Population Health Management and Inequalities: What can we learn and how can we learn it?

Bringing together people working across population health management, public health, and academia to explore research priorities for population health management systems

10 June 2022

Event summary

Over 50 people with an interest in population health management (PHM) across different regions in England came together in person and online to discuss some important questions arising from the introduction of PHM in health and care systems in England and learn from each other.

In Session 1, **The success and potential of PHM to reduce inequalities,** we heard a local perspective on North Central London's PHM system. Dr Sarah Dougan, Director of Population Health Intelligence, North Central London CCG, described the different kinds of population health intelligence programmes underway in the area and key enablers for progress. *[see slide set 1]*

Andi Orlowski, Director of the Health Economics Unit and Senior Advisor for NHS England on Population Health Management then powerfully illustrated why consideration of determinants of health is key to the success of any health care endeavour. Sophie Hodges, Lead Client Service Manager at the Health Economics Unit, followed with some inspiring examples of how population health management can be used to inform the delivery of non-health interventions outside of the healthcare sector, such as preventing eviction and possible subsequent homelessness. *[see slide set 2]*

Key questions/discussion points:

- How to establish and maintain trust within the system, and manage concerns about mutual accountability and clinical governance?
- What is the right data and how to obtain it?
- What is the optimal geographical level at which to do PHM to address wider determinants?

In Session 2, **How should we evaluate PHM?,** Dr Lucy Heath, Academy Director at Healthier Futures - Black Country and West Birmingham [*slide set 3*], gave a reflective talk illustrating the ways in which evaluation was used in their system, often retrospectively, but successfully to generate and share learning about local programmes. Lucy discussed key barriers and enablers to evaluation including resource and capacity, and building evaluation in from the start.

Georgia Watson, public health strategist and CRN-funded research practitioner, London Borough of Islington, shared findings from an evaluation of NCL's system, focused on COVID-19 vaccination uptake specifically.[*slide set 4*] One important piece of learning from the evaluation was that people engage with PHM in very different ways; the design of PHM tools and communication should take that into account, for example, by working with 'super users' and influencers to make bespoke, tailored products and by supplementing training available for tools with more general application.

Key questions/discussion points:

- Who to communicate PHM reports to? Who can actually make the decisions you want to influence?
- The COVID-19 Vaccine uptake Dashboard shows PHM in a the very specific and urgent context of a pandemic: what learning is transferable beyond this?
- Financing: several challenges were noted, first to gaining a comprehensive understanding of where money was spent in the system, and secondly in engaging the right people to re-allocate spend once inequalities are identified. Financing PHM and its evaluation also requires a leap of faith from leaders, significant upfront cost and the understanding that benefits may not be realised for many years.
- How can local systems ensure evaluation is built into programmes from the beginning?
- In the current climate, what is the right balance to strike between outcomes maximisation and outcomes equalisation?

In Session **3, How can learning about PHM be used for improvement?**, Amy Bowen, Director of System Improvement at North London Partners in Health and Care, gave a convincing argument for focusing on Population Health Improvement, rather than management. *[slide set 5]* Amy described the need to remember the individual patient and that improvements are for each person as well as the population

Professor Al Mulley, Managing Director of the Global Health Care Delivery Science Program, The Dartmouth Institute for Health Policy and Clinical Practice, gave powerful evidence of why decision quality and listening should be integral to care delivery. *[slide set 6]* Al described that decision quality as an outcome is not part of how we measure care at the moment because it is not visible through measurement of health outcomes. Al recommended that primary care should have the function of listening to patients and learning what they want. This needn't be through already overstretched GPs; he gave an example in the US system where trained community members are now delivering many aspects of care, and – importantly – listening and connecting with patients.

Key questions/discussion points:

- **Shifting to population health improvement** – might this engage front-line clinicians - and patients more in using systems?
- **Learning preferences – what can we do at an aggregate level?** Al's view is we need to learn them at an individual level, e.g. through research, and this is what should inform investments (as well as investments into wider determinants)

Take-away points from the research team

Many areas are on a journey to link enough data to understand from PHM which populations are at risk of inequitable health outcomes, or access to healthcare. This is still work in progress for many sites and undoubtedly, more data would lead to more powerful insights. Questions remain about:

- What enablers and facilitators are required to make PHM work? Which people, which roles, which processes? This may involve **reframing Population Health Management to Population Health Improvement**: we can all get behind the aspiration to improve health!
- How to **build mutual accountability and trust** and address concerns about clinical governance and responsibility?
- How to gain commitment within the system to **(re)allocate resources** to address inequity once identified?
- How are different areas using PHM to conceptualise, identify and respond to inequity?
- How best to **involve patients and communities in decisions** about a) their individual care and b) designing responses to address inequity?