Population Health in the 21st Century: Everything Old is New Again

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18th Population Health Colloquium

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Outline

1. Long history of interest in “social determinants”
2. Why the current explosion of interest in “Population Health”?
3. Challenges and Concerns
4. Reasons for optimism

(and 2 disclaimers)

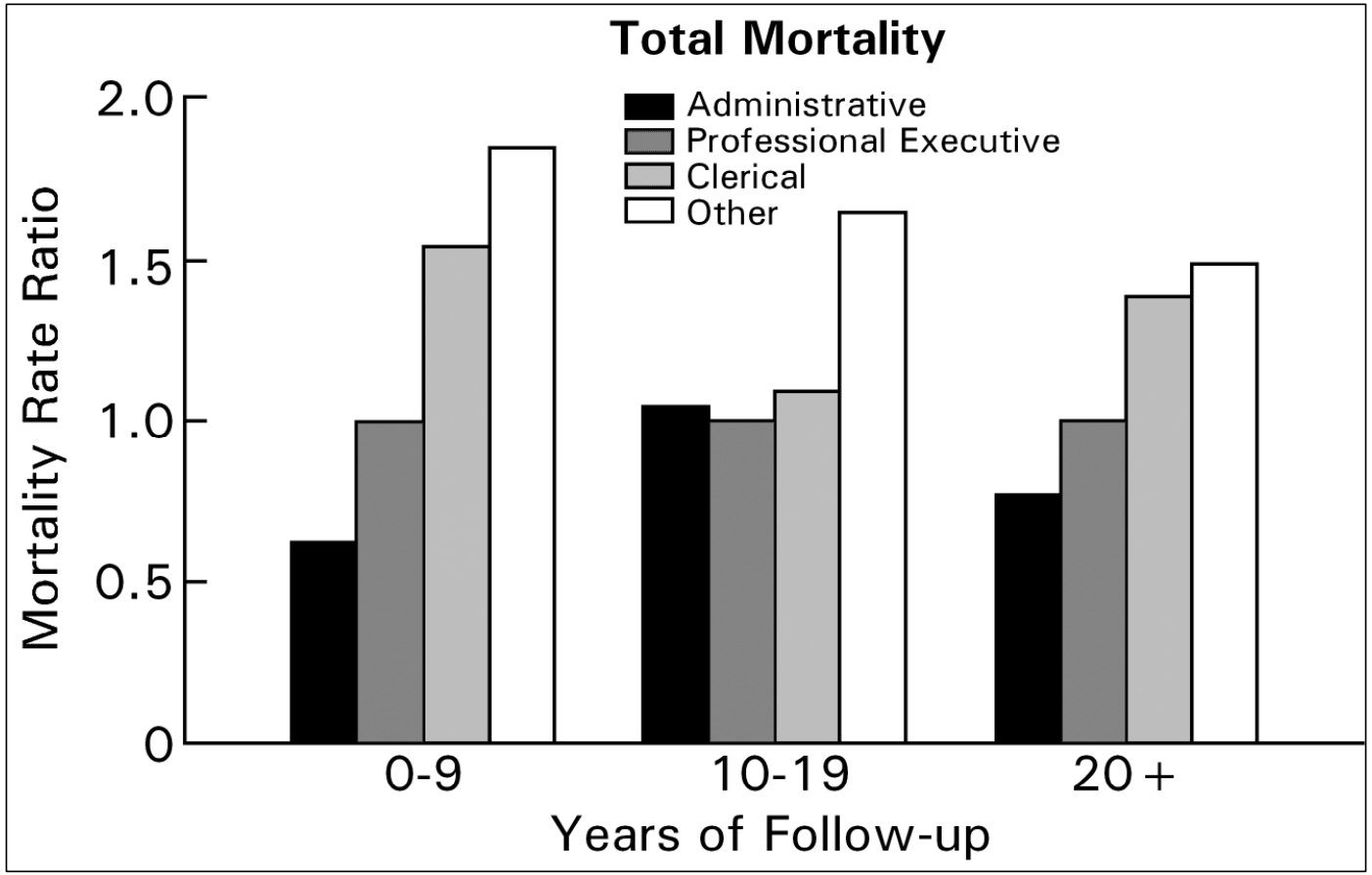
Disclaimer #1 …

A personal speed-reading history of social determinants

The Whitehall Studies

"Medicine is a social science, and politics is nothing else but medicine on a large scale"

Whitehall Studies – 25 years of follow-up

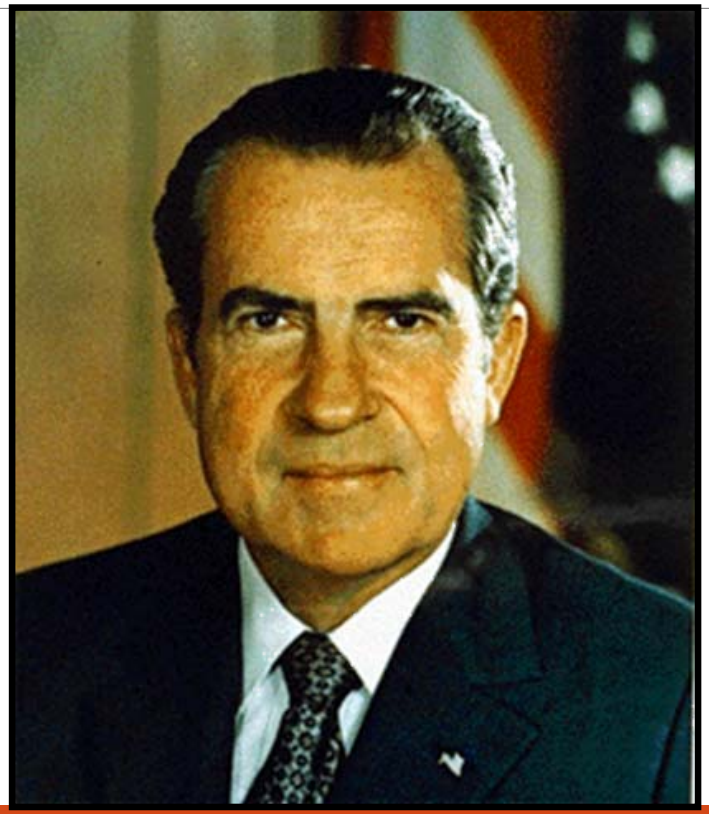


Source: Stanford Encyclopedia of Philosophy

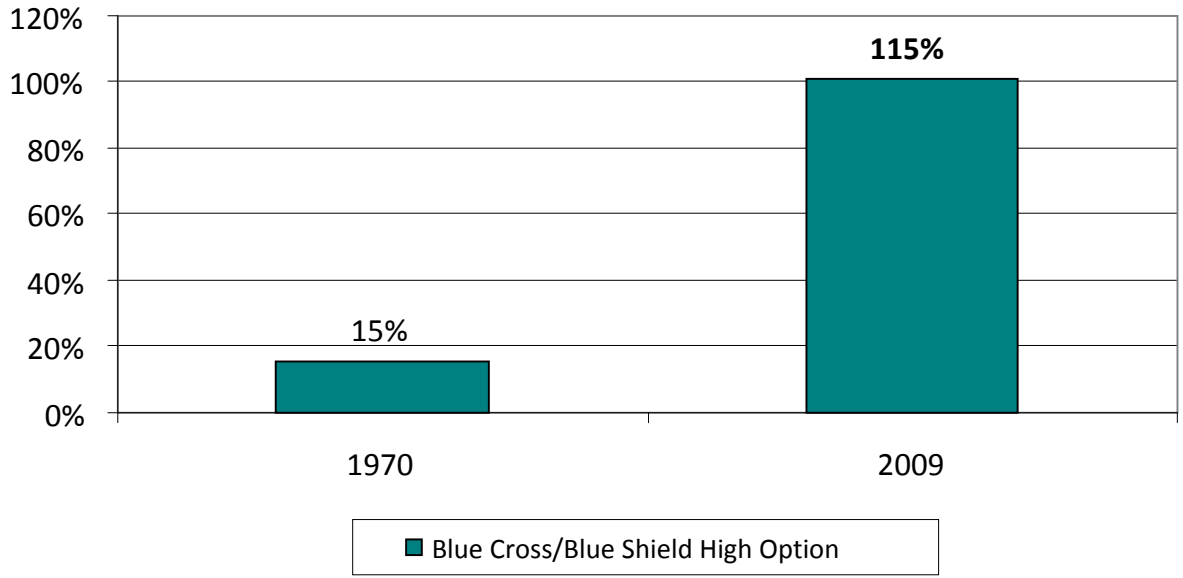
Why Now??

1. Health Care Costs

The good old days?

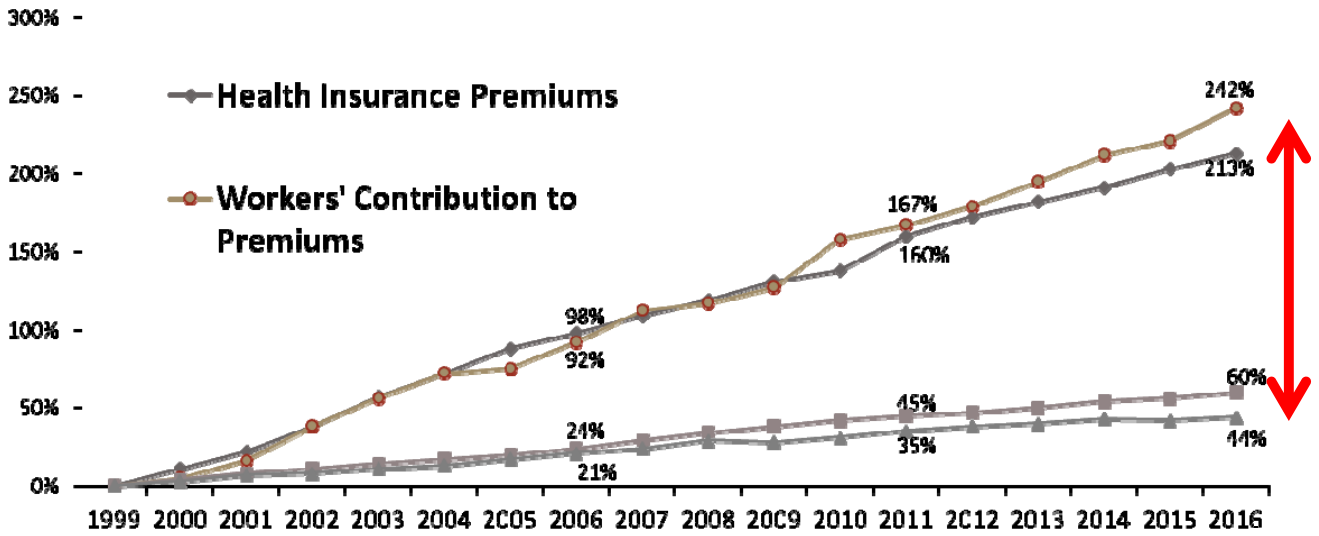


Health Insurance Total Family Premium as a Percent of US Minimum Wage Earnings



Source: U.S. Office of Personnel Management; U.S. General Accounting Office Staff Paper, "Information on 1976 Health Insurance Premium Rate Increases for Federal Employees Health Benefits Program," pub. # 094882.
Note: Figures reflect monthly Federal Employees Health Benefits (FEHBP) total premiums for the government-wide Blue Cross/Blue Shield options for non-postal workers and minimum wage earnings for full time work of 173.33 hours per month (2080 hour per year/12) in California.

Cumulative Increases in Health Insurance Premiums, Workers' Contributions to Premiums, Inflation, and Workers' Earnings, 1999-2016



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2016 (April to April).

Why Now??

1. Health Care Costs
2. Payment Reform

Payment reform

"Volume to Value"

Volume to Value

Volume

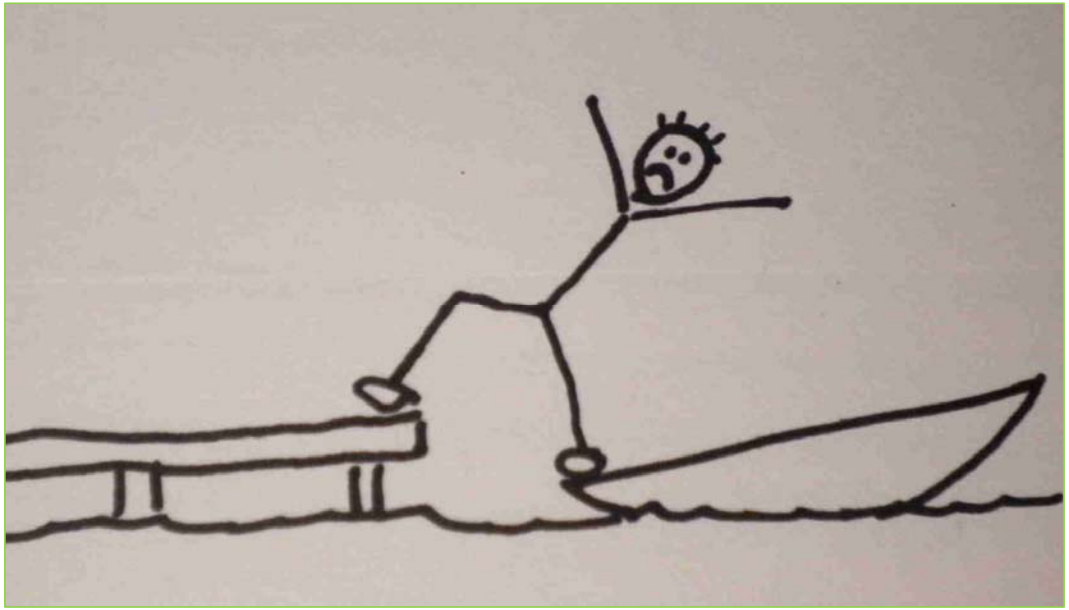
- Visits
- Inpatient days
- Procedures performed
- Units sold

Value

- Outcomes
  - ✓ clinical
  - ✓ patient - reported
- Quality-linked processes
- Patient satisfaction
- Peer/co-worker ratings

Volume to Value: Hospitals and Doctors

One foot on the canoe, one on the dock…



The LAN's Goals for U.S. Healthcare

2016

Goal: 30%

In 2016, at least 30% of U.S. health care payments are linked to quality and value through APMs.

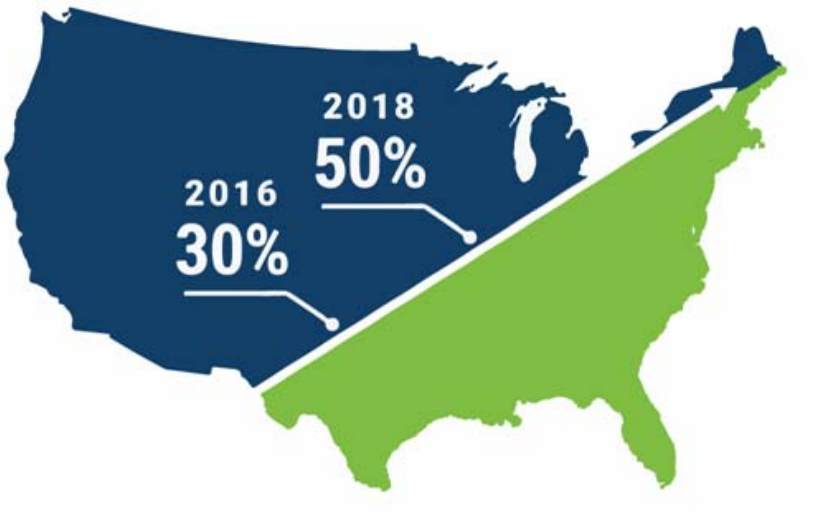
2016 Results: 29%

2018

50%

In 2018, at least 50% of U.S. health care payments are so linked.

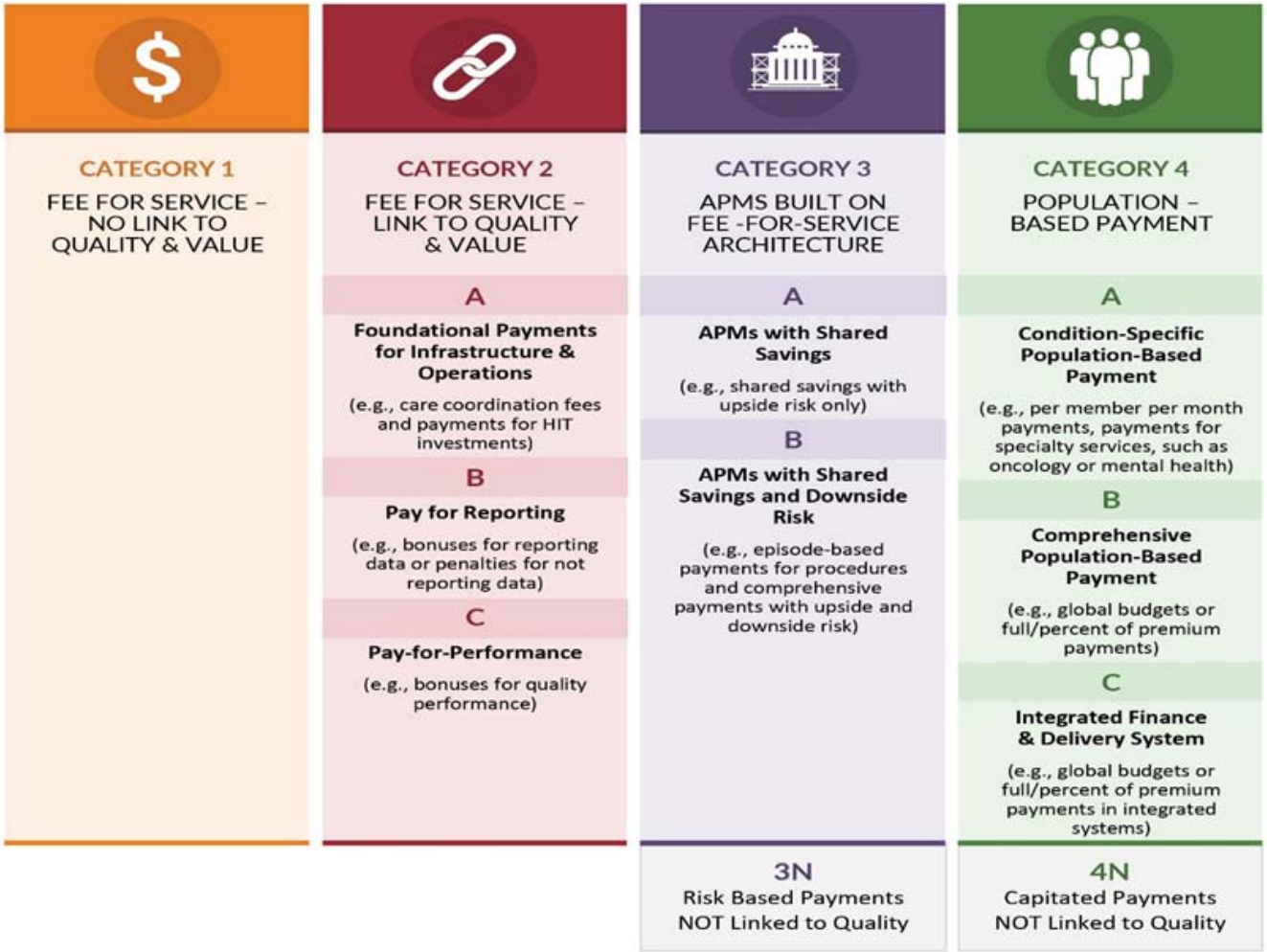
Adoption of Alternative Payment Models (APMs)

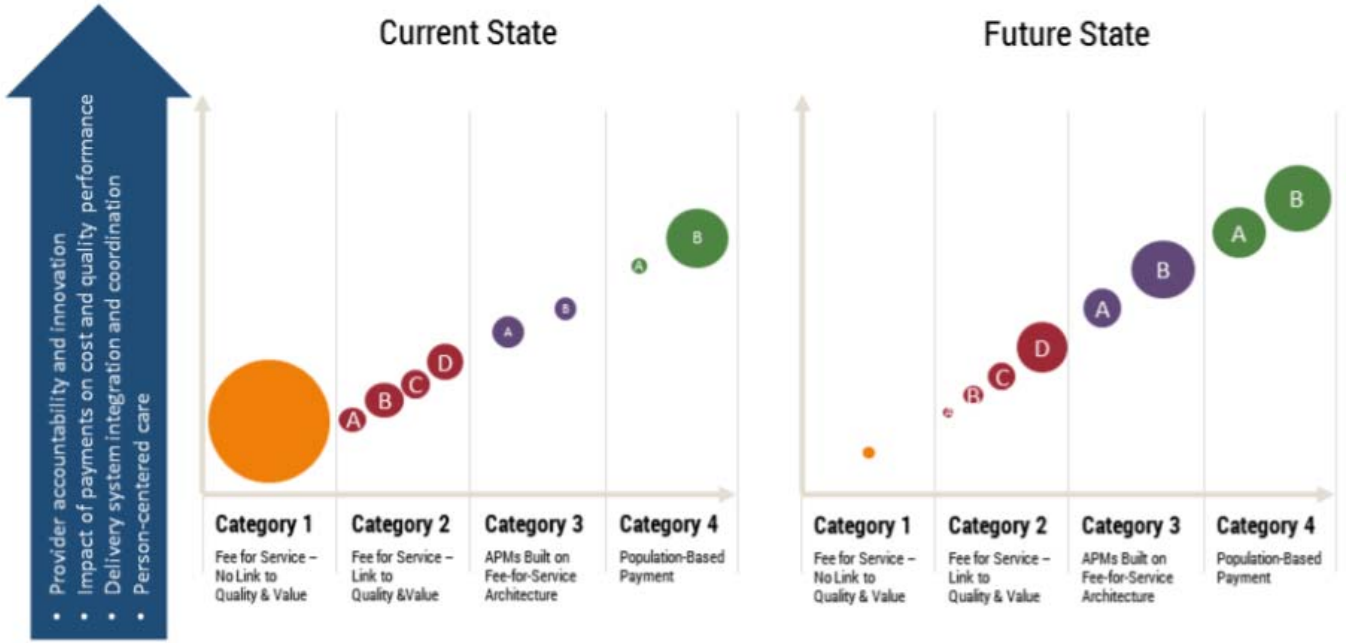


These payment reforms are expected to demonstrate *better outcomes* and *smarter spending* for patients.

HCP LAN
Health Care Payment Learning & Action Network

2017 “refreshed” framework





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The NEW ENGLAND JOURNAL of MEDICINE

THE NEW MEDICAL-INDUSTRIAL COMPLEX

ARNOLD S. RELMAN, M.D.

Abstract The most important health-care development of the day is the recent, relatively unheralded rise of a huge new industry that supplies health-care services for profit. Proprietary hospitals and nursing homes, diagnostic laboratories, home-care and emergency-room services, hemodialysis, and a wide variety of other services produced a gross income to this industry last year of about $35 billion to $40 billion. This new "medical-industrial complex" may be more efficient than its nonprofit competition, but it creates the problems of overuse and fragmentation of services, overemphasis on technology, and "cream-skimming," and it may also excercise undue influence on national health policy. In this medical market, physicians must act as discerning purchasing agents for their patients and therefore should have no conflicting financial interests. Closer attention from the public and the profession, and careful study, are necessary to ensure that the "medical-industrial complex" puts the interests of the public before those of its stockholders. (N Engl J Med. 1980; 303: 963-70.)

IN his farewell address as President on January 17, 1961, Eisenhower warned his countrymen of what he called "the military-industrial complex," a huge and permanent armaments industry that, together with an immense military establishment, had acquired great political and economic power. He was concerned about the possible conflict between public and private interests in the crucial area of national defense.

The past decade has seen the rise of another kind of private "industrial complex" with an equally great potential for influence on public policy — this time in health care. What I will call the "new medical-industrial complex" is a large and growing network of private corporations engaged in the business of supplying health-care services to patients for a profit — services heretofore provided by nonprofit institutions problems that it raises and attempt to show how the new medical-industrial complex may be affecting our health-care system. A final section will suggest some policies for dealing with this situation.

In searching for information on this subject, I have found no standard literature and have had to draw on a variety of unconventional sources: corporation reports; bulletins and newsletters; advertisements and newspaper articles; and conversations with government officials, corporation executives, trade-association officers, investment counselors, and physicians knowledgeable in this area. I take full responsibility for any errors in this description and would be grateful for whatever corrections readers might supply.

THE NEW MEDICAL-INDUSTRIAL COMPLEX

Population health perspective forces the medical-industrial complex to think:

- beyond the individual to group outcomes
- beyond treating sickness to preserving health
- beyond medical care to adjacent human services and the social determinants of health

Challenges to *21st Century* Population Health

1. The **complexity** of chronic disease prevention
2. The relatively **short-term perspectives** of payers and insurance markets
3. The rigidity of governmental **departmental siloes**
4. The **power** and **expense** of health care stakeholders
5. Difficulty bringing innovations to **scale**

"Nobody knew health care could be so complicated"

- Donald J. Trump
  February 27, 2017

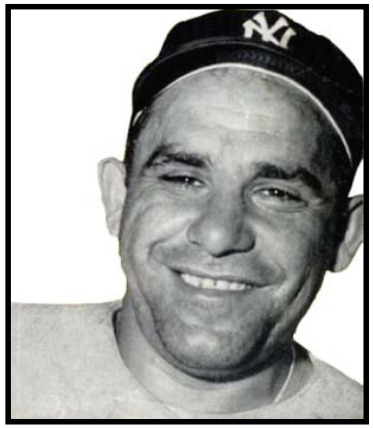
Reasons to be optimistic

1. Political leaders increasingly “get it”
2. New tools and new science
   a. Greater understanding of pathophysiology and risk factors
   b. Digital medical records
   c. Big Data
   d. Behavioral economics
   e. Sophisticated workforce

Disclaimer #2

This is uncharted territory, and there will be twists and turns, unexpected breakthroughs, and setbacks along the way.

So we need lots of PDSA cycles, because much of this – at least at scale – is *theoretical*.



On Theory

"In theory there is no difference between theory and practice. In practice there is."

- Yogi Berra (maybe)

On Planning and Adaptation(I)

"The tactical result of an engagement forms the base for new strategic decisions because victory or defeat in a battle changes the situation to such a degree that no human mind can see beyond the first battle."

No battle plan survives first contact with the enemy

Field Marshall Helmuth Karl Bernhard Graf von Moltke

(aka "Moltke the Elder")

On Planning and Adaptation (II)

Mike Tyson

"Everybody has a plan until I hit 'em in the mouth."

Recap

1. Long history of interest in “social determinants”
2. Why the current explosion of interest in “Population Health”?
3. Challenges and Concerns
4. Reasons for Optimism

The Future is Bright