



# When Populations Become the Patient

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FR. MICHAEL ROZIER, SJ, MPH

**T**he 25th chapter of Matthew distills some of the concrete actions that Christian faith demands of its followers. But more important than any particular action is the call to cultivate our instinct to see Christ in the other and to respond to his or her needs as if they were the needs of Christ himself.

“For I was hungry and you gave me food, I was thirsty and you gave me drink, a stranger and you welcomed me, naked and you clothed me, ill and you cared for me, in prison and you visited me. Then the righteous will answer him and say, ‘Lord, when did we see you hungry and feed you, or thirsty and give you drink? When did we see you a stranger and welcome you, or naked and clothe you? When did we see you ill or in prison, and visit you?’ And the king will say to them in reply, ‘Amen, I say to you, whatever you did for one these least brothers of mine, you did for me.’”<sup>1</sup>

Pope Francis recently gave renewed attention to the works of mercy when he suggested that being “stewards of creation” would be a worthy addition.<sup>2</sup> The pope proposes “care for our common home” as both a new spiritual and a new corporal work of mercy, but he also invites us all to imagine the new ways mercy might be lived out in today’s world. What if we took that same imagination and applied it to the Gospel of Matthew?

“For I was hungry and you ensured I did not live in a food desert, I was thirsty and you guaranteed my tap

water was safe to drink, a stranger and your laws allowed me to find asylum, naked and your donation did not shame me, ill and you ensured I had affordable health insurance, in prison and the system rehabilitated me.”

Admittedly, it does not have the same ring as the original. It isn’t divinely inspired. But for those of us in health

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care, the new passage helps us reflect on new ways we might ensure the well-being of our brothers and sisters as if they were Christ himself. Health depends on the concrete actions of caregivers, but it also depends greatly on the social context in which one lives. Just as concrete actions can be characterized by mercy or not, the social structures we build as a society can be

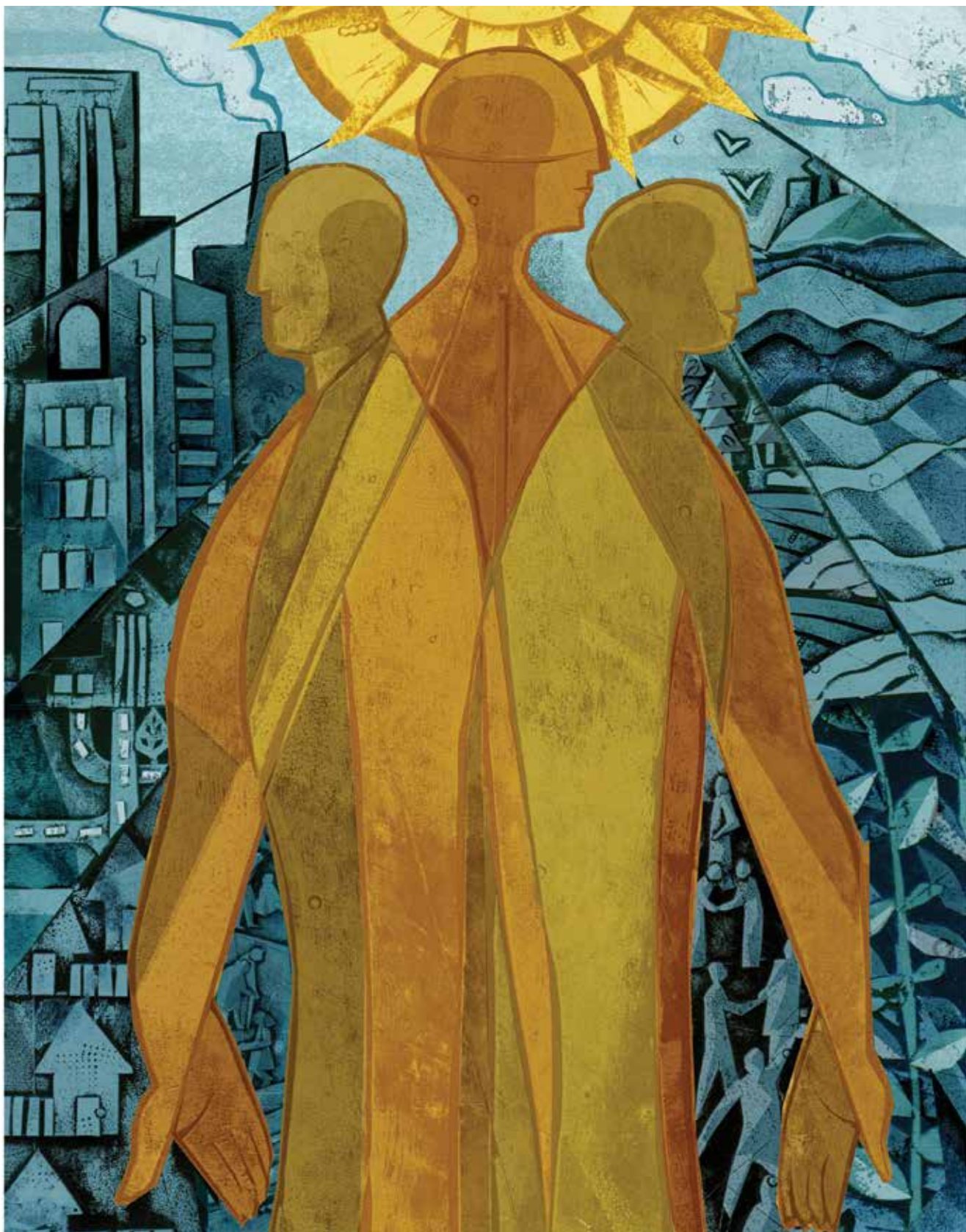
vehicles of mercy or not.<sup>3</sup>

In addition to expanding our religious imagination, the pope’s addition of stewardship of creation has several other helpful reminders embedded within. We know that addressing climate change requires personal efforts, but it also requires systemic change. The same is true for health. We know that climate change must be anticipated and not only addressed when its negative effects are fully realized. We hope to do the same with health. And we know that climate change’s ill effects are first and most forcefully felt by the poor. This, too, is true for health.

## BREATHING WITH BOTH LUNGS

The re-imagined works of mercy do not supplant those that have been with us since Christ himself. Just so, working to improve the health of populations does not replace delivering high quality clinical care. Our health care organizations always will have their primary focus as excellence in medical care. But that does not mean medicine is the exclusive way of achieving our goals.

We need look no further than the Flint, Michigan, water crisis to realize that when lead levels ran high, individual citizens needed to be given water that was safe — an invocation of the classic work of mercy. And yet such is neither sufficient nor, dare I say, even preferred. We should be pursuing a situation where an individual’s tap water



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has been, is, and will be safe to drink when they are thirsty. This is also a work of mercy.

Caring for children born with microcephaly is certainly a work of mercy. But so is eliminating the risk of Zika before the children's mothers are infected. Caring for those with tobacco-related cancers or cardiovascular diseases is a work of mercy. But so are the programs designed to help people quit using tobacco products, as well as wise laws that prevent people from starting in the first place. Promoting decent housing, transportation, food security and social connectedness — if done for the purpose of helping human beings live fuller lives — undoubtedly are works of mercy that our society, especially the poor and vulnerable, are in desperate need of.

Some may object and suggest that our health care organizations are not responsible for municipal water systems, criminal justice systems or laws and regulations. That is true. And we should not pretend that we can or should be all things to all people. But that doesn't mean our health care organizations do not have a significant role to play in ensuring that other sectors of civil society are meeting the needs of the community. Physicians can use their social status to give voice to issues when other people are not listened to. Board members and executives can use their networks to convene groups and set agendas that benefit the poor and marginalized. Health care organizations can be models of fair hiring practices, just compensation, healthy workplaces and commitment to a strong social mission for other businesses in the community.

Our communities need us not only to deliver high quality medical care, but also to be leaders in the social determinants of health. This more expansive notion of our mission has been emerging for a while, but its time clearly has come.

#### **DRIVERS OF CHANGE**

There are several reasons why community health is taking on new importance. The most obvious is the changing reimbursement structure in health care. There have been many attempts to find a payment structure that properly incentivizes high quality care and reduced costs. The most recent changes center on value-based care — from making health care organization bear the cost for preventable readmissions to introducing partial capitation. Success with these new reimbursement

structures requires addressing risk factors that occur outside of the clinical setting. And while we do not know the pace or exact shape of the changing payment structures, it is highly likely that movement away from traditional fee-for-service will continue apace.

A second motivation for taking population health more seriously is a higher profile being given to community benefit and the community health needs assessment. Community benefit often has been treated as a worthy side project, but nonprofit hospitals should take the wisdom that

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community benefit has gathered over the years more seriously. Strong community benefit programs not only are the best way to avoid further regulatory pressures, but their hard-won relationships with community partners, their knowledge of community health needs and assets, and their experience with evidence-based programs can be tremendous assets for the rest of the organization.

A third driver of this change is the epidemiologic profile of diseases affecting our patients. As important as treatment is, we are unable to treat our way out of cardiovascular disease, obesity, diabetes, mental illness and drug overdoses. We have more evidence than ever before as to how amenable our most significant diseases are to prevention and nonmedical intervention. It is not only cheaper to deal with disease before it manifests in patients, it is more humane to do so as well.

These are not the only reasons for the shift to population-level and preventive measures. Advances in technology make gathering and using the necessary data more possible. The expansion of Medicaid means that we have more patients in need of connecting to social services. The pressures are largely external, but, in the end, the move is quite resonant with our ultimate mission.

#### **SACRED AND SOCIAL**

Efforts to promote the health of our communities do not only bring financial and operational questions. These efforts also carry new questions of



ethics and values. We would be wise to discuss these questions as deeply as we consider implications of new reimbursement models.

I present the new version of Matthew 25, just as I have presented other parables,<sup>4</sup> in an attempt to remind us that we must see this work as a moral exercise. If we do not understand the work as an extension of the healing ministry of Jesus, as a work of mercy or as the next chapter in a religious congregation's story, I fear it will not survive the inevitable challenges to come. Catholic health care in the United States has been successful not primarily because of astute business decisions, but because those in our company believed so deeply in the human dimension of the work that an organization's roots could weather whatever storm came its way.

The promotion of population health will raise many new ethical questions for our ministries. To what degree do we shift limited resources from patient care to community health? What role do we have in remedying unsafe situations noticed during telehealth or home health care? How do we balance obligations to our enrolled lives with our obligations to the community as a whole? Where do we draw the line when faced with nearly bottomless needs related to behavioral health? In a data-intensive environment, to what degree do we share information with competitors in efforts to improve community health? These questions may not seem as pressing as the beginning- and end-of-life issues that get a lion's share of attention, but I would suggest ethics involving the years in between life and death needs more consideration than it has thus far received. Perhaps this is our chance to give the vast middle the attention it deserves.

The ethics required for this work carries new demands for us all. For example, our medical care always has been rightly rooted in the notion that the human person is sacred. This new paradigm of care demands that we appreciate the human person also is social. Ethics that focus exclusively on a discrete action in the hospital risks losing the social context of the persons involved. In Christian anthropology, the sacred nature of human persons cannot be understood apart from our social nature. Practically, this means where we build the next primary care clinic or the degree to which vulnerable groups feel comfortable in our facilities is as pressing as whether we perform certain reproductive services.

The ability to complement clinical care with

community health requires strong commitment in data management, financial services, clinical operations and much more. But it also requires a commitment to consider how this work shifts the very way we think of our ministry as a moral enterprise. As important as the technical components are, they will be insufficient for those interested in having a truly Catholic version of population-level health.

### **SPEAKING THE SAME LANGUAGE**

The Catholic Hospital Association changed its name to Catholic Health Association in 1979. This was a prescient move, acknowledging the need to think of health more broadly than just the important work done in hospitals. And it recognized the importance of language. This change nearly four decades ago opened the door to where we find ourselves today.

What language is most fitting for the work of promoting the health of populations and attending to social determinants of health? It should be the language that best captures the breadth and depth of our commitment. The leading contenders seem to be population health and community health.

The challenge with population health is that the term frequently is confused with population health management or population medicine. Although population health management is an important move to attend to our sickest and most expensive patients, there is great danger in defining a Catholic hospital's population only by its covered or enrolled lives. Therefore, unless we can avoid the conflation of population health and population health management, I am starting to believe we should avoid the terminology.

Community health also holds much promise. However, community health has its own history, with a large chasm between it and clinical care (except when used in community health nursing). If we use the term community health, a central task will be avoiding the notion that community health is separate from work inside the hospital. Community health will have to be used in a way so that physicians see medical care as integral to a larger community health strategy.

The truth is, there is no clear winner in the contest of language. Others have attempted to reconcile this very point.<sup>5</sup> We must strive to find and use shared language that communicates the work's comprehensive nature. It is both giving drink and ensuring safe tap water; both caring for the diabetic patient and ensuring she has access

to healthy food. Our patients and community members do not see their health as demarcated between clinical concerns and community-based issues. It is simply whether they are healthy or not. Therefore, our language for preventing illness and promoting health inside and outside the hospital should reflect this integrated worldview.

### LEADING THE WAY

Caring for the sick clearly promotes the dignity of the individual. It shows we believe everyone deserves to lead a flourishing life and have a dignified death. We would be remiss if we pretended population or community health is merely a technical exercise in which we search for the right metrics to be achieved by the best evidence-based interventions. It is certainly that. But it also is seeing the advocacy for new laws as much a work of mercy as any healing touch. It is being as passionate about preventing illness through systemic change as we are about treating patients when crisis hits.

The shift to population health is not unique to Catholic health care. Everyone is facing the same external pressures to achieve high quality clinical outcomes, low cost and improved population health measures.<sup>6</sup> Everyone will be rightly focused on the clinical, financial and operational aspects of this shift. The unique contribution of Catholic health care — the contribution other systems may not even know they need yet — is a strong case for why this matters to us as a human community.

I hope Catholic health care will lead the way on the technical elements of the shift. But I am confident we must lead the way on the social case for why this work is necessary. Our vision must be rooted in the human person and the common

good. This vision will not only sustain our ministries when challenges emerge, but it allows us to show others the way forward, even when the path is not as clear as we would like.

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### NOTES

1. Matthew 25: 35-40.
2. Francis, "Show Mercy to Our Common Home," message for the celebration of the World Day of Prayer for the Care of Creation (Sept. 1, 2016). [http://w2.vatican.va/content/francesco/en/messages/pont-messages/2016/documents/papa-francesco\\_20160901\\_messaggio-giornata-cura-creato.html](http://w2.vatican.va/content/francesco/en/messages/pont-messages/2016/documents/papa-francesco_20160901_messaggio-giornata-cura-creato.html) (accessed Sept. 20, 2016)
3. Michael D. Rozier, "Structures of Virtue as a Framework for Public Health Ethics," *Public Health Ethics* 9, no. 1 (2016): 37-45.
4. Michael D. Rozier, "A Catholic Case for Public Health," *Health Care Ethics USA* 22, no. 2 (Spring 2014): 1-11.
5. Dawn Marie Jacobson and Steven Teutsch, *An Environmental Scan of Integrated Approaches for Defining and Measuring Total Population Health by the Clinical Care System, the Government Public Health System and Stakeholder Organizations*, (commissioned paper, April 2012): 2. [www.improvingpopulationhealth.org/PopHealthPhaseIICommissionedPaper.pdf](http://www.improvingpopulationhealth.org/PopHealthPhaseIICommissionedPaper.pdf) (accessed Oct. 5, 2016).
6. Donald M. Berwick, Thomas W. Nolan and John Whittington, "The Triple Aim: Care, Health, and Cost." *Health Affairs* 27, no. 3 (2008): 759-69.

## QUESTIONS FOR DISCUSSION

**F**r. Michael Rozier, SJ, argues that addressing population health is a both/and proposition. We should take care of immediate needs, AND we should address issues with a long-term, preventive mindset.

- How does your ministry attend to immediate needs of the sick and also address related community health needs? How does that play out in conditions like HIV/AIDS, diabetes or cardiovascular disease?
- After reading Fr. Rozier's contemporary version of Matthew 25, can you think of system-level "works of mercy" that could support your community?
- In terms of the ethical issues involved in moving to population health models for disease prevention, how is your ministry prepared to address the long-term reality of behavioral health concerns when the low-hanging fruit is still acute care?

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