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Population healthcare: a new clinical responsibility

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Before 1948, Public Health doctors were population doctors and clinicians were responsible for the patients who consulted them or had been referred to them. After 1948, the situation changed because the whole population was covered by the NHS with clearly defined responsibilities for Scotland, Wales and Northern Ireland, and in England the 14 Regional Hospital Boards had a clearly defined population. General practitioners too suddenly became population doctors each with a list of 2000 patients.[1] The hospital doctors were still responsible for dealing with the patients who were referred to them by general practitioners but in the early days of the NHS each district general hospital, and each teaching hospital too, had a clear sense of relationship to a population. In the era before the motorcar, people knew that Derby Royal Infirmary looked after most of Derbyshire but there came a point towards the North when people were referred to Chesterfield. People knew that the Radcliffe Infirmary in Oxford looked after most of Oxfordshire with the Horton Hospital in Banbury looking after North Oxfordshire and a little bit of Warwickshire and with some parts of Oxfordshire beyond Henley looking to Reading and the Royal Berkshire Hospital.

When there is a relatively small number of consultants, two per specialty was the 'Noah's Ark principle' of the time, and a limited number of general practitioners, all of them full-time, relationships developed between generalists and specialists. Furthermore, in the era before car parking became one of the major problems for every hospital, it was feasible to arrange regular lunchtime sessions in which the consultants from one specialty could meet with a large proportion of the GPs. So the hospitals had a clear sense of population until the market was introduced.

The introduction of the purchaser/provider split, as it was called with the expectation that hospitals would compete with one another to attract patients, significantly weakened the relationship between specialists and the population they served and other initiatives such as the choose and book scheme combined with factors such as the growing number of specialists and general practitioners and the increasing proportion of both who were part-time has led to a significant breakdown between hospitals and the populations they serve. This has been a problem, and it is of particular importance as we look to an era in which need and demand will increase faster than resources, an era in which we will have to significantly increase the value that we derive from the resources available.[2]

Consider the questions that cannot be answered at present, questions such as is care for people with asthma better in Somerset or Devon or is care for people with epilepsy better in Liverpool or Manchester?

One reason for this is that we have focused on measuring the quality of care for patients who have been referred to a service and not the outcome for those patients, or even more important, the outcomes for all the people in need in the population.[3] Low-quality care is of low value but high-quality care is not necessarily of high value, and there is a need to broaden the leadership and management focus from the four activities that have dominated the service provision and professional practice for the last 20 years, namely prevention, evidence-based decision-making, quality improvement and cost reduction. All of these remain vitally important, but after 50 years of amazing progress in clinical care, every society on earth still faces three problems.

The first is unwarranted variation in access, quality, cost and outcome, which reveals the other two.[4] One, overuse of lower value interventions, which always leads to waste and often results in patient harm, even when the quality of care is high.[5] The other is underuse of higher-value interventions, which leads to failure to prevent and treat disease effectively, and is often aggravated by inequity.[6]

What is needed therefore is to shift the focus from quality to value, and there are two aspects of value from a population perspective. The first is allocative value, determined by how the assets are distributed to

different subgroups in the population; and the second is technical value, determined by how well resources are used for all the people in need in the population.

We need therefore to think of the health status of subgroups of the whole populations, for example the population of people who are breathless or people with atrial fibrillation. We also need to align the resources in this way. We know to the nearest pound what we spend on every hospital and health centre but not to the nearest 100 million what we spend on epilepsy or rheumatoid arthritis or bipolar disorder. Similarly, although the unwarranted variation in clinical activity has received a great deal of attention, smaller variations in spend are still unexplained and almost certainly unwarranted. Spend on people with musculoskeletal disease, for example, varies from around £6 million per population to £12 million per population We absolutely need well-managed bureaucracies, namely well-managed hospitals, Mental Health Trusts, health centres, primary care teams and federations; however, this is only one dimension of healthcare. The other dimension focuses on what might be called the eternal verities of healthcare – mental health problems and cancer, for example.

What is emerging is the concept of population healthcare defined by Public Health England in the following way:

> The aim of population healthcare is to maximise value and equity by focusing not on institutions, specialties or technologies, but on populations defined by a common symptom, condition or characteristic, such as breathlessness, arthritis, or multiple morbidity.

Obviously, the payers need to be involved and the NHS Rightcare programme is aimed at them and so to do the organisations that provide the care but it is vitally important for clinicians, both generalist and specialists, to be involved also. The financial and other implications of variation vary so much that they need to be addressed in each population asking questions, using rheumatoid arthritis as an example, such as have we got the balance of resources right between drug treatment, rehabilitation and smoking cessation?[7]

Population healthcare is different from medical management of a service. Both require clinicians with special skills and recognised authority. Population and personalised care are two sides of the same coin and complement the traditional split into primary, secondary and tertiary care in a health service that is not a bureaucracy but a matrix.

Hospital chief executives will need to decide if they are in the real estate business or the knowledge business; clinicians are clear they are in the knowledge business taking specialised knowledge 'beyond the hospital walls'.[8]

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