The Disconnect between Public Health and Health Care

By KATHLEEN BENTON, DrPH, and SHARON POLITE

Terms like "population health" and "social determinants of health" are current buzz words in the health care arena, but what do these terms mean for patients served by our health care systems, and how are they connected to the state of public health as monitored and upheld by local, state and national health departments?

Historically health care has responded to illness and disease in individuals. It encompasses emergency, acute and chronic health services to people in hospitals, health systems, physicians' offices, clinics, rehabilitation facilities and nursing homes.[1,2,3,4,5] Public health, on the other hand, refers to the health of a community. Whether city, county, state or federal, a public health entity is intended to be proactive for its population's health. For instance, it tests and monitors the community's water supply, develops immunization policies and programs, conducts healthy people studies, creates educational materials against smoking, drug and alcohol abuse, collects mortality data, supports better wellness for moms and babies, screens residents for diabetes or high blood pressure and promotes safety campaigns

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for drivers. Public health conducts surveillance in some areas and implements policy in others. As a state- or county-funded resource, there is a myriad of approaches to public health agendas nationwide.

Population health is a concept that extends beyond the individual and focuses on the health outcomes of an entire group, community, culture or institution. Population health considers the social determinants of health — such as socioeconomic status, residential environment, education and income, access to transportation, technology, telephone and nutritious food — as factors that can affect wellness. Research shows that such variables, plus elements of behavior, influence health and may determine the success or failure of an acute treatment.

The U.S. health care environment is shifting in focus from acute care of individuals to patient and population wellness, so one might assume public health and health care systems would work together, share the metrics and other data that each collects and use them in congruence. But for a variety of reasons, they don't. Here is an example: If you are a professional employed in a health care facility, you are aware that the intake documents for a patient's admission rarely include the attendant social determinants of health. Yet federal law requires nonprofit hospitals to conduct community health needs assessments (CHNAs) every three years and to report annually on measures taken to address such needs. The absence of socioeconomic status data makes it unnecessarily difficult for the hospital to quantify and address overall

population health concerns or take into account aspects of public health that could be relevant to outcomes.

In light of the Affordable Care Act, health care systems in the United States are expected to deliver services more efficiently to patients and to reach out to the surrounding community to improve care. Though many systems have outreach programs, the walls of the hospital still tend to confine the efforts, and outreach tends to focus on acute care issues over social determinants.

If a health care facility heeded the call to collect patient socioeconomic information and share it, the local public health entity could use the same patient data to include preventative and management education programs in its budget. We would be working together on population health.

CONNECTIONS?

What is the connection between health care and public health? The short answer is not much. The lack of commonality has to do with the ways and reasons for collecting information but keeping it in silos. If a health care facility were able to collect patient socioeconomic information and share it, the local public health entity could use the same data to include preventive and management education programs in its budget. If a public health department provided the most accurate demographic information on disease patterns and environmental concerns, the health care system could better design facilities and build staff.

One might assume that the local public health department has ready access to data in local hospitals' electronic medical records, but that is not the case. The electronic medical record is owned by its health care facility or office, and these databases of information rarely are shared among health care facilities, much less channeled to a public health entity.

The federal Health Insurance Portability and Accountability Act, better known as HIPAA, protects the confidentiality of individually identifiable health information and sets security standards for electronic medical records. Violations carry penalties, and health care facilities take patient privacy seriously. Given the litigious state

of medical care, it is not surprising that they are more interested in protecting information than devising ways to share it.

Another factor is that while public health is motivated by an aim of public well-being, health care is driven by revenue and competition. Sharing information from proprietary electronic medical record systems may be a detriment to revenue sources and competitive edges. As facilities move from paper charts to the EMR, a new entrepreneurship is exploding. The idea of universal health information has been outpaced by the lucrative business of selling EMR systems designed specifi-

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cally for client hospital systems and physicians' offices. The EMR collects only information the client requests, and there is no compatibility built in to "talk" to any other EMR system. The more recent concept of clinically integrated networks between facilities, which would theoretically allow such EMR integration, is on the horizon, but the jury is still out on its success. Keep in mind this would be between noncompeting health care facilities only. Public health is still disconnected from this network.

EMR data could be a treasure trove of community health information, especially if it recorded data about socioeconomic status such that it could be used to shed light on public health issues that need attention. For now, though, privacy concerns, software design and competition among health care facilities are serious barriers to sharing.

To be sure, there is a shift on the horizon, or at least some possible crossover. Public health departments across the country are offering flu shots, providing HIV/AIDS testing and clinical services and becoming involved in community preventive services that show up as statistically significant in the health care disease categories. Health care is refocusing on wellness, preven-

tion and helping patients manage their health status before they become acutely ill. To that end, health care entities are funding and serving free clinics and providing screenings for those who cannot otherwise get the services. Community needs assessments required by the Internal Revenue Service may encourage collaboration among health care competitors in order to share costs.

Still, it is necessary to acknowledge that in most places, public health and health care don't yet recognize their overlaps and possibilities for mutual progress. That state of oblivion even extends into academe. It was only a few years ago that professors in a Doctor of Public Health program questioned how palliative care tied into the public health realm — even though quality of life is one of the key measurements of public health programs and study. Eventually they conceded that it was appropriate to research the quality of life to which palliative care contributes, but their question makes the disconnect evident.

The root of the disconnect between public health and population health is somewhat explained in the history of each structure. Public health has had a long history of splits and restructuring supported by government entities from local to federal. The underprivileged and less educated people in the U.S. population generally have been served by public health initiatives, especially if they had no health insurance.

Health care grew out of the private sector — both nonprofit and for-profit. It has become a huge revenue producer, and Americans view medicine as an occupation aligned with financial success, power and influence. Privately insured individuals, those who can afford out-of-pocket costs and those with Medicare are all eligible to receive private health care; people with only Medicaid, no insurance at all, and who cannot afford out-of-pocket medical costs must rely on charity care.

ETHICAL QUESTIONS

The disconnect between health care and public health is not just a matter of operating procedures. There are deeper questions rooted in basic elements of Catholic social teaching such as justice, human dignity, patient autonomy and the common good.

Justice encompasses human dignity and autonomy, which are of primary interest to clinical health care, especially with regard to treatment choices and privacy. But justice also emphasizes

the common good, which is of primary importance to public health. Even within the virtue of justice there are tensions. Commutative justice is mainly concerned with transactions — you get what you pay for. This kind of justice regulates quality, charges, compensation and the like. Distributive justice, on the other hand, is more concerned with allocating limited accesses, charging according to a patient's ability to pay, and assuring broad access to basic care. This is particularly important in a society like ours where there is growing economic imbalance.

The matter is further complicated by the fact that many decisions about funding and allocation of health care resources are made by community officials and elected representatives who know little about the specifics of clinical care. Patients outside the reimbursement system have limited possibilities. Ironically, those who are hospitalized seem to have almost limitless options.

The tensions are apparent if we consider a patient who is seeking an expensive, minimally effective or even futile treatment. Such a request is based on the patient's human dignity, autonomy

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and right to choose medical treatment. However, even when such a choice is rooted in justice, it may well conflict with a public health notion of justice that stresses population health, a broader view of where these resources will do the most good and concern over equitable access to limited medical resources.

The tension between various aspects of justice makes it hard for health care and public health to connect because they have different priorities. They are each, appropriately, protecting their primary interests. But the fact that they both honor justice means they have to come to more consensus and find more effective ways to collaborate. Health care, for example, does not know enough about patients because the parameters of their intake data do not include important social determinants. Public health often is limited in its ability to serve patients because, although it has social determinants data, it has no access to patients' EMRs. Debate, dialogue and adjustments to pub-

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lic policy are critical to the resolution of these issues. Health care and public health need to join forces to support good health on an individual and on a population level.

Here are some specific recommendations to help achieve that end:

■ Health care providers should connect to the public health programs in their areas and couple them with health care delivery by forming resource groups. Beyond safety nets, we need collaboration in programs and knowledge for the public and the patients we help.

■ Consider the patient's social support. For example, focusing on caregiver support and including this support in end-of-life discussions can be undertaken jointly with public health agencies. This will be particularly important as the population continues to age.

■ Expand intake data to include patients' socioeconomic status (e.g., income, education, transportation, occupation) to link clinical care to population health and to address social determinants in a more specific way.

■ Work with outpatient programs and community benefits services, utilizing resources such as mission integration, palliative care clinics and other services in medical group management, free local clinics and senior-care programs like PACE, the Program of All-inclusive Care for the Elderly, or Georgia's SOURCE program.

We all are working for quality health care, quality of life, and, above all, justice. Our common commitment to justice, in all its forms, suggests that this is the time to take down the silos and find new ways to work together for patient health and public health. Public health should look to collab-

orate on efforts that may improve quality of life for the public, including nutrition and wellness efforts and even the Physician Orders for Life-Sustaining Treatment (POLST) education at the heart of end-of-life decision-making

Most importantly, public health should look to collaboration with health care facilities on advisement for collection of socioeconomic status data to improve what they know from census tract data.

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