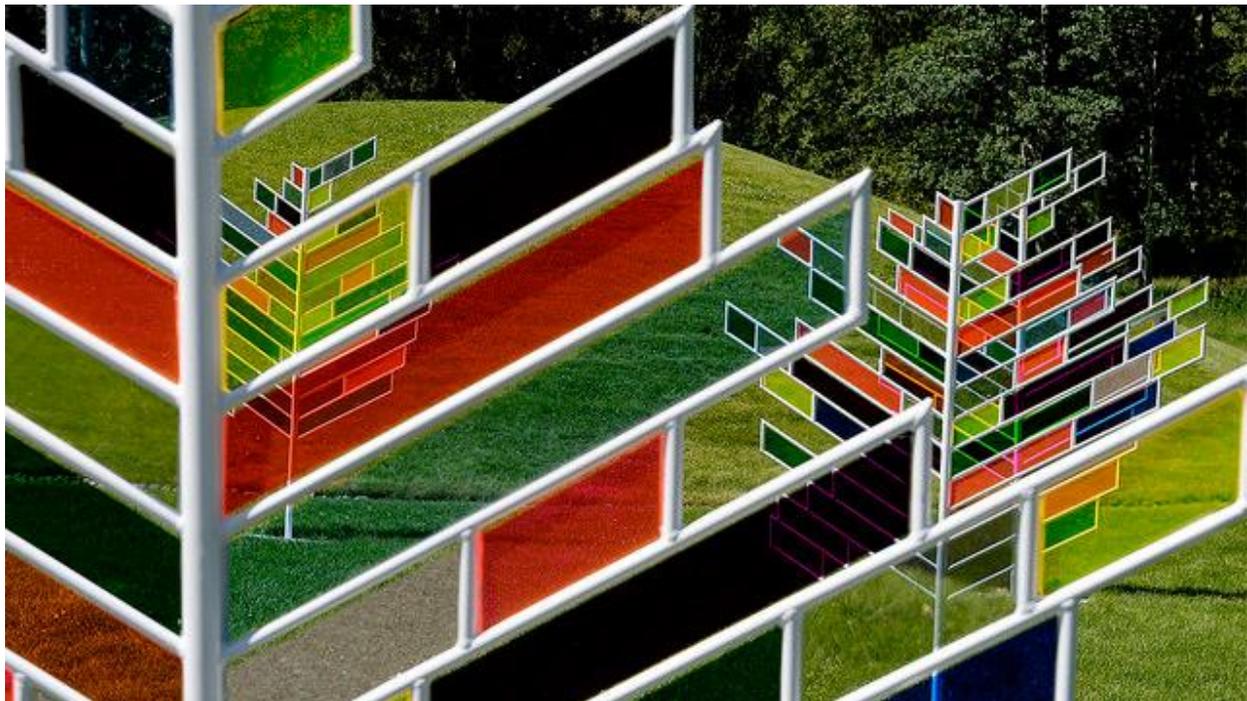

With The ACA Secure, It's Time To Focus On Social Determinants

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Editor's note: *This article is part of a series of blog posts by leaders in health and health care who participated in **Spotlight Health** from June 25-28, the opening segment of the Aspen Ideas Festival. This year's theme was Smart Solutions to the World's Toughest Challenges. Stayed tuned for more.*

While Medicaid expansion remains a dream for Americans in many states, the integrity of both the state and federal marketplaces for insurance remained intact following the June 25 Supreme Court decision to allow the federal government to provide nationwide tax subsidies to help people buy health insurance. The following morning, Kathleen Sebelius led a discussion at the **Aspen Ideas Festival** calling the Court's action "The strongest possible decision. Definitive." The judicial victory provided space for participants to commit to asking new questions about how to improve health at a

reasonable cost. After months of uncertainty, many of the leading minds in US health policy began to ask: What's next?

In the days that followed, Festival participants repeatedly identified the misalignment between the health care system and social service providers as a rate-limiting step to improving population health. Many believe that aligning these sectors would allow for a more systematic approach to improving the social determinants of health.

Unequivocal literature reveals that the vast majority of premature mortality and morbidity is attributable to **social, behavioral, and environmental factors**. Nevertheless, the US expenditure on health care, largely targeting the medical determinants of health, comprises 18 percent of the gross domestic product (GDP) while investments in key social determinants of health such as housing, income support, education, and nutritional support is dwarfed in comparison, **consuming less than 10 percent of GDP**. Some have argued that federal, state, and local tax structures compensate for this relative limited spending in social welfare; however, **the major beneficiaries of tax subsidies are middle-income**, rather than low-income families and individuals for whom the negative social determinants of health are most pressing.

A Distinctly American Predicament

The spending of our international peers in Western Europe and Scandinavia reflects a very different pattern than that of the US, as the ratio between spending on social services and health care is 2:1 in many peer countries compared to **the ratio 1:1 in the US**. If spending on social services is interpreted a proxy for attention paid to the social determinants of health, the US is lagging. This predicament emerges out of a distinct American history characterized by ambivalence toward government and pride in individualism, punctuated by the rise of employer-based health insurance as a mechanism to attract workers under the wage controls during World War II.

The roots of the US spending paradox—in which we spend more on health care but have poorer health outcomes than any other country—are deeply embedded in our political, economic, and social history. Recognition of this reality leads us to suggest that only slow and incremental shifts will be possible; however, greater evidence about the impact of social service investments and of partnerships between health care and social service providers on health and health care costs may stimulate adoption of a

new mental model in which health is created by a variety of interventions apart from health care. In fact, **our review of the literature** funded by the **Blue Cross Blue Shield of Massachusetts Foundation** boasts several rigorous and longitudinal studies that produce credible findings about just that — investments in specific types of social services and partnerships with health care providers can result in improved health outcomes and have been cost neutral or cost saving.

Investments in selected social services—nutritional assistance programs and supportive housing programs—have been associated with health care cost savings and improved health outcomes. According to **a comprehensive review by the Government Accounting Office in 1992**, investments in The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) can be more than fully offset by savings in Medicaid spending, and WIC reduces the risk of low birth weight, developmental problems of young children, and vaccine-preventable deaths among infants.

At the other end of the age spectrum, the health of older adults who are homebound has been shown to **benefit significantly from home-delivered meals**. And supportive housing for families and individuals with low-income who would otherwise be homeless, as well as income support for living expenses have also been shown to produce net savings through reduced health care utilization as well as improved health outcomes such as reduced depression, obesity, and diabetes.

Building Partnerships

Similarly, several partnerships between health care and social service providers—particularly those with intensive case management and community outreach and those that connect health care and housing providers with community building and individual counseling services—have demonstrated cost savings and better health outcomes. Examples of case management and community outreach programs that have been shown to be cost neutral or cost saving include **the Nurse-Family Partnership** originated in Tennessee for low-income mothers and children, **the GRACE program** begun in Indiana for low-income adults, and **the Family Van**, a Boston-based free mobile clinic with health educators, dieticians, and HIV counselors operating in communities with high emergency department use.

Many of the most efficacious programs target at-risk populations with track records of high health care utilization and poor health outcomes. For the more general population, faith-based efforts have been piloted, and the Church Health Center in Tennessee, which provides health behavior education and spiritual counseling for individuals and the community, has shown cost savings through **reduced hospitalizations and decreases in participants' anxiety and depression**. Integrated health care and housing support efforts funded through Medicaid waivers in several states are also showing optimistic results with cost neutrality or modest cost savings as well as **improvements in mental health outcomes and reduced unmet physical health needs**.

Shared Goals

These types of findings remind us that health care services and social services are working towards shared goals — healthy communities. This perspective may help us to more honestly assess an unintended consequence of the notoriously high health care spending in the United States: crowd-out.

At the **Society of General Internal Medicine Annual Meeting** this year, one presenter estimated that the cost equivalent of 20 MRI scans is one year of a social worker; one emergency department visit costs about as much as a month's rent for many. Which creates more health? It is difficult to say for sure, but the tradeoff is rarely examined. While other countries can engage in a democratic process of priority setting and resource allocation, the US system has constructed elaborate public and private systems that sometimes results in competition among siloes rather than collaboration across complementary offerings.

Integrating the work of health and social services will be long-term work requiring many hands. Encouragingly, many local communities around the country have already begun. In part from their experiences, we can begin to see what enables successful collaboration. Key to the efforts is (1) the reinforcement of a common agenda, (2) the alignment of budget processes and evaluation metrics and (3) the creation of shared data and information systems.

Some health care providers and institutions are hesitant to engage in this work on the basis that it will distract them from their core mission — to deliver high quality medical care. Ironically, **our experience interviewing people** who participate in integrated efforts

has suggested that the opposite is true. By coordinating health care efforts with social services, physicians and health care institutions are freed to return to the work they feel best equipped to do.

Although the support for the ACA is an enormous step in the right direction to enable greater access to health care services, the time is now to ensure those health care services are aligned with the substantial evidence base about what creates health in the most cost-effective ways. Relying strongly on medical care to attain a healthy population has proven an expensive strategy to date. If we take seriously the evidence about what works to create health and to conserve health care spending, we will consider a more balanced and creative spending portfolio in which the most trenchant roots of ill health are exposed and addressed.

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