

Opinion

The Medicalization of Population Health: Who Will Stay Upstream?

PAULA M. LANTZ

POPULATION HEALTH, DEFINED BROADLY AS THE DISTRIBUTION of health-related risks and outcomes within and across populations, has been developing as a subject of scientific inquiry and public health practice for more than two centuries.¹ More recent attention has been fueled by the growing understanding of both upstream (macro-level) and downstream (micro-level) social determinants of health, and increased recognition of the limits of medical care in reducing socially driven health disparities.²

A robust finding from population health research is that the United States spends a much greater percentage of its GDP on medical care than any other developed country, yet ranks quite low in broad population-level indicators of health status, including life expectancy and infant mortality. In response, the Institute for Healthcare Improvement introduced the Triple Aim framework in 2007 to optimize health care system performance: reduce *costs*, improve *quality*, and improve *population health*.³

This explicit focus on population health within the context of health care improvement has fueled significant growth in what is generally called “population health management.”³ In these efforts, the term “population” typically refers to individuals who are covered by a health insurance plan or the patients of a health care delivery organization. Although population health management significantly narrows the concept of a “population,” it also promotes an expanded approach to health care delivery. Common approaches to population health management include data-driven chronic disease management, lifestyle and behavioral health interventions, case management approaches that attempt to address patient social circumstances, and partnerships with public health and social service agencies.⁴

Not surprisingly, there has been a contemporaneous explosion of new business-oriented tools, products, and consulting services designed to

assist providers in managing the health care use, costs, and outcomes of the populations for which they are financially responsible. There has also been concurrent growth in the number of schools, departments, and degree programs whose names include the words “population health” or “population health management.”

The population health management movement has been shaped by a strong force within the modern medical care system, what Conrad calls the “engines of medicalization.”⁵ Medicalization is a process by which personal, behavioral, and social issues are increasingly viewed through a biomedical lens, and defined as individual pathological or biological problems. Medicalization provides medical professionals the primary authority to “diagnose” and “treat” what are ostensibly social problems within the boundaries of biomedical expertise and clinical practice.⁵ And, importantly, medicalization leads to a conflation of “health” and “health care,” giving credence to the fallacy that societal problems having to do with health primarily need health care solutions.²

Examples of medicalization abound. A medicalized approach to the steep rise in the rate of people who are obese includes defining obesity as a disease, which in turn emphasizes individual treatment rather than community-based or public policy prevention approaches. Another example is defining racial disparities in school behavior problems primarily as differences in the incidence of brain disorders without acknowledging disparities in the social conditions of children compounded by racial differences in teachers’ responses to behavioral disruptions in the classroom.

As a social demographer who has worked in the field of population health for three decades, I am adding my voice to a growing chorus of concern about the conflation between population health and population health management in terms of science, practice, and policy. In the midst of many innovative endeavors, I see several serious problems with population health management’s predominantly medicalized approach to the key social, economic, and political processes that produce and constrain health in populations.

The first problem is that of “denominator shrinkage,” or the move from focusing on populations based on broad sociopolitical criteria to small groups of people who temporarily share the same clinicians or insurance plan. This severely narrows the focus of the field of population health, including the number and types of people of interest for research, service, and policy attention.

Second, the medicalization of population health emphasizes the *downstream* drivers of and solutions to health problems in aggregates of people. Programs and services are primarily aimed at the individual or micro level. Some interventions involve community-based partnerships between health care and social service delivery systems. However, these efforts are typically focused on the delivery of services to individuals or families, and are responding to rather than preventing health risks and problems.

Third, with few exceptions, population health management is silent about the upstream institutional, systemic, and public policy drivers of population health problems and distributional disparities. Before the emergence of population health management, population health was primarily focused on the social structural, systemic, and sociopolitical forces that push people into rivers of bad health according to their racial or ethnic backgrounds, their socioeconomic position, their place of residence, and other social factors. However, this historical upstream focus of the field is shrugged off by most population health management efforts as being outside of its purview because it is outside of the health care system and its usual partners.¹

Population health management can be described as a collection of downstream efforts earnestly working to build a strong scaffolding from which people can be pulled from treacherous waters. This scaffolding requires significant resources so that it can support search and rescue efforts for individuals as they struggle in unhealthy currents. Many people with longstanding commitments to health equity are greatly encouraged that the health care system—with its vast resources and control of most of the country's investments in health—is building these efforts and has embraced a social determinants of health perspective. This shift is essential, in their view, even if the primary populations of interest remain those of health plans or patient systems.

Although these efforts are indeed necessary and generally positive, they are also woefully insufficient if the overarching goal is improved health outcomes and health equity at the societal level. There is a difference between upstream efforts aimed at increasing affordable housing within gentrifying urban neighborhoods and downstream efforts that provide supportive housing to chronically homeless individuals. There is a difference between broad public education system reform and patient-centered interventions focused on health literacy. And there is a difference between advocating for public policies aimed at poverty

prevention/income security and screening patients for trouble paying for their prescriptions or utility bills.

The labors of population health management that are building a bigger and stronger platform of efforts to rescue individual people from downstream waters of poor health are extremely important. Yet they must not divert research, resources, and policy attention from the upstream forces that are pushing groups of people and their communities into the rivers of health inequity in the first place.

Many of us—policymakers, public health leaders, resource allocators, advocates, researchers, teachers, and students—need to stay fully committed to upstream population health. Amidst the loud, revving engines of medicalization, we need to remain steadfastly focused on interventions and reforms that will influence and impact the key institutions, social systems and public policies that are the fundamental drivers of health inequities.

References

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Address correspondence to: Paula M. Lantz, University of Michigan, 4125 Weill Hall, 735 S State St, Ann Arbor, MI 48109 (email: plantz@umich.edu).