

3. Who Has Responsibility for a Population's Health?

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NORALOU ROOS AND HER COLLEAGUES HAVE OPENED up a possible scenario for U.S. health care: creation of a population-oriented database that allows policy makers to allocate resources to areas of greatest need. The data system described in their article allows users to analyze information about the demographic characteristics and health needs of populations in various parts of Manitoba. It also contains information about costs and utilization as well as about the number and types of available services. Some information about health outcomes is entered as well. Taken together, the entries allow policy makers to identify areas of apparent unmet need and to make decisions that expand or restrict the services provided to those areas.

Their article is a reminder of some of the differences between the Canadian and U.S. health care systems, and it illustrates important differences between public- and private-sector decision making. I would like to develop the basic idea that the data system described by Roos's group, attractive and useful as it may be for some kinds of policy decisions, is incompatible in many ways with the set of relations that currently exist among involved parties in the U.S. health care system. The use of such a data system by public policy makers presupposes a set of conditions that may hold in Manitoba now but do not appear to be present, or even

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just over the horizon, in the United States. Conclusions about the potential benefits of the Manitoba system (and there certainly are some) will have to be “filtered” or “translated” in order to account for the different sets of conditions existing elsewhere.

The Public Sector’s Responsibility for Health Outcomes

The design of a population-based data system presumes that one can both define a population with meaningful boundaries and identify individual or group policy makers who have a legitimate role in acting on behalf of that population. It is probably desirable, although not strictly necessary, for the members of the population not only to recognize themselves as belonging to that population but also to feel that their membership has a meaningful impact on their health status. (Readers might find it an interesting exercise to think of all the different “populations” to which they belong and, of these, to speculate on which ones have a legitimate connection to their present or future health status. How many databases would you expect to find yourself in, and who would you expect to be using them?)

In this particular example, the database developers have divided the province of Manitoba into several geographic regions for purposes of analysis and reporting; geography defines the population to which one belongs. The regions are characterized by basic economic dimensions, like urban versus rural or richer versus poorer, for purposes of descriptive analysis, but no economic or other factor constitutes an alternative to “region” as a basis for defining populations.

The database is used to determine whether a region is “underserved” (or perhaps “overserved”) and then to provide support for public policy decisions that, for example, would deny billing privileges to physicians not willing to locate in designated areas or would change the regional distribution of hospital beds. If the supply of resources across Manitoba is relatively fixed, at least in the short term, one region’s gain is another’s loss. Citizens of Manitoba have apparently granted provincial authorities the power to make these kinds of health care resource allocation decisions and are content (perhaps with some exceptions) to live with the results.

The situation is obviously different in the United States, where the public sector authority over such decisions is weaker. There are certificate-

of-need programs that control the location and size of hospital facilities, and there are programs that encourage physicians to locate in underserved areas. However, decisions about practice location and expansion of facilities are generally made in the private sector under a perspective that might be called the "Hopeful Field of Dreams Model": that is, "If we build it, we think they will come."

A less obvious point, but a critical policy issue in the United States, is that private sector entities — health plans, delivery networks, hospitals, or anything else — do not yet, and may never, carry the same sort of responsibility for the health of a defined population that is exemplified in the Manitoba initiative. Although many hospitals and managed care organizations sincerely wish to be responsible for the health of a "community" or "population" — even including words to that effect in their mission statements — the members of those populations have not yet granted them the authority to act on their behalf. City, county, and state health departments *are* responsible for the health of populations in defined geographic areas, but they lack many of the policy levers necessary to allocate resources like physician staff. Compared to Canada, we have a much more fragmented mix of responsibility and authority to make decisions that affect the services available to populations.

Healthy Populations/Healthy Communities: Whose Responsibility?

There is a "movement" to increase hospital and health-care network responsibility for the health status of populations that is clearly evident, for example, in the Community Care Networks initiatives (American Hospital Association 1993), the Healthy Communities Summits and related programs (Healthcare Forum 1994), the "Healthy Cities" programs in several large U.S. cities (Flynn, Ray, and Rider 1994; Hancock 1993), the "Community Benefit Standards" initiative for hospitals (Sigmond and Seay 1994), and the Foster McGaw prize for hospitals with the strongest community benefit programs (Johnsson 1991). In these examples, the term "community" is used to refer to a particular kind of population for which a hospital or health care network is responsible, typically a geographic area smaller than a state but possibly as large as a county or major city.

In principle, a hospital or health care network taking responsibility for a community's health could use a database like the one described in Manitoba to allocate resources and evaluate the success of program initiatives. Actually doing this, however, requires getting past some significant conceptual challenges:

- Relationships between individuals and providers are voluntary. People *join* a health plan, *go* to a hospital, or *choose* a physician. Individuals may not wish to have anything to do with a local hospital or network that claims responsibility for their health status, and they are typically not obliged to form a relationship just because they live in a certain city or neighborhood.
- In most urban or suburban areas, there are several hospitals/networks, and it is unusual for one to have sufficient "market share" of the population to influence the health of large segments of the population or the population as a whole.
- Provider organizations can collaborate voluntarily on community-level programs (e.g., "health fairs" or campaigns to encourage seat-belt use), but they still lack the authority (and in many cases are forbidden by antitrust statutes) to decide together how to allocate community-level resources.
- Providers are also being asked to be more supportive of "patient empowerment" or "patient autonomy" perspectives (Anderson 1995) in order to remove the paternalistic aspects of the doctor-patient relationship. These philosophies typically view the patient or family as the locus of responsibility for health outcomes, with providers adopting a more limited educational, advisory, and supportive role.

Taken together, these factors form a significant barrier to U.S. private sector organizations' assuming formal responsibility for the health outcomes of populations. The concept can work reasonably well if we are willing to define "population" as the membership of a managed care plan, but it faces serious difficulties when it is viewed as encompassing everyone within a certain geographic area, regardless of whether the individuals so designated have chosen to be affiliated with the provider organization. In smaller communities, where it is easier to identify a single entity responsible for health care (e.g., the local community hospital), there is still the issue of whether the hospital is the best base for pro-

grams that involve lifestyle, education, and "public health" matters rather than acute care.

Consequently, we may not be ready yet for a population-oriented data system in this country, except for limited use by various public health departments, or perhaps mental health agencies, that deliver a higher proportion of services in the public sector. Current community-oriented initiatives notwithstanding, private sector providers still care for individuals and families, not for populations and communities. Responsibility is linked to a discrete set of voluntary relationships and commitments, and is limited by the boundaries of those relationships. A health care system or hospital's responsibility for outcomes is clearest in those situations (e.g., invasive surgical procedures) where individuals voluntarily put themselves in the hands of providers and, at least temporarily, relinquish control. For most people, however, this relinquishing of control and responsibility is a rare event. Particularly in "lifestyle" areas like diet, smoking, exercise, drug use, and participation in risky activities, the private health care system has limited power, and is therefore restricted in its ability to see its actions reflected in a state- or regional-level database.

Does this mean that private sector health care providers in the United States have no interest in population-level data or in a database like that described for Manitoba? No, but their interest will be circumscribed and different in nature. The data will probably be useful, for example, in understanding the community context from which the individual patient's needs are derived or in supporting decisions either to expand service options or not to expand services in areas already saturated with doctors or hospitals. If the database includes good information on incidence or prevalence of specific diseases, it will help guide decisions on investments in programs, services, or equipment to handle those diseases. The information will probably *not* be useful, however, for determining whether specific programs have been "successful" or whether systems are providing high-quality care. The causal chains are too complicated and the lines of responsibility too vaguely drawn to make those sorts of inferences.

Other Observations

We seem to be continually surprised when measures of spending and of outcomes do not correlate. During the national health care reform "de-

bate” recently, commentators found it remarkable that the United States spends more per capita on health care than other countries while failing to achieve better health outcomes. In educational policy discussions, it is occasionally noted, with surprise or astonishment, that per pupil spending and educational achievement are not necessarily correlated. In the Manitoba example, the authors comment on “unexpected” relations between high cost and poor health indicators, or on high use of both inpatient and nursing-home beds. Isn’t this all explained reasonably simply by a concept like “need” or “risk”? A group of extremely high-risk pregnant women will typically incur high costs during pregnancy and delivery periods and will typically have poorer birth outcomes. Should we conclude that spending more on pre- and perinatal care causes poorer outcomes, or be surprised that this apparent relationship exists? The authors are clearly sophisticated analysts of these kinds of connections and perhaps are correct in pointing out that the database can serve as an educational vehicle for a less sophisticated public, which may expect dollar investments to translate directly into better outcomes at a population or regional level. The fact is, however, as the authors state succinctly, that “high use of the health care system does not guarantee health.”

Near the end of their discussion section, the authors make an observation that goes a long way toward explaining why this kind of population-oriented database is not in more widespread use and why population-oriented research is not yet more popular. They state: “The role of the health care system as a determinant of health has been overemphasized. To improve the health of the population, resources must be reallocated from health care to activities that more directly prevent illness.” This is not a new observation, but it is an important one. We cannot look at population health statistics like those described in this data set and see reflected clearly the value, quality, or success of health care systems. Therefore, the most logical users of such a system are really a very diverse set of public policy makers who normally work in separate spheres and do not typically view population health as one of their important outcomes.

Conclusion

The authors have provided a valuable illustration of what a population-oriented health data system can and cannot do. If there is a clearly defined relationship between a public or private entity and a population,

and a group of policy makers or decision makers authorized to allocate resources for that population, such a system can be a valuable tool for the allocation process. Where these conditions do not hold, however, knowledge about the health of populations has to be used in a way that recognizes the limitations that individuals have left in place regarding public and private decision makers' ability to act on their behalf. As Roos and her colleagues remind us in their conclusion, most of the factors that affect the health of populations are not part of what we refer to as the health care system at all. Perhaps as a next step in the evolution of the data system, the authors can study its use by public authorities in the areas of education, job creation, family relationships, and housing.

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