

10/13/1999 REVISION

PUBLIC HEALTH VS. POPULATION HEALTH:
A CONVERSATION

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NJK: You have been recently advocating strongly for aligning financial incentives towards health outcomes (1,2), but many in the public health community aren't happy with your use of the term "population health" to describe this concept (3).

DAK: Why is this?

NJK: Because you appear to have adopted this term used by the public health field, whose modern concepts of practice embodies a broad mission of population-based health outcome improvement. This seems to me to be confusing and unnecessary.

DAK: Well, marketing ideas and concepts is important, and I do believe we have semantic confusion between these two terms. The concept of population health is new and relatively undefined, and many think of it as describing the general activities of primary care, prevention, and public health. Public health, on the other hand, is still understood by many as what public

health agencies do, but is trying to emerge into a fuller role and definition of assuring health outcomes at a population level. But in my view we are far from this vision in practice.

To advance the ideas of linking financial incentives to health outcome improvement, I was looking for a term that describes and can measure the ultimate health outcomes of a group of individuals, either geographic or enrolled. I support the broadest concept of health and function as called for by Evans, including its multiple determinants such as medical care, genetics, the physical environment, the socioeconomic environment, and individual behavior and biology (4). He, however, chooses not to suggest a measure; I believe a measure is necessary if we are to plan and evaluate health outcome improvement.

I have therefore suggested that the measure of population health be considered as the sum of individual health adjusted life expectancy (5), a summary measure that combines length of life and health status or health related quality of life (6).

NJK: But public health and its population health focus has such breadth. The IOM in 1988 defined the mission of public health as “fulfilling society’s interest in assuring conditions in which people can be healthy” (7) and reinventing public health is carrying this role to new levels of responsibility (8). It seems as if you have done what Johns Hopkins Dean Al Sommer has stated- “meekly accepted the restrictive, traditional public health agency dominated mold that the IOM prepared for us” (9). He urges that we speak instead of a “complex, diverse, and dynamic enterprise, composed of many disciplines, whose goal is protecting the health of the public.....the job of public health should be to ensure that everyone’s health in a capitated care

system is maximized”. There is now broad support at a conceptual level for public health to be organized around population-based core functions and essential services.

DAK: Well, I agree with such a broad “health of the public” goal, but at the current time I believe that many public health agencies remain focused on a collection of essential categorical programs and activities which are far narrower in scope. Many are in constant struggle to hold onto or increase resources for their critical population based prevention and environmental services, not to mention the safety net provision of health care services needed until we achieve universal coverage. In my opinion, public health is under funded for these responsibilities, and in addition does not have and is not likely to get the mandate for determinants such as improving education, bringing more equality to income distribution, or increasing social capital (10,11,12). So I guess I think that public health practice should be limited to these critical functions that encompass modern public health practice, but not be overextended into these other areas. If this is so, another term will be needed for the broader health outcome mission.

NJK: Public health agencies do provide essential services, but in the “assurance of healthy conditions” role they must assume overall responsibility for the health of populations. This includes additional data collection and monitoring so that we know if health outcomes are being improved.

DAK: I agree that someone has to take responsibility for an overall health outcome strategy, and in my view no one is currently doing it. I have suggested local Health Outcomes Trusts (Figure 1), responsible for integrating the multiple agents responsible for the determinants of health

outcomes (including public health)...and Steve Shortell advocates Community Health Management Systems (13).

NJK: There you go again! Why do you keep introducing new entities when modern public health should do the job with other government and private sector partners? Public health agencies are more acquainted than most with the health disparities created by low income and education, since they have been working for years with disadvantaged populations. They have been highly creative in working around these barriers, and not just with low income populations.....public health has responsibility for the entire population.

DAK: Being aware of, and having responsibility for, are two different things. The concept of partnership you call for means that neither the public or private components have the entire responsibility. I suppose that public health agencies might evolve to such entities, but they are far from it today. I am not aware of a public health agency that has been given or has taken the responsibility for the adequacy and quality of private sector medical care, education, and income. Such partnership will require public-public (schools and public health) and public-private (welfare and medical care) collaborations not yet imaginable. Private sector agents like employers may well resist using the term “public” health for a partnership of public and private entities.

NJK: One of public health’s responsibilities in its assurance role is to broker and sustain these collaborative relationships. I am also concerned that public health practitioners and systems will

be swept aside, having little role in what you propose, once the powerful engines of traditional medicine and payment systems adopt the term “population health” for what you are proposing.

DAK: I understand this fear, given the professional and financial dominance of medical care historically. But medical care alone will also be unable to produce a broad outcome of population health defined by a combination of the length and health related quality of life. That is the point. Neither medical care, public health, nor the other sectors such as education and income can do it alone.

NJK/DAK: Let’s conclude this conversation by agreeing on the following points. First, the most important issue is the need for societal agreement that health outcome improvement is a critical challenge, and that resources need to be aligned with this goal. Second, public health practice has embraced a modern mission of health outcome assurance through population-based core functions and essential services, and public health agencies need to be encouraged and supported to evolve towards this vision. Third, health outcome improvement will require the synergy of actors such as medical care providers, educational systems, and public agencies dealing with income policy which are not currently under public health jurisdiction. Some integrating function will have to emerge for this role, either public health in a broader role or a public-private partnership such as a Health Outcomes Trust or Community Health Management System. Finally, summary population health measures that can be understood and practically applied are needed to allow us to determine if our resource allocations across sectors and agents are achieving the broadest goal of health outcome improvement.

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