

Population health management

My perspective?

I would like to focus on the aspect of data, as it is central in PHM and it has always been central in my research & policy work.

The WHO definition: PHM= a people-centered and **data-driven pro-active approach** to managing health and well-being of a defined population, considering the differences within that population & their social determinants of health.

For me **two things are particularly important** and they were shared by the participants of a workshop on introducing PHM in Belgium, organized by the FOD/SPF and the European Health Observatory.

1. The focus is often on quantitative data. We talk among researchers about the pro and cons of data from administrative databases on the one side and surveys on the other side, for example. But what I learned from working in Brussels, in the Observatory of health of social affairs, is the **absolute necessity of complementing figures, numbers with qualitative information, with interviews**, talking to stakeholders etc... Let me give an example.

Figures from the mutualities (which are gathered together by the Intermutualistic Agency) give us an idea about how many times a year people from a certain neighborhood or city, on average go the gp , for example. But they do not give an idea about the **social and cultural barriers** some people face (and as a consequence don't go or go to little according to their health status). Qualitative research learned us that in Brussels, it is not an exception to rely on more "traditional African medicine", that not all people define their health or their ill health in the same way, that the GP is most of the time still accessible for vulnerable groups, but there is no money left to buy the prescribed medicines... All these insights we would not have, if we relied on quantitative data only. So I find the term "data-driven" sometimes somewhat misleading as it suggest for me the reliance on figures, numbers, %...

2. Now, in the second point I would like to bring back in some nuance as well, with regard to the importance of data and of quality of data. **Data should be viewed as a tool, as a means of bringing people together, as a means of starting a discussion with the appropriate stakeholders about some health or health care issues, as a means of sharing the perspective of public health rather than individual case management which is the core of the work by care professionals.** We will never have all the perfect, complete data, up to date etc. We should not hide behind the excuse of imperfect data for not moving forward.
3. And maybe I would like to add a 3th thought based on my current work of trying to develop a methodology for calculating in which zones in the Brussels Capital Region, there is a lack/potential lack of GPs. In this project it becomes very clear that **some public health questions are not only purely scientific, but there is an important role for policy makers & politicians.** For example, we are calculating in terms of the number of consultations with a GP a year that are available for the habitants in the neighborhood. But an important choice for example, it to decide how many minutes we think a GP needs for a consultation with a patient on average. The results are completely different when we take 20 min of 10 min, as in the

Netherlands for example. So, my point is, sometimes political decisions need to be made in order for researchers to do the calculations. And these decisions or choices should be clearly stated. For the question of shortages of GPs there is no single answer. As a result, we present the results in different scenarios according to the methodological and political choices that can be made.