

VIEWPOINT

Finding the Role of Health Care in Population Health

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Enhanced focus on population health is increasingly invoked as a potential solution to the persistent problems facing the US health care system including failures to achieve targets for health outcomes, eliminate disparities in health and health care, and function within a sustainable budget. Shortell¹ recently discussed how the Affordable Care Act (ACA) and related developments could change incentives to align health care, public health, and social services. Sox² further specified the inherent tensions in allocation of resources to balance the needs of individuals and those of the population overall and highlighted new aspects of medical professionalism that will be needed to improve population health outcomes. However, additional clarity is needed regarding the specific health system-based activities that may contribute most to improvements in population health and well-being and the barriers that must be overcome for them to succeed. These include stakeholder interests that may not be aligned with investments in population health, barriers to information transfer and

pand partnerships with other entities with the potential to influence health, and (3) respond to societal demands for equity and value.

Populations Under Care

Health care systems will always have the greatest influence on the health of patients for whom they are directly responsible. Spurred in part by the Affordable Care Act, health care provider organizations are experimenting with a range of new care delivery models that bring a population view to clinical care, often termed *population management*. Advances in health information technology (IT) make it easier to identify populations of patients; measure and track risk factors, quality of care, and outcomes; and facilitate team-based care. There is also increased potential for the identification and management of at-risk individuals within a practice or delivery system who may benefit from community resources to address nonmedical drivers of health such as housing, education (eg, early intervention for children), or remediation of environmental threats. However, although the capacity of electronic health records (EHRs) to promote communication and linkages across sectors is substantial, significant barriers to integration and data sharing remain. These include insufficient capabilities for transfer and receipt of information in both health care and community partner IT systems; lack of common taxonomies and data sharing structures; concerns about privacy and security that must be overcome; and insufficient funding for such initiatives. This lack of fluid information exchange in turn undermines communication and integration of services across sectors.

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service integration between health care and other sectors, and persistent difficulties in addressing health care disparities. Without solutions to these challenges, integration of population health-focused activities into the routine work of health care systems will be neither robust nor sustainable.

Population health is viewed by Kindig³ and others as both a social imperative and a framework for establishing state and national policy. In this context, populations are generally defined by geopolitical borders (eg, counties) or sociodemographic factors (eg, poverty). In contrast, health care systems may define populations as groups of individuals who receive care as part of a particular practice, delivery system, or insurance plan. Compared with social, environmental, and behavioral factors, medical care has only a relatively small influence on health for populations whether defined by health system or by geopolitical boundaries. However, health systems have a particular responsibility to improve meaningful health outcomes for those under their care and for society at large. To meet this responsibility, they will need to (1) take additional responsibility for the health of the patient populations under their care, (2) create and ex-

and insufficient funding for such initiatives. This lack of fluid information exchange in turn undermines communication and integration of services across sectors.

Partnerships

For meaningful contributions to population health initiatives to occur, health systems or payers must believe that such contributions will produce value (outcomes per unit cost)⁴ for their own patients or members. For very large insurers, including governmental and private insurers with large market shares, incentives for investing in improving overall population health may be aligned with the imperative to produce better health outcomes at lower cost for their own patients. However, smaller insurers or private employers, which fund much of the health care in the United States, may not see a direct return on investments in community-wide infrastructure or services. In an era of smaller margins and increased competition, these organizations will be challenged to contribute resources to promoting population health beyond those for whom they are directly responsible.

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A model developed by the leadership of HealthPartners, a non-profit Minnesota health insurance and care delivery system,⁵ provides a framework for assessing participation in community-wide activities based on the alignment with the organization's mission, its capabilities, and the degree of control the organization can have in improving health through the activity or partnership. The framework reflects the reality that a health system's influence on health will be greatest for those under direct care, but it also recognizes that the system can contribute to partnerships that are important to achieving desired population outcomes when health systems alone have less capacity and control. This alignment of goals, capacity, and control assists in the identification and prioritization of activities in which the participation will have value for both society and the health care organization.

Innovative partnerships between health care system stakeholders and other sectors with influence on health (public health, education, transportation, employers, and others) are increasing. These include multisectoral approaches to combat obesity (the "Let's Move!" national prevention strategy), diabetes (YMCA diabetes prevention program), violence ("Cure Violence"), and childhood asthma ("WIN for Asthma"). A particularly ambitious and broad-reaching approach is exemplified by the Vermont Blueprint, a statewide health care reform program led by the Vermont Department of Health Access. The program includes partnerships among health care delivery systems, payers, communities, and public health entities to improve the health of all Vermont residents.⁶ Data about whether these programs are improving health are limited; however, they provide instructive examples of collaborative approaches to improving population health and well-being. Financing models that overtly foster partnership may also hold promise for improving population health. For example, some have suggested that accountable care organizations specify partnerships with local public health agencies⁷ or the creation of regional accountable health communities⁸ to realign investments and local stakeholder engagement in health.

Equity

Any effort by health care systems to improve the health of either the patients they serve directly or the broader population must overcome the challenge of inequity of both access to and quality of medi-

cal care. Eliminating persistent disparities by socioeconomic status, race, and ethnicity has been the most elusive goal for the US health care system. The first responsibility of any health care organization is to address disparities in the provision and outcomes of clinical care within its system. In addition, health systems can contribute to the amelioration of broader health-related disparities in the community in partnership with others. In all cases, reducing disparities requires comparisons between groups identified by some defining characteristic, such as income, race/ethnicity, or sex. As with the use of group-level distinctions in biomedical research,⁹ such comparisons must be approached with care to avoid erroneous attribution of risk, misinterpretation of outcomes, and inadvertent exacerbation of the disparities one seeks to address. Health systems must be confident that a group-level focus will decrease disparities and that key stakeholders (group members and leaders) are engaged fully in setting priorities and implementing solutions.

Value

Ultimately, the extent to which health care delivery systems see themselves as responsible for populations will rest on the value they and their stakeholders receive. However, for population approaches to be sustained, they must also demonstrate value to society at large. To the extent that value is reflected in lower costs (particularly for health care funded by government), resources should be freed for other sectors that improve health and well-being including public health, education, transportation, and the environment. Whether savings from health care will be used to promote population health through these pathways is a question that will be answered by the political process, but this does not absolve health care systems from providing a higher value of care.

The increasing inclusion of a population perspective is not a natural evolution for the US health care system. In fact, it is counter-cultural in a society that values personal independence and is often mistrustful of the centralized efforts of large organizations, public or private. However, the pressure to change is evident in the form of poor population-level outcomes, unsustainable costs, and persistent disparities. Clarifying both the potential actions and the challenges for health care systems in promoting population health may allow the setting of new, if ambitious, expectations for what can be achieved.

ARTICLE INFORMATION

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REFERENCES

- Shortell SM. Bridging the divide between health and health care. *JAMA*. 2013;309(11):1121-1122.
- Sox HC. Resolving the tension between population health and individual health care. *JAMA*. 2013;310(18):1933-1934.
- Kindig DA, Asada Y, Booske B. A population health framework for setting national and state health goals. *JAMA*. 2008;299(17):2081-2083.
- Porter ME. What is value in health care? *N Engl J Med*. 2010;363(26):2477-2481.
- Isham G. HealthPartners' approach to assessing opportunities to improve community health: a perspective of consumer governed. 2012. <http://uwphi.pophealth.wisc.edu/about/staff/kindig-david/Isham-HealthPartners%20model.pdf>. Accessed January 9, 2014.
- Department of Vermont Health Access. Vermont blueprint for health: 2012 annual report. February 15, 2013. http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf. Accessed January 13, 2014.
- Hacker K, Walker DK. Achieving population health in accountable care organizations. *Am J Public Health*. 2013;103(7):1163-1167.
- Magnan S, Fisher E, Kindig D, et al. Achieving accountability for health and health care. *Minn Med*. 2012;95(11):37-39.
- Kaplan JB, Bennett T. Use of race and ethnicity in biomedical publication. *JAMA*. 2003;289(20):2709-2716.