Public Health & Health Reform: Integration, Disintegration or Eclipse?

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Agenda:

- Why integration?
- ACA Provisions That Point Towards Integration
- Other Initiatives Pointing Towards Integration
- A Preliminary Assessment
- Barriers
- The Republican Vision
- The Dangers of Eclipse
- Questions for Further Study

  - **Our goal today is to outline the issues & present the questions that warrant additional research and analysis.**

Why Integration?

- The US health care system ignores the social determinants of health (SDOH)
  - As of 2013, 97% of health care dollars go to health care services
  - Under-investment in public health agencies & programs.
- The US ranks poorly compared to other countries in terms of life expectancy & infant mortality, but spends more than other countries on health care.
- Theoretically, integration could lead to coordination between systems, address SDOH, improve population health, and save money.

What is “Population Health”?

- Discussions of integration emphasize the ways in which the health care system can aim to improve “population health.”
- But what is meant by population health?
  - Patient population
  - Insured group (covered lives)
  - People living in a defined geographical area
  - Group of people connected by some variable (immigrants, children, etc.)
  - The whole population?
- Public health agencies and health care systems often focus on different populations.

Integration of What?

- Perspectives?
  - Health care systems adopting public health's population perspective?
- Concerns?
  - Health care systems addressing population health?
- Systems?
  - Health care systems partnering with or merging with public health agencies.

ACA: Towards Integration?

- Several ACA provisions offered promise of both increased emphasis on population health & potentially integration of systems:
  - Clinical reforms: No co-pays for preventive care; essential benefits; mental health parity; payment model experiments
  - Payment reforms: Accountable Care Organizations (ACOs); Patient-Centered Medical Homes (PCMHs)
  - Community-focused reforms: Public Health & Prevention Trust Fund, Community Health Needs Assessments (CHNAs); Accountable Health Communities (AHCs); National Prevention Strategy

ACA: Implementation

- Clinical reforms: Increased access to primary prevention
- Some success for population-focused/payment reforms: ACOs; patient-centered medical homes
- Some innovations for community-based reforms, CHNAs; AHCs
  - But – Funding for Prevention & Public Health Task Force has been slashed, National Prevention Strategy has not been implemented, and National Prevention Council is not active.

Non-ACA Reforms

- Health in All Policies
- Health Equity Approaches
- Anchor Institutions
- Sec. 1115 Waivers
  - Limited empirical evidence regarding outcomes

Some Preliminary Thoughts

- Emphasis remains primarily on clinical care
- Reforms are pushing clinicians and payers to pay more attention to primary and secondary prevention.
- Upstream prevention remains neglected
- Competing definitions of population health may impede integration
- Integration of systems appears more theoretical than actual.

Barriers Remain

- Scalability & sustainability of innovations?
- Who pays?
- Lack of staffing
- Conflicts remain between definitions of populations, perspectives, and duties to patients and populations
- Lack of compelling theory as to what systems integration looks like or why it is preferable
- Efforts aimed at SDOH remain limited and continue to face political (and legal) resistance.

Republican Proposals

- Efforts to “repeal and replace” the ACA have targeted clinical and community-based reforms:
  - Essential benefits
  - Access to contraceptives
  - Prevention and Public Health Trust Fund
  - Tanning Tax
- Proposals did not target payment reforms: ACOs, Medical Homes, CHNAs, or AHCs (in part because of parliamentary reasons).
- Republican plans would increase individualization of the insurance market, and weaken any move toward a population perspective

Medicare for All

- Specifically continues certain reform activities such as the Medicare Shared Savings Program (MSSP)
- Also continues funding for CMS Innovation Center (CMMI)
- However, some CMMI activities would have to be changed or discontinued, such as those that partner with commercial payers

Questions to Consider

- Is integration of perspectives possible? Of systems?
- What incentives/reforms would be needed for providers to shift their long-term focus to population health as that term is used in public health?
- Is integration of systems even appropriate (considering the different perspectives/mandates)?
- What are the potential downsides (in terms of quality, cost and ethics) of expecting providers to adopt a population focus?

The Danger of Eclipse

- Would integration "free up" space for public health agencies or eclipse them?
- What happens to public health agencies' regulatory role?
- What happens to their "*public*" role? To political accountability?
- Can integration actually address social determinants?

Future Research

- What legal strategies would facilitate integration?
- What would be a useable theoretical model supporting integration?
- To what extent have existing innovations shifted the focus from clinical care to population health?