The American Health Care Paradox

What do we (really) know about intervening on the social determinants of health?

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Structure for Today

1. What is the American health care paradox? What’s new here?
2. Do ratios of health to social services matter at the state level?
3. How can social services be integrated with health services?
4. Which social services are our “best bets”?
5. How might we think about health services and social services in relation to one another at the systems level?

Discussion = ~20 minutes

Health Expenditures as a % of GDP, 2009*

*Turkey is missing data for 2009
**US HEALTH RANKINGS**

- **Maternal Mortality**: Rank 136th among OECD countries
- **Life Expectancy**: Rank 25th among OECD countries
- **Low Birth Weight**: Rank 28th among OECD countries

**What Determines Health?**

- **Healthcare**: 20%
- **Genetics**: 20%
- **Social, Environmental, Behavioral Factors**: 60%

**Health Expenditures as a % of GDP, 2009**

*Turkey are missing data for 2009*
Social Services

- Employment programs
- Supportive housing & rent subsidies
- Nutritional support & family assistance
- Other social services that exclude health benefits

Total Expenditures as a % GDP, 2009*

Ratio of Social to Health Expenditures, 2009*

*Switzerland and Turkey are missing data for 2009.
In OECD, for $1 spent on health care, about $2 is spent on social services.

In the US, for $1 spent on health care, about $0.90 is spent on social services.

**METHOD:** Multivariable regression using OECD pooled data from 1995-2007 on 29 countries and 5 health outcomes.

**FINDING:** The ratio of social to health spending was significantly associated with better health outcomes: less infant mortality, less premature death, longer life expectancy and fewer low birth weight babies.

**NOTE:** This remained true even when the US was excluded from the analysis.

**Does it matter?**

*Bradley, BMJ Qual and Safety, 2010*

Can we replicate this analysis at the *state* level?
States with higher ratios of social-to-health spending have statistically better health outcomes.

- Lower mortality among those with lung cancer
- Lower rates of asthma and obesity
- Lower rates of limitation in daily activities per month
- Lower rates of mentally unhealthy days per month
- Lower post-neonatal mortality

Not necessarily. But we do have to align the work of health and social services more thoughtfully.

Evidence Exists for Various Integration Models

A Case Study:
Project HEARTH
Los Angeles, CA
Features of the Case Base

• Vulnerable, high cost population
• Straightforward intervention
• Small scale evaluation
• Savings attributed to decreased utilization
• Funded through community benefit

Which social services produce better health and save dollars?

LEVERAGING THE SOCIAL DETERMINANTS OF HEALTH: WHAT WORKS?
The Crowd-out Issue in MA

(Un)intended Consequences

Should health care organizations invest?

Research base for health impacts of individual social service interventions is not widely accessible or accepted.
Continuing Challenge of Perverse Incentives

“We had a really successful outpatient diabetes center: so successful that it reduced the number of hospitalizations, amputations etc, dramatically. So the hospital shut it down because it lost them money.”

- Interviewee for The American Health Care Paradox

Key Questions for the Future

What should we pay health care to deliver?
For what population should a hospital be responsible?

Traditional Health Care Sector

Those that walk through the door

Those that are assigned to it

Those in a designated geography

What should health care’s role be in creating health?

Skilled Nursing

Job Training

Home Health

Rehab Centers

Housing

Closing Thoughts

• Traditionally, we’ve tried to solve health care challenges by intervening in health care markets and policies. It’s not worked.

• We need systems-level thinking to make sustainable change. (This is not necessarily intuitive.)

• Plotting a new course forward will require bold physician leadership, and primary care is especially well suited to lead.

• The next phase of discussion is not about “What should we do?” but “Who should do what?”
Looking forward to learning from you.

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The aim of medicine is to prevent disease and prolong life – the ideal of medicine is to eliminate the need for a physician. (1928)

We have never been allowed to lose sight of the fact that the main purpose to be served by the Clinic is the care of the sick. (1935)

My sense is that the near-term business case exists for all hospitals to do something out-of-the-box for some population of patients.
Longer term, the case probably depends more heavily on access to capital and leadership’s value base, risk tolerance and vision for the future.

Shifting, Complex Policy Landscape

1. Expanded insurance coverage in many states
2. Renewed focus on community benefit spending requirements
3. Shift to a more outcomes-based or value-based financing mechanisms

What impacts the math for a given hospital?

- State-level policies and regulatory schemes (How FFS or VBF?)
- Population being targeted (Who is the payer, what are the rates?)
- Organization type and business model (Non-profit, for-profit?)
- Leadership’s value-base, risk-tolerance, vision for organization
Why might hospitals be a leverage point?

• Hospitals have a timeframe, consumer engagement and skills in order to make changes that policymakers often cannot. They can shape consumer behavior.
• Hospitals are where the lion’s share of health care resources are currently invested.
• Providers can stymie policies if they aren’t on board.

2. What I Think

Hospitals are a key leverage point in transforming the system to be attune to social determinants of health.

A business case is emerging to support hospitals in reaching beyond their traditional roles as providers of acute care.