility Administrators** (hospitals and specialized clinics)
> 3. **Insurers**
> 4. **Employers** (as purchasers of insurance)
> 5. **Program Administrators**
> 6. **Public Health Officials**
> 7. **Regulators** (government agencies and professional associations)
> 8. **HIEs** (and other information services)
> 9. **Community Organizations**
> 10. **Individual Patients and Households**

12. For this research project we interview individuals selected from stakeholder groups in three communities (Bloomington, IN, Cedar Rapids, IA, and Grand Junction, CO).
    a. These communities are NOT a representative sample of the diversity of healthcare regions in the United States. We selected them on the basis of analytical convenience, since we had already developed contacts with healthcare and community leaders in each of these communities.
    b. We envision this as a pilot study for a larger and longer term research and action program.

13. In this initial stage we interview representatives from all of the groups listed above except individual patients/households.
    a. **In the short term, collaborative stewardship among professional stakeholders is critical to reducing costs and improving the quality of health care.**
    b. **In the long run, the active participation of ordinary citizens is critical, especially their everyday choices between healthy and unhealthy behaviors.**
        i. Health is NOT a product that can be purchased from suppliers; instead it requires **co-production**, a process in which individuals actively contribute to determining their own health.
        ii. In subsequent projects, we plan to expand coverage to citizens.

14. This research project is being conducted in collaboration with other research-action teams in the **ReThink Health Initiative**, funded by **The Fannie E. Rippel Foundation**. Related projects include efforts to (1) identify potential leadership teams in particular communities and work with them as they implement their initial projects, (2) offer training seminars in effective and innovative leadership to healthcare professionals and community organizers, (3) develop simulation models and interactive game experiences that help leaders better understand the systemic dynamics of health and healthcare in their communities, (4) compare lessons from diverse cases of initiatives that have been successfully implemented in different communities, and (5) analyze specific settings or programs, with initial research focused on state-level reform in New Jersey and the development of measures to evaluate the performance of accountable care organizations.

15.

> **RESEARCH QUESTION for Managing the Health Commons project:**
> **What factors determine the dynamic pattern of expansion and/or contraction in the range of stakeholder coordination on health and healthcare?**

16. We will develop a **self-assessment tool** to help stewardship teams select issues for collaboration and identify resources that can be used to improve health and healthcare in their community. Our initial research has identified the following **list of issues** that have been used as a focus of coordination at the regional level, or that could be used to catalyze increased cooperation:

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Allocation of human capital in healthcare services
Availability of primary care
Physician training & recruitment
Hospital-physician relations
Care transitions

Healthcare facilities & physical capital
Coordination of emergency care
Facility construction
Market concentration; anti-trust
Consolidation of hospital systems

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

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Public/community health
Preventive care
Health promotion
Emergency preparedness
Built environment

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

Other issues
Employment & economic conditions
Mental health care
Clinics for dental care
Equity; urban/rural disparities
Legal culture (malpractice)

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17. Tentatively, we expect that ***collaborative stewardship of the health commons works best if***:

1. A formal or informal leadership team involving all (or most) stakeholder groups which are critical in shaping healthcare practices and health outcomes within a clearly defined region
2. Has been given the authority (or has taken upon itself the responsibility)
3. To manage that community's resources in a responsible and sustainable manner by collectively crafting rules and procedures regarding local healthcare practices and health promotion activities;
4. These rules and procedures fit local circumstances and participants consider the resulting distribution of the costs and benefits of their collective action to be fair and equitable;
5. Participants have routine access to information generated through monitoring of actions and health outcomes, with monitors held accountable for their work;
6. Participants who violate agreements are subjected to a graduated series of increasingly severe sanctions, but rule violators are also given opportunities to regain the trust of others;
7. Participants can resolve disputes among themselves or with the help of others, and these procedures do not take an unreasonable amount of time and are not excessively costly;
8. When the group is working on a complex problem or an inter-related set of goals, the team can break itself down into sub-teams to focus on achieving specific goals;
9. Regular channels of communication facilitate identification of shared goals and help team members develop a common understanding of the system within which they are operating,
10. As well as nurturing a sense of trust in each other and reinforcing shared norms;
11. Team and sub-team leaders keep discussions going in productive directions and
12. Actively pursue opportunities to reach out to stakeholders not yet included on the team.

18. Collaborative stewardship is a form of **polycentric governance**, a complex political system in which multiple public authorities from overlapping jurisdictions as well as relevant private, voluntary, and community-based organizations govern through an ongoing process of *mutual adjustment*, within the constraints of general rules and cultural norms.
    a. Although messy in practice, polycentric governance provides plenty of opportunities for all interested parties to participate in policy-making and implementation, and facilitates the fine-tuning of rules and procedures to fit distinctive characteristics of local situations.
    b. For several decades, the concept of polycentricity has been the central focus of research conducted by scholars affiliated with the Workshop in Political Theory and Policy Analysis.

This research project is part of **ReThink Health** (http://www.rethinkhealth.org/),
a collaborative research and action initiative funded by
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Appendix: Design Principles for Sustainable Governance of Common-Pool Resources*

1. **Clearly defined boundaries**:
   [A] Individuals or households who have rights to withdraw resource units from the common-pool resource must be clearly defined;
   [B] The boundaries of the common-pool resource must be well defined.
2. **Congruence between appropriation and provision rules and local conditions**:
   [A] Appropriation rules restricting time, place, technology, and/or quantity of resource units are related to local conditions.
   [B] The benefits obtained by users from a common-pool resource, as determined by appropriation rules, are proportional to the amount of inputs required in the form of labor, material, or money, as determined by provision rules.
3. **Collective-choice arrangements**:
   Most individuals affected by the operational rules can participate in modifying the operational rules.
4. **Monitoring**:
   [A] Monitors are present and actively audit common-pool resource conditions and appropriator behavior;
   [B] Monitors are accountable to or are the appropriators.
5. **Graduated sanctions**:
   Appropriators who violate operational rules are likely to be assessed graduated sanctions (depending on the seriousness and context of the offense) by other appropriators, officials accountable to these appropriators, or both.
6. **Conflict-resolution mechanisms**:
   Appropriators and their officials have rapid access to low-cost local arenas to resolve conflicts among appropriators or between appropriators and officials.
7. **Minimal recognition of rights to organize**:
   The rights of appropriators to devise their own institutions are not challenged by external governmental authorities.
8. **Nested enterprises**:
   Appropriation, provision, monitoring, enforcement, conflict resolution, and governance activities are organized in multiple layers of nested enterprises.

*Source: Michael Cox, Gwen Arnold, and Sergio Villamayor Tomás. 2010. "A Review of Design Principles for Community-Based Natural Resource Management." *Ecology and Society* 15(4):38 http://www.ecologyandsociety.org/vol15/iss4/art38/ES-2010-3704.pdf; updated version of design principles initially stated in Elinor Ostrom, 1990. *Governing the Commons: The Evolution of Institutions for Collective Action.* New York: Cambridge University Press, pp. 88-102.