Bridging the Divide Between Health and Health Care

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THE US HEALTH CARE SYSTEM CAN DO A BETTER JOB OF providing patient care while moderating the rate of increase in cost, but it can do little about improving overall population health. This is because health care delivery accounts for only 10% of preventable deaths, with the remainder attributable to personal behaviors, social and environmental determinants, and genetic predisposition.[1] As currently constituted, the health care delivery system has little direct control over these other factors. However, consensus is developing that truly controlling health care costs and improving the overall health of the American people will require a much closer partnership, permeable boundaries, and increased interdependence among the health care delivery system, the public health sector, and the community development and social service sectors.

Stimulus for Action

Until recently, health care professionals and organizations had little incentive to do anything other than deliver the best medical care possible to ill and injured patients. This is what they were paid and trained to do. But no more. In addition to significantly expanding insurance coverage, the Affordable Care Act (ACA) has challenged the health care system to address the escalating costs of care and the underlying determinants of health and illness. Among other initiatives, the ACA charges the Centers for Medicare & Medicaid Services with the authority to implement new payment and delivery models, such as accountable care organizations, that place clinicians and health care organizations at financial risk for meeting predetermined expenditure targets for a defined group of patients. The federal program has spurred more than 200 private sector risk-bearing payment arrangements between health care organizations and commercial insurance companies. Thus, at least for the enrolled populations they serve, health care organizations have an incentive to work with the public health sector and the community development and social service sectors to help prevent unnecessary office visits, emergency department visits, and hospital admissions and readmissions and, overall, to promote the health of their enrollees.

The ACA also includes $10 billion over 10 years to improve population health by focusing on disease prevention and health promotion initiatives. However, the health care system and the public health, community development, and social service sectors hold different definitions of population health. For the delivery systems, the definition is typically limited to their own enrolled group of potential patients for whom they are financially accountable. For the public health and community development and social services sectors, it is the health of the total population that contributes to the quality of life and economic well-being of the entire community. Paying for population health is not the same as providing risk-based payments to health care delivery systems serving segments of the population.[2] Thus, the bridge between health care delivery, public health, and community development and social services is only partially built.

Completing the Bridge

If the goal is improved overall population health, all 3 sectors need to take certain actions. The delivery system needs to redefine its product and place and define who can provide what kinds of care.[3] The product needs to be redefined from the treatment of illness and injury to the production of health, working with other sectors such as education and urban planning. There needs to be a movement from patient-centered care to population-centered health. The place of care delivery moves from the office, clinic, or hospital bed to the home, workplace, school, or wherever people live their lives. The "providers" expand beyond physicians, nurses, pharmacists, and other health professionals to include community health workers, promotoras, health educators, teachers, social workers, planners, architects, and community development specialists, among others.

The public health sector needs to capitalize on the funding provided by the ACA and the recommendations of 3 recent Institute of Medicine reports on Public Health Strategies to Improve Health.[4] Key among these is the need for greater flexibility in the use of funds to leverage partnerships with health care delivery systems to mutually address the root causes of poor health. Greater use of

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community-wide assessments of health status needs and impact can identify those populations most in need of preventive services. Although not all prevention interventions are either cost-effective or have a positive cost benefit, increasing evidence suggests that successful interventions to reduce obesity, hypertension, and diabetes can reduce lifetime medical spending while adding years of life.[5] Primary care clinicians and public health leaders are needed to develop population health improvement goals with defined metrics to measure progress, active engagement of communities, and a shared infrastructure that can withstand staff turnover and changes in funding.[6]

The broader-based community development and social services sector needs to recognize the importance of "health in all" policies for successful community economic development and quality of life. The health effects of zoning regulations, housing permits, transportation, labor and education policies, and business incentives and related development initiatives need to be assessed. The health care delivery and public health sectors need to be active participants in the process, using data to show how a healthier population contributes to the goals and strategic priorities of the business, labor, education, transportation, housing, and related sectors.

Examples are emerging. In Boston, the Cambridge Health Alliance uses community health workers to access a variety of medical, public health, and social support resources to reduce childhood asthma and has achieved a 45% decline in hospital admissions and 50% decline in emergency department visits, with a return on investment of $4 for every $1 invested.[7] On a national level, the Robert Wood Johnson Foundation has partnered with the Community Development Group of the Federal Reserve Board to help finance investments in human capital that include health, early childcare, education, and job training.[8] Building on these examples, the Centers for Medicare & Medicaid Services could take a bold step by offering a risk-adjusted community population–wide health budget to local consortia of health care, public health, and community and social service organizations. The budget would be tied to multi-year performance targets that show a reduction in the numbers of patients with newly diagnosed diabetes, reduced infant mortality among target populations, reductions in numbers of obese children and adults, lower blood pressure among patients with heart disease, reduced disability and work loss days, and greater functional health status scores.

Conclusions

To create a culture of health will require creating a market for health, moving away from the current market for treating disease. Thus, devising new payment models and common financial incentives for the health care delivery system, public health sector, and the community development and social services sectors is essential to advancing population health goals. These incentives provide the essential motivation to engage in the difficult work of building effective partnerships based on shared goals, information systems, innovations in the use of human resources, and cross-sector leadership. Like a hologram in which the whole is embedded in each part, health care delivery is embedded into population health and population health is embedded into health care delivery. It is now the responsibility of clinicians and health care delivery organizations to help maintain the health of the community and the responsibility of the community to help maintain the health of the individual.

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REFERENCES

1. McGinnis JM, Williams-Russo P, Knickman JR. The case for more active policy attention to health promotion. *Health Aff (Millwood)*. 2002;21(2):78-93.
2. Kindig DA. *Purchasing Population Health: Paying for Results*. Ann Arbor: University of Michigan Press; 1997.
3. Asch DA, Volpp KG. What business are we in? the emergence of health as the business of health care. *N Engl J Med*. 2012;367(10):888-889.
4. Institute of Medicine. *Public's Health: Investing in a Healthier Future*. Washington, DC: Institute of Medicine; 2012.
5. Goldman DP, Zheng Y, Girosi F, et al. The benefits of risk factor prevention in Americans aged 51 years and older. *Am J Public Health*. 2009;99(11):2096-2101.
6. Landon BE, Grumbach K, Wallace PJ. Integrating public health and primary care systems: potential strategies from an IOM report. *JAMA*. 2012;308(5):461-462.
7. Bielaszka-DuVernay C. Taking public health approaches to care in Massachusetts. *Health Aff (Millwood)*. 2011;30(3):435-438.
8. Braunstein S, Lavizzo-Mourey R. How the health and community development sectors are combining forces to improve health and well-being. *Health Aff (Millwood)*. 2011;30(11):2042-2051.