



Milbank Memorial Fund

## **EXECUTIVE SUMMARY**

# Investing in Social Services for States' Health: Identifying and Overcoming the Barriers

by Erika Rogan and Elizabeth Bradley

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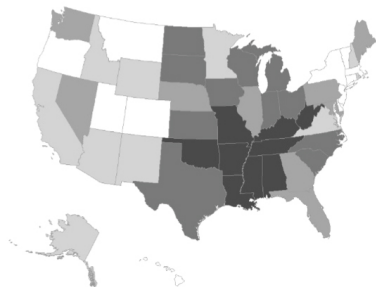
## Introduction

The United States spends a greater percentage of its gross domestic product (GDP) on health care than any other country in the world, but has poorer health outcomes than many other industrialized nations.<sup>1,2</sup> As the financial burden of health care continues to grow, policymakers and researchers alike are interested in understanding why such a mismatch exists and how to resolve it. Evidence suggests that the paradox of high spending and poor health outcomes may be related to an overemphasis on health care—the medical services focused on addressing clinical conditions rather than on health—the aggregate state of well-being that is influenced by medical, social, behavioral, and environmental factors.<sup>3,4</sup> In the public health literature, services targeting the non-medical determinants of health—social services such as income support, education, transportation, and housing programs—are envisioned as “upstream”<sup>5</sup> from medical determinants because they shape the contexts in which health system interactions occur, individuals behave, and biological systems function.

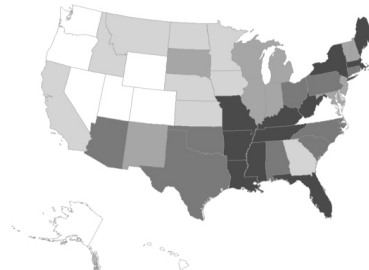
Substantial research has demonstrated that investments in social services can improve health outcomes and reduce health care costs.<sup>3,6-8</sup> Research has shown that across countries, higher levels of spending on social services relative to health care (i.e., a higher ratio of social spending to health care spending) is associated with better performance on several population-level health measures.<sup>9</sup> Similarly, a recent study<sup>10</sup> found that, within the United States, higher ratios of social services (including public health services) spending to health care spending were statistically associated with better health outcomes at the state level. This result was found across a wide variety of health outcomes, including obesity, asthma, mentally unhealthy days, days of activity limitations, postneonatal mortality, and lung cancer mortality (see examples in Figure 1), even when accounting for the states’ sociodemographic, economic, and political characteristics.

Figure 1: State Social-to-Health Spending Ratio and Selected Health Outcomes, by Quintile (2009)<sup>10</sup>

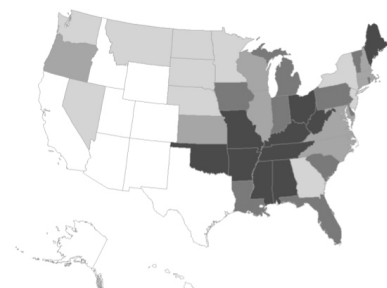
a) Percent of adult population that is obese



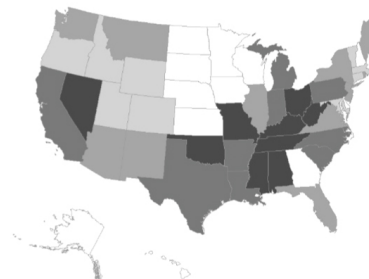
b) Percent of adults who reported 14 or more days in the last 30 days as mentally unhealthy days



c) Lung cancer mortality rate per 100,000 population



d) Social-to-health spending ratio



**Legend (a,b,c):** dark gray indicates highest quintile (i.e., poorest health outcomes) and white indicates lowest quintile (i.e., best health outcomes).

**Legend (d):** dark gray indicates lowest social-to-health spending ratio; white indicates highest social-to-health ratio.

## Our Study

To better understand the implications of this work for state policymakers, the Milbank Memorial Fund (MMF) partnered with researchers at Yale University to conduct a study to elicit state officials' perspectives on these emerging research findings. The study included a strategic problem-solving approach<sup>11</sup> conducted with a diverse group of state officials from the MMF's Reforming States Group in a one-day session and site visits carried out in Vermont, Kentucky, Rhode Island, and San Diego County, California. During the one-day session, participants were asked to consider an agreed-upon problem statement. They conducted a root cause analysis and assessed strategies to address the problem.<sup>11</sup> During the site visits, a Yale researcher held interviews with various state and local government officials to ascertain a deeper understanding of states' experiences with health and social services investments and programming.

## Key Findings

### Problem statement and objective

After discussing and revising an initial problem statement drafted by the study team, participants concurred that the primary problem to be resolved is that “states do not make overall budget and policy decisions that optimize the health of the population in the state.” Framing and restating the problem from the officials’ perspectives helped align the group for the discussion on an attainable objective: “to inform and improve overall budget and policy decisions to optimize the health of the population in the state.”

### Root Causes

After a consensus on the problem statement and objective was reached, the discussion turned to identifying the root causes of the problem. A *root cause* is a causal factor that drives an identified problem; it is an issue whose reduction, resolution, or removal would eventually solve the problem at hand.<sup>11</sup> State officials were encouraged to identify the core “upstream” issues whose removal would ultimately improve upon suboptimal investments in health. Participants outlined three root causes to the problem statement:

- 1. The health of the state’s population is not always prioritized relative to other societal goals in the states.** Participants commented that state population health competes with other political and social issues for attention and resources. They acknowledged several reasons for why health may be superseded by other policy issues, including relatively low public attention to population-level health and measurement complexities that limit the evidence base for policymaking.
- 2. Incentives, including financial and political incentives, to improve health are misaligned.** State officials widely agreed that financial and political incentives are not consistently aligned with the evidence of effective ways to improve health, leading to suboptimal investments. In the health care sector, participants observed misaligned incentives that encouraged service volume over quality, or disregarded broad health goals by focusing primarily on costs or predetermined targets. Across sectors, officials noted that social service agencies do not necessarily see health outcomes as within their purview, which can limit their engagement and investment in state health initiatives. In particular, these agencies may not be willing to dedicate resources to programs whose returns (e.g., cost savings) are mostly captured in another sector. Despite the potential advantages of “all-hands” approaches to promoting health (e.g., Health in All Policies), participants cautioned that incentive misalignment across sectors results in decision-making silos in which agencies or organizations consider only their own investments and benefits. Officials also pointed out that political incentives, related to institutional features such as interest group lobbying or short policymaking timelines, may direct attention and resources away from opportunities to improve state health

- 3. There is a lack of consensus regarding who is responsible for health.** Participants in the session noted a lack of consensus regarding who has—and who ought to have—responsibility for keeping populations healthy. They cited several accountable parties, ranging from individuals themselves<sup>12</sup> to collectives<sup>13,14</sup> such as families, communities, employers, health care providers, and varying jurisdictions of government. Although they agreed that accountability is shared across multiple actors in practice, the officials noted that the ambiguity, subjectivity, and inconsistency regarding responsibility for health results in fragmented health promotion efforts that have little likelihood of success and may even be counterproductive.

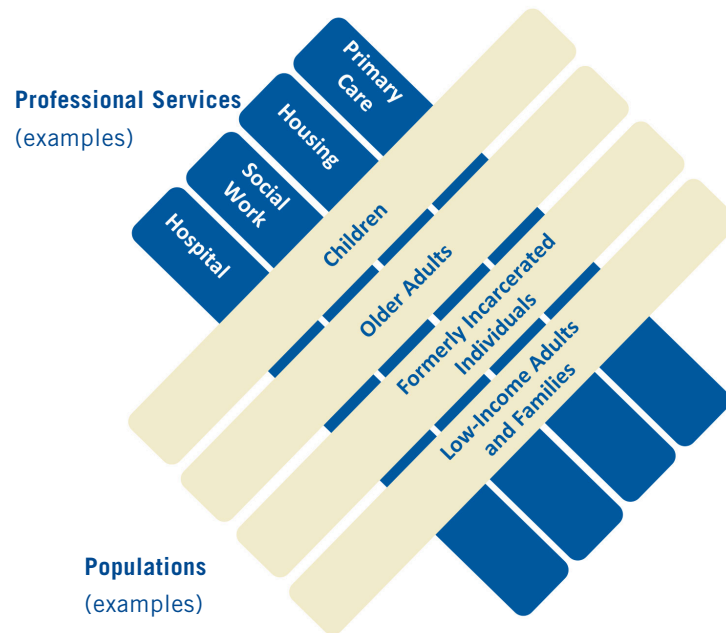
## State Strategies to Address Root Causes

Despite the widespread challenges identified in the session, government agencies and their partners across the United States are nonetheless taking action to make populations healthier. We sorted our findings into four broad strategies:

- 1. Cultivating legitimate public-sector leadership.** Site visits revealed that leadership is vital to overcome the frequently balkanized nature of health care and social services administration. Having a person in a leadership position with a vision of bridging divides between social and health sectors was seen as a cornerstone of improving the health of state populations. Although the leadership roles varied from site to site, these individuals were similar in that they were trusted by their colleagues and partners; they took action to encourage collaboration within their home agency and with other organizations; they leveraged windows of opportunity (e.g., new organizational structures); and they were attuned to community-level leadership activities (e.g., grassroots initiatives).
- 2. Navigating the political environment.** The work of politics—understanding, navigating, and negotiating among competing individual and institutional interests—was acknowledged as an ongoing influence on efforts to improve state health. Participants observed that politics at all levels of government have impacts on state program financing (e.g., relative and absolute funds available for services), service administration (e.g., emphasis on direct or contracted service delivery), and organizational structures (e.g., extent to which health and social service agencies are integrated). They pointed out that political turnover was a persistent barrier to achieving health goals; for government staff and contractors politically-driven changes in services often meant learning new processes, producing new materials, and shifting focus to new objectives. While state officials recognized the power of politics to stymie progress, they also emphasized the importance—and possibility—of finding common ground among political stakeholders. Participants described several examples of bipartisanship in which state policymakers leveraged shared objectives (e.g., cost containment, improved quality) rather than focusing on points of contention.

- 3. Using evidence to support decision making.** According to state officials, data are critical to monitor the needs of the community and evaluate the performance of interventions. In some areas, comprehensive data collection efforts were used as a way to collaborate across groups in health and social sectors; agencies have come together to determine appropriate measures and gather information. Some states are currently working toward integrating IT systems so that data can be more readily linked. Participants described the importance of evidence to demonstrate value, which could increase support for scaling up and sustaining the policy or program. Performance evaluation data was noted as particularly necessary for health initiatives that incorporate social services in order to appeal to funders who may not initially trust the connection between social services and health outcomes. Some localities chose to implement pilot programs as an approach to demonstrating value to grant organizations or government agencies. State officials also identified several challenges to developing and acting on evidence, including unwillingness to share information, uncertainty in selecting measures, and representativeness and standardization of data. Some participants mentioned that they look to their neighboring states for ideas on how to address these challenges, while others seek guidance from federal agencies.
- 4. Targeting populations that have high medical and social needs.** In their efforts to coordinate social and health services, many states are targeting groups that have high social and medical needs. Some of those groups included children, older adults, people with disabilities, individuals transitioning out of correctional facilities, and low-income families (i.e., people who are typically eligible for numerous assistance programs). Because these individuals are associated with a high financial cost of care and administration, they present the greatest opportunities to improve service delivery and align incentives.<sup>15-20</sup> Sometimes, agencies are legislatively mandated to coordinate and budget for certain populations in the state. This population-driven approach delivers services based on the needs of a group,<sup>21</sup> in contrast to the professionalized approach, which organizes care based on service provider expertise (See Figure 2). According to some participants, cross-sector collaboration for target groups offer starting points for more comprehensive coordinated efforts to improve the health of whole populations across the states.

Figure 2: Population and Professional Approaches to Service Provision



Although each state context is unique, discussions with government officials and community partners revealed several common experiences nationwide. Our findings suggest that, despite pervasive challenges in decision-making, efforts made in the states—in leadership, political action, data utilization, and targeted programming—demonstrate both the willingness and capacity for state-level actors to enhance health of the population.

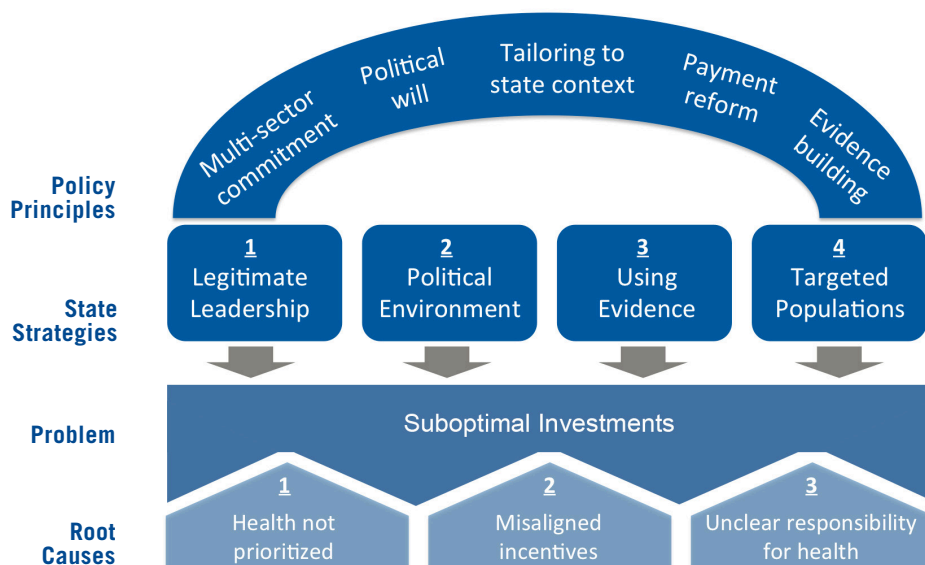
### Policy Principles for Improving the Health of Populations in States

Although different state environments may dictate local strategies in practice, certain values and approaches may be common regardless of setting. Based on our findings, we identified five policy principles to continue moving states toward better health for their populations. Each addresses root causes of suboptimal investments, builds on existing progress in the states identified in the report, and reflects the needs of state and county officials to make effective decisions (Figure 3).

- 1. Multisector involvement and commitment.** Engaging a range of agencies across social and health sectors is important for building relationships, optimizing resources, and ultimately achieving state health goals. Concerted efforts may emerge from political directives or funding opportunities that require shared metrics; however, participants explained that external pressures are not sufficient for successful multi-sector commitment. Officials emphasized the importance of early engagement and formalized partnerships—including those with philanthropic and private organizations—for successful and sustainable collaboration.
- 2. Gaining political will.** According to participants, political will among executive and legislative policymakers drives state objectives and efforts to improve the health of the population. They commented that state leadership must not only rally support

among state government officials but also account for the perspectives of decision makers at the federal and local levels. The officials described leveraging a “galvanizing” issue, simplifying complex population-level health problems, and effectively translating evidence into action as approaches to build political will.

Figure 3: Policy Principles for Improving the Health of Populations in the States



3. **Flexibility in tailoring programs to a state’s context.** Developing policies and programs that are unique to state population needs may be more effective than standardized interventions because they fill specific, local gaps.<sup>22-24</sup> The ability to modify investments to the specific context and needs of the state may encourage data sharing among stakeholders, enhance program implementation for target groups, and more closely align efforts with local norms and values.
4. **Commitment to payment reforms to align incentives with broader health goals.** Officials acknowledged the strength of incentives in all aspects of promoting state health. They expressed a desire for provider payment reforms within health care and encouraged shared accountability across the social and health sectors to reflect more holistic health goals for state populations. Within health care, participants supported reforms that move away from volume-based payment structures and focus instead on care quality and coordination. Across sectors, they suggested an integrated reward system associated with both social and health outcomes as an approach to steering efforts of separate agencies in the same direction.
5. **Evidence to initiate and sustain programs.** Evidence plays an important role in decision making to improve health of populations in the states. Findings from research



studies and local assessments can demonstrate health needs in the state, offer recommendations for intervention designs, and provide rationale for next steps in policy implementation. Although engaging in research activities and developing cross-sector database interoperability may require substantial time and resources, state officials underscored such investment as a foundation for strategic coordination in the future.

For many states, improving the population’s health has remained an elusive but persistent goal. Although officials seek to optimize health in their states, policy decisions and investments do not necessarily align with the evidence regarding promising approaches. Specifically, state interventions do not regularly “move upstream”—that is, social services to promote health are not consistently being used before expensive health care services (“downstream”)—even though research strongly suggests that more attention to nonmedical determinants can benefit health outcomes for the population. This study offers insights into this apparent contradiction from the perspectives of state officials, as well as the current efforts by some states to incorporate both social and health services in their health improvement activities. By discovering and following the paths that lead upstream, state officials can make policy decisions that enhance service delivery, maximize the impact of existing resources, and improve the health of their populations.

## Notes

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