

Population Health Matters

GUEST EDITORIAL

The Population Health Revolution

A quiet revolution is underway. It may not be televised, but it's happening on computer screens, in doctor's offices, hospitals, pharmacies, public parks, private homes and communities across the nation. Population health is a truly revolutionary means of tackling the twin dilemmas plaguing the US health system: high costs and poor outcomes. Like it or not, change is occurring, but we won't know the final outcome until the smoke clears.

The seeds of every revolution are sown years, if not generations, before they actually start. Here in Philadelphia, our nation's founders embraced and adapted a system of government born centuries earlier in the city-states of ancient Greece. Population health is a revolution born of the long-standing public health concept that collective community action improves health outcomes. It's also an old idea that dates back to the very dawn of civilization. Old Testament religious edicts mandating the specific management of people with leprosy and contaminated homes were the public health laws of the time; regulating individual behavior to prevent the spread of communicable disease.

Even though medical science has defeated many ancient scourges, we now face other challenges. The financial trajectory of our current health care system, driven largely by the increasing cost and volume of medical treatment, is unsustainable. Unfortunately, McGinnis and colleagues estimate that improving clinical care will forestall only 10 – 15% of the preventable deaths.¹ Better and more efficient doctors, hospitals and medicines are not enough to bridge the gap because the vast majority of premature deaths are influenced by ministrations not found in a treatment room or hospital ward. To achieve real change, we need to engage more powerful drivers of population health outcomes: lifestyle, living conditions and

the social determinants of disease. Despite the potential impact, only about 5% of all health expenditures are dedicated to health promotion and disease prevention activities. However, the tide is turning.

The very name of the vast health reform bill – the *Patient Protection and Affordable Care Act* (more commonly known as the ACA or “Obamacare”) – embraces the dual notions of effectiveness and efficiency, and includes many provisions designed to encourage providers to adopt a population health approach. The 2010 law realigns economic incentives to hold providers accountable for their patients' outcomes through new entities such as *Accountable Care Organizations*, *Patient-centered Medical Homes* and other shared-risk arrangements. Private insurers are also jumping on the accountable care bandwagon, building a critical mass for change.

If you've been around awhile, it may seem like déjà vu. Similar approaches were tried in the 1990s when managed care was all the rage. Instead of charging an à la carte fee for each service rendered, primary care doctors were allocated a fixed amount for each patient under their care—capitation. It didn't stop medical inflation or improve outcomes. Neither did other cost-control mechanisms such as pre-certification, limiting specialist care, retrospective review, etc. The reason was simple: the main goal of managed care was to reduce cost. Improving overall health was an afterthought. Furthermore, under this system, the insurer reaped most of the benefits at the expense of both patients and providers.

This time it's supposed to be different. Providers will receive a piece of the savings from reduced costs, but—and this is an important distinction—they are also more accountable for their patients' health outcomes. The strong incentive to

scrimp on care is counterbalanced by a loss if the patient's health status suffers. New care delivery structures allow doctors to coordinate and manage the patient's care more effectively as well as share in both the risk and rewards. The ACA's yin and yang will hopefully achieve economic nirvana: better outcomes at lower costs.

Population health is seen as a means to this end. But before we can act, we must first reconcile two different notions of the term itself. Kindig and Stoddart define population health broadly, consistent with the public health paradigm, as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.” This is health from the 30,000-foot view.

Health care providers and the consultants helping them adapt and thrive under Obamacare view population health at ground level. Their “population” is limited to those under active care and the interventions are limited to services they already provide. For instance, the question is less about why the population has high rates of diabetes and more about how to ensure every person with diabetes in the practice receives timely and effective care. This narrow view of population health won't be enough to truly bend the cost curve. We must think beyond the walls of the clinic and address the underlying determinants of poor health, even if they seem unrelated to health care. Providers who can crack this code will be rewarded with healthier patients and, in this new era, greater income.

Adopting this new paradigm will not be easy. I see my students—especially the clinicians—struggle with this different way of thinking. It clicks when they realize they're in the business of improving health by any means necessary. In this new world,

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the emergency department physician helps local government identify unsafe routes to schools and the pharmacist profits by advising patients on healthy eating. They understand that providers can and should share in the gains from a reduction in health care costs they help to bring about.

The Population Health revolution is underway. Our opportunity and challenge is harnessing the momentum to build a financially sustainable national health system that promotes health, prevents disease and improves health outcomes for all Americans. ■

Drew Harris, DPM, MPH

*Program Director, Health Policy
Jefferson School of Population Health
Drew.Harris@jefferson.edu*

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