SOMOS COMMUNITY CARE

From the desk of the CEO
Mario J. Paredes

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Effective healthcare reform requires focus on social determinants of health

ANOTHER STUDY has revealed that the US spends considerably more per capita than other developed nations—but that higher spending is not a reflection of Americans making more use of healthcare. The findings by the Johns Hopkins Bloomberg School of Health show that US healthcare is simply more expensive.

The study finds that in 2016 per capita health care spending in the US stood at nearly $10,000 , some 20 percent higher than spending in Switzerland, coming in at second place at almost $8,000, and more than twice the health care spending in Canada, which stood at approx. $4,700; and the US spends 145 percent more than the average of some $4,000 in other developed countries. What's more, US per capita annual spending on healthcare more than doubled between 2000 and 2016. But Americans are none the healthier for it.

An important new book by Robert Kaplan, director of research at the Stanford School of Medicine Clinical Excellence Research Center, puts the new data in perspective. In "More than Medicine: The Broken Promise of American Health" (Harvard University Press), the former associate director of the National Institutes of Health cites various studies that show that, measured in terms various longevity indicators, the US fares very poorly compared to mortality rates in 17 other developed nations—including when it comes to mortality rates before age 50.

Kaplan concurs that US healthcare—in terms of the price of drugs, salaries for medical personnel, hospital administrative costs, and the cost of medical services across the board—is too expensive. But he goes further and pinpoints what he considers to be a fatal flaw in the American approach to healthcare: "the tendency in the United States … to double down on fighting disease at the cellular level." Too much money, he charges, is going toward biomedical research," which reflects reliance on "a fundamentally mistaken, mechanistic view of the human."

He continues: "Our tendency is to impute great power to a system driven by medical interventions, and to deemphasize the effects of social and behavioral risk factors." In sum, the American healthcare system fails to pay proper attention to the social determinants of health, Kaplan insists, adding: "the biomedical paradigm is well-intentioned, but it is crowding out the kinds of effective heath care interventions most urgently needed."

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In a major chapter that forms the heart of his book, Kaplan surveys the various ways social factors impact individuals' health. Citing various urban studies, he demonstrates a "systematic relationship between health and social conditions such as wealth and poverty," "an unmistakable correlation between inequality and poor health;" "for every incremental increase in inequality, there is a decrease in longevity." The impact of poverty, Kaplan writes, is "particularly striking in the case of children, because deprivation in childhood carries forward throughout the life course."

Being poor and living in a poor neighborhood most often means residents must cope with greater pollution, unhealthful living conditions, reduced access to healthy foods, etc. Kaplan also argues that "race is systematically related to health outcomes," as the "consequences of racial discrimination can also place people in risky environments." On this score, he cites the water crisis in Flint, Michigan, "a poor, minority-majority city [that proved] vulnerable to environmental and urban planning failures."

Kaplan also calls attention to the "strong relationships between social support and health outcomes," citing research showing that "those who were more socially connected, as measured by self-reported number of social contacts, had significantly greater longevity than those who were less connected." On this front too, being poor and of minority background puts individuals at a disadvantage.

Finally, Kaplan turns to the impact of education, or the lack thereof, as another key social determinant of health, and another realm where poverty and race play a negative role. He reports that "the difference in life expectancy between those with less than a high school education and those with an advanced degree is 10 to twelve years"—and "ensuring that everyone gets a high school education could prevent an estimated 240,000 deaths a year." The more education a person has the less likely he or she is to smoke, neglect exercise, indulge in an unhealthy diet and become obese, etc. Kaplan believes that "education is more important to health than are other social effects."

Kaplan argues that a "socially conscious approach" to healthcare "is a simple matter of doctors and nurses asking patients the right questions"—questions that go beyond medical conditions, questions that probe a person's family situation, educational background, housing conditions, employment and/or educational status, etc.
Kaplan notes that "we are in the early stages of understanding social determinants of health." Yet, SOMOS Community Care, a network of 3,000 independent physicians—mostly primary care doctors—serving some 600,000 minority Medicaid recipients in New York City,

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has begun asking "the right questions" for some years now. Doing so, and creating a comprehensive patient profile, enables doctors to provide holistic care that considers all the factors—medical, psychological and social—that impact a patient's health.

SOMOS operates as a Performing Provider System under the mandate of Delivery System Reform Incentive Payment (DSRIP) program. At its core, the unique experiment of the New York State Department of Health, is driven by the Value-Based Payment model, delivering Value-Based Care; doctors are compensated, not according to the number of discreet transactions, such as tests and office visits, but according the longer-term health outcomes of their patients.

To deliver better, comprehensive and personalized care—which hinges on the doctor establishing a relationship of trust with the patient, thus filling a role once played by the neighborhood family doctor of old—the social determinants of health simply must be considered. The SOMOS team of Community Health Workers are the eyes and ears of doctors when it comes to getting to know a patient's social circumstances. Such a highly proactive approach is key to the billions of dollars in savings for New York State taxpayers from the DSRIP program keeping people out of hospitals.

In fact, DSRIP's architect, Jason Helgerson, the former Medicaid director of the New York State Department of Health (and presently a consultant for SOMOS), has called attention to the social determinants of health from the very start of the DSRIP program in 2015. For Helgerson, the primary care doctor is called to be genuine community leader, someone who helps galvanize the efforts of community activists who specialize in helping people in the gamut of social areas: employment, education, criminal justice issues, poverty, etc.

Kaplan cites statistics showing that healthier nations like Sweden, Belgium, Denmark and Germany spend considerably more on social services than on healthcare, about $2 on non-health social services for each 1$ spent on healthcare; the US spends about $0.55 on social services for each $1 spent on healthcare. Professor Kaplan argues that policy-makers should think seriously about expanding social services, "even if doing so might result in diverting resources from health care" proper.

Given the mounting evidence that social factors can impact physical and mental health for good and ill, Professor Kaplan's fellow travelers at SOMOS Community Care could not agree more.