JAMA Forum: Addressing Social Issues Affecting Health to Improve US Health Outcomes

BY GAIL WILENSKY, PHD *ON* MARCH 16, 2016

In a recent *JAMA Forum*, Ashish Jha, MD, MPH, wrote about tackling the social determinants of health as a process that will require taking "small steps on a long journey." I agree with him about the complexity raised by the social issues affecting health. And his admonition that investments in social determinants such as education, housing, and nutrition may not reduce spending on medical care—especially in the near term—are important warnings.

I want to use a different rationale in advocating more attention to the social determinants of health: they reflect our best opportunity to improve health outcomes reported for the United States that are relatively poor, despite how much we spend on medical care.

For many years, the United States has focused on the need to slow spending on health care. Although levels of spending increases for health care have been historically low during the last 7 years, the higher spending reported for 2014 is expected to continue for the next decade, averaging 5.8% per year. That would bring the share of the gross domestic product (GDP) spent on health care from 17.5% to 19.6% by 2024. The estimated spending growth rate may not be precisely correct, but the end of the recession and the continued numbers of baby boomers entering retirement age guarantee continued upward pressure on health care spending.

Fortunately, there are many strategies available to help slow health care spending, some of which are currently being tried. Some of the most promising pilot projects include various types of payment changes, including bundled payments across clinicians and institutions that reward improved value, as well as changes that encourage the delivery of more integrated, evidence-based care. There are also efforts to provide better, more reliable and easily accessible information on quality and prices.

I'm not suggesting that sustaining a slower rate of growth will be easy. The mixed results reported thus far for many accountable care organizations (ACOs), including the more experienced Pioneer ACOs, suggests otherwise. But sustained efforts in these directions should produce results.

The reason to focus on social determinants of health is the relatively poor health outcomes the country reports, particularly disturbing given our high rate of spending. Even though it should be possible to improve outcomes with increased use of evidence-based medicine and comparative effectiveness research, along with more cogent use of

electronic medical records and payment incentives, a more effective way to improve health is to focus on social determinants.

Focusing on Social Factors

There is substantial evidence that addressing social or nonmedical determinants of health such as early childhood development, economic opportunities, and education is more important than medical care per se for better health outcomes and avoiding premature death. And the role of social determinants for health is as important for developed countries as it is for developing countries. People know that life expectancy tends to be low in the developing world compared with the developed world. But differences in life expectancy for the poorest versus wealthiest populations or for minorities versus the majority population in developed countries are also large. Life expectancy, for example is just 63 years for black men in Washington, DC, compared with 80 years for white men in affluent, adjacent Montgomery County.

I and the other 19 commissioners on the World Health Organization (WHO) Commission on the Social Determinants advised the agency that beyond health legislation, improving health and reducing differences in health outcomes required more focus on the social factors affecting health: daily living conditions, healthy places to live and work, investments in early childhood development, and recognizing the health effects resulting from all legislation. When so much attention has been focused on the health care system these past 7 years—an understandable preoccupation when 15% to 16% of the population is without health insurance—it is easy to forget how much more effective focusing on the social determinants can be for improving health outcomes, especially for children.

Former US Surgeon General David Satcher, MD (another WHO commissioner) and I raised this point in an article jointly written after the commission reported its recommendations for action to the WHO's Director-General. Improving the conditions that shape early childhood development can enhance opportunities for health throughout a lifetime. Conditions such as obesity, cardiovascular disease, cancer, and mental health problems often have their roots in the early years of life. Programs that address the needs of children with very low food security are important, as are the various food programs for pregnant and postpartum women. Similarly, investing in early childhood education, especially for individuals living in poverty, can be a cost-effective strategy for preventing disease and increasing productivity later in life.

A Healthy Early Start

Efforts to reduce substance abuse are also important for young adults and for pregnant women in particular. Too many children start life with serious medical challenges because their mothers had substance abuse problems. These women almost always are covered by Medicaid or other insurance, but for various reasons don't receive the help they need—a reminder that coverage is important but frequently not sufficient to ensure that care is available. Securing a healthy start in life for children and improving living conditions for adults will require a more integrated policy environment than typically occurs in the United States, although the increase in capitated health care make

this easier to occur than the past silos of health care. Responsibility for full health care encourages insurers to look beyond the narrow provisions of traditional health care plans. However, most plans focus primarily on better aligning the provision of traditional medical care than expanding their mission to include the social determinants of care.

The potential flexibility for states to innovate in the delivery of care that seemed to be part of the ACA with its 1332-waiver process is now looking to be more constrained. The waivers are limited to direct ACA coverage, require budget neutrality in each year, with at least the same number of people covered and receiving as much coverage as without the waiver. More importantly, the waiver process doesn't create opportunities to count savings from other government programs, such as Medicaid, for purposes of calculating budget neutrality.

When I was a policy adviser to President George H. W. Bush, the city leaders of Atlanta, with assistance from the Carter Center, approached the White House with a request to be allowed to pool their federal resources to provide their residents with better care and support through health and other social service programs. The federal resources, along with commitments of support from the business community, were believed to be adequate—just in the wrong buckets, with too many silos separating (and duplicating) programs. The White House was very supportive but recognized the prospect of getting all the committees of jurisdiction to waive control over all the federal programs in question was too daunting.

We spend enough money on health care and other social services to improve health outcomes. We just spend it badly.

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