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Developing a Balanced Investment Strategy

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Many factors influence population health including: health care, social and economic supports, and the environment. Achieving the best population health outcomes for dollars spent in a region requires a balanced investment strategy that recognizes the contributions of all the determinants of health and is informed by local needs and preferences. Most regions in the United States are fortunate to have ample resources available for investment in health, but these resources are not being invested wisely. Redirecting existing resources, most of which are locked in a poorly organized and wasteful healthcare sector, is very challenging.

It is well documented that the U.S. spends far more on health care than all other industrialized countries while achieving poorer health outcomes on a wide array of indicators (Institute of Medicine, 2013). The Institute of Medicine (IOM) estimates that one-third or more of healthcare expenditures represent waste, attributable in no small part to fee-for-service payment programs that reward providers for volume of services rather than value; encourage fragmented, specialty-based service programs as opposed to coordinated systems of care; and over-value specialty and hospital services and under-value community-based primary care and social supports (IOM, 2010).

Other countries spend far less on health care and a larger share of their total resources on social and economic supports (e.g., pensions, disability, employment programs, housing subsidies (Bradley, et al., 2011). As shown in Exhibit 1, although the U.S. ranks first on healthcare expenditures when compared to 30 industrialized countries, many other industrialized countries outspend the U.S. on combined healthcare and social service expenditures. Absence of a comprehensive approach to managing individuals' needs for health care and social services fuels higher healthcare costs due to avoidable hospital readmissions and emergency visits. It is estimated that 25 percent of hospitals admissions and 60 percent of ambulatory emergency department visits would have been avoidable if there were adequate supports and coordination in the community (MedPAC, 2012).

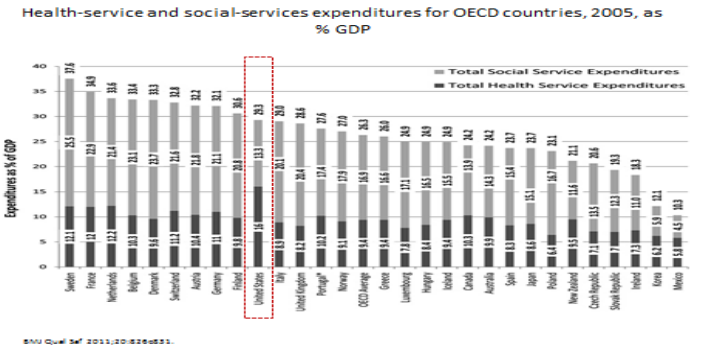

Exhibit 1: Health-service and social-services expenditures for OECD countries, 2005, as % of GPD

Growing evidence also points to the importance of pursuing a more balanced health investment strategy that recognizes and leverages the contributions of all of the determinants of health. As illustrated in Exhibit 2, the U.S. currently invests most of its health resources in health care, yet it is estimated that health care accounts for only about 10 percent of population health (NEHI, 2013).

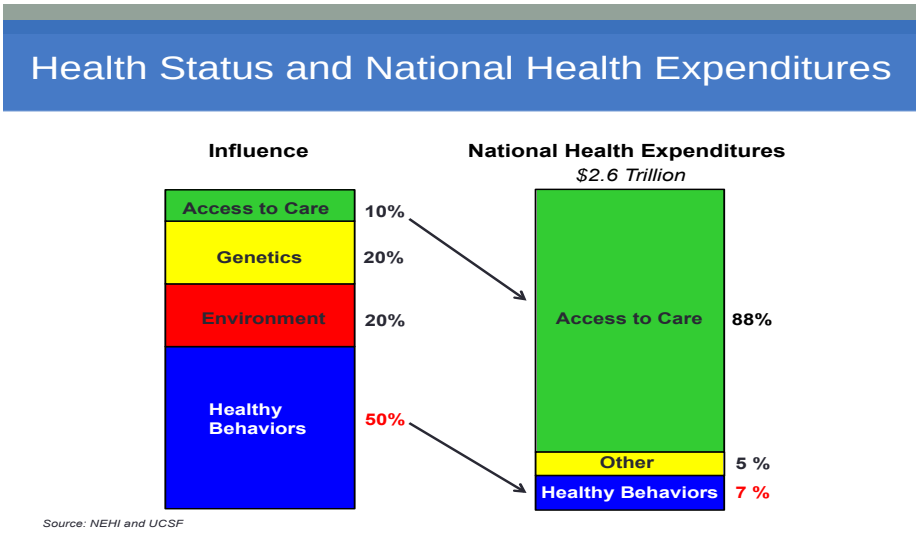

Exhibit 2: Health Status and National Health Expenditures

Social, economic, and environmental determinants (e.g., income, housing, access to healthy foods, parks and recreational areas, safe walking and biking paths, early childhood education) shape health behaviors from a very early age with significant downstream effects on health outcomes and healthcare costs (RWJF, 2013), and yield very positive returns (see Exhibit 3). If the U.S. could redirect even a portion of the estimated $750 billion in healthcare waste to non-health care determinants, the return on investment in terms of a healthier population and more vibrant economy would be enormous and the results transformative for American society (McCullough, et al., 2012).

Exhibit 3: Return on Investment

It also is important to note that health and health care are not equitably distributed. Disadvantaged racial and ethnic groups exhibit poorer health than whites; and recent years have seen growth in disparities in life expectancy between individuals with high and low income and between those with more and less education (Congressional Budget Office, 2008). Ten percent of the population accounts for nearly two-thirds of healthcare spending (Conover, 2011), and high healthcare utilizers are disproportionately located in low-income neighborhoods (Gawande, 2011). Some of the highest returns on investment in terms of better health and lower healthcare costs can be achieved by targeting disadvantaged sub-populations.

Characteristics of a Balanced Health Investment Strategy

It is apparent that closing the health disparity gap and "bending the healthcare cost curve" requires shifting the center of gravity from a provider-driven *healthcare* system to a community-centered *health* system—also referred to as "bridging" health and health care. Recent changes in healthcare financing and delivery, some tied to provisions of the Affordable Care Act and others to state health reform initiatives, have opened up opportunities for the diverse stakeholders in local communities and regions to organize around shaping new healthcare payment programs and delivery systems to achieve better outcomes and remove waste; and to provide greater flexibility at the local level to pursue a balanced health investment strategy.

To enhance population health and lower healthcare costs, these regional multi-stakeholder groups will need a health investment strategy that:

- Provides adequate health resources, both capital and ongoing programmatic funds, and some degree of flexibility to direct resources;
- Maximizes the contributions of the full set of health determinants and also recognizes interdependencies (e.g., frail elderly need health care *and* social supports to achieve desired health outcomes);
- Balances near- and long-term returns recognizing that some very high-yield investments take 15 or more years to realize; and
- Strives for equitable distribution of both health and costs.

In developing a strategy, a region will want to take stock of its current health resources, which typically fall into four major categories (see Exhibit 4). The bulk of resources are currently devoted to *personal health care* financed through public and private insurance plans and much of these resources are wasted due to poorly designed payment and delivery systems. Regions also have resources devoted to *personal social supports* (e.g., home health aides, meals on wheels, transportation assistance, senior centers) financed through a variety of sources including: state block grants, county tax revenues, philanthropy, volunteerism and private pay. These two categories represent *personal services* in need of greater coordination and integration to better address interdependencies (e.g., a frail elderly living in the community needs social supports to avoid re-hospitalization).

Exhibit 4: Four categories of health expenditures

Most communities have policies and programs aimed at encouraging people to adopt healthy behaviors (e.g., educational programs targeted at adolescents to avoid tobacco and elicit drugs; exercise programs) and adhere to evidence-based prevention guidelines (e.g., colonoscopy screening). Examples of funding sources for these types of programs in this third category include: the U.S. Centers for Disease Control and Prevention, state and local public health departments, major employers support for health and wellness programs; hospitals' community benefit contributions to community health improvement programs; and private expenditures (e.g., dues to health club).

The fourth category is comprised of the wide variety of investments—most sponsored by the non-health sectors—focused on social, economic, and environmental determinants. Although generally not thought of as part of a region's health budget, many of these programs either contribute to the health of residents or represent costs incurred as a result of poor health. Examples of programs that contribute to better health include: public transportation, subsidized housing, parks and recreation, jobs training, early childhood education and clean air. Programs that represent costs incurred as a result of poor population health, some of which might be avoided with increased upstream investments, include homeless shelters and prisons.

In all four categories, there are both public and private sector expenditures, which can be difficult to ascertain. Per capita expenditures under public health plans (e.g., Medicare and Medicaid) are readily available, but this is not always the case with private health plan expenditures. Personal, out-of-pocket expenditures are generally not available, although a rough ballpark estimate may be derived from other sources (e.g., national health expenditure survey data). Public sector expenditures in all of the other three categories flow through a variety of federal, state, and county block grants or categorical programs oftentimes with very different geographic configurations at the regional level. For example, a recent analysis of public sector health investments in Wisconsin counties in selected categories of health care, public health, human services, income support, job development, and education encountered serious challenges in data usability and accessibility (Casper & Kindig, 2012).

Key to a region's success in bridging health and health care will be its ability to invest health resources wisely. Most regions in the U.S. have considerable public and private sector resources already being invested in health, but regional leaders have limited understanding of how the resources are currently

being spent, lack a well-thought out strategy for how the resources should be spent, and have limited ability to redirect the flow of resources.

There are many steps that regional coalitions can take to pursue a more balanced health investment strategy including: coordinating and aligning current investments across and within sectors; working in partnership with health systems to effectively transition to global payments that enable integration of health care and social supports; and skillfully leveraging funding from health insurance, community development financing, and private investors to provide additional resources for enhancing non-health determinants. Most regions will want to pursue efforts in all three areas to expeditiously move to a balanced investment strategy.

Works Cited

Bradley, E. H., Elkins, B. R., Herrin, J., & Elbel, B. (2011). Health and Social Services Expenditures: Associations with Health Outcomes. *BMJ Qual Saf , 20*, 826-831.

Casper, T., & Kindig, D. S. (2012). Are Community-Level Financial Data Adequate to Assess Population Health Investments? *Preventing Chronic Disease , 9* (E136), 1-9.

Congressional Budget Office. (2008, April 17). *Growing Disparities in Life Expectancy.* Retrieved from Issue Brief: www.CBO.gov/sites/default/files/cbofiles/ftpdocs/91xx/doc9104/04-17-lifeexpectancy_brief.pdf

Conover, C. J. (2011, November 22). *The Health Spending 1 Percent: The Healthcare Fact of the Week.* Retrieved from American Enterprise Institute : www.aei-ideas.org/2011/11/the-health-spending-1-percent-healthcare-fact-of-the-week/

Gawande, A. (2011, January 24). The Hot Spotters. *The New Yorker* .
Institute of Medicine. (2002). *The Future of the Public's Health in the 21st Century.* Washington: National Academies Press .

McCullough, J. C., Zimmerman, F. J., Fielding, J. E., & Teutsch, S. M. (2012). A Health Dividend for America: The Opportunity Cost of Excess Medical Expenditures. *American Journal of Preventive Medicine , 43* (6), 650-654.

MedPAC. (2012). *Population-based Measures of Ambulatory Quality: Potentially Preventable Admissions and Emergency Department Visits.* Washington .

The Network for Excellence in Health Innovation & The Boston Foundation. (2013). *Healthy People Healthy Economy: Third Annual Report Card.*

RWJF Commission to Build a Healthier America. (2013). *Overcoming Obstacles to Health in 2013 and Beyond.* Robert Wood Johnson Foundation.