

Embracing New Competencies for Ethics in an Era of Population Health

Rev. Michael Rozier, SJ, MPH

Doctoral Candidate, Health Management and Policy

University of Michigan

mrozier@umich.edu

Background

For the last 60 years, health care ethics has resided largely at the bedside. Bioethics has rightly wrestled with the right and wrong of various actions that occur in clinical settings. Although there are large bodies of work that address matters of research ethics^{1,2} and public health ethics,³⁻⁵ the most highly cited articles in bioethics for over 40 years have focused on matters of clinical medical ethics.⁶

However, we must now prepare for health care ethics to move steadily from the bedside into the community. Just as advancement in medical technology pushes us to consider new questions of clinical ethics, the health care system's adoption of population health as a strategic direction demands that we take seriously the ethical matters that will soon

be upon us. I contend that the new health care realities rooted in population health – especially prevention over intervention -- require us to expand the basic areas of competency possessed by those in the field of health care ethics.

One of the first challenges for this topic is that every corner of health care is using the term “population health” in its own way. In 2003, David Kindig and Greg Stoddart wrote that population health is “the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners.”⁷ Yet this definition falls victim to one of the central

confusions of population health as it is used today. Some believe it is best used for a broad population that is geographically defined. Others use it for more discrete populations such as those in an employee health plan or those for whom the health care organization bears some financial risk. Kindig himself later clarified to suggest that the stricter definition is better referred to as population health management or population medicine.⁸ Population health management is a key strategy for health care organizations to meet quality measures while lowering cost for enrolled or attributed lives, but population health management is not exhaustive of population health as I mean it here.

When I refer to population health, I intend something closer to community health. Community health is a “collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities.”⁹ This usage of population health is particularly appropriate for non-

profit health care because non-profit institutions have a legal responsibility (and for many organizations, a moral responsibility as well) to their entire community, extending well beyond enrolled or attributed lives. This does not exclude population health management strategies, but for the purpose of this article, population health management is best conceived as a subset of population health activities.

There are several reasons why population health is becoming a key strategy within the U.S. health care system. First, several new payment structures were instituted either as part of or alongside the Affordable Care Act and will likely continue in a potential replacement that may be signed into law. These new payment structures – Hospital Readmission Reduction Program, MACRA’s quality payment programs, partial capitation – all move away from simple fee-for-service and try to incentivize quality of care and reduced costs. Successfully meeting value-based health measures often means including more preventive measures and attending to non-clinical determinants of health. Second, Community Benefit (CB) requirements for

non-profit health care were enhanced as part of the Affordable Care Act and will likely remain as part of any potential Republican law signed by President Trump. Among other things, CB must take more seriously the collaborative and community-oriented nature of the work. Third, the epidemiological profile of our communities, primarily driven by chronic disease, requires a strategy of prevention. We know we cannot treat our way out of cardiovascular disease and diabetes. We can therefore move quality or cost metrics only by pairing quality medical care with community-based prevention. Fourth, data on health and its social determinants are more readily available than ever before. This makes population-level assessment, programming, and evaluation more possible than in the past. Fifth, expansion of health insurance over the past five years has brought more people into the health care system. The new patient mix includes a greater proportion of people with significant social needs in addition to their health needs than the patient mix that existed before insurance expansion. We could see even more drivers of population health in the years to come. For example, it would not be surprising if local health department budgets were

substantially cut in the near future. Local health care organizations may be expected to fill in some of those gaps.

Many areas of health care are taking the movement to population health quite seriously. Clinical departments, finance, and strategy are often out front on this topic, especially as it relates to population health management. Other areas of health care, including ethics, must also address issues of population health. I am not the first to suggest ethics is encountering the field of population health.^{10,11} However, I have only rarely seen articles from those in the field of population health (broadly or narrowly conceived) saying that they see the need for more engagement with ethics.¹² My hope is that this new reality is not ethics imposing itself on population health, but a genuine collaboration where each benefits from the other. Let me suggest several “competency domains” that ethics might work with to create mutually beneficial collaboration.

Areas of Competency

Like traditional health care ethics, population health ethics must partner with

experts in other fields. For example, someone evaluating the ethics of a given research study must know the difference between a retrospective case-control study and a prospective cohort study. They do not need to be experts but they must know that it is hard to identify causation in retrospective case-control studies. This makes it difficult to calculate risk and benefit from an ethical standpoint. Or an ethicist may be asked to consult on a terminal cancer patient who wishes to pursue an aggressive treatment plan that the health care providers do not endorse. The ethicist must be able to process the basic treatment options for the patient's particular kind of cancer, each treatment's risks and benefits, and many other factors that influence care decisions. Otherwise, the ethical issues embedded in the clinical question cannot be properly evaluated. Again, ethicists are not asked to be specialists in clinical medicine or in research methods. But a basic familiarity with these domains is required for ethicists to apply their knowledge to the question at hand.

Public Health

The first domain is public health, broadly understood as the “science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research, and detection and control of disease.”¹³ In order to achieve population health objectives, health care organizations will have to engage in some activities that have largely been in the realm of public health. For example, behavior change has always been a part of a physician's conversation with his or her patient, but health care organizations will increasingly engage in large-scale efforts to change the health behaviors of their patients and community. When do such organizational efforts become coercive? How do we avoid treating individuals as objects in need of modification? These are not new questions for those who work in the ethics of behavior change,¹⁴ but they may be new questions for those used to working in clinical settings. As another example, harm reduction programs could easily become more popular options for health care organizations as they consider their role in population health. Efforts such as needle exchange programs, supervised consumption facilities, and peer

support groups may be effective ways to achieve certain health objectives, but they will also need an ethical assessment if they are to be carried out by health care organizations. Much ink has been spilled over these ethical questions, including an entire issue of the *International Journal of Drug Policy*,¹⁵ but I suspect the ethical analysis of such programs are less known by those who work in clinical settings.

The field of public health is vast. No one, including those with graduate degrees in public health, can be experts in the disciplines that span from epidemiology to nutrition, behavioral health, and environmental science. I am not suggesting that clinical organizations will morph into local health departments, but I do believe that many of the strategies that clinical organizations will use to achieve population health metrics will be similar to the strategies used in the field of public health for many years.

Community Engagement

The second domain is community engagement, or the many ways in which the health care organization interacts with those

outside of its walls. The broad notion of community engagement will not be new to most health care organizations. We are used to community members as participants on local hospital boards, on Institutional Review Boards, and as active members of various organizational projects. But population health will bring about questions of community engagement that are more frequent and less formal than the engagement that has traditionally taken place. Population health strategies will call the health care organization outside of its walls for a variety of activities – from building infrastructure like a walking trail, to educational programming on violence, to home visits to target environmental concerns, and much more. These are not new, but their frequency is bound to markedly increase. The question health care organizations must ask is how much control to cede to the community in assessing needs, in determining strategies to address those needs, in allocating resources, in evaluating effectiveness, and in communicating the results. How should the community be involved? What happens when there is a disagreement on how to proceed? A health care organization often has more power than it realizes. The power itself is not a bad

thing; in fact, it can be crucial to improve community health. It is the misuse of the power that should concern us as hospital-community engagement becomes more common.

There is a helpful parallel here in the patient-provider relationship. Not that long ago, the health care provider was viewed paternalistically as the expert and the patient was viewed as the object in need of improvement. Clinicians today are still considered experts, but now patient experience and preference are seen as important factors as well. The relationship between the two is far more balanced than it was a short time ago. It was the field of ethics – emphasizing the autonomy of the patient – that helped shift this dynamic and I suspect it will once again take the field of ethics to ensure that the dynamic between the health care organization and the community it serves is appropriately balanced. As this engagement becomes more regular, it would be wise for us to evaluate these relationships through the same critical lens of ethics that we evaluate the relationship between providers and patients.

Business Operations

The third domain is the broad umbrella of business operations, including strategy, data management, and finance. This might be the most challenging because its functions are often seen as ancillary to the real mission of health care. At the same time, it may be the most important area of the organization with which ethicists must build bridges in the era of population health. For example, when an organization is looking to make an investment either through acquisition or through building a new facility, what factors should be taken into account? More to the point, how much should an organization risk for a population that has a poor payer mix but is in desperate need of health services? Or when engaged in purchasing, should the organization always go for the least expensive option that meets its needs? Or is there a time to pay slightly more to support the local economy, especially when it has a known impact on community health? Or in an era of integrated health systems, how do we ensure that decisions continue to be made in the best interest of the patient when the same organization bears the risk and delivers the care? And even at a time when resource allocation

among patients can prove difficult, health care organizations will be faced with the challenge of allocating resources between their patients and the community as a whole. What factors should be taken into account when deciding where to place limited resources when we need to meet both individual- and population-level health outcomes? The examples in this area of health care are growing rapidly and such issues often get embedded into the organization itself, rarely manifesting as an ethical issue *per se*.

Business operations may be the ideal location to build a strong team whose primary expertise is a particular area of operations but who also have sensitivity for matters of ethics and mission. This is akin to the many physicians and nurses who have received training in ethics and have led their particular specialties to think about their work through that particular lens. A pediatrician who can lead a seminar on the ethics of vaccination is likely to be more effective with his or her clinical colleagues than an ethicist without the peer relationship. The same will be true with a data manager or financial analyst who is sensitive to matters of mission and ethics

and can help their colleagues consider issues as they emerge within their profession.

Organizational Ethics

The fourth domain is organizational ethics, which includes behavior at the micro (individual), meso (team), and macro (organization) levels. Organizational ethics is a large field in its own right and it is certainly not new to health care. A recent systematic review in *Nursing Ethics* found several dozen empirical articles alongside several hundred other articles on organizational ethics in health care settings.¹⁶ But population health will bring new examples of ethical dilemmas at each of these levels. For example, at the micro level there will be more positions that span multiple organizations due to unique funding structures, like a community health worker that is jointly funded by multiple non-profits. Many of the issues that are already complex with employees will become even more so when it involves joint ventures with other entities. At the meso level, care transition teams will become increasingly common. These teams may have less formal structures and a more diverse set of expertise than we typically see in clinical settings.

Therefore, disagreements on what is needed for proper care or what level of resource expenditure is appropriate for a patient with great social need are likely to be quite frequent. And at the macro level, population health strategies will require new partnerships with community-based organizations. What if an organization has a choice between partnering with a high quality elder care organization that has publicly supported physician-assisted suicide legislation and lower-quality elder care organization that does not have such a public position? These questions are not new, but they are likely to become more frequent as health care organizations require more partnerships to achieve population health metrics.

The area of organizational ethics, like the competency domain of business operations, is another area where the best strategy is not to develop ethicists who are organizational ethicists, but rather to cultivate a sensitivity for ethical questions among those who are already experts in these other areas of the organization. John Glaser identified three realms of ethics – individual, organization, societal – that are not entirely unlike the three levels I identify above.¹⁷ He rightly

observed that even while focusing on one level, our analysis must take into account the impact we are having at other levels of any given situation. The same is true here, and we must listen to voices at all levels of the organization and in the community if we are to negotiate ethical questions that arise as health care identifies new goals, builds new teams to achieve those goals, and develops new partnerships to support those teams.

Collaborators for Population Health Ethics

No single person can be an expert in all the domains described above. Clinical ethics has worked because it has appreciated the expertise that many people bring to the table. The same will be true for matters of population health ethics.

There have been two primary routes to becoming involved in health care ethics. One begins in ethics and moves to knowledge in the setting of health care. The other starts with clinical experience and moves to a particular interest in matters of ethical import. I would hope that no professional ethicist would try to negotiate a complex clinical question without consulting someone more expert in the clinical matters

involved. I would also hope that clinicians who face a complex ethical issue that is beyond their expertise would consult others more trained in this area. The same should be true for population health ethics. There will certainly be some ethicists who take an interest in matters of public health or health administration, and they will be valuable interlocutors for these questions. But matters of population health also offer a unique opportunity to involve many more divisions of health care organizations in questions of health ethics and organizational mission.

As medical ethics came into its own, ethics training became more integrated into the education and ongoing training of clinicians. We would do well to consider who will be the key partners in population health and to consider ways to increase their training in ethics. This is not to pretend that every action within a health care organization is ethically laden and must be agonized over. But it is to build cultures where health care ethics are not just thought of in clinical terms.¹⁸ Not everyone in strategy needs to have professional training in ethics, but it might be good to have someone within that department who is considered a “go-to”

person. Perhaps they are trained in mergers and acquisitions, but they are sensitized to matters related to health equity or community access. The same can be said for operations, information technology, and finance. For example, database managers have tremendous influence on how we think about our patients and our populations because we only see what is made available to us through the data structure. How we are able to code race, ethnicity, gender, income, neighborhood, and much more has profound implications for how we think of caring for patients and all of that can be strongly influenced by a data manager who has a sensitivity to ethics. The goal of identifying issues of population health ethics will require building a larger team within the health care organization to be sensitive to matters that are value-laden or ethical in nature.

In addition to building competency at the individual level, health care organizations will also need to rethink the composition and role of the ethics committee. Ethics committees have traditionally been thought to have a three-fold role: education, consultation, and policy development.¹⁹ We know that there is great diversity across

hospital ethics committees and that the composition and activities of ethics committees change over time,²⁰ but to my knowledge there have been no national studies assessing their composition in the past decade.²¹ What we do know of ethics committees is that they primarily address questions of clinical ethics and much of the input comes from clinicians. I am not suggesting that clinicians participate less in ethics committees. What I am suggesting is that we may need to augment the work of ethics committees with explicit questions about population health.

Population health ethics will be a challenge because it may not generate the kinds of high-profile, crisis dilemmas we are used to, that is, those involving acute situation where two or more moral principles are in direct conflict with one another and where there is often an imminent connection to life and death. Instead, questions of population health become embedded in the structure of the organization itself to the point where they are barely noticed, but they can have just as much impact on life and death as a traditional matter of clinical ethics. Therefore, a committee that considers matters of population health ethics will not

be called together for an emergency meeting to deliberate on a pressing dilemma in need of immediate resolution. One central challenge is the motivation for this work. The incentive for clinical ethics committee is the resolution of a complex, acute situation. What will be the incentive for population health ethics? A more just organization? An organization more responsive to community concerns? While laudable, I doubt these are sufficient motivations to guarantee a committee that is seen as bringing value to many organizations.

Ultimately, I hope the coming issues of population health give health care organizations the excuse to involve more people in matters of mission and ethics. And I hope organizations are willing to learn from one another's experiences in the way that occurred as clinical ethics committees were forming decades ago.

Conclusion

One of the central challenges of writing on population health is that it is a new concept and a new field of study, and its future shape is unknown. Therefore, the specific domains of knowledge for ethicists remain somewhat

unknown as well. If this had been written three years ago, I suspect that Accountable Care Organizations would have played a much bigger role in this analysis. Moreover, the difficult truth is that we cannot even be sure whether or not value-based payments are here to stay. And even though the Affordable Care Act seemed positioned to strengthen local public health departments, the current political and economic realities in the U.S. make local health departments far more vulnerable and far less able to be counted on as major partners in population health strategies

As clinical medicine has gotten more complex, largely through new sub-specialties and new technologies, the role of ethics has increased as well. For example, the first NICU opened just over 50 years ago, which obviously required ethicists to learn about this new field and apply their expertise in new ways.²² The same will be true for population health. It may not seem as pressing because population health rarely has the kind of life-and-death moments that capture our imagination. Population health ethics is to bioethics as chronic disease is to HIV, measles, or Ebola. While less apparent, life and death are truly at play in

these questions. We must not ignore the fact that people live and die based on resource allocation, access to care, and organizational priorities.^{23,24} Therefore, they must not just be treated as technical or operational issues, but must also be seen as matters of ethics and values. At the same time, we must avoid imposing ethics as a heavy hand on every matter that arises in health care. That is not helpful to anyone. But we must prepare for the ethics of population health insofar as possible and insofar as doing so leads to healthier lives among our patients and in our communities.

References

1. Committee on Underrepresented Groups and the Expansion of the Science and Engineering Workforce Pipeline (U.S.). *On being a scientist : a guide to responsible conduct in research*. 3rd ed. Washington, D.C.: National Academies Press; 2009.
2. Shamo AE. *Responsible conduct of research*. Third edition. ed. Oxford ; New York: Oxford University Press; 2015.
3. Nuffield Council on Bioethics. *Public Health: Ethical Issues*. London: Nuffield Council on Bioethics;2014.

4. Powers M, Faden RR. *Social justice : the moral foundations of public health and health policy*. Oxford ; New York: Oxford University Press; 2006.
5. Daniels N. Equity and population health: toward a broader bioethics agenda. *Hastings Cent Rep*. 2006;36(4):22-35.
6. Jin P, Hakkarinen M. Highlights in bioethics through 40 years: a quantitative analysis of top-cited journal articles. *J Med Ethics*. 2016.
7. Kindig D, Stoddart G. What is population health? *Am J Public Health*. 2003;93(3):380-383.
8. Kindig D. What are we talking about when we talk about population health? *HealthAffairsBlog*. Vol 2016. Washington, D.C.: Health Affairs; 2015.
9. Goodman RA, Bunnell R, Posner SF. What is "community health"? Examining the meaning of an evolving field in public health. *Preventive medicine*. 2014;67 Suppl 1:S58-61.
10. Hamel R. Catholic identity, ethics need focus in new era. *Health Prog*. 2013;94(3):85-87.
11. Bouchard C. The social dimension of health care ethics. *Health Prog*. 2017;98(1):70-71.
12. May T, Byonanebye J, Meurer J. The Ethics of Population Health Management: Collapsing the Traditional Boundary Between Patient Care and Public Health. *Population health management*. 2016.
13. CDC Foundation. What is public health? 2017; <http://www.cdcfoundation.org/content/what-public-health>. Accessed June 20, 2016.
14. Buchanan DR. *An ethic for health promotion : rethinking the sources of human well-being*. New York: Oxford University Press; 2000.
15. Fry CL, Khoshnood K, Power R, Sharma M. Harm reduction ethics: Acknowledging the values and beliefs behind our actions. *Int J Drug Policy*. 2008;19(1):1-3.
16. Suhonen R, Stolt ME, Virtanen H, Leino-Kilpi H. Organizational ethics: a literature review. *Nurs Ethics*. 2011;18(3):285-303.
17. Glaser J. *Three realms of ethics : individual, institutional, societal : theoretical model and case studies*. Kansas City, MO: Sheed & Ward; 1994.
18. Worthley JA. *The ethics of the ordinary in healthcare : concepts and cases*. Chicago, Ill.: Health Administration Press; 1997. See also John Paul Slosar, "Embedding Clinical Ethics Upstream: What Non-Ethicists Need to Know" (Health Care Ethics USA, Fall 2016) for his

- description of proactive ethics integration.
19. Garrison NA, Magnus D. The instrumental role of hospital ethics committees in policy work. *Am J Bioeth.* 2012;12(11):1-2.
 20. Courtwright A, Brackett S, Cist A, Cremens MC, Krakauer EL, Robinson EM. The changing composition of a hospital ethics committee: a tertiary care center's experience. *HEC Forum.* 2014;26(1):59-68.
 21. McGee G, Caplan AL, Spanogle JP, Asch DA. A national study of ethics committees. *Am J Bioeth.* 2001;1(4):60-64.
 22. Lantos JD, Meadow W. *Neonatal bioethics: the moral challenges of medical innovation.* Baltimore: Johns Hopkins University Press; 2006.
 23. Woolf SH, Braveman P. Where health disparities begin: the role of social and economic determinants--and why current policies may make matters worse. *Health affairs.* 2011;30(10):1852-1859.
 24. Warhover A. Zip Code Overrides DNA Code When It Comes to a Healthy Community. *HealthAffairs Blog.* Vol 2016. Washington, D.C.: Health Affairs; 2014.

RESEARCH ASSISTANCE REQUESTED FOR STUDY ON POPULATION HEALTH

The U.S. health care system is beginning to emphasize prevention and community health. This changes the operational aspects of health care delivery, but it also changes the ethical questions that we must address.

- How should we allocate limited resources for community health?
- What ethical challenges do hospital face when doing community-based work?
- Are ethicists consulted on questions of population health ethics?

Anyone who works in ethics or community health for a health care organization is invited to take a survey on these and other questions. The survey takes **no more than 15 minutes to complete** and is available at <http://tinyurl.com/healthpriority>

If you have any questions, please contact Michael Rozier (mrozier@umich.edu).