Population and Community Health Terms: Navigating the Territory

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The goal and expressing it measurably

Health—*the ultimate goal*
"A dynamic state of physical, mental, spiritual and social wellbeing and not merely the absence of disease or infirmity."[1]

Population Health—*the health goal expressed in measurable form*
"The health outcomes of a group… including the distribution of such outcomes within the group" [2], but knowing that population health outcomes in actual communities are more than the "sum of individual health", as described in the "community health as a goal" bubble below

Community Health as a goal—*the population health outcomes goal expressed for <u>particular</u> communities*
Population health outcomes in a specific community of interest, geography, neighborhood, or other defined boundary—sharing an identity that entails systemic influences on health [3,4]
Community health is more than the sum of individuals' health—the community's systemic or collective assets and strengths for individual and collective health ("communities of solution");[5,6] health not only as absence of disease but people thriving as well as they can even with health conditions; and with compassionate support for suffering and dying.

Realities that affect and shape how goals can be achieved

Social and Environmental Determinants of Health: *Influences*
Social, economic, environmental and policy realities responsible for most health inequities / disparities.
"…The conditions in which people are born, grow, live, work & age… shaped by the distribution of money, power & resources [e.g., systemic racism] at the global, national & local levels." [6,7]

Health Disparities*: Effects*
"Preventable differences in the burden of disease, injury, violence, [systemic racism], or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, & other population groups & communities." [8,9]

Health Equity: *A goal and design principle*
As a goal: "… The absence of avoidable, unfair, or remediable differences among groups of people…defined socially, economically, geographically or by other means…ideally everyone has a fair opportunity to attain their full health potential…" [10]
As a principle: Strive for highest possible standard of health for all, with special attention to needs of those at greatest risk of poor health based on social conditions.[11]

Background realities affecting determinants, disparities, and equity—more examples: Public and private policies, payment, insurance, illness classification & coding schemes, implicit bias, and underlying epistemology (theory of what counts as real). For example, *people* speak of lives, problems, and troubles—what besets families and communities, while *healthcare* speaks of diseases, diagnoses and codes.

The most general ways to get the job done

Health Care Delivery Systems: Private or public *provision of care to individuals & families*
An array of systems designed to manage the health care of individual patients & populations who are signed up with private or public providers or healthcare systems.
Includes primary and specialty care, mental health, substance use/addiction care, hospital, other levels and venues; usually privately or publicly owned, and commonly paid through private or public health insurance.

Primary Care- *first contact, coordinated, continuous, comprehensive*
"…Integrated, accessible health care services [including behavioral health] by clinicians accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in context of family and community." [12]

Public Health: *A population-based civic-level activity*
An array of service provided to city, county and state residents that includes data collection, surveillance, advocacy, policy development, enforcement of regulations and services to individuals.
Supported by administration and taxes at different levels of government; often with collaboration from a wide range of non-profit or for-profit healthcare delivery and non-government community organizations; with many different kinds of practitioners/workers.
"… Promotes and protects the health of people and the communities where they live, learn, work and play." [13]

With a broad zone of potential collaboration to achieve *community health as a goal;*
A way of operating: *healthcare delivery, public health and others in active partnership with served communities on behalf of community health.*

"A perspective on public health that takes community to be an essential determinant of health and the indispensable ingredient for effective public health practice" [14]
"In active partnership" means relationships, interconnections, alliances, collaborations, and understood division of labor across care delivery, public health, and the many community and philanthropic organizations working with, and for, healthy communities—where streams of effort converge in effective action. **Examples below:**

Community-oriented Primary Care (COPC) *"Helps clinicians respond to population-level concerns by marrying public health with primary care…focuses not just on individuals but also on families and communities in the context of social determinants"*; [15] "COPC mirrors steps for clinically evaluating [individual] patients…one conducts similar steps on a population within a defined community; [16]
"A continuous process by which primary care is provided to a defined community on the basis of assessed health needs through the planned integration of public health practice with the delivery of primary care"[17]

Population Health Management (and improvement)—*what care delivery* and *public health systems do "on the ground" to achieve population health goals.* Clinical and IT processes and tools;
"Design, delivery, coordination, and payment of high-quality health care services and public health monitoring and intervention to achieve the "Triple Aim" for a population (care delivery-defined or public-health defined population) using the best resources we have available.[18]
"Changes in the way primary care is delivered, reimbursed, and measured… to support the health promoting and healing work that happens continuously, not just during a clinic visit or inside the clinic walls" [17]

And other examples or paradigms for action in the broad zone of collaboration

Figure appears in:

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Abstract

People working on behalf of population health, community health, or public health often experience confusion or ambiguity in the meaning of these and other common terms—their similarities and differences and how they bear on the tasks and division of labor for care delivery and public health.

Shared language must be clear enough to help, not hinder people working together as they ultimately come to mutual understanding of roles, responsibilities and actions in their joint work. Based on an iterative lexicon development process, the authors propose a definitional framework as an aid to navigating among related population and community health terms.

These terms are defined, similarities and differences clarified, and then organized into three categories that reflect goals, realities, and ways to get the job done. *Goals* include *health* as well-being for persons, *population health* as the goal expressed in measurable terms for groups, and *community health* as population health for particular communities of interest, geography, or other defining characteristic—sharing an identity and systemic influences on health. *Realities* are *social determinants* as influences, *health disparities* as effects, and *health equity* as both a goal and a design principle. *Ways to get the job done include health care delivery systems* for enrollees and *public health* in population-based civic activities—with *a broad zone of collaboration* where streams of effort converge in partnership with served communities.

This map of terms can enable people to move forward together in a broad zone of collaboration for health with less confusion, ambiguity, and conflict.

Diagram references

Health

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Community health as a goal—emergent properties:

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Social determinants

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Health disparities

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Community health as a way of operating

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