BROOKINGS

OP-ED

Social spending, not medical spending, is key to health

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Given the cost of health insurance, prescriptions, and deductibles, few Americans would be surprised to learn that we spend a much higher proportion of our economy on healthcare than other major countries. The major European countries, for instance, spend between about 9 and 12 percent of their GDP on health services. We spend more than 17 percent.

But despite this heavy investment in medical services, we actually have similar or worse outcomes on several key measures of health, such as infant mortality and the prevalence of chronic diseases. So why do we get so little when we spend so much?

A clue comes from the balance of spending in America between medical services and social services, including such things as housing assistance, food aid, and child support. Medical experts are increasingly coming to the conclusion that improving these "social determinants" often results in better long-term health than does intensive and expensive medical care. That's led to such developments as the American Academy of Pediatrics urging its members to screen all patients for food insecurity as a way of tackling poor childhood development and health problems in adolescence. Doctors and hospitals are beginning to ask more questions about the home life of their patients, and the supports in their community, and some are even taking steps to help patients to enroll in such services as housing or food assistance.

The US is very much the outlier on spending devoted to social services compared with medical care. The major (OECD) countries on average spend about $1.70 on social services for each $1 on health services. But the US spends just 56 cents per health dollar. Yet research shows that basic measures of health in countries are more closely and positively associated with social service spending than with health spending. That's also true when you look at different states within this country; states with a higher ratio of social to health spending have significantly better health outcomes in many areas, including adult obesity, diabetes, lung cancer, asthma, and heart disease.

It's hard to escape the conclusion that we should gradually be redirecting a lot of money from medical services to the so-called "upstream" factors that are associated with health.

Better to spend money on prevention, in other words, than on expensive medical repair shops after the damage has been done.

Deciding to redeploy money in this way would be no easy task, unfortunately. For one thing, we could expect fierce resistance from a health sector concerned about protecting its revenues and jobs. But one way to reduce that opposition would be by deciding to deliver more social services from within the health sector. Fortunately some forward-looking health systems, like Dignity Health and Trinity Health, are pointing the way for others, by already investing in community health workers, housing, nutrition, and other upstream factors.

Government budget silos are also a problem. When systems like Dignity and Trinity invest in nonmedical services, these investments often generate value in other ways that are linked to better health, such as improved high school and college graduation rates, and higher government tax revenues due to more people working regularly. But Medicaid and other government health programs often do not cover this nonmedical investment, and so there is a financial disincentive to making them. We need to change budget and payment rules in order to encourage hospitals and health professionals to diversify and address social conditions.

Another obstacle is that sharing information on individuals is difficult. Thus, it is usually hard to bring together in one place the full range of information on a person's housing conditions, educational progress, medical history, and other aspects of their life. Partly this is because of understandable concerns about sharing private information. It's also due to technical problems, such as computers and databases that don't "talk" to each other, and also bureaucracies that simply don't like sharing information. But without effective and secure data-sharing, it is very difficult to identify which resources could be best used to improve somebody's health over the long-term. In addition, it is harder to study which services are most effective in improving health for certain types of people, making policy reform more guesswork and less evidence-based. So we need to address these problems as well to have confidence that switching health spending into social services will significantly improve the community's health.

The spending numbers show that we clearly have the will and the money to improve the health care of Americans and to address health inequities. But we have got to realize that improving health and spending money on health services is not necessarily the same thing.

Editor's note: This piece originally appeared in Inside Sources.