2. NOT EASY—JUST EASIER THAN ANY OF THE OTHERS

22 August 2026

Winning affordable high-quality health care for all Americans is the easiest problem to fix. First, because it is the only problem on which—by all standards—we already spend enough money.

Second, it is the easiest not because it is easy but rather because all the others are harder.

Addressing each of the other challenges you, I, or other people care about—rebuilding manufacturing capacity, investing in clean energy and addressing environmental pollution, housing all Americans well, speeding transportation, educating for good citizenship and good jobs, renewing infrastructure, winning neighborhood security and fixing criminal justice, financing defense, and all other problems—will require more money.

A. 1 – 2 – 6

One reason all these other problems are hard is that health care sponges up money that would be available—and is available in other rich democracies—to finance greater investments to address the other problems.

What does it mean to assert that Americans already spend enough money on health care? Enough for what? Not immortality, so far. Not all the care that anyone might conceivably want. But rather "*health security—confidence that each ill or injured American will get appropriate, competent, kind, and quick medical care without worrying about the bill*."

Ten out of nine Americans don't know how much we spend on medical care.

By 2025, the three types of spending were in a ratio of 1 to 2 to 6, as shown in Exhibit 2 - 1.[1099]

I regularly ask smart health care reporters to rank yearly total spending on defense, education, and health care in the U.S. In the past three years, only 3 health care reporters out of some 58 polled correctly labelled defense spending as 1 (about $850 billion yearly), education spending as 2 (about $1.7 trillion, roughly double defense spending), and health care spending as 6 (about $5.6 trillion in 2025, or six times defense spending). Almost all ranked defense spending highest.

(Perhaps this should not be surprising. Only 36 percent of Americans passed a multiple-choice U.S. Citizenship Test. Only 13 percent knew when the Constitution was ratified and only 40 percent knew which nations the U.S. fought in World War II.[1100])

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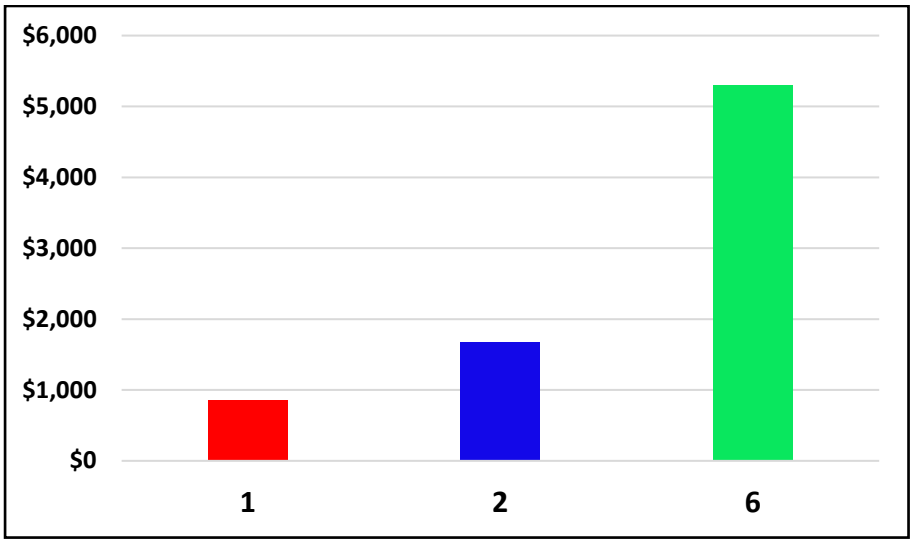
In 2026, health care spending will be a little over $17,500 per American.[1101] [1102]

That is more than double the rich-democracy per-person average. Despite their lower spending, citizens of these other nations typically get more medical care and live longer, as discussed in chapter 3.

Exhibit 2 - 1
Spending on Defense, Education, and Health Care in the U.S., 2025



Since other nations cover all people and provide more medical care and attain better health outcomes while spending much less—and since medical care's failure rate is exactly 100 percent, why do we Americans spend so much on it?

A number of conflicting reasons have been offered. They range
- ✓ from insufficient market competition to excessive competition,
- ✓ from government over-regulation to inadequate or incompetent regulation,
- ✓ from failure to cover all people to excessively generous insurance coverage,
- ✓ from lack of incentives to contain cost to payment methods that reward giving more care,
- ✓ from excessive focus on aggressive treatment to inadequate attention to prevention,
- ✓ from shortages of caregivers to excessive care driven by excessive caregiver capacity, and more.

Many of these topics are discussed in chapters 3, 4, 5, and 8.

All of the big and important decisions, public and private, about U.S. health care are made badly. Why is that?
Partly because we allow notional competitive markets to make most of the decisions. And because we restrict government actions to subsidizing care for many of us, to striving futilely to make markets work by fighting monopolies and by forcing Americans to behave like informed consumers in a market, and to fighting abuses like theft and indecently poor care.

2. Not easy—just easier than any of the others

Market failure and government incompetence allow financial and clinical anarchy to govern U.S. health care. Nothing close to traditional free market competition can be attained in health care for the reasons set out in chapter 4. And traditional government action to protect Americans against health care costs, to make markets work, or to regulate against abuses has not and cannot succeed.

What are the results of bad decisions? Extraordinarily expensive care—so expensive we can't afford to protect all Americans against its cost. Efforts to expand coverage that are matched by efforts to suppress care by covered people. Malconfigured caregivers—too many of some, too few of others, and not well distributed. Very uneven quality of care and outcomes not remotely commensurate with our high spending.

What is a workable alternative?

To rely on careful public action to establish a trustworthy structure for health care:

- ✓ To fully protect all Americans against costs of medical care.
- ✓ To cap spending by analyzing causes of the 4 types of waste—clinical waste, administrative waste, high prices, and theft—squeezing out the fat, and recycling it as clinical bone and muscle. With up to one-half of health care spending wasted today, opportunities to do better are enormous.
- ✓ To advance desirable configurations of care—the right numbers and types and capacities of hospitals in the right places; the right numbers and types of doctors in the right places; and much more adequate long-term care and mental health services. This means identifying needed hospitals and paying them enough to efficiently deliver needed care. It means vast improvement in the number of primary care doctors by paying them enough.
- ✓ To pay needed caregivers fairly and by financially neutral methods that liberate them to deliver needed medical care and to weed out low-value/high cost services.
- ✓ And to raise the floor under health care quality across the nation—to level quality upward.

This publicly-shaped structure should be designed to liberate trusted doctors and other caregivers to serve all of us well.

Public action should, then, enable caregivers to regulate themselves.

All this means overthrowing business-as-usual in today's anarchic and unaccountable U.S. health care—a world of ineffective cost controls, coverage combined with suppression of use of care, and intrusive, ineffective, and unwise private efforts to regulate doctors' decisions about how to diagnose and treat our illnesses and injuries.

It means largely reversing the jobs of public and private action in health care. Governments make a dozen or so large types of decisions that shape the structure of health care. This requires governmental commitment to put its arms around health care needs, problems, and realities. That requires building competence to understand how health care works. And to prepare for the crises described in chapter 1—crises that will make health care reform politically possible and exigent.

But doctors and other caregivers are liberated to make the millions of clinical decisions that marshal the vast sums already available to deliver better care for all of us.

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The result of bad decisions is that we spend so much on health care, protect people poorly, suffer inferior outcomes, and malconfigure our caregivers. (Configuration of caregivers refers to their types, numbers, and locations. This vital matter is dangerously ignored. The care we get depends heavily on the caregivers we've got.)

It's worth noting very briefly here that prevention *also* has a 100 percent failure rate. When illness or injury inevitably strike, actual medical care usually becomes helpful.

Again, I suggest that care's health care's core aim should be medical security for all Americans. That means appropriate, effective, competent, speedy, and kind care—without worrying about the bill, and without fear of liens on property or garnisheeing of wages or debt collectors or bankruptcy.

Winning medical security for all differs from pursuing immortality. Affordable medical security for all Americans is actually attainable, and Americans already spend enough to finance it.

If that's true, why does the U.S. lack medical security for all? Important reasons include weak political commitment to covering all people, financial and political unwillingness to contain health care spending or costs—and acceptance of vast waste of health care dollars, widely diffused clinical and financial anarchy throughout U.S. health care, simple lack of accountability for anything in health care, nearly complete inattention to the actual configuration of caregivers, tolerance of very uneven quality of care, and a number of accidents and misjudgments.

Flipping the sequence: Fix health care first

Many people believe that prevention and greater attention to social determinants of life will save money on health care. I believe that is usually just wishful thinking. We should prevent every harm that's reasonably preventable. But our aim should be better and longer lives, not saving money. We don't ask that health care save money, so we should not ask prevention to save money. We should oppose double-standards.

Rather, fixing health care will save money—or at least dampen health care's appetite for more money to finance business (and waste) as usual.

And fixing health care will liberate money to spend on prevention, social determinants of life, defense, or anything else you may care about. And that failure to fix health care will impair or entirely block our efforts to fix other sectors.

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B. What is medical security?

Assuring medical security—affordable high-quality health care for all people—has three layers. Americans talk loudly but only half-seriously about the first, and ignore the other two.

a. The first is *full financial coverage*. This means that all people have a plastic insurance card stapled discretely to their clothing. The card covers the full range of effective health care services—primary and specialized physician care; outpatient emergency care, labs and imaging care; acute inpatient hospital care; post-acute rehab and long-term care; mental health services; meds; and others. Full coverage entails very low out-of-pocket (OOP) costs to the patient and very low rates of other types of under-insurance.

   Almost one-tenth of Americans are entirely without health care coverage. Most of us are under-insured since we lack coverage for one or more important services and because we are hamstrung by financial and bureaucratic barriers to care. Across rich democracies, Americans pay the second-highest share of costs OOP. This heavily burdens lower-income people and also people who need a great deal of care.

b. The second is *an appropriate configuration of caregivers* who accept everyone's insurance. A plastic insurance card is worthless unless competent caregivers are available, able, and willing to redeem it.

   Such a configuration would mean that the nation has the right types and numbers of caregivers in the right locations. The nation would have the right numbers of primary caregivers, specialist physicians, dentists, hospitals, long-term care facilities, mental health services, pharmacies, and other caregivers in reasonable proximity to where Americans live and work. Caregiver-to-citizen ratios in some U.S. regions are double, triple, or even greater than ratios in other regions.

c. The third is *a commitment to appropriate high-quality care everywhere*. Appropriateness means the right care—the services that are needed to diagnose and treat medical problems optimally. Care is of high quality when it is delivered proficiently and safely.

   Appropriateness and quality of care vary greatly within every region and for every group of Americans. But systematic problems are evident. Lower-income and minority citizens are more likely to receive lower-quality care. So are rural Americans.

   Health care quality and appropriateness are probably distributed in a normal bell-shaped curve. Care below the median is less appropriate and of lower quality—less competently given. The first challenge is first to shift the entire distribution of care in a positive direction. The second is to raise the floor for quality and appropriateness so no groups of people suffer disproportionately.

Chapter 1 asserted that international, economic, social, and political forces—combined with the delegitimization of more money for business-as-usual in health care will result in a freeze on public payments for health care. And that this will magnify employers' fear that more health care costs would be shifted to them. So all payers will sign on to limiting total revenue growth.

It also asserted that both politicians and employers will quickly recognize that safely constraining costs of care and capping revenue would be impossible—medically or politically—without protecting medical security for all Americans.

At the same time, caregivers' own problems and shortcomings—and their resulting lobbying—propelled demands to reform payment methods in ways that protected all needed caregivers financially. Caregivers had to be paid in ways commensurate with cost containment and with medical security.

As discussed in chapter 3, ensuring both medical security for all Americans and financial security for all needed caregivers requires going after the four types of waste—clinical waste, administrative waste, high prices, and theft—that grab up to one-half of health care spending. That, in turn, requires organizing and paying for care in ways that lead trustworthy and accountable caregivers to take responsibility for frugally spending our vast but finite resources.

Winning medical security will oblige the U.S. to finally put its health care on the same three-legged stool—of coverage for all, cost control, and trustworthy payment methods—that all other rich democracies adopted in the years since the Second World War.

That required abandoning at least four long- and deeply-held notions. One was that enough of a functioning competitive free market in health care existed in health care—or could be insinuated into health care—to contain cost and boost outcomes in self-regulating ways.

A second, closely related, was that financial incentives could be trusted to induce caregivers, patients, or payers to act better.[1103] [1104]

A third was that public regulatory management of the details of health care could be effective.

A fourth is that caregiver configuration doesn't matter—so it's OK that it is no one's job to be accountable for configuration and to address it seriously.[1105]

Also, that progress required focusing on health care itself—services of doctors, nurses, hospitals, dentists, nursing homes, and other caregivers.

The *social determinants of life* (SDLs)—housing, nutrition, education and job training, income, environment, and personal and social safety—all powerfully influence health outcomes. So do behaviors and, to a lesser degree, genetics. But each year, the nearly uncontrolled rises in health care spending sponge up money that might otherwise have been available to finance much better large-scale attention to the social determinants.

Some experts hope or claim that spending more money on SDLs will keep us healthier and thereby save money on health care. I think this is very unlikely. Worse, talking about devoting dozens or hundreds of billions of dollars of added money to address SDLs on a large scale is unrealistic financially and politically and pragmatically. The money is not now available. Finding it would require boosting taxes or debt. And even experts in housing, education, and other fields lack clear, solid, affordable, agreed, and demonstrably effective ways of using more money. Each sector needs to clean up its own act.

Further, talk about SDLs without hope of serious action has the effect of letting health care itself off the hook. Despite the wonderful motives of those who propose focusing on SDLs, that talk would add up to just another theoretical—and failed—attack on health care costs.

2. Not easy—just easier than any of the others

Health care is where vast sums are spent badly. When the crisis described in chapter 1 arrives, health care is the arena in which reformers can hope to win a victory for compassion and competence, for equity and efficiency. That victory will rebuild confidence in our capacity to fix large and complicated problems.

And it will liberate the money to finance wholesale attention to housing, transportation, education and job training, manufacturing, the environment and security—for individuals, communities, and the nation.

Most immediately, putting health care's house in order will require ensuring medical security for all Americans.

Then, having a dedicated primary caregiver, a nearby hospital and emergency room, skilled specialists, adequate numbers of good nurses and other workers, rehab and long-term care, mental health care, dental care, affordable meds, and other forms of medical care can restore us to better health, slow our decline, and offer support and comfort during our last months or days.

Then, solid financial coverage for all needed care—with no more than trivial out-of-pocket obligations—help make medical care a source of security. And cease to be what it is for many Americans today—yet another threatening source of debt, impoverishment, and insecurity.

$5.6 trillion in health spending in 2025 is more than enough to finance medical security for all. Once we cut waste—as discussed in chapter 3. And once we focus on health care itself—as now follows.

2. Not easy—just easier than any of the others

C. Addressing social determinants of life—what, why, when, and how?

Health security for all Americans entails full financial coverage, cost containment, the right caregivers in the right places, and equitable delivery of appropriate and high-quality care.

Within a decade, a crisis in U.S. health care access, cost, and caregiver bankruptcies is very likely. It will be visible, deep, dangerous, and oppressive to patients, caregivers, and payers. Responding to that crisis competently will have to include winning health security for all Americans.

The U.S. can win affordable health security for all Americans without fixing all of the other problems afflicting us. That's partly because current health care spending is enough to pay for health care for all. And it's partly because health care is mostly distinct and separable from most other problems and their remedies—most of the time.

While it is difficult to reform health care spending, doctors, hospitals, and other caregivers are potential political allies for reform during a crisis (chapter 1). So are Americans needing care but unable to obtain or afford it today. Political support for health equity will be broader and deeper in times of crisis than will support for addressing housing or other SDLs.

Reforming health care itself is central. It can't be finessed by diverting energy and attention to housing, nutrition, education and job training, community and personal security, behavior changes, environmental action, and other social determinants of life (SDLs).

SDLs first?

Still, many smart and dedicated people believe that much higher spending on SDLs is an essential way to improve health. A related belief is that medical care does little to enhance overall health outcomes.

Gladwell provides a striking example in an otherwise brilliant analysis of wasteful variations in rates of use of medical care. After concluding it would be reasonable to cut rates of low-value cardiac catheterization procedures, he suggested that the savings could be devoted to "encouraging people with high blood pressure to eat better and get more exercise." [1106]

Gladwell did not propose using the savings to pay primary care physicians more money or boost pay to nursing home workers. *Defaulting to promoting prevention or behavior change has become a frequent reaction to medical care's many glaring problems. This view has become almost intuitively obvious to many who care about better health or health reform.*

Many smart and dedicated people also believe that higher spending on SDLs is the best way to contain health care costs, in part by markedly cutting need for medical care.

Many also believe that medical care is irretrievably unequal.

Those holding these beliefs often assert that improved health, lower cost, and greater equity are best pursued by investing in SDLs.

2. Not easy—just easier than any of the others

I think these views are flawed in four main ways. One is that money needed to make a wholesale improvement in housing, transportation, nutrition, community safety/personal safety/criminal justice, education and job training, income inequality, behavior, and the other SDLs is not available today and, absent changes, won't be available tomorrow. A big reason for this is health care's regularly demonstrated ability to sponge up so much new money each year.

The second is that no one knows which SDLs are strategic and should be prioritized.

The third is that, were the money magically to appear, we don't yet know how to spend it well. Housing experts don't know how to build the dozens of millions of affordable dwelling units—and associated transportation—that would lower housing costs and boost real incomes. Education experts are hard put to agree on effective ways to improve our schools.

The fourth is that proponents of higher spending on SDLs and other forms of upstream prevention usually assert that prevention saves money. As will be discussed shortly, this is not usually true and, worse, it subjects prevention to a self-defeating double standard—one that has not even been effective in prying loose more money from medical care to finance prevention.

We don't spend money on medical care to save money. Our usual aims include better health, medical security, improved functioning, reduced pain, and the like. So why should be assert that prevention saves money? Usually, to buttress claims that higher spending on it would be valuable. Those claims can and should stand on their own—in advancing health, well-being, and equity.

A greater emphasis on health care

Fixing health care first, by contrast, is attractive for several reasons. This is a matter of focus, sequencing, and strategy.

One reason is that *current spending is enough to pay for the care that works for all who need it*.

A second is that *evidence already exists to chart the path to affordable, accessible, equitable, appropriate, and high-quality health care for all*. Undoubtedly, the way forward is rocky. Political, professional, organizational, and other boulders will slow our passage. But this is a path we can follow.

A third is that assuring health care for all will liberate money needed to finance substantial wholesale attention to strategic SDLs. *Health care reform is strategic. It is valuable in itself. But, just as important, it will liberate money and energy to address other big problems*. By winning a victory for competence and compassion, fixing health care can and should spark reform in other sectors.

A fourth is that, for the reasons described in chapter 1, rising health care costs, declining access, and caregiver bankruptcies will soon collide with federal financial crises to clearly end business-as-usual in health care. *By providing the explosive force to blast loose the enormous sums now wasted inside health care, this crisis will be an opportunity to make real reforms—but only if we take its threat seriously and prepare to respond cohesively*.

And a fifth is that—despite much higher U.S. health care spending per person, *growing numbers of Americans find health care unaffordable, unavailable, or ineffective*.

Even the rich. Survival chances for the wealthiest quartile of Americans aged 50 to 85 are inferior to those of their counterparts in northern and western Europe. Indeed, the wealthiest quartile of Americans die at rates similar to the poorest quartile in northern and western Europe.[1107] This suggests that inferior U.S. health care is at fault.

That said, a greater emphasis on fixing health care for Americans is not exclusive. The SDLs are always important. After people seek medical care, their doctors and other caregivers often discover that treatment can't be fully effective without addressing problems of nutrition, housing, health-related behavior, or other SDLs.

Further, both long-term care and mental health are inextricable—inseparable—from housing, food, personal security, personal relationships, and other social determinants of life. These relationships are taken up in chapters 13 and 14.

Addressing SDLs for individual patients is both essential and affordable.

Chapter 3's comparisons of health care services, spending, and outcomes across the world's rich democracies reveal that Americans spend much more on health care—per person and as a share of GDP—while providing less care to smaller shares of its people—and dying younger.

Those findings helped to raise interest in social determinants of health (SDOH), here called *social determinants of life* (SDLs). This term is used because it underlines the many different and valuable lifelong benefits of investing in housing, nutrition, personal/family/social security, education, job training, environmental protection, and the rest.

After the phrase "social determinants of health" became widely used, some began to urge substituting "social drivers of health." One health insurance company explained: [1108]

> Why We're Using the Word *Drivers* Instead of *Determinants*--
> Social drivers of health, also known as social determinants of health, are conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. However, "determinants" suggests nothing can be done to change our health fate. By saying social factors drive our health, we reframe the conversation about health. We show that social factors don't force health to be fated or destined, but rather they are something that people and communities can overcome or change.

Does changing a word really "reframe the conversation about health"? Probably not. Also, the word "determinants" suggests greater power than "drivers." It focuses attention on addressing the determinants in order to win better health.

I hope to suggest something different by writing about social determinants of life.

A focus on the health benefits of various investments, while understandable, is narrow. It appears to make health alone a reigning or supreme value. And doing so can lead to ignoring

the trillions of dollars already spent each year on the housing, food, education, transportation, clean air and water, and other SDLs by individuals, families, and governments.

Addressing a social determinant can yield benefits that go far beyond health, alone. Better nutrition can enable us to get and hold a better-paying job, which can make housing more secure. A more secure and crime-free neighborhood means less personal worry; it also makes it easier to run a small business profitably owing to lower payments that criminals extort for protection or losses from robbery.

A narrow focus on social determinants of health can also lead to neglecting opportunities to forge alliances with people who see the value of addressing an SDL. And it makes returns on investments (ROI) look artificially low. ROI, crudely, is the benefit of an investment divided by its cost.

Consider the simple example of investing in new windows and casings for older homes. This substantially cuts harm from lead poisoning.[1109] It has a certain ROI. But that ROI is artificially suppressed below its real-world value. That's because the investment also yields substantial savings in cost of heating or cooling—along with reductions in greenhouse gases. Calculating the return in the form of reduced lead poisoning from investing in new windows requires partitioning the cost of the investment—splitting it in proportion to the various benefits. ROI = health benefits in reduced lead poisoning divided by the share of the cost of the windows that should be apportioned to winning those health benefits. Otherwise, calculated return on investment will be badly understated.

U.S. health spending has been wasteful, inefficient, ineffective, and inequitable. These failings have causes and those causes must be directly addressed. Large and well-integrated reforms are needed in how we raise money, cover people, pay and configure caregivers, contain cost, and boost quality.

The tough jobs of devising and implementing effective programs to address the causes of U.S. health care's problems of access, cost, caregiver configuration, and quality can't be finessed or ignored by talking endlessly about vast imaginary proposals to tackle SDLs society-wide.

At the same time, greater investments in addressing social needs of individual patients are essential to making health care work better. So addressing social determinants complements health care reform. These efforts can be called *retail investments* in SDLs. They are very different from *wholesale investments* for millions or tens of millions of Americans.

American patients often benefit when their medical treatments are accompanied by attention to non-medical sources of illness, barriers to recovery, weak coordination of care, and the like.

One way is to employ navigators to address low-income Americans' greater barriers to cancer care, greater cancer pain and fatalism, and the complexity of cancer care itself.[1110] Another is to support family members who care for elders outside nursing homes.[1111] A third is to employ community health workers[1112] to help improve nutrition, housing, or other life-circumstances. Fourth is arranging or paying for housing or food. Examples include hospital food pantries for patients who are diagnosed with malnutrition and efforts to secure housing for street-homeless citizens who frequently seek care at a hospital's emergency room for medical problems closely tied to homelessness.[1113]

2. Not easy—just easier than any of the others

These ways to address social determinants of ill health could be called retail or micro efforts because all involve the health-related circumstances of identified individual patients.

They should be distinguished from wholesale or macro calls to help millions of inevitably anonymous Americans enjoy better housing, nutrition, education, income, environment, neighborhood security and criminal justice, and other valuable things.

Some advocates of attention to the wholesale or macro SDLs might consider U.S. health care too hard to fix—politically, financially, legally, and institutionally. And many of those advocates argue, further, that we don't need to fix health care itself.

In this view, the social determinants of health in the U.S. are more powerful or important than health care. Many who hold this view believe that massive social investments would yield better and more equitable health and also save money.

Building on decades of interest in prevention and public health, some urge large-scale financing of wholesale efforts to improve housing, nutrition, income distribution, education and job training, the environment, criminal justice, and other social determinants of the life of millions of Americans.

Attention to individual patients—retail or micro investments—is often conflated with investments in wholesale—macro or population-level—social determinants. The title of one paper on ACO investments in helping individual patients with housing, food, and transportation referred to this as a way to improve *population health*.[1114] (A paper by Allen and others is a valuable exception.[1115])

One reason for this conflation is that the two have shared roots in dismay over the performance, equity, and cost of U.S. health care. That dismay often leads reformers to urge greater attention to prevention and less to medical treatment. Some forms of prevention, like immunization, are medical. Many involve behavior, housing, and other SDLs.

Proponents claim these will save money. But savings are rare. Their main aim is to extend healthy life by reducing risks to health.

We don't spend money on health care to save money. As documented in chapter 3, saving money on health care requires addressing the waste and related problems *inside* health care itself. Prevention offers relatively few opportunities to save money by cutting that waste.[1116]

A second reason for the conflation is that both do concern themselves with housing, food, transportation, and other SDLs.

A third reason may be that some advocates of higher spending on social determinants intend to mingle the two types.

A fourth may be that the estimates of SDLs' effects on health outcomes seem to concern population-level interventions while most actual public and private financing and delivery is individual-level help to patients whose social needs were identified in the course of medical treatments. Possibly, advocates of each level of intervention hope to draw support from the other, under a general umbrella of "social determinants."

2. Not easy—just easier than any of the others

But the two types of attention to SDLs, retail and wholesale, are very different in how they operate, in their current levels of effort, in their costs, in their prospects for securing more adequate financing, and in evidence of their efficacy. They deserve very separate attention.

Apparently focusing on micro level, on individual patients, Samra and Kehn believe that "The Biden administration has made it clear that meeting health-related social needs (HRSNs) Is key to lowering health care costs and improving outcomes for Medicaid beneficiaries and those dually eligible for Medicaid and Medicare…." [1117]

This is an aggressive position. It raises several questions. Was the administration's position valid—was its position accurate, true? Or was it mainly the latest instance of decades of political posturing on health care?—as discussed in chapter 5. Was it backed by more than new definitions and reporting requirements? Could those requirements change anyone's actual behavior? If so, would those changes make much of a difference to patient health and well-being?

The factors explaining the growing interest in SDLs are now discussed. Then follows an examination of the retail and wholesale versions' successes to-date and future prospects.

One important issue to consider is whether much money obtained—by prying it out of health care spending or from other sources—enough to make a meaningful wholesale difference in SDLs.

A second is whether public health and other experts know enough about how to fix housing, nutrition, personal and social safety/security, income distribution, education, and other sectors.

A third is which of those sectors need more money and which need to find ways to better spend the vast sums already expended on them?

1. Why the growing interest in social determinants of life (SDLs)

First, some experts and advocates rightly note that very high U.S. health spending—in real dollars per citizen or as a share of GDP—have not paid for high volumes of care, have not covered all people, have not yielded high levels of health, and have not overcome great inequality of health outcomes or use of care.

Second, some people seem to believe that finding new money for large wholesale programs to address macro social determinants will be politically and financially easier than trying to reform health care itself.

And much easier than trying to find money to address social determinants by wrestling existing health spending away from politically powerful and entrenched medical care insiders--doctors, hospitals, other caregivers, drug makers, employers, insurance companies, Medicare or Medicaid.

2. Not easy—just easier than any of the others

Some advocates of focusing on macro social determinants like unaffordable housing, inadequate nutrition, poor education and job training, and precarious family and neighborhood security appear liberated to condemn the waste and inequity embedded in medical care without developing concrete programs to directly address those macro determinants. Those would need to be programs backed by actual evidence of efficacy, resting on both solid cost estimates and analysis of political feasibility.

Third, scientists, journalists, and advocates have long and truthfully linked bad health to many social and economic problems and inequalities.

Michael Harrington wrote sixty years ago about the poor health of impoverished Americans.[1118]

Bailey and Goodman-Bacon note that the War on Poverty of the 1960s began with a focus on human development efforts like Head Start and Job Corps. But program administrators discovered that poor heath impaired participation—and that many poor people simply lacked access to health care owing to lack of insurance, lack of nearby caregivers, or discrimination by available caregivers. (Indeed, before Medicare conditioned payment on integration, many Southern hospitals refused to serve Black patients.) All that prompted public financing for the first two community health centers, one in Mound Bayou, Mississippi and the other in Boston's Columbia Point.[1119]

Geiger and colleagues at Mound Bayou diagnosed grave malnutrition and, reasonably, prescribed food for individual patients, and paid for it from the health center's budget. OEO initially refused to repay the center for that cost.[1120] Moran and Roberto see limits on the view that food is medicine. They suggest, instead, greater reliance on existing programs like SNAP, WIC, and school meals. And on improving food industry practices.[1121]

Radley and colleagues have comprehensively documented persisting unequal insurance coverage, use of care, and health outcomes by race/ethnicity and income.[1122]

Adler and Newman found that education, income, and occupation predict low birth weight, heart disease, arthritis, diabetes, and cancer.[1123] Winkleby and colleagues found that attaining higher levels of education was more closely associated with low rates of risk of heart disease than income or occupation.[1124] Tucher and others reported that higher levels of social risk were associated with higher rates of use of medical care.[1125]

Hansmann and Razon asserted that the health care sector is boosting investments in social conditions, including transportation and urge including transportation justice in "health care research, delivery, and policy."[1126]

Makaroun and others found that less wealth was associated with higher rates of death and disability in both the U.S. and the U.K. for people over age 54. They concluded that steady access to care in the U.K. "may not attenuate" that relationship.[1127] Analyzing health of non-Latine Whites, Banks and colleagues found a much sharper relation between health and both income and education in the U.S. than in England.[1128] Health of Americans was markedly worse. Still, in Glasgow, Scotland, where all people are protected by the National Health Service, the gap in life expectancy between the most and least deprived areas was 15 years, and growing.[1129] [1130]

2. Not easy—just easier than any of the others

Woolf and Braveman noted that unequal health stems partly from gaps in medical care and partly from social and economic factors.[1131] They highlighted life expectancy differences by race, ethnicity, and income. And they pointed to the steady and alarming relations between excellent/very good health and education, by race/ethnicity.

Yearby and colleagues asserted that structural racism characterizes past and current U.S. health care policy.[1132]

Galea displayed large differences in diabetes prevalence across small areas in Boston that are all located near sources of very good medical care.[1133]

Powerfully, Schoen and colleagues showed that higher insurance coverage, lower rates of premature deaths, lower burden of OOPs, timely preventive care, and more would result if lower-income U.S. states were to reach the levels of care or spending found in higher income ones.[1134]

Fourth, a number of researchers have asserted that social determinants do more to explain differences in health outcomes like longevity or disability than do medical services.

That may be true. But that does not tell us how to invest scarce dollars to do as much as possible to improve health outcomes in the future. It is easy to complain about costly or ineffective health care. Because that complaint is so well justified.

But it is hard to develop affordable, effective, and efficient ways to improve health outcomes by addressing housing, nutrition, income distribution, and other SDLs. Baicker and Chandra caution about the risks of wishful thinking.[1135]

A 2022 report from the office of the assistant secretary of HHS for planning and evaluation (ASPE/DHHS) began with these words: [1136]

> Long-standing health inequities and poor health outcomes remain a pressing policy challenge in the U.S. Studies estimate that clinical care impacts only 20 percent of county-level variation in health outcomes, while social determinants of health (SDOH) affect as much as 50 percent. Within SDOH, socioeconomic factors such as poverty, employment, and education have the largest impact on health outcomes.

This view is so important that it is worth unpacking. First, as discussed shortly, the estimated 20 percent role of clinical care apparently rests mainly on one study.

Second, it is indeed likely that about one-half of health outcomes depend on SDLs. It is implied that addressing SDLs will do more to improve health.

Unfortunately, that does not mean that wholesale investments in one or more SDLs would improve health outcomes. Possibly, health and ill health parallel Tolstoy's observation about families: "All happy families are alike; every unhappy family is unhappy in its own way." This is sometimes called the Anna Karenina principle.[1137]

That is, healthy people may be generally likelier to eat healthy foods, exercise, enjoy secure income and housing, live in safer neighborhoods and suffer lower rates of victimization by crime,

have lower levels of use of dangerous chemicals, and the like. By contrast, possibly, people in poor health are likelier to suffer from different problems in one or more of these are related areas. But which ones? How to remedy them?

Ill health, then, can stem from one or more of a constellation of problems—low incomes, poor or unaffordable housing, poor or unaffordable food, unaffordable or unavailable or unstable access to health care, high levels of environmental pollution, unstable social supports, high levels of personal insecurity or crime at home or in the neighborhood, or use of dangerous chemicals.

If this is so—and despite the strong association between SDLs and health outcomes—it may be inherently very hard to improve health by programs that address the SDLs that harm individuals and families.

Therefore, as hard as it is to fix U.S. health care to win health security for all Americans, that may be easier than improving health by addressing SDLs. Especially when the health care crisis hits.

One look at forces shaping health

Many writers identify four or five elements that influence health outcomes: medical care, genetics, personal behavior, the environment, and social and economic determinants. Evidence on the importance of each is fairly sparse, weak, and frequently conflicting. This is not surprising. Use of medical care, for example, can be influenced by social determinants like income (associated with stronger insurance coverage and ability to afford OOPs) and location (proximity to doctors or hospitals). Similarly, personal behaviors can be linked to social determinants.

In 2011, Bradley and colleagues sought to gauge correlations between shares of GDP devoted to either social services or health services, and five measures of health outcomes, across 30 rich democracies in the OECD. The measures were life expectancy at birth, potential years of life lost, infant mortality, low birth weight, and maternal mortality. They found that higher spending on social services was positively associated with three health outcomes (life expectancy, potential years of life lost, and infant mortality), while higher health spending was associated with two outcomes (life expectancy and maternal mortality).[1138] [1139]

One big problem with this paper is that public and private old-age pensions and social security were included in social services spending. In most nations, these were probably the largest component of social services spending. Because spending on all the social services was aggregated, this study can't inform decisions about which types of services might be targeted for higher spending to boost health outcomes.

A second problem with this study emerged when Papanicolas and colleagues challenged aspects of Bradley's and others' findings. They observed that the social spending's share of U.S, GDP was only slightly below the OECD average and that it was two percentage points higher than the average if education is included in social spending.[1140]

Peres and Anderson insightfully noted that the work of Papanicolas and colleagues challenges what has been becoming the conventional wisdom that nations spending more on social services would spend less on medical care.[1141] Suggesting that the two types of spending do not substitute for one another, they identified several ways in which social and medical services

are complementary. This is particularly important in long-term care, since so much of long-term care involves living standards and quality-of-life concerns. Importantly, they highlighted the need to look beyond the numbers of dollars spent on social services in different nations to analyze how they are spent.

The third—and largest—problem with Bradley's and other studies comparing medical with social spending is so big it is rarely considered. They suffered from tunnel vision. That is, they include all medical spending, whether the money to finance care is channeled through taxes, private insurance, OOPs, or other sources. But they usually included only that social spending financed by public dollars for housing, food, education, and other goods and services. They made an apples – octopus comparison.

It helps to look at the numbers. As shown in Exhibit 2 – 4, total spending in the U.S. on housing, food, education, and transportation is double health care spending. And, as discussed later in this chapter, each sector faces its own challenges. Affordable housing can't be won from a public health or other external viewpoint. It has to be won by addressing housing—by building much more housing and building it more efficiently. And by coordinating it with adequate transportation.

Freedman ecstatically endorsed the work of Bradley and colleagues. He wrote that Bradley is "widely seen as the world's foremost expert in the relationship between social services and health and then cited Bradley's assertion that:[1142]

> 'The right question for our political agenda is "What's going to give us the most bang for the buck in health outcomes?" What our work has shown is that the answer is spending on social services.'

Freedman's 2010 book *Wrong: Why Experts Keep Failing Us* was praised vividly by reviews published in the *New York Times, Wall Street Journal,* and *Washington Post.*

When Foster and Conwell wrote about "Advancing Equity in Health Care Facilities and Delivery," they focused on "promoting patient-centric, culturally humble care," "addressing social determinants of health," and "investing in people".[1143]

Those are a little vague but all still sound like worthwhile policies. But would they do as much to advance equity in health care facilities and delivery as ending out-of-pocket payments (OOPs) for meds, doctor visits, and other health services; securing adequate numbers and types of caregivers in the right places; ensuring that all citizens' illnesses and disabilities are diagnosed and treated equitably and effectively; or other reforms in health care itself? I don't think the answer is knowable. But I do think that each sector needs fixing.

Prevention, public health, and social determinants

McGinnis and colleagues complained that only about 5 percent of U.S. health spending was devoted to population-wide approaches to health improvement.[1144] But this is not surprising since the overwhelming share of money for medical care is devoted to diagnosing and treating problems of individuals in each rich democracy.

Worse, they failed to place the U.S. spending pattern in context. Gmeinder and colleagues found that the U.S. was second-highest (after Canada) in real spending per citizen on public

health and prevention, and about 2.5 times the OECD average. And the U.S. was slightly above the OECD average percentage of health spending devoted to public health and prevention.[1145]

It's helpful to look at the numbers.

In 2022, U.S. GDP was roughly $25.5 trillion. That year, national health expenditures for individual health services, public health, research, and investments totaled $4.44 trillion, or 17.4 percent of GDP. The remaining 82.6 percent of GDP was spent on housing, food, transportation, education, clothing, recreation, insurance and financial services, and other consumer goods and services; on public goods and services like fire protection and defense; and on investments in construction and equipment.[1146] Most of the 82.6 percent could be regarded as spending on SDLs.

Spending on SDLs to boost health ineluctably boosts other aspects of well-being generally.

The commonly-used acronym SDOH deserves examination. The SDOHs influence much more than health: they shape living standards, education and occupation, financial security, family and personal security, many of our behaviors and attitudes, and most of our life circumstances. To call them social determinants of health—or social drivers of health—implies that health is their core aim and that, therefore, health care institutions, payers, and caregivers have a large share of the responsibility for addressing them.

That is an expansive view of health care. Though well-intentioned, it might be viewed as arrogant or over-reaching, or even imperialistic. Since experts in other fields, like housing, have difficulty finding ways to make affordable housing available to all Americans, why might we suppose that health care experts have any useful insights into how to fix housing?

So it is probably more useful to call them SDLs—social determinants of life.

Sources of differences in health outcomes

Several researchers and policy analysts have sought to estimate the shares of various health outcomes attributable to various factors. They and others—usually others—summarize their results in various pie charts. *The pie charts are appetizing but are they healthy?* That is, do they rest on solid evidence?

Investigators vary in their measures, methods, and findings. They may sometimes make either small hops or large leaps from data to estimated shares.

The CDC's Bureau of State Services polled 40 health care professionals and paraprofessionals and asked them to quantify causes of mortality. These were averaged. The results were deemed "in close agreement with the medical literature." But only one piece of that literature was referenced.[1147] Remarkably, social and economic factors were not considered.

In one widely-cited paper, Hood and colleagues estimated that health care services seem to account for only about one-fifth of health care outcomes like length-of-life, acute or chronic illnesses, or disability.[1148] That study is the single item cited in support of medical care's one-fifth share of health outcomes highlighted in the 2022 ASPE/DHHS review just mentioned.[1149]

2. Not easy—just easier than any of the others

Hood and colleagues examined factors affecting county-level differences across 45 states in premature death and morbidity or quality of life (being in poor or fair health, days of poor physical health, days of poor mental health, and low birthweight). Of the four sets of estimates summarized in Exhibit 2 – 2, this is the only one that rests on original and detailed empirical work.

In another widely-citied paper, Schroeder presented very different estimates;[1150] these were in Schroeder's word, "adapted" from work of McGinnis and colleagues.[1151] Unfortunately, some of the numbers offered by McGinnis and colleagues were themselves not very solidly substantiated.

For example, Schroeder asserts that clinical care accounted for 10 percent of health outcomes but McGinnis and colleagues blandly wrote only that "perhaps 10-15 percent" of preventable mortality in the United States could be avoided by more available or higher-quality medical care. But they offered only a 1980 report on causes of death to back up that view.[1152] And an earlier paper by McGinnis and Foege noted that "Socioeconomic status and access to medical care are also important contributors [to mortality], but difficult to quantify…."[1153]

The Bipartisan Policy Center circulated behavior-focused estimates that excluded social and economic factors; these relied on data from The Boston Foundation and the New England Healthcare Institute.[1154]

The four are set out in Exhibit 2 – 2. They disagree considerably. This inconsistency undermines confidence in the causes of health problems and, therefore, in which to target remedially.

Exhibit 2 – 2

Various Estimates of Sources of Differences in Health Outcomes

Study	CDC 1980	Hood and others 2016	Schroeder 2007, after McGinnis and others	Bipartisan Policy Center 2012
Outcome(s)	Total mortality	Premature death, morbidity, quality of life	Premature death	Health
	Shares of differences in health outcomes			
Source	Percent	Percent	Percent	Percent
Behaviors	50	30	40	50
Clinical care	10	20	10	10
Social/economic	--	40	15	--
Environment	15	10	5	20
Genetics/biology	25	--	30	20
Total	100	100	100	100

2. Not easy—just easier than any of the others

Sources

Bureau of State Services, Center for Disease Control, "Ten Leading Causes of Death in the United States, 1977," July 1980, p. 35, https://stacks.cdc.gov/view/cdc/7655/cdc_7655_DS1.pdf.

Carlyn M. Hood, Keith P. Gennuso, Geoffrey R. Swain, and Bridget B. Caitlin, "County Health Rankings: Relationships between Determinant Factors and Health Outcomes," *American Journal of Preventive Medicine,* Vol. 50, No. 2 (2016), pp. 129-135, https://www.sciencedirect.com/science/article/pii/S0749379715005140?via%3Dihub.

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J. Michael McGinnis, Pamela Williams Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs,* Vol. 21, No. 3 (March – April 2002), pp. 78-93, https://www.healthaffairs.org/doi/10.1377/hlthaff.21.2.78.

Bipartisan Policy Center, "What Makes Us Healthy vs. What We Spend on Being Healthy," 5 June 2012, https://bipartisanpolicy.org/report/what-makes-us-healthy-vs-what-we-spend-on-being-healthy/.

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These papers, cited repeatedly,[1155] [1156] [1157] seem to be the main sources of the assertion that medical care services explain or account for 10 to 20 percent of differences in health outcomes.

Nixon and Ulmann agreed with McGinnis and Foege in suggesting it is difficult to isolate effects of medical care on health outcomes.[1158]

Effects of social determinants of life should probably be viewed similarly.

An important complicating factor is that experts disagree on the role of behavior. To what degree is it a personal and autonomous influence on health? And to what degree is behavior powerfully shaped by social and economic factors? Psychologists and sociologists might have different views on this.

It is tempting to seek and cite evidence that supports what we would like to believe or what we would like to do.

Summarizing the results of 16 empirical studies, Nixon and Ulmann concluded that health spending and numbers of physicians improve life expectancy several times more than spending on nutrition, while pollution lowers life expectancy.[1159]

Food, housing, and other SDLs—along with personal behavior and environmental conditions—undoubtedly explain a high share of health outcomes. But that does not mean that we know how to address the SDLs to change health outcomes. Doyle and colleagues offer an example of this point. A controlled trial of food-as-medicine "did not improve glycemic control".[1160]

The growing attention to social determinants rests on a widening foundation of interest in prevention and public health.

The field of public health has long focused on primary prevention—preventing health problems from developing—through vaccinations and quarantines to prevent spread of communicable

diseases, ventilation standards for housing to prevent transmission of tuberculosis, prenatal medical care and nutrition, improved highway safety, attention to environmental sources of illness, and some efforts to improve behavior. The broadening boundaries of public health have helped prepare more ground for the growing attention to social determinants.

Proponents of public health interventions assert they save money. Many do. Collins has written compellingly about the medical, human, and financial value of expanding diagnosis and drug treatment for hepatitis C.[1161]

Mohan and Gaskin posited that "targeting social determinants of health may contribute to identifying and controlling health care expenditures." [1162]

But many other public health or preventive interventions do not save money.

Russell found that prevention rarely saves money.[1163]

Van Baal and others estimated that healthy-living people had higher lifetime medical costs than obese people, while smokers had lower lifetime medical costs than either group.[1164]

That is a helpful reminder: We do not spend money on health care to save money. We spend to live longer and better. And if we prevent one problem, another will whack us: that other one might be costlier to treat.

Reformers who accede to demands that their proposals must save money are playing a fool's game. Does anyone ask that defense spending save money? Or spending on education? Or food? Or ERs.

Two of primary caregivers' main roles are early diagnosis and effective treatment that minimize harm. This is usually called secondary prevention. Some writers argue that better secondary prevention will compress morbidity and disability, thereby cutting lifetime health care costs. Whether better primary care, treatments, rehabilitation, long-term care, and other services actually compress morbidity or save money has been hotly debated for many years.

Beginning in 1980, Fries prominently advanced the notion that better care and improved behavior delay morbidity and disability without increasing the number of subsequent years of ill-health or disability. One reason was his belief that humans were approaching a natural ceiling on average longevity.[1165] [1166]

Gruenberg worried that increased life expectancy would result in more years of chronic illness or disability.[1167] House and colleagues asserted that compression of morbidity was likelier for higher-income groups.[1168] In one review, Manton concluded that it is hard to assess the prospects for compression of morbidity.[1169]

In 2002, as many experts noted that public health institutions had deteriorated, and as they contemplated a surge of investments in public health, Lurie asked whether0 old structures should be rebuilt or new ones created.[1170] In 2010, Hemenway listed four main reasons public health is under-financed: its benefits are in the future; its beneficiaries are not identifiable; so are the benefactors; and a number of public health initiatives arouse political or social opposition.[1171]

2. Not easy—just easier than any of the others

For a time, some private employers sought to try to save money on health insurance by promoting healthy behaviors by workers and their families. But high shares of workers reported that employer wellness programs intruded on worker privacy.[1172] These programs did not reliably save money. And if they did save, employers that financed them were exposed to the "wrong pocket" problem—since later employers or Medicare would hypothetically benefit from cuts in lifetime costs of care—if any materialized. The ACA's heavy insurance premium penalty on smokers probably failed on both counts.

In 2005, the World Health Organization created a Commission on Socal Determinants of Health. It identified large gaps in health outcomes both within and across nations and urged greater spending on social and economic factors affecting health.[1173]

In 2006, in the wake of Katrina, Tilson and Berkowitz wrote that public health's traditional and "overarching challenge is to build a core infrastructure, connected to the rest of the preparedness infrastructure, to deliver essential services to every community." [1174]

That challenge was simply not met. When Covid hit the U.S., the levels of public health preparation and response were not optimal. Did the four general factors Hemenway described impair readiness? Or did the growing attention to social determinants distract attention from pursuing the traditional missions that Tilson and Berkowitz identified? Alternatively, has much of the public health field embraced social determinants out of frustration over its inability to win financing to accomplish those traditional missions? Finally, is the general frustration with the inefficiency, ineffectiveness, and inequality of U.S. health care responsible? Or all of these?

For these or other reasons, the territory claimed by public health has expanded markedly during the past two decades. Brookfield's provocative 2023 paper, "What Isn't Public Health?" urges embracing "the strong and progressive political and theoretical positions" on which, in his view, the field was founded.[1175]

Currently, according to the Centers for Disease Control: [1176]

- Public health is concerned with improving the health of groups of people and populations in an equitable way.
- Public health seeks to eliminate health disparities, which are systematic and preventable differences in health between groups of people.
- Public health efforts are typically based on the socioecological framework, which shows that it is not just an individual's choices and behaviors that matter but that family, community, and national policies and actions also influence health.
- Public health complements health care received in settings like hospitals and clinics by addressing factors that contribute to poor population health.
- Many local health departments offer vaccinations and nutrition services, and some provide more comprehensive prenatal and preventive or primary care at Federally Qualified Health Centers and other sites.
- Any condition, exposure, event, or experience that negatively impacts health or quality of life at a population level is a public health issue.

Four of these six concern population-level wholesale social determinants. Much of the desire to spend more on social determinants at the wholesale, population, or macro level is reflected in—and strengthened by—increasingly broad views of what constitutes a public health problem.

The theme of "Health in All Policies" captures aspects of this broad thinking.[1177] So does Goozner's notion of rejuvenating state and local public health departments through federal

financing of public health workers. These would prepare for pandemics by designing protocols for public education, testing and screening, contact tracing, and quarantining.

A number of groups have proposed at least 25 different problems that should be concerns of public health. The first six were offered by the University of Southern California's MPH program.[1178] The rest are attributed individually.

a. The opioid crisis
b. Social media misinformation/disinformation
c. Health inequity and unequal access to medical care
d. Food insecurity and food deserts
e. Cannabis
f. Education
g. Chronic school absence[81]
h. Alcohol abuse [82]
i. Problem gambling [83] [84]
j. Violence, rooted in historical disinvestment and racism [85]
k. Policing [86] and police violence [87]
l. Crime and criminal justice[88] [89] [90]
m. Incarceration [91] [92] [93]
n. End of life [94]
o. Human trafficking [95] [96]
p. Racism [97]
q. Social justice [98]
r. Income inequality [99] [100]
s. Climate change [101]
t. Cost of living crisis [102]
u. Housing and homelessness [103]
v. Worker exploitation [104]
w. Migration [105]
x. Stigma [106]
y. Social media [107]
z. Loneliness [108]
aa. Extremism, right-wing only [109]

While awaiting that pandemic, the public health workers would "organize mass screening tests for cancers, chronic kidney and liver disease and other maladies where early detection can reduce deaths and avoid late-stage and high-cost interventions." And offer pre-natal care. And help people needing food, housing, money, and stress, focusing on low-income urban and rural areas.[110]

Goozner regards these activities as money-savers, paralleling his proposal for aggressive testing and medications for people infected with hepatitis C. Limiting infectious disease through vaccinations or medications usually does save money.

The other activities probably do not. Few health-related investments actually save money. But that's not a fatal flaw because saving money is a dangerously wrong-headed standard. Again: We don't spend $5.6 trillion on health care in the U.S. in 2025 to save money.

Goozner's suggestion is ambitious, costly, and more than optimistic in its hope of saving money. It is hard to imagine where the money would be found to finance wholesale remedies for food, housing, income, stress, and other substantial problems. Finding that money is both an economic and a political challenge today. And tomorrow. Demands on the U.S. economy and on the federal budget, discussed in chapter 1, will not disappear soon. Until we first contain health care costs.

Rarely published are expressions of skepticism about the feasibility of getting much more money to address SDLs wholesale, or about our ability to spend that money effectively if we got hold of it. Exceptions are therefore noteworthy.[111] [112]

2. Not easy—just easier than any of the others

Growth in the number of schools of public health and their graduate degrees awarded testify to rising interest in the field. In 2023, some 60 schools of public health were accredited and over 100 other programs offered degrees, up sixteen-fold from 1936.[113]

Is it a paradox that the growth of both the span of concerns of the public health field and the volume of professional training in public health coincide with weakening of traditional public health agencies?

Exhibit 2 – 3

Schools and programs in public health, and graduate degrees awarded

Year	Public health schools	Public health programs	Graduate degrees awarded
1936	10		
1960	12		
1975	20		2,295
1999	29		5,568
2011	46	45	13,629
2023	60	100	*19,624

* The 19,624 degrees were awarded in 2020.

Sources

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Although U.S. public health spending as a share of health spending has long been in line with the rich democracy average,[114] many U.S. public health agencies faced financing challenges pre-Covid.[115] Diverting funds from general public health toward terrorism-related preparedness in the wake of 9/11 was one reason. About one-sixth of workers at local and state public health agencies left their jobs pre-Covid, between 2008 and 2019. And about one-half did so between 2017 and 2021.[116]

Public health's widening breadth and its growing interest in the macro or population-level social determinants are worth examining.

If health or public health aspires to be everything, will it be more vulnerable to accomplishing nothing?[117]

2. Not easy—just easier than any of the others

Possibly, improving any health outcomes—especially for people who suffer more health problems and die younger—requires changing most aspects of health care and the larger society and economy.

Alternatively, trying to change everything may make it harder to change anything. It will probably be impossible to obtain the hundreds of billions of dollars to spend on programs to address SDLs across a broad front. It may even be hard to find the money to make a substantial dent in any one of the powerful SDLs. Are we charging at high speed into a box canyon? If that's likely, why all the talk about SDLs?

The current interest in wholesale social determinants parallels in important ways the design of the Model Cities program between 1966 and 1974. In the 1960s, smart and dedicated city planners and anti-poverty experts came to regard city planning's traditional focus on housing or land use or transportation reforms as insufficient to lift urban Americans out of poverty or overcome legacies of racial injustice. And they deemed existing federal programs ostensibly devoted to helping low-income urban citizens to be too fragmented and uncoordinated to be useful to those citizens—and, indeed, often damaging to them. Problems were deemed too entrenched and mutually reinforcing to be addressed piecemeal or incrementally.

So they developed a comprehensive broad-spectrum intervention: improving the lives of urban residents, fighting poverty, and racial justice was thought to require a) enough supplementary money—coordinated with repurposed money from existing programs—which was to have a large impact on some 60 – 70 cities; b) multi-front attention to health care, education, land use, housing, transportation, criminal justice, and the environment; and c) mobilization of widespread citizen participation.

In 1966, Pres. Johnson proposed testing the Model Cities proposal by providing substantial Model Cities supplemental money to the 60 – 70 cities. Congressional pressure watered down the initiative by dispersing the money across 150 cities. Still, the $3 billion authorized in the 1966 legislation equaled $28 billion in CPI-adjusted constant dollars in 2023.

Section 101 of the Model Cities statute declared:[118]

> [I]mproving the quality of urban life is the most critical domestic problem facing the United States. The persistence of widespread urban slums and blight, the concentration of persons of low income in older urban areas, and the unmet needs for additional housing and community facilities and services arising from rapid expansion of our urban population have resulted in a marked deterioration in the quality of the environment and lives of large numbers of our people while the Nation as a whole prospers.

Today, the program is considered largely to have failed to make a dent in urban poverty and related problems.[119] [120] [121] Three main factors explain this.

First, previous programs' failures to ameliorate urban poverty and other problems were deemed to have been caused by lack of coordination of worthy programs, pursuit of unworthy ones (like urban renewal or disruptive urban highways), or failure to focus on needs of low-income urban citizens. Model Cities sought concentration and coordination of existing program dollars and mobilization of city governments and neighborhood residents. But Model Cities officials—in Washington and in each of the cities—lacked legal, administrative, or political tools to coordinate the various federal programs to benefit citizens of the Model Cities neighborhoods.

They could not pry loose the dollars separately programmed by Congress. Not even when the White House—through domestic policy coordinators for two successive presidents—sought to make that happen.

Second, even programs that had sought to benefit low-income citizens—like public housing—involved buildings. They had ignored factors like human social or behavioral problems and lack of skills owing to education or job training gaps. But *evidence on how to design and implement effective programs to ameliorate those problems or fill those gaps was simply lacking*.

Third, owing to that lack, Model Cities fell back on detailed local planning to find ways to spend the supplemental money in innovative and effective ways—ways that also filled gaps among existing federal programs. Sustained local citizen participation was supposed to provide ideas and advice to the plan-writers. Process sometimes became more important than outcome.

Health care experts are not yet competent to fix U.S. health care. Similarly, it is very hard to win improvements in overall outcomes and also equity in each of the other sectors that fall under the heading of social determinants: housing and transportation, education and job training, environment, income security, personal and family and neighborhood security, and the rest of the 25 items listed a few pages ago.

Three important but separate ideas deserve examination. First, social determinants are powerfully associated with ill health and early death. But, second, health care experts know little about how to improve health outcomes by spending more on housing, nutrition, transportation, criminal justice and policing, and other sectors. Evidence is weak. Frustratingly, third, money to address social determinants on a large, wholesale scale is lacking today and for the foreseeable future.

Many who write about SDLs hold only the first idea in mind, though some hint at the third. Consider this from Nichols and Taylor:[122]

> Good research evidence exists to suggest that social determinants of health, including access to housing, nutrition, and transportation, can influence health outcomes and health care use for vulnerable populations. Yet adequate, sustainable financing for interventions that improve social determinants of health has eluded most if not all US communities.

It would be costly to try to address the main SDLs for dozens of millions of Americans who suffer ill health. We don't know where the money will come from or how to develop the political capacity to obtain it.

We don't know which SDLs are most important—to health or to overall well-being. Separately, we don't know which investments would be the most efficient and effective. We don't know the degree to which ill health causes housing or food problems. Or whether other factors cause both.

That is not surprising. Most of the actual experts in most of these fields are uncertain about what interventions might work.

Homelessness is so hard to address because each of its two main causes have proven intractable.

One is mental illness. A review and meta-analysis concluded that two-thirds of homeless Americans suffer "mental health disorders".[123] Use of dangerous chemicals is often involved. Reasons these have proven so difficult to remedy are taken up in chapter 14.

The other is the high cost of housing. What are the best ways to lower the cost of housing, reduce homelessness, and ameliorate housing-related health problems? Clearly, building more housing is essential. So is stabilizing and salvaging many millions of dwelling units now vulnerable to deterioration and demolition. But it is very costly to acquire the needed land, build the needed transportation infrastructure, and construct the needed dozens of millions of dwelling units. A remarkably perceptive and realistic *Boston Globe* series published at the end of 2023 makes this clear.[124]

And no one seems to have a credible idea about where to find the trillions of federal and other dollars required to finance the work to be done. Especially when many in Congress are more focused on how to shrink the federal deficit (or finance more tax cuts) by slicing non-defense discretionary spending.

The opposite of a negative should not be another negative.

U.S. health care does not work well today to raise either health care outcomes or their equity.

But this does not mean that spending more on housing or other things will work *better* to attain better or more equitable health tomorrow. Especially if we don't really know how to spend money effectively on those other things. And, even worse, if we can't get hold of that money.

It is centrally important to distinguish among a) the longstanding power of social determinants to affect health and life and b) knowing how, today, to intervene to improve health by addressing social or economic forces and c) getting the money to intervene wholesale.

It is therefore likely that sustained high-volume production of words about wholesale investments in social determinants will have three predictable effects:

1. Talk will continue to substitute for action.

2. Great waste and inequity *inside* health care will get less attention from reformers and equity advocates than they deserve.

3. We will see continued suppression of access to health care for low-income urban and rural citizens as financial barriers to care grow, as hospitals and nursing homes close, as maternity and mental health and other services are closed, and as primary care continues to erode—both overall and particularly for low-income urban and rural citizens.

It would be more productive to work to improve the efficiency, effectiveness, and equity in each social sector. How to make housing more affordable for Americans? (This one step would greatly boost families' real incomes.) How to make individuals and families more confident, trusting, and loving—and safer? How to improve nutrition? How to avoid dangerous chemicals? How to boost education generally and job skills particularly so more Americans can secure work that pays more money?

2. Not easy—just easier than any of the others

2. Retail and wholesale SDL versions' successes to-date and future prospects

Supporters of higher spending on social determinants advance hopes that, by preventing health problems from developing or worsening, they can both cut need for health care and lower its cost while winning better health outcomes.

Some assert that it is possible to exploit capitation and value-based payments for medical care to finance meaningful increases in spending on the social determinants. Some believe, often with good reason, that primary caregivers and other health care professionals are well-positioned to learn about social needs and to design or deliver interventions that address them.[125]

Some imply that, if more money became available to spend on social determinants, we would know enough to target it to improve health outcomes substantially. Certainly, it is valuable to finance housing for a person who lacks a home and wants one. The same is true for nutrition and many other needs.

Batniji and colleagues, though, doubt that health care professionals know how to address what they call health-related social needs (HRSNs). They call for "social accountable care organizations" (ACOs) for Medicaid managed care patients. And for empowering social workers or community health workers, not medically-trained people, to control budgets and spending decisions.[126]

Whether to rely on medical people or social/community health workers depends considerably on whether the needs in question are discrete and visible, requiring compensatory actions, so that any reasonably competent person could identify and address them—if resources were available. Or whether addressing social needs is a complex and multifaceted challenge whose aim is to thoroughly elevate a person's overall competence or capacity to be more independent, safe, and secure.

But this doesn't hold for spending many hundreds of billions of dollars on large scale wholesale interventions. We don't know what's more valuable—housing or food or personal/neighborhood security or education and job training or other important things.

Some believe that spending on social determinants is inherently more equitable than spending on medical care.

And others hope that focusing on the wholesale or population-level social determinants can leverage a wide-ranging shift toward equity of life circumstances and life chances in the U.S. This rests in part on the steadily broadening view of public health.

These five hopes, assertions, implications and beliefs will be considered in brief analyses of the individual- and population-level efforts and proposals to invest more money in the various social determinants of health.

2. Not easy—just easier than any of the others

a. Better health? Saving money?

It appears that almost all of the actual, explicit spending on social determinants in hopes of improving health is at the individual patient (micro or retail) level, not at the population (wholesale or macro level). For individual patients, failure to address social, behavioral, economic, environmental, and similar factors was found to undermine the value of medical care to treat many health problems. So it became desirable or even essential to pay real attention to those factors.

Generally, social determinants and medical care face a double standard in the U.S. And within medical care itself efforts to raise the floor under American health care and efforts to raise the ceiling face a similar double standard.

Goozner has highlighted the value of pilot programs supporting spouses and other family members who provide help to patients suffering from Alzheimer's. Supports include teams including a navigator, nurse, pharmacist and social worker; and training, respite care, and guides to adult day health and other programs. Some of these underlying supports are themselves currently available but others are in short supply.

Goozner criticizes the federal response to Alzheimer's as another low-budget and fragmented pilot or demonstration program.[127] These are endemic in U.S. health policy. Witness the elevation of ineffective programs to boost primary care, for example (chapter 11).

Valuably, Goozner contrasts weak supports for spouses with the FDA's approval of another drug, Leqembi, that might be barely useful in briefly delaying symptoms of Alzheimer's at a yearly cost of $82,500 per patient. Together with a similar med, it is expected to generate $21 billion in global sales over the next 5 years.

Supporters of higher spending on social determinants often observe how helpful that spending has proven to individual patients afflicted by combinations of medical and non-medical (housing, nutrition, safety, isolation, and other) problems. While often expensive for individual patients, it is also often affordable because only small numbers of patients are helped. And it is practical when tangible resources—like vacant housing—happen to be in sufficient supply.

Mountford's and Davie's valuable delineation of "whole pathway" attention to stroke diagnosis, treatment, and rehab dovetails well with the view that acute, long-term, and social services are complementary.[128] It is discussed further in chapter 16.

These retail investments in individual patients are very hard to scale up to the wholesale or macro level to help populations of hundreds of thousands or millions of citizens suffering deprivation. One reason is lack of money. A second is lack of knowledge of where to invest to do the most good. A third is that real or concrete (non-dollar) resources to address social determinants—particularly housing—are already in very short supply in many parts of the nation.[129]

Francis has set out six sensible steps to integrate medical and social efforts in clinical settings. They are: which patients to target and how will they be assessed; which social needs will be addressed, and how intensely; how will team members support patients and how will supports be integrated with medical care; what data will be collected to evaluate the efforts; and what partnerships with community agencies will be needed.[130]

2. Not easy—just easier than any of the others

Some believe that spending more on SDLs would prevent many health problems from developing, thereby saving money now spent on medical care. Shrank and colleagues confidently posit that "Certainly, as MCOs [managed care organizations] invest in more social services to improve the health of their members, the offsets in health care costs should enable more of the nation's resources to be invested in the health of other groups…." [131]

They adduce little evidence in support of this view. More realistically, Brownlee and colleagues find that "the strategy of increasing social spending to lower health care costs remains unproven…." [132]

While medical care certainly has a 100 percent failure rate, so does prevention. Greater attention to SDLs means more effective prevention of some health problems. But prevention is not durable. In time, it fails. After illness or injury hits us, medical care is a reasonable response. It is rarely cheap.

Investing in some preventive or screening programs may not save money or boost health outcomes.[133] [134] [135] And in the longer term, a fair amount of evidence suggests that preventing some health problems can boost lifetime per-person health spending. This is particularly likely when eliminating one form of illness or premature death allows the beneficiary to become the victim of more prolonged—and costly—illnesses.

As mentioned earlier, Van Baal and colleagues found in a simulation study that preventing obesity cut cost of obesity-related diseases but that healthy-living people had the highest lifetime health costs while smokers had the lowest. Obese people were in the middle.[136]

One possibility is that many efforts to prevent illness, disability, or accident are effective. These may save money today. And health problems are averted. This is undeniably good. *But this resembles taking a short backward step on the up-escalator*. One problem is prevented but others are inevitable. And they may be costlier.

This is absolutely not an argument against prevention. Any bad thing that can be prevented—effectively and practically and affordably—should be prevented.

But prevention's aim should be understood to be more good years, not saving money. Savings will depend in part on the validity of the compression of morbidity notion, discussed elsewhere.

Cohen and colleagues analyzed cost-effectiveness ratios for 279 preventive and 1,221 curative interventions. The two sets of ratios were distributed very similarly, suggesting that preventive and curative interventions have been equally cost-effective.[137] But only a tiny share of the preventive interventions saved money.

Moran and Roberto examined the attractive "food is medicine" notion.[138] They found that some $350 million in research funding had been made available by NIH, the Rockefeller Foundation, and the Patient-centered Outcomes Research Institute. But they asserted that strong evidence for health benefits of retail interventions is lacking. And that their:

> own enthusiasm for this approach is tempered by the significant behavioral challenges plaguing the proposed interventions. First, people must be enrolled in food is medicine programs through the health care system, which is difficult for many to consistently access. Second, the health care system is overburdened. Even in primary care settings, most physicians lack capacity to address nutrition with their patients. Third, patient care

> coordination in the US is poor, with many physicians rarely making referrals to existing nutrition counseling services despite high need. Fourth, patient adherence to chronic disease medications is low even though the positive health effects from medications are relatively immediate. Eating healthy foods involves a far more complex sequence of behaviors….

Therefore, Moran and Roberto urge working to modify "food industry behavior to ensure that unhealthy foods are not ubiquitous and not as cheap and heavily marketed…." That sounds challenging, both politically and financially.

Similarly, Doyle and colleagues found that a controlled trial of food-as-medicine "did not improve glycemic control".[139]

Bond financing has been proposed as a way to raise money to address social determinants. Investors would buy these bonds only if they were confident they would be repaid. Repayments could be financed by reduced health costs, made possible by the investments in SDLs financed by the bonds. They could also come from the borrowing entities' general reserves. Such bonds have not been sold in any visible amounts. This suggests that investors have not yet found the promised cuts in health care costs to be credible.[140] [141] [142] Or that savings, if they were won, could be captured and returned to investors.

Chapter 15 describes a parallel and troubling proposal by several free market-oriented economists to persuade patients needing costly new meds to mortgage their homes to generate the money to buy those meds.

b. Finding more money to address individual- or population-level social determinants

The great majority of programs to address social determinants have aimed to pay for social services, housing, and similar supports to complement medical care for identified patients.

Many of these began as small-scale pilot programs financed with philanthropic dollars. Some have slowly won access to Medicaid or Medicare dollars. Some hope that value-based payments for health care have the potential to permit shifting meaningful sums to address social determinants if measurements of equity were built into the objectives of value-based payments for health care.[143]

Kindig and Milstein call for a balanced portfolio of investments in health care and in individual and population-level social well-being. They identify sources money that might address social well-being.[144] These include grants; bonds and loans and private equity investments that would be repaid with dollars saved by averting health spending; and a share of value-based payments for health care.[145] But they provide no estimates of how much revenue might be needed or of shares that might be raised by any these methods.

Uccello and colleagues describe difficulties and opportunities facing those who would redesign health insurance benefits to address social determinants of life. They urge looking past the ways in which broader benefits would immediately cut health care costs. That means considering effects on worker productivity, higher incomes, and other benefits.[146] This is a creative idea, but one that does not adequately confront the realities of high health care

spending—much of it wasted—that absorbs money that might otherwise be available to address social determinants of life. Health care is a car with an inefficient engine, but cutting its fuel supply won't make it run better. Improving its efficiency will mean better mileage, reducing intake of gasoline.

It is useful to examine actual past and current efforts to redirect health dollars toward social determinants. This reveals that almost all of these redirections actually finance micro, retail interventions to complement medical services for identified individuals.

Public payments

The first highly visible example, discussed earlier, was the effort at Mound Bayou, the first rural community health center, to prescribe food to tackle medical problems associated with malnutrition. Almost 60 years later, the Biden administration approved use of Medicaid dollars to pay for food-as-medicine and for nutritional counseling.[147]

The second, probably, was an early-1970s section 1115 Medicaid waiver in Worcester, Massachusetts to pay the first personal care organization (PCO) to deliver personal care and social services to accompany medical services. Designed by Robert Morris, the PCO evolved into the social/health maintenance organization (S/HMO), which combined Medicare and Medicaid dollars to finance medical care, long-term care, and social services.[148] [149] [150] The S/HMO concept—coupled with the experiences and insights of Robert Master and colleagues in providing and organizing acute, long-term, and personal care to elders (in home care and nursing home settings), to wheelchair-bound patients, and to people with HIV/AIDS—helped to give rise to the One Care program for dual eligibles.[151] Master's Community Care Alliance evolved into the first self-declared Social ACO.[152]

Emergence of the capitated PCO and S/HMO to help people needing long-term care is unsurprising. Chapter 13 discusses ways in which most long-term care dollars and efforts have always been devoted to social determinants like housing, food, personal care and other activities of daily living, and personal security.

Medicare and Medicaid launched small projects that spend money on social determinants. These have grown in scope and numbers of people. Data have not been compiled on how much money has been spent over time on which services for how many people—or to what effect.

Medicaid payments

Each easing of Medicaid rules to allow spending on social determinants works at a retail or micro level. That is, they might help a number of individual patients with medical problems that could be remedied or ameliorated by attacking a social, economic, environmental, or behavioral problem. The spending on social determinants would usually complement spending on medical care.

The initial visible attempt to use Medicaid dollars to address a health-linked social determinant was Rhode Island's effort to replace windows and frames whose movement generated lead dust and poisoned young children.[153] [154] Unfortunately, the program was administratively unwieldy and replaced very few windows. As often happens, Medicaid set a payment rate below

customary cost of the work. Also, local agencies had to pay for the replacements and then seek reimbursement from the state Medicaid program.[155] This approach will always be constrained by the amount of working capital available to front the money and await repayment.

Since 2013, a few Medicaid managed care plans have financed help to complete high school GEDs.[156]

No actual systematic (non-waiver) diversions of Medicaid dollars to pay to address social determinants of population health are visible. One proposal to do so would have Medicaid try to leverage greenhouse gas reductions.[157]

Regulators and researchers have sought fair ways to encourage Medicaid managed care plans to spend on social determinants.

Ash and colleagues studied the usefulness of adding social determinant variables to the diagnosis variables customarily used to predict spending on different Medicaid patients. They found that predictive power improved only slightly and that adding social determinant variables would reduce under-payments for people residing in the most severely stressed neighborhoods by only about 2 percent or $130 per person yearly.[158]

Machledt wrote in 2017 that it seems attractive to try to address social determinants like housing insecurity or parenting skills via Medicaid managed care, but that the managed care plans and individual clinical caregivers had both been reluctant to do so. CMS's 2016 revision in managed care rules explicitly added dollars to capitation rates to pay plans to address social determinants for individual patients.[159]

States might require managed care plans to offer incentive payments to in-network caregivers who screen for social, economic, or behavioral problems. States could withhold some capitation payments from plans that fail to screen for lead poisoning or fail to improve maternal morbidity. And plans could pay for minor home modifications and could count that outlay toward its minimum care share (medical loss ratio). Bachrach and colleagues identified complementary tools that states could use to encourage Medicaid managed care investments in social determinants.[160]

Late in 2019, North Carolina's Medicaid program released a schedule of fees for 29 interventions focusing on housing, interpersonal violence and stress, food, and transportation under the state's Section 1115 Medicaid waiver. The state contracted with social service agencies that would be paid for their work in these four areas when authorized by Medicaid managed care plans.[161] Huber and colleagues have reported early lessons from planning and initial implementation of the waiver in three regions of the state.[162]

In the waning days of the first Trump administration, CMS affirmed its belief that Medicaid spending on social determinants would boost health and save money. CMS declared its commitment to accelerating its shift to pay-for-value, and to its belief that value-based payments would enable states to address social determinants.[163]

Mann and Reyneri described a shift in CMS policy in the spring of 2022 that widened and routinized use of Medicaid dollars to finance attention to social determinants.[164] Until then, they wrote, Medicaid money was available only under Section 1115 waivers for small numbers of people.

2. Not easy—just easier than any of the others

Young wrote about efforts by 7 states to use Medicaid dollars to try to address gun violence.[165] Some talked of employing public health approaches to do so. Gun violence—like car crashes, abuse of chemicals like nicotine, alcohol, and opioids, and obesity—cause vast misery and early death. All involve tangled behavioral, economic, and social factors that are difficult to address.

Since Medicaid dollars are already inadequate in most states to finance needed medical care, it's important to ask whether spending more on gun violence will generate replacement dollars to sustain medical care spending. And it's even more important to ask whether programs to address gun violence are effective.

The Prevention Institute named 14 steps to prevent gun deaths. They included:[166]

1. Sensible gun laws. Reduce easy access to dangerous weapons.
2. Establish[ing] a culture of gun safety….
3. Public health solutions: Recognize gun violence as a critical and preventable public health problem….
4. Comprehensive solutions: Support community planning and implementation of comprehensive community safety plans that include prevention and intervention.
5. Trauma, connection, and services. Expand access to high quality, culturally competent, coordinated, social, emotional, and mental health supports and addresses the impact of trauma.

It is hard to argue against any of these. But it's equally hard to assess which of them actually work to cut gun violence in a nation awash with some 400 million firearms.

Smart and colleagues assessed research evidence on over 200 gun-specific policies' (or combinations of policies') effectiveness in cutting harm. They found that "few have been the subject of methodologically rigorous investigation."[167] They did find that reducing children's access to guns or requiring that guns be stored safely did cut accidents, injuries, and murders. They found moderate evidence that background checks and waiting periods cut murders. They found the same for keeping guns out of the hands of domestic violence perpetrators. These activities did not yield dramatic improvements. They do not seem to be amenable to strengthening by diverting Medicaid dollars.

CMS authorized California to spend Medicaid dollars for in-home asthma remediation, nourishing foods, paying deposits to rent apartments for people seeking to avoid nursing home care, and many other SDLs. Medicaid managed care plans would receive higher capitation payments if they chose to pay for these services. (All plans authorize at least two of the services, one of which must be intensive case management.)

These new items are supposed to be "medically appropriate and cost-effective substitutes for Medicaid services." That's why this approach is called "in lieu of services" (ILOS). States would need to offer evidence that the ILOS would be cost-effective. That probably means something equal to or approaching budget neutrality.

Jacey Cooper, California's Medicaid director, estimated that a 3.3 percent drop in ER, inpatient hospital care, mental health crisis care, and nursing home use would offset the cost of the ILOS supports.[168]

2. Not easy—just easier than any of the others

California intended to spend about $1.8 billion yearly—$9 billion over 5 years—to test the efficacy of this approach, called CalAIM. This looks like a lot of money. In one sense, it certainly is. Since state fiscal year 2023 Medicaid spending in California was expected to total about $133 billion,[169] and this would rise over the 5 years, CalAIM is budgeted to cost about 1 percent of yearly Medicaid spending. Is that still a lot of money?

Some think so.

California's Medicaid program has long been criticized for low rates of payment to doctors and hospitals. The head of MLK Community Hospital, in south-central Los Angeles, questioned shifting Medicaid dollars to pay for food or housing "'but they're still not willing to pay [adequately] for medical care.'"[170] One reason for MLK's financial distress is that three-quarters of its patients are covered by the low-paying state Medi-Cal (Medicaid) program.[171] Several organizations of caregivers in the state endorsed this view.

It is hard to reconcile three truths. One is that, while health spending is high, spending for lower-income people by Medicaid and other sources is usually inadequate. A second is that high—and rising—U.S. income inequality means that lower-income Americans often lack enough money to cover high costs of housing, food, and other necessities. And a third is that diverting money from health care for lower-income people isn't adequate to finance substantial retail investments in SDLs for individual payments—let alone large-scale wholesale attacks on homelessness, addictions, income inequality or their consequences.

Cooper, the state Medicaid head, said the state had been pressing the various Medicaid managed care plans to improve adequacy of care. But it is hard to see how that regulatory and punitive approach could offset shortages of Medicaid dollars in the state with the nation's 7th-highest share of people in Medicaid. California must pay one-half of the cost of traditional Medicaid with state dollars.[172]

At the same time, the shortage of affordable housing in Los Angeles and in other cities has made it hard for CalAIM to place homeless Medicaid patients in permanent housing.[173] This underlines the need to address housing principally as housing, not principally as an SDL.

Machledt cautiously concluded that "Medicaid cannot shoulder the whole burden of our social infrastructure. But the program can and should bridge the divide between health care and health more broadly defined." It is a little difficult to decide what those two sentences mean in practice.

Silverstein and colleagues described complicated and sometimes confusing relationships between health care and social determinants in a Medicaid ACO.[174] If clinicians prescribed use of social services more frequently, they thought, more comfortable relationships between the two might develop.

But one potential danger is that more frequent use could point more distressed citizens toward medical care in hope of obtaining Medicaid-financed investments in housing, social services, or personal care. That could strain budgets and supplies of goods and services available to address individual patients' social needs. As with housing in California cities, this points to the difficulty of leveraging large-scale social change from inside medical care.

2. Not easy—just easier than any of the others

The California Health Care Foundation issued a report on implementation during the first 18 months of CalAIM. It reported some successes but also a number of challenges. First, only about one-half of primary caregivers and hospital discharge planners said they were somewhat (or more) familiar with the program. Both groups are key to identifying and referring people in need. Second, most people in organizations actually providing social services under the program said that state payments were below their cost. Third, half said they were already saturated and lacked capacity to serve more Medi-Cal patients. Fourth, almost one-half complained about different managed care plans' different rules and covered services.[175] [176]

In May of 2024, Hart reported that "worker shortages, negotiations with health insurance companies, and learning to navigate complex billing and technology have hamstrung the community groups' ability to deliver the new services: Now into the third year of the ambitious five-year experiment, only a small fraction of eligible patients have received benefits." Still, a number of patients have received valuable help.[177] It remains to be seen whether implementation problems can be solved and whether efficient and effective aid can be delivered to people who stand to benefit substantially from it.

Financially, California Medi-Cal has faced challenges from time to time. In March of 2025, the state announced it would have to borrow almost $3.5 billion from a special fund that had been established to boost pay to caregivers in order to cover Medi-Cal costs through the end of the month. One reason was that the cost of expanding the program to cover undocumented immigrants was about $16 billion over the two most recent fiscal years, much more than the $6 billion expected. Another was a rise of $2.5 billion in cost of meds over the two years.[178] These challenges arose before any possible cuts in Medicaid, then under discussion in Washington.

In 2026, California's Newsom continued to back using Medicaid dollars to purchase housing, food, and other non-medical needs. He saw this as a way to complement medical care spending and magnify its value. Some Republican critics complained about scattered marginal uses of the money.[179]

A number of state Medicaid programs have begun to use program dollars to pay for housing.[180] Hart cites Cindy Mann, a former federal Medicaid director, as saying "'The singular focus on a financial return on investment is not as clear as it was previously….States are just seeing how little sense it makes to treat people and then release them back to the streets without the support they need." [181]

This vividly manifests two competing truths: Medicaid is under-financed, so diverting some of its money from health care to housing will mean less health care. And social determinants of life, like housing, affect health strongly.

Possibly, a related truth is that, sometimes—or often—neither medical care nor housing is enough to address human suffering.

A study of older Americans' housing needs from the Joint Center for Housing Studies identified growing problems of affordability, homelessness, and—for disabled Americans—need to coordinate housing supports with personal care. It recommended increased public financing for housing assistance and also personal assistance.[182] Since Medicaid is the main public payer for long-term care, the adequacy and quality of both nursing home and non-institutional care rest on the adequacy of Medicaid financing. These topics are taken up in chapter 13 on long-

term care. As discussed in chapter 14, mental health is also inseparable from social determinants of life and quality of life.

Medicare payments

The bipartisan 2018 Chronic Care Act allowed Medicare Advantage plans to pay for non-medical services for patients diagnosed with chronic illnesses like diabetes, Alzheimer's, Parkinson's, rheumatoid arthritis, and some cancers. Its aim was sustaining independence and reducing the number of acute episodes requiring costly hospitalization. Those supplemental benefits might include installing railings to prevent falls, a home health aide to assist with bathing, help managing multiple meds, rides to medical appointments, and supervised housing for people suffering dementia.[183]

The next year, DuGoff and colleagues urged expanding the Act's benefits beyond patients with certain medical diagnoses to cover people with certain medical and social risk factors.[184]

After 2018, some MA plans advertised offering help with transportation, air conditioning, pest control, and other social supports.[185] Marketing promises may have outstripped provision of help in addressing SDLs.

It is hard to imagine that MA plans will market to people needing costly non-medical supports unless MA capitation payments cover those added costs. Kindig wrote that "Population health improvement will not be achieved until appropriate financial incentives are designed for this outcome."[186] Phillips and colleagues briefly described several approaches to adjusting for social risks in setting capitation and other payment levels.[187] This may be difficult to do. Ash and colleagues, cited earlier, found that adjusting for social risks did little to shrink the gap in deficit between care costs and capitation revenue.

Any attempts to adjust MA capitation will run afoul of the current corrupt practices of a high share of MA plans—plans that make their members look costlier than they really are, and plans that skew their enrollment toward healthier members. It is hard to imagine how Congress or CMS would allow adding social risk factors to the formula for calculating rates until they find ways to address MA plans' stark ability and motivation to manipulate their revenues using only medical risk factors. As discussed in chapter 3, MedPAC's March 2025 report put overpayments at about 20 percent of MA income, or $84 billion for 2025.[188]

Hostetter and Klein examined very early implementation of the Chronic Care Act and, after noting it does not provide any added revenue to finance the expanded benefits, found that most MA plans were cautious in moving forward. One company that did offer benefits found that transportation and acupuncture were the two services most popular with patients initially, but that use of personal care assistance was rising. A MA plan in Minnesota and Wisconsin offered acupuncture to avoid or reduce opioid use for patients suffering severe chronic pain from cancer, multiple sclerosis, and diseases. Other plans have sought to address food insecurity or isolation.[189]

Evidence on use of services—or their costs is not yet available. Lankford wrote that "benefits may sound generous, but they can be limited."[190]

2. Not easy—just easier than any of the others

MA also offers three types of special needs plans. Severe chronic or disabling condition special needs plans (C-SNPs) are for patients with diagnoses including COPD, dementia, heart disease, and end-of-life kidney failure. Dual eligible special needs plans (D-SNPs) can enroll patients covered by both Medicare and Medicaid. And Institutional special needs plans (I-SNPs) are for those residing in nursing homes or are living at home but require nursing home-level care.

Enrollment in SNPs doubled between 2018 and 2023, reaching 5.7 million or almost one-fifth of total MA enrollment in 2023. Nine of 10 SNP enrollees are dual eligibles; almost one in ten suffer from severe chronic or disabling conditions, and only 2 percent reside in nursing homes or need that level of care.[191]

Some have suggested that ACOs might be a source of Medicare money to address social determinants. Fraze and colleagues reported that some Medicare ACOs, in their early years, paid attention to some patients' non-medical needs like transportation, housing, and food security.[192] It is noteworthy that Fraze and colleagues considered these to be ACOs' attempts to address *population health*. This speaks to the inconsistency in the words used to describe retail/individual- and wholesale/population-level efforts to address social determinants.

The ACO REACH (Realizing Equity, Access, and Community Health) program, which replaced a troubled and short-lived ACO model, has the right words and a cute acronym.[193] But is it likely to make a substantial difference? There is reason to worry that the flurries of activity in Medicare entail satisfying symbols but few real dollars or real help.

Unfortunately, the ACO effort has long been long on rhetoric about "paying for value, not volume" but very short on accomplishments. One consulting group wrote "few value-based programs under CMMI [CMS's Center for Medicare and Medicaid Innovation] have produced reductions in spending or improvements in quality." The various ACO options are confusing; they often overlap.[194]

Given ACOs' failure to save money, as discussed in chapter 8, Congress and ACOs themselves may be reluctant to see them spend substantial sums on social determinants.

<u>New money from ARPA-H</u>. Congress established the Advanced Research Projects Agency for Health in 2022. One of its programs invests in population health. Sanghavi and Alley think it will address "misaligned economic incentives in the U.S. health system [that] lead to an emphasis on individually focused interventions that respond to acute needs rather than community-based prevention."[195] They see ARPA-H as "buying" outcomes and expect the agency will prefer investments that elicit a two-fold match of federal dollars by local philanthropies, businesses, insurers, or caregivers that are willing and able to also buy in. Their reasons for expecting that response are unclear.

ARPA-H will make new money available. Whether its investments will be well-designed, well-targeted, and actually pay off remains to be seen. A month after his 2025 inauguration, Trump fired its director; the agency's future is uncertain.

Some real spending on population health or wholesale social determinants by private organizations, but also some posturing, virtue-signaling and smokescreening.

2. Not easy—just easier than any of the others

Anxious to mobilize money to help people who are vulnerable to denial of needed health care, advocacy groups like Community Catalyst have long pressed non-profit hospitals to justify some of their public subsidies (such as exemption from local property taxes, state sales taxes, and federal and state corporate income taxes) by demonstrating community benefits.[196] Initially, some hospitals responded by conducting immunization campaigns or community health screenings for diabetes or high blood pressure. Some critics condemned these activities as mainly marketing devices.

Subsequently, some state governments tried to systematize or, at least, compile data and report on hospitals' (and also non-profit HMOs) community benefit efforts. The Massachusetts attorney general was among the first.[197] [198] But those requirements were weak.

In 2008, the IRS began requiring non-profit hospitals to complete a Schedule H form when filing their annual IRS-990 forms. This may have been prompted by criticisms of non-profits—and possibly a preference for for-profits—by some politicians and by reports in the *Wall Street Journal* [199] and elsewhere.[200] [201]

Complying with ACA requirements, individual hospitals began carrying out assessments of their communities' health (CHNA).[202] Butler noted sustained efforts by the Bronx's Montefiore Hospital to address social determinants. But he recognized that if hospital responses to community health problems were effective, others might benefit but hospitals would incur costs.[203] He referred to this as another "wrong pocket" problem. He urged seeking ways to align hospitals bearing costs with those reaping benefits, learning which investments in social determinants actually pay off, and finding new sources of capital to finance those investments.

It's possible that this is actually a "no pocket" problem—that hospitals might spend money but health care costs would not be lowered. Almost as bad, it is very hard to measure, monitor, or regulate SDL spending mandates for 5,000 acute care hospitals.

Sandhu and colleagues have identified types of hospitals that report themselves to be more engaged in social needs activities. Larger non-profit teaching hospitals, those in the Northeast, and those not designated as critical access hospitals were more likely to report screening for one or more of the 5 social drivers of health identified by CMS.[204]

The Lown Institute embraced the demand that non-profit hospitals spend on community benefits at least as much as the value of their exemptions from local, state, and federal property, sales, and corporate income taxes.[205] Lown proposed 6 changes in federal law to improve community benefits. One would clearly define what actually counts as a community benefit. A second would require better reporting. A third would set clear standards for eligibility for hospital free care. A fourth would set a floor under required community benefit spending. A fifth would restrict aggressive hospital actions to squeeze patients unable to pay their bills. A last would cap CEO income and fringe benefits.[206] Subsequently, Lown's Garber added that hospitals should invest in the upstream drivers of health.[207]

Despite weak evidence of effective action, Johnson believed that "hospitals tackling social determinants are setting the course for the industry." [208] Sullivan analyzed hospitals' obligations to address SDLs. She hoped that the ACA, by lowering the number of uninsured people needing hospital care, would liberate more hospital dollars for that purpose.[209] In 2019, 14 large hospital groups promised to spend $700 million over 5 years ($140 million yearly) to fight economic and social inequalities.[210]

2. Not easy—just easier than any of the others

Pointing to high U.S. health care costs and inferior outcomes, Berwick and Williams asserted that hospitals need to devote more money to SDLs. They opined that disillusionment with health care—seeing treated patients discharged to poor housing or food, for example—is partially responsible for professional burnout. Profitable hospitals, they said, should therefore devote a minimum of 2 percent of yearly budgets to housing, food, child care, and other SDLs.[211]

Since Berwick has devoted decades to trying to fix health care itself, and has written some of the most insightful criticisms of health care and has offered some of the most valuable ideas for reforming it, his co-authorship of this commentary is noteworthy.

CMS's Office of the Actuary projected that spending by hospitals would reach $1.63 trillion in CY 2025. Suppose that two-thirds of that sum is spent by hospitals with total margins above 2.0 percent, or almost $1.1 trillion. Two percent of that sum would approach $22 billion yearly. It's worth noting that, unless hospitals could cut their expenses by an average of 2 percent, these hospitals' margins would drop.

By contrast, Horwitz and colleagues identified $2.5 billion in commitments by 57 health systems to social determinants during 2.9 years, or only about $860 million yearly. $1.6 billion was devoted to housing, or about $550 million yearly. Supposing a very low cost of $100,000 per dwelling unit newly constructed or renovated to make habitable, the $550 million translates into 5,500 added dwelling units yearly.

But Fannie Mae estimated the nation's housing shortage at 3.8 million dwelling units in 2019, pre-Covid.[212] The rate of household formation exceeds the rate of building housing, so the gap between need and supply has grown.[213]

Jacsamana and others perceived growing attention by hospitals to community health.[214] Some activities—like stabilizing housing costs—seemed aspirational, or even futile in today's world.

This underlines the importance of distinguishing the longstanding power of social determinants to affect health and life from the current ability to intervene to improve health by addressing those social or economic determinants.

Allen and colleagues distinguished hospital programs aiming to help individuals suffering social problems from those aiming at population health. They believed that "sustained improvement in the SDOH is likely to require community-level change."[215] They cited rhetorical support for this view from the AHA, the AAMC, and America's Essential Hospitals. But do hospitals have the resources to spark such change? And what is "community-level change"?

Allen and colleagues cited evidence that, they believe, supports greater interest in community-level change. I think they are optimistic in doing so. They mention CMS's rule that hospitals must report results of social risk screening beginning in 2024 as part of their Hospital Inpatient Quality Reporting Program. And that about half of states require Medicaid contractors conduct social risk screening. But do these amount to community-level change? What would?

Various organizations offer to finance investments in SDLs. Some of the organizations seem sincere in their motives and actions. The sums may look large in dollars—7, 8, 9, or even 10 figures—and they will help real people. But they are tiny shares of what needs to be spent to make a difference in housing, nutrition, education and job training, environment, personal and

neighborhood security, and other SDLs. Some of these efforts are sincere but most seem more like bandwagon-climbing and like opportunities for symbolic virtue-signaling.

CVS said it would put $114 million into affordable housing in 2020. In one sense, that's a lot of money. But with housing spending of $2.4 trillion in 2020, the CVS contribution added less than 5 1/1000th of 1 percent to the national total. CVS said its dollars would build or rehab 2,800 affordable dwelling units in 30 cities, including 460 permanent supportive units for homeless citizens. That would be just under 100 units in total per city. [216] Spending would be almost $41,000 per dwelling unit.

In 2021, Massachusetts Blue Cross said it would commit $25 million in grants to advance physicians' efforts to boost equity of care and to prepare for new agreements with doctors that would incentivize greater equity starting in 2023.[217] That's just 7 cents per Mass. Blue Cross enrollee per month.

In 2020, Boston Medical Center promised to invest $6.5 million over 5 years to support housing for homeless people. State legislation obliged hospitals receiving approval for capital projects to spend this money; it chose to devote all of it to housing.[218]

And in 2023, BMC trumpeted a program to use clean energy credits accumulated by rooftop photovoltaic cells to offer 80 families credits toward their electric bills of $50 monthly for a year. The credits would go to families covered by Medicaid who use lots of medical care and suffer a chronic health problem. This program built on a continuing effort by doctors to write utility companies to prevent shut-offs that could harm a citizen's health.[219]

Kaiser Permanente announced it would spend $400 million on affordable housing between 2018 and 2030, or $33 million yearly. It hoped to create or preserve some 30,000 affordable housing units with this money. The cost per dwelling unit would be only $13,333—a very low figure.[220] It was only one-third the low per unit cost projected by CVS.

Buying camouflage

Big drug makers have been criticized for high prices that disproportionately harm Black Americans.[221] [222] [223]

In August 2023, Pfizer paid for an article published in *Health Affairs Forefront* titled "How Can We Turn the Tide on Health Equity." Its lead author was a Pfizer vice president. It focused sharply on the very real "lack of diversity among health care professionals" and reported an assertion by 80 percent of participants in a Pfizer-sponsored summit that "investing in workforce diversity was the single greatest opportunity to advance health equity in the U.S." It mentioned Pfizer's support for STEM for New York City middle school students and other Pfizer-financed activities.[224]

It is worth asking whether these activities outweigh Pfizer's harm to health equity by setting high prices for its meds. And whether the *Forefront* article aimed to oil the stormy waters of prescription drug inequity. Drug makers have a history of mobilizing racial and ethnic groups to support their pricing practices.[225]

Pfizer's highlighting the value of making the racial/ethnic/linguistic/cultural mix of doctors and other caregivers better resemble the mix of the American people has the potential to advance

health equity. But so would actual efforts to finance health insurance coverage for each person, shift the configuration of caregivers to better match citizens' medical needs and locations, and equalize quality of care for all people.

In sum, three conclusions seem reasonable. First, new money adequate to address SDLs on a population or wholesale level will not materialize in the next decade. Substantial new public or private money from outside health care appears unavailable.

Second, diversions of money from inside health care—through greater public or private payer flexibility, or growth in value-based care—are likely to be devoted to addressing social needs of identified individual patients, usually in coordination with medical services, not population-level programs.

Third, this is not to say that efforts to address social determinants of life for individual patients are remotely adequate today.

Renaud and colleagues [226] and Basu and colleagues [227] have found substantial gaps between identified needs and current capacity.

Noting supply shortages, Vangani and colleagues have urged doctors to go beyond "screen-and-refer" for individual patients to "screen-and-intervene." [228] This might prove a more effective way to help individual patients secure housing or meet other needs, but it does not address the housing or other shortages themselves.

CMS has required hospitals to screen inpatients for 5 "drivers of health" starting in 2024.[229] And it requires doctors subject to MIPS to report on screening.[230]

Chang and Nuzum believed that requiring Medicare and Medicaid patients to be consistently screened for "drivers of health" (DOH) "would represent an historic shift in national resources to standardize such measures as well as progress in aligning our collective resources to achieve equitable health outcomes for all." [231]

Historic shift? This seems to suppose that greater attention to individual patients' unmet social/economic needs, and to documenting those unmet needs, will leverage substantial shifts in dollars toward SDLs. Developing a standard tool might allow clinical assistants to consistently assess patient needs. Standardization might also provide a consistent cross-walk between SDLs and ICD-10 clinical codes.[232]

It is not easy to discern a historic shift here.

In December of 2023, Abrams, Nuzum, and Chang wrote to re-emphasize the view that measuring DOHs will yield big dividends in shifting attention and resources to address those DOHs. They applauded five recent CMS actions. One asked doctors to screen patients for DOH problems and report percentages screened and percentages needing help. A second measured whether patients who screened positive were connected to help. A third embraced the term "drivers of health" and "vehemently reject[ed] the phrase 'social determinants of health' as demeaning and confusing." A fourth was defining 5 core DOHs—food, housing, transportation, paying for utilities, and "interpersonal safety." A fifth was outlining "measurement and reporting specifications for the five DOH domains." [233]

2. Not easy—just easier than any of the others

Abrams, Nuzum, and Chang bemoaned inconsistent definitions of the five DOH domains and weak efforts to actually document patients' problems or do anything about them. They supposed that better definitions would reduce burdens on caregivers.

More important, they believed:

> We have an opportunity at this early stage to press for consistency in the DOH domains measured in federal, state, and private sector programs. More consistent and routine collection will help providers and CMS track factors that influence people's health and improve coordination among providers and between clinical and social service providers. Without this consistency, there is significant risk of care fragmentation and data quality issues—as well as frustrated clinicians, patients, and care plans—that may impede efforts to improve health outcomes, reduce disparities, and lower costs.

It is difficult to understand how more consistent definitions and better reporting or coordination will do much to improve the health or lives of vulnerable Americans. CMS or insurers could certainly try to compel caregivers to report how they assess or try to remedy food, housing, and the other 5 core DOHs.

Many primary caregivers, already stretched thin, have begun requesting this information from patients upon checking in before visits. Also, as mentioned earlier, Sandhu and colleagues have identified which types of hospitals are likelier to report screening patients for the 5 core DOHs.[234]

But without much more money to actually address DOH problems, how would any of this help these doctors' or these hospitals' patients?

Taylor and Nichols describe a "community-based model for collaborative public good investing" that, they hope, will be a way to raise money and also identify opportunities for improving well-being or cutting costs.[235] It seems worth pursuing.

c. If very substantial dollars somehow materialized to address population-level social determinants, would we know how to spend them effectively, efficiently, and equitably?

More money to address social or economic factors that impair health of identified individual patients could probably be spent reasonably well. These patients' medical problems have been diagnosed. Their doctors and other health workers could spot social factors undermining recovery. Helping individual patients whose clinical problems are caused or worsened by homelessness, isolation, malnutrition, or lack of personal care often follows tangible and well-defined paths.

But if very large sums of money—somehow, at some time—were made available to address wholesale or population-level social determinants, it would be very hard to target or prioritize how that money might be spent effectively. The same lack of knowledge that plagued efforts by Model Cities programs in 1966-1974 to spend money effectively persists today. Which social or economic or behavioral or environmental problems are greater? Which programs are actually effective in making available more housing, food, income, or social supports? And which of

these investments do more to improve health and life generally? Which are more strategic—multiplying their effects?

We don't know.

Right now, this problem is moot. The money is lacking. Congress is far more focused on the federal deficit and the national debt than on substantial increases in spending on social determinants or other non-defense discretionary items. But it would be useful to know what to do with more money when or if it became available. And it is more likely to become available, other things equal, if we could offer evidence that it could be spent efficiently and honestly—and that the resulting goods or services will improve health and well-being.

Tikkanen and Schneider note that U.S. social spending per person is similar to that of other rich democracies. So they ask, if SDLs are important to health, why are U.S. outcomes inferior? Pointing to factors like high U.S. spending on income for elders and low spending on younger people, they suggest that the mix of U.S. social spending may be responsible for some of our low health outcomes.[236] Peres and Anderson identify specific gaps in social service spending such as the failure to provide meals-on-wheels to over four-fifths of disabled Americans in need.[237]

Shrank and colleagues, who support shifting health dollars to address social determinants, concede that "gaps and inconsistencies in the collection of SDOH information and lack of robust program evaluation data make it difficult to ensure that the right blend of services is targeted to the right people in the right way."[238]

Kindig and Milstein write that "An impressive body of research reveals why health and well-being depend on much more than clinical care. However, more empirical studies could make the causal connection clearer for investment purposes."[239]

These two assertions are somewhat under-stated.

Nikpay and others find that "Despite the strong interest in investing in SDOH initiatives by various stakeholders, the literature on the return from such investments is scarce."[240]

Taylor and colleagues examined 39 papers studying effects on health outcomes and health spending of investments in social services alone or in social services and health care combined.[241] Of these, 20 reported statistically significant positive effects on health, 5 on costs, and 7 on both health and costs. The remaining 7 had non-significant, mixed, or negative effects. The authors found evidence supporting housing, income, food, and care coordination interventions. While they measured statistical significance, Taylor and colleagues did not compile evidence on percentage improvements, cost-effectiveness, or benefit/cost ratios. That makes it hard to use the studies to identify the more productive targets for investing inevitably scarce dollars in social determinants. Taylor and colleagues reasonably concluded that "Further testing of models that achieve better outcomes at less cost is needed."

Taylor and Nichols describe a decentralized approach, mentioned in the previous section, that seems more promising. It invites investment in SDLs that may offer improved health or cuts in health or other costs.[242]

Muennig and colleagues recently reported mixed results from boosting the earned income tax credit. In New York, economic well-being, health, and mental health all improved. In Atlanta,

though, economic well-being and health did not change, and mental health may have worsened.[243]

Considering hospital attention to social determinants, Butler called for "developing the metrics required to identify and measure the social and economic benefits of a hospital's community work—the true return on investment."[244]

Nonetheless, the Commonwealth Fund has prepared a "tool to measure return on investment in addressing health-related social needs." The tool sought—or purported—to make it easier for health care organizations and community-based organizations to partner—by estimating resulting cuts in health care use, improved patient experience, quality of life, and member retention.[245]

Evidence needed to provide the data required to objectively estimate ROI is in very short supply. The Commonwealth ROI tool therefore invites creativity or optimism, which may shape the model's predicted results.

Williams and Marks wrote in 2011 that:[246]

> Because there has been little research to date documenting which aspects of community development could have the greatest impact on health, it will be increasingly necessary to rigorously evaluate the impact of various interventions to guide policy makers in identifying the most important measures to take in an environment of constrained financial resources.

As noted, this problem plagued Model Cities programs five and six decades ago. It persists.

Someday, opportunities will arise to conduct experiments to learn more about the value of investing in various social determinants. It will then be important to avoid the errors plaguing design and evaluation of the health insurance experiment of the 1970s. That large undertaking came to the not-very-remarkable conclusion that people who had to pay more OOP used less health care—even when they were compensated for the OOP spending. The researchers seem to have downplayed resulting harms to health, especially for lower-income people.

It's possible that much of the interest in higher wholesale spending on SDLs is a reaction to the high cost of health care, its inequitable use and outcomes, and the growing belief that spending more on SDLs will do more for health outcomes and equity. Much of this reaction is understandable and even valid. But reaction is vague and indiscriminate; it is closer to an emotion than to specific remedial action. Investments are much more effective when targeted. Targeting is hard in the absence of agreement on specific objectives and lack of strong evidence on which programs will be effective in attaining any of those possible objectives.

d. Spending on SDLs or medical care to advance equity

What is the evidence that public spending on social determinants is inherently more equitable than spending on medical care?

2. Not easy—just easier than any of the others

Because much of the spending on primary prevention—through immunization or screening campaigns—addresses entire groups of people, regardless of income, race/ethnicity, age, or geography, it is inherently more equitable than spending on either prevention or treatment for individuals. (Nonetheless, use of most clinical preventive services—like screenings for blood pressure, breast cancer, cervical cancer, or cholesterol—are much higher for insured Americans than for people who are uninsured.[247])

Current provision of publicly-financed goods and services to address socially-determined health problems afflicting individual patients is heavily weighted toward Black or Latine patients and those with low incomes. Americans unable to afford housing, food, or other necessities would be the overwhelming share of beneficiaries. In practice, these attacks on retail SDLs probably help greatly to improve equity of social care, health care, and health outcomes. Were money available to boost wholesale spending on SDLs afflicting populations, that money would probably also be spent very equitably.

Much of current health care spending in the U.S. is decidedly unequal. Different payers pay different prices for the same care. Payers also differ in the public and private regulatory barriers and OOPs they place between patients and care. Uninsured patients find it much harder to get needed care. So do Medicaid patients in many places. So do privately insured and Medicare patients who are unable to afford OOPs. Patients also differ greatly in having primary caregivers who know them, in use of dentists and mental health caregivers, and in proximity to emergency rooms and hospitals.

All this is decidedly true in today's U.S. health care. It is much less true in nations committed to equity in health care delivery.[248] [249] [250] So inequitable spending on medical care is neither inherent nor inevitable.

Given current U.S. medical care inequities, Schoenbaum and colleagues find that much mortality is "amenable to health care." Higher shares are amenable to health care in states with higher percentages of people who are Black or poor.[251] So more equitable health care has potential to address profound differences in today's health outcomes.

Horstman believes that changing how health care is financed can improve equity. But value-based care, she asserts, would need to be reformed if it is to advance equity. Early models, she writes, failed to address inequity, sometimes (as with hospitals readmission penalties) discriminated against caregivers serving patients with greater problems, and failed to attract sufficient caregivers to serve many Black or low-income patients.[252]

A Families USA report also highlights the need for payment methods to explicitly advance equity of health care.[253] It asserts that FFS's low payments for primary and preventive care undermine equity since both types of care are associated with greater equity.

Focusing on social and other non-medical determinants of health has the potential to threaten equity. In 2006, West Virginia obtained a federal waiver allowing it to impose behavioral burdens on Medicaid patients. Those burdens include signing an agreement to take meds, keep appointments, and avoid unnecessary ER visits. Violating the agreement entails loss of some benefits or entire eligibility. But a patient with cognitive or emotional difficulties—or low income or transportation problems—could have considerable difficulty adhering to the agreement. Then-director of CMS Mark McClellan lauded the waiver because "'Medicaid enrollees in West Virginia will now become part of an emerging trend in health care that

empowers patients to make educated consumer-driven decisions related to their own treatments.'" [254]

Similarly, advocates of work requirements for Medicaid have cited the value of work to health. In pushing work requirements, a Trump-era CMS statement asserted that "'CMS recognizes that…a growing body of evidence suggest that targeting certain health determinants, including productive work and community engagement, may improve health outcomes.'" [255]

Steinbrook notes substantial public support for asking people who smoke, eat more, exercise less, or otherwise lack a "healthy lifestyle" to pay higher health insurance premiums and OOPs [256]

The ACA permitted states to impose health insurance premium surcharges of up to 50 percent for tobacco users. Some states ignored this provision and some others set lower surcharges. But the financial penalty on smokers is substantial because they must pay the entire surcharge themselves since federal subsidies are set in line with base premiums for non-smokers. The surcharges seem to have cut insurance coverage but not smoking. [257]

e. Could greater attention to wholesale, population-level social determinants strategically leverage greater overall equity in the U.S.?

Would greater attention to social determinants and higher spending on them leverage a wide-ranging shift toward equity of life circumstances and life chances in the U.S.? Is it useful to adopt this broad view of health care and of public health?

This is partly a political question and partly a financial one. How much more money would have to be spent on social determinants to make visible and valuable improvements in the health of Americans? What is the range of estimates?

Iton and colleagues wrote that building community power could "dismantle policy-based structural inequity in population health." [258] They pointed to positive and valuable examples of ways in which organized local communities won more parks in Fresno, widening insurance coverage in San Diego, and buying less polluting buses in New York City.

It's useful, though, to consider the feasibility of scaling up from successes in moving millions of dollars to efforts requiring dozens or hundreds of billions of dollars.

Allen and colleagues categorize hospital actions to address SDLs. [259] One would "leverage business operations for community economic development" via hiring and buying locally. This aligns with the anchor strategy articulated by Ansell and colleagues. [260] A second would "improve the availability of local social services." And the third would "advance systems and policy change." These are all potentially positive. The last would be the most macro or population-level attention to SDLs.

But the examples cited don't appear very substantial. Both concern housing. One is Cone Health's partnership with community groups to push for enforcement of building codes. The other is three Boston hospitals' financing of community organizations to fight displacement, protect tenants, and other efforts. Unfortunately, neither of these efforts lowers cost of housing or makes more available.

2. Not easy—just easier than any of the others

f. Directly confronting each problem

SDLs

Emphasis on prevention, not treatment, and on addressing the wholesale- or population-level SDLs is one of a number of distractions that undermine public action to ensure affordable medical security for all Americans.

One of the promises of the health maintenance organization was better health and lower cost through prevention, particularly early detection of illness.[261] As just discussed, it is reasonable to assert that prevention is more equitable than treatment if prevention aims to help broad groups of people indiscriminately—free of discrimination—and since current treatment quantity and quality improve with income and vary with insurance coverage.[262]

Some experts and advocates assert that higher spending on SDLs would do more to improve health outcomes than higher spending on health care services. And some believe that spending more on SDLs would prevent many health problems from developing, thereby saving money now spent on medical care.

These assertions are seductive. But many seductions rest on things that are not true.

Prevention may be more effective than treatment for many problems. But it is a complement, not a substitute. That's because prevention has a 100 percent failure rate. (So does medical care, but that's a separate matter, one that will be discussed shortly.)

Prevention is not durable. When illness or injury hits us, medical care is a reasonable response. It is rarely cheap. Indeed, if the illnesses and injuries that kill us quickly and inexpensively are well-targeted by preventive interventions, prevention would lead to higher spending on medical care.

Since social determinants are very powerful, they should be addressed. Where will needed money come from? Should it be squeezed out of current or future health spending? Should it come from new taxes? Or should it come from smarter spending or redistributed spending within each sector of the economy or society?

Often, just as social factors influence health, so does health influence social factors. We have a two-way street. For example, people who suffer debilitating chronic illnesses suffer lower incomes.[263]

Finding the money

If we wish to spend more on the SDLs, we should note the very real possibility that failure to assure health security for all Americans and failure to contain health care costs are the biggest political and financial barrier to finding the money to finance more effective attention to SDLs.

In this view, substantial boosts in population-level public spending on SDLs are almost inconceivable before medical security and health care cost control are attained.

2. Not easy—just easier than any of the others

High levels of talk about SDLs have the effect of letting health care off the hook. If health care explains only one-fifth of health outcomes, maybe health care doesn't matter very much, and we should devote our substantial but finite energies to touting the social determinants.

But allowing U.S. health care to continue business-as-usual would be a terrible mistake. It would perpetuate high-cost, unequal, and often ineffective medical care. And that, in turn, would absorb money that might otherwise be available to address the various SDLs.

Worse still, stripping money from health care could well disproportionately harm the very people who are already the most vulnerable to deprivation of needed medical services.

Politically, it would be very difficult to cut today's health spending without systematic reforms. Many patients and caregivers and politicians would resist such reforms. Even harder would be the job of capturing any cuts in health spending in a bucket and pumping that money to another sector. How could saved health dollars be made available to be spent on improving education, nutrition, housing, the environment, or other sectors? Without careful and strong reforms in health care financing, any such savings would probably be returned to payers, like water pumped on to sand. They would not be available to build more housing.

As discussed earlier, some have proposed that hospitals, HMOs, physician groups, and drug makers be obliged to spend some of their own money to house homeless people, feed hungry people, and do other vitally important things.[264] UnitedHealth, for example, touts $11.1 million in "empowering health" grants to address social determinants in 2023.[265] The money would address problems like nutrition, isolation, behavioral health, and health literacy. This spending may signal virtue, offer good publicity, and make hospitals or insurers feel good about themselves, but it is dubious for several reasons.

Millions of dollars might be involved, but they are tiny sums in proportion to the size of the large social problems they purport to address. When Medicaid pays for these things, the result is likely to be less adequate Medicaid payments for actual medical care, which can make fewer doctors willing to care for Medicaid patients. Also, hospitals, doctors, drug makers, and other parties inside health care face enough challenges in actually delivering health care. They are not experts in housing, nutrition, transportation, or other sectors. Finally, if caregivers were to shift spending from medical care, to which sector should they shift it? No one knows whether spending more on education and job training, for example, would do more good than spending on housing or the environment.

That said, it is useful to distinguish small-scale from large-scale investments in SDLs. Health care organizations could develop competence in the former, and devise ways to afford them. A cancer clinic may offer to help patients navigate their care.[266] An emergency room might offer a frequent visitor who is homeless a path to temporary or permanent housing. A pediatric clinic might refer a family suffering inadequate nutrition a weekly visit to the hospital's food pantry. Patients suffering ill health compounded by poverty-related problems might be helped by a community health worker who is expert in securing income and social supports.

Advocates of greater investment in SDLs often seem to conflate two very different sorts of interventions. This retail-level help to individual patients differs enormously in ambition, scope, and cost from the large wholesale-level interventions to address community-level homelessness, inter-personal violence, family and behavioral challenges, food insecurity, environment, and other problems.

With expert partners, health caregivers could learn how to effectively and efficiently address the retail SDLs that are closely tied to specific health outcomes that caregivers understand. But there is no reason to suppose that health caregivers, themselves, have any expertise in addressing community-level housing challenges for hundreds or thousands of homeless humans, for dozens of thousands suffering food insecurity or personal/family/neighborhood-level personal insecurity and danger, and for all who suffer from lack of job skills and other sources inadequate income. Guilamo-Ramos and colleagues sketch ways to address clinical and social needs while setting limits.[267]

Still, it is easy to imagine a slippery slope here. If health caregivers have resources they can use to address patient-by-patient SDLs tied to specific health outcomes and treatments, will more Americans needing help with SDLs seek medical treatment as their path to that help? Probably. How many? We don't know. So we should pay attention and monitor events as they unfold. This will be particularly important in the future, once health care is reformed post-crisis. Then, all will have good access to health care and more people needing help with SDLs tied to specific health problems and treatment.

An example: The value of mental health courts in helping people change bad behavior has been discussed for decades. Fields described the working of a mental health court in Brooklyn in 2006.[268] Smith summarized the value of mental health courts in Massachusetts. Those referred by the courts went to the head of the line of people waiting for inpatient or outpatient mental health services.[269] This is not identical to the slippery slope problem, but it points to a parallel risk. Shortages of mental health care resemble shortages of housing, food assistance, and other vital resources.

Confront each problem

The share of health outcomes attributable to forces outside medical care is simply not known. But even if four-fifths of health outcomes are attributable to forces outside medical care, it does not follow—in logic or in evidence—that the most practical way to improve health outcomes is to shift money from medical care to other sectors.

One important reason is that key information is lacking. We observe that poor health is associated with problems with housing, nutrition, environment, education, income, behavior, and other elements of life. But this does not mean that health—or general well-being—can be—or is best—improved by improving housing, nutrition, and the rest. It may be that all these problems stem from—or are most heavily influenced by—one or more powerful factors.

A second important reason is that shifting money from health to other sectors is politically, financially, and logistically challenging.

A third important reason is that each of the other sectors is—like health care itself—plagued by its own problems. People in health care who are intimately aware of health care's many flaws are rarely aware of the many problems elsewhere. The grass may be greener. Or the observer may be color-blind. All humans can be tempted to magical thinking. For example: "I'll be happier if I move to a different city."

This outlook has long been embedded in health care reform itself. One of the reasons U.S. health care remains an expensive, inegalitarian, and wasteful mess is that health care reformers

pursue indirect policies and programs. Some of those are escapist "big fixes" like Medicare Advantage or Health Savings Accounts or competition or accountable care organizations or alternative payment mechanisms for doctors or closing hospitals.

This is understandable. Escapism is often the only politically and financially acceptable alternative to doing nothing. But indirect reforms are no substitute for direct attacks on problems. If the shortage of primary care is grave and growing, the remedy is higher pay and lower paperwork burdens. The remedy is not free med school or debt relief. If needed hospitals close, the direct remedies are to identify which facilities are needed, to learn how much money they require to efficiently deliver effective care, and to ensure that sufficient revenue is available.

With escapist thinking so well established in the minds of many well-intentioned health care reformers, it is not surprising that some make a larger getaway flight to advocating wholesale investments in SDLs.

A fourth, discussed earlier, is that pointing fingers at SDLs reduces pressure for reform inside health care. This has the effect of letting health care off the hook.

Confront housing

Other sectors—like housing—suffer grave problems of their own. These are problems that experts in housing do not yet seem to know how to address.

An important related idea is that each problem has its own causes, so progress requires confronting those specific causes individually and head-on. Chapters 7 through 16 of this book are devoted to examining problems in individual health care sectors, analyzing their causes, and pointing to specific remedies.

In the same spirit, it may be that each sector of the U.S. economy and society will benefit from greater efficiency, effectiveness, and equity—and can make its own contributions to enhancing life chances, overall well-being, and health.

For example, as Exhibit 2 – 4 shows, housing is about 15 percent of the U.S. economy. On a given day in 2020, some 580,000 Americans were identified as homeless. Three-fifths were in shelters or transitional housing and the others were on the street or in cars or abandoned buildings.[270] But, at the same time, Americans owned some 8.2 million second homes.[271] This is fully 14 times the number of homeless Americans.

Clearly, geographic, financial, political, and legal barriers preclude simply housing today's homeless people in today's second homes or other vacant homes. Still, the U.S. might consider steps to ensure that each person have one home before anyone has two or more homes.

Similarly, the U.S. Census Bureau's Housing Inventory Estimate counted 15 million vacant dwelling units that were believed to be habitable in 2022.[272] If we subtract the 8 million second homes, some 7 million vacant homes would remain. But again, a high share of these are in rural or urban places where jobs are lacking and where many would not choose to live. Millions of dwelling units have been abandoned. Detroit, St. Louis, and Youngstown lost more than three-fifths of their people from 1960 to 2020. Pittsburgh, Buffalo, Cleveland, and Gary lost more than one-half of their people.

2. Not easy—just easier than any of the others

Causes of homelessness differ for different groups and remedies must respond to those differences. Generally, homelessness grew after about 1980 owing to gentrification and rapidly rising housing costs in many urban downtown neighborhoods, rapid expulsion of many former residents of state mental hospitals, household formations greatly exceeding net gains in supply of housing, and cuts in federal HUD housing aid.[273]

A contributing factor was the Obama Administration's shameful reluctance to use appropriated funds to re-write mortgages to protect homeowners from foreclosure during the housing crisis that followed the 2008 sub-prime financial crisis.[274] (During the Depression of the 1930s, a similar program, the Home Loan Bank Board, had been successful.) Another contributing factor has been the increase in one-parent families. One income, too often, is not enough to afford today's rents in many places.

Many street homeless citizens have suffered grave personal traumas and tragedies.[275] Winning durable housing will often require human supports as well as bricks and mortar.

But for people suffering homelessness owing mainly to inability to afford high housing costs, the core aim should be to bring down those costs. With the shortage of housing approaching 4 million dwelling units, very substantial new construction is required.

Interestingly, HUD Secretary Fudge estimated a shortage of 7 million affordable and available rental units pre-Covid [276] but Biden supposed only a housing shortfall of 1.5 million units, citing Moody's Analytics.[277]

After mentioning estimates ranging from 1.5 million to 2.3 million to 4.3 million to 5-6 million, Lewis asserts that the housing crisis "can't be fixed with polite nudges and pocket change, while cities and towns continue to restrict new construction."[278]

All of the usual excuses for failure to build—NIMBY, zoning, high construction costs, shortages of skilled construction workers, high interest rates, high land costs, transportation problems, lack of accountability, and the rest—are real. But that doesn't make them acceptable.

Bailey reported that between 2001 and 2021, median U.S. rents rose by 18 percent while median renters' income rose by only 3 percent—both in inflation-adjusted constant dollars. Covid pushed rents even higher. In the 5 years from winter 2017 to fall 2022, median rent in new leases rose by 32 percent. Almost all of that was in the latter two years.[279]

Robinson and colleagues reviewed evidence on housing-first programs. They concluded that these programs did improve "housing stability. Findings on health outcomes and costs are mixed…." [280]

Housing is strategic

High housing costs' harms go far beyond homelessness. By depressing real incomes, they impoverish. They leave less money to buy everything else citizens want and need. By raising manufacturers' production costs, they impair U.S. international competitiveness. It is hard to think of a way to combat homelessness and poverty as much as a massive investment in housing.

New data illuminate this. Between January 2019 and May 2021, median mortgage payments on a median cost home hovered between 28 and 30 percent of median household income. Between May 2021 and May 2022, they rose steadily to 40 percent and has remained above that level.[281] This is caused partly by a tight supply of housing and partly by high interest rates. Without action on both fronts, housing's squeeze on incomes will persist. Unfortunately, some experts now expect sustained higher interest rates to persist.[282] If this is so, only building more housing can lower its cost.

But surprisingly, many reform remedies emphasize higher federal subsidies to lower-income people, not building new housing.[283] [284] More money chasing inadequate numbers of dwelling units could drive up rents on existing housing.

In May 2022, Biden announced 32 recent or proposed steps to build more housing. They included direct grants, interest subsidies, and incentives to ease local barriers.[285] Individually, some would be helpful. Combined, though, they are unlikely to do much to create enough new housing to ease shortages and visibly lower rents or housing prices.

Ivory and Colton offer several reforms with practical examples of each. One would remove local, state, and federal regulatory barriers, allowing more housing to be built more quickly and cheaply. By eliminating single family zoning, Minneapolis and Oregon hope to lower land cost per dwelling unit. A second is innovation in construction methods to lower cost. A third is creative financing, such as low-cost insurance to substitute for renters' security deposits. A fourth is auxiliary dwelling unit construction.[286]

Tokyo's exceptional success across large cities world-wide offers one set of ideas. Prominent among these are very few restrictions on land use and very extensive public transportation that opens up wide areas for housing construction.[287]

Many more ideas are needed.

Food

It is probably easier to confront equity problems inside food security than homelessness. Food absorbs just over 8 percent of the economy, as shown in Exhibit 2 – 4. In 2021, pre-recession GDP was $23 trillion;[288] total food spending that year was $2.12 trillion, fully 55 percent ($1.17 trillion) of which was for food away from home.[289]

In 2021, about 42 million Americans received Supplementary Nutrition Assistance Program (SNAP) benefits averaging almost $220 per person per month, for a yearly total program cost of $114 billion, including the federal share of administrative costs.[290]

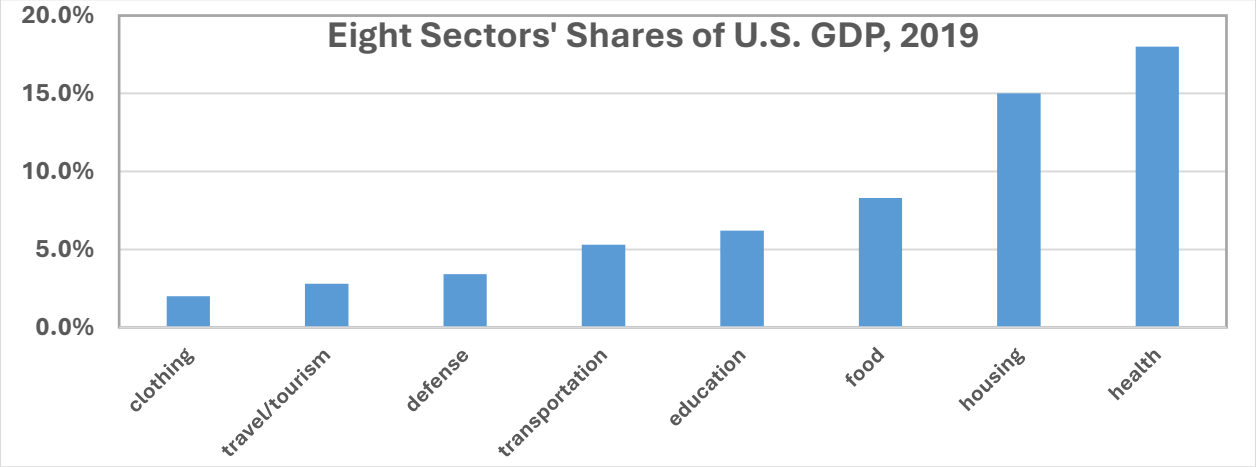
Suppose that a federal 5 percent food assistance tax (FAT) were imposed on food away from home costing more than $10, and that such costs were about one-half of food away from home. That tax would raise about $30 billion yearly, enough to boost monthly SNAP payments by about one-quarter—or to cover an added 10 million people monthly.

The 5 percent FAT would be highly progressive. Still, this specific program to advance food security may not be optimal or even desirable. But it is offered as an example of intra-sector redistribution. It asks the food sector to improve equity of nutrition, addressing an important

social determination of life. And politically, many people paying the tax might feel good about their money going to help others who lack food.

As with housing, protecting food security requires monitoring and responding to shocks like Covid. For example, inflation-adjusted spending on food by Americans earning less than $50,000 yearly fell by 20 percent from 2021 to 2023. Other Americans' spending was unchanged.[291] So low-earners' probably needed extra help, at least temporarily.

Exhibit 2 – 4



Addressing each problem head-on is superior to hoping that some magical or escapist solution to problem B will bail out problem A's sinking boat. In 1942, according to Blanpain:

> There was a strong conviction, and it was one of the tenets of Lord Beveridge's blueprint for the National Health Service in the United Kingdom, that enabling early access to hospital care would reduce the onset of irreversible and costly disease. It was predicted and believed that this would eventually lead to a substantial reduction in health expenditures in the near future.[292]

Similarly, early HMO boosters in the 1970s and 1980s touted primary prevention or early detection. Subsequently, promises to "pay for value, not volume" and other painless panaceas have pervaded U.S. health care.[293] Those who call for diverting vast sums from health care to address population-level SDLs are assuredly driven by the most positive and sincere motives. Doubtless, they are frustrated by the difficulty of reforming U.S. health care and to attain medical security for all.

But incessant talk about SDLs can blight two of our most cherished aims. That talk doesn't generate substantial new money for SDLs. And it takes the heat off health care reform. End-runs around health care problems won't work. Confronting those problems head-on just might.

Racial, ethnic, and religious bigotry, sexism, ableism, and other types of discrimination or exclusion are partly responsible for much of the unequal use of medical care and unequal health outcomes. All should be overcome as quickly as possible.[294]

2. Not easy—just easier than any of the others

But doing so is no substitute for covering all Americans fully and equally, configuring the right caregivers in the right places to redeem financial coverage through actual health care, and equalizing quality and appropriateness of medical care for all people in all places. Overcoming discrimination and winning medical security for all Americans are complements, not substitutes for one another. It would be sad if rhetorical endorsement of abstract ideals were to allow U.S. health care off the hook. Words of equality don't substitute for deeds of equality.

2. Not easy—just easier than any of the others

D. Assuring affordable medical security for all is the strategic intervention

It is useful to ask, What is gained by trumpeting the importance of social determinants or by steadily broadening the boundaries of public health?

I worry this approach will not yield substantial shifts in dollars to address population-level SDLs.

And that it will reduce pressure to reform health care itself.

It is more realistic to suppose that health care reforms that cap spending, cover everyone, and boost quality will be essential to liberate dollars to address population-level SDLs.

Fixing health care confers immediate benefits, since it would eliminate medical debt—a major cause of financial insecurity, impoverishment, and denial of needed medical care.[295]

Chapter 3 will assert, with evidence, that U.S. health spending is already enough to finance medical security for all. Nonetheless, decade after decade, health care has sponged up rising shares of U.S. economic growth. (See chapter 8, especially Exhibit 8-2.) This rise has not been steady. It has proceeded unevenly, with flat plateaus and sharp upward spikes. A wide range of political, financial, and medical forces power this growth.

Devoting rising shares of GDP to health care crowds out spending on all other things Americans care about. It means less money and less political willingness to rebuild family relationships and social bonds, reinvigorate manufacturing, invest in clean energy and address environmental pollution, house all Americans, assure adequate nutrition, educate for good citizenship and good jobs, renew infrastructure, fix criminal justice, finance defense, and anything else you care about.

This book rests on the belief that containing health care costs needs to be an inside job. And that it will require covering all people equitably, reforming caregiver payment, reconfiguring caregivers, and boosting and equilibrating quality of care.

Indeed, this book asserts that these jobs are mutually reinforcing—both politically and financing. Pursued carefully, they do not conflict with one another.

Hernandez-Cancio and others describe the importance of crafting payment methods to sustain and improve equity of health care by reforming both care delivery and caregiver payments. They highlight the value of adequate payment to safety net hospitals.[296]

While acknowledging these important and challenging requirements, this book deems medical security for all Americans the easiest problem to fix in our nation. And better, the combination of saving money on health care with making care and outcomes both better and equitable, will enable and power higher public spending on the social determinants of life.

Goozner offers a different and provocative view. He notes, accurately, that CMS's and CBO's forecasts of increased health care spending—including Medicare and Medicaid spending—have erred on the high side. And he believes that these incorrect forecasts discouraged Congresses and presidents from urging higher spending on SDOHs. He writes:

> When CMS gets it wrong, organizational planners around the country are given a faulty notion of how much money will be flowing through the system, which could lead to a misallocation of resources.
>
> When CBO gets it wrong, Congresspersons get a faulty notion of what resources are available to spend on other programs. It also feeds the GOP's hysteria around balancing the budget, which undermines political support for other social programs, including those that would actually improve the health of the nation.[297]

This is an interesting theory. It seems very unlikely, though, that politicians decide about higher or lower spending on housing, nutrition, or other valuable things in light of CMS's Office of the Actuary's predictions about health care spending during the decade ahead. How many politicians—or other Americans—think that far ahead?

Rather, it is the reality of current worries about deficits and debts, along with high health care spending—not the gap between forecasts and future spending—that crowds out and inhibits federal and other wholesale investments in SDLs.

Even more important, Americans are more likely to see a tension or trade-off between winning health security for all and containing health care costs. This book posits that neither can be attained without the other. Not politically. Not financially. Not clinically.

And that winning affordable health security for all Americans will constitute a highly visible victory for competence and compassion. For affordability and equitable access for all. That will do more than liberate money to address SDLs. It will help Americans imagine that building more housing will help the people who are newly housed affordably—and also all the people who can't afford today's costs of rent or home-buying. It will thereby boost real incomes. It will help us imagine that addressing transportation and land use could lower time and cost of getting to work for most of us. And that better education and job training will make more people more productive, which will help them earn more money and also lower costs of domestically produced goods and services.

None of these are zero-sum activities that make some people better off only by making other people worse off. Everyone wins.

Spending substantially more money on SDLs—to considerably balance life chances stemming from differences in income, housing, education and job training, environment, family structure, personal behavior, and other factors—would entail very large rises in taxes, public spending, and the role of government. SDL advocates hope that, by highlighting health care's own flaws, they will be able to somehow get the money needed to make big changes in U.S. society and economy. And, they assert, this will lower cost of health care through prevention. But they lack ways either to squeeze money out of health care to finance greater spending on SDLs or ways to pry added dollars out of governments. If they somehow succeeded, they would not slow the rise in health costs.

This book takes the opposite view. It asserts that leveraging the cascading political, social, and economic crises in the U.S. (sketched in chapter 1) to reform health care is the strategic step—the one that will build equitable medical security for all Americans. And the one that will liberate hundreds of billions of dollars to address the SDLs. The SDLs, in this view, deserve to be addressed because they are so important to life, not because they might be expected to save

money on health care. Besides, the illnesses prevented might be less expensive to treat that their successors. The way to save money on health care and to make it more equitable and effective is by fixing health care.

Similarly, at the macro or policy level, the way to fix housing is by fixing housing. Housing is too costly today for many people in many parts of the nation. And this problem is not new. Ehrenreich's brilliant *Nickled and Dimed* revealed the role of high housing costs in impoverishing low-income workers.[298]

Each sector that's broken requires repair. One broken sector can't ask other broken sectors to throw life preservers—they have none to spare. Levey's report on the role of medical debt in impairing credit rating needed to obtain housing illustrates the need to fix health care and housing individually.[299] The same for nutrition.

Health care and public health know almost nothing about how to address any of the SDLs. It is probably optimistic to say that experts in each field are not yet in agreement about the best paths forward.

At the micro or individual level, sadly, shifting health dollars to housing will be unproductive if housing is already in very short supply, as was suggested by some of the early CalAIM experience in Los Angeles.[300]

We should note the very real possibility that failure to assure health security for all Americans and failure to contain health care costs are the biggest political and financial barrier to spending more—to finding the money to finance more effective attention to SDLs.

Touting higher spending on SDLs may feel good. But where does it get us? Can we hear the proponents of business-as-usual in health care cheering us on—knowing that, like the French and British armies in May 1940, we are rushing headlong in the wrong direction, downplaying the murderous threat? Leaving those proponents free to harvest even more money without accountability.

Social factors have enormous power to affect health. But *it is vital to separate that longstanding power from our current ability to intervene effectively.*

Health care can't—and shouldn't—be asked to address the social determinants of life. They determine—to some degree—not only our health but many of the other things we care about We don't know which buttons to push—the most important things to invest it.

We don't know which investments in any one SDL will pay off more than others. *Focusing on the SDLs lets health care off the hook. It enables business-as-usual to continue. It liberates health care to continue to sponge up hundreds of billions of dollars in added spending yearly. It allows grave unfairness to persist in access to care and quality of care.*

If everything is a public health problem, does that mean nothing is a public health problem?

By contrast—
We know how to make health care more equal.
Enough money is already in health care to finance medical security.

2. Not easy—just easier than any of the others

2. Not easy—just easier than any of the others

E. Triple aim or iron triangle?

Can we win equal access to care, boost quality, and better configure caregivers while containing costs? Can these aims be pursued compatibly or must they conflict?

Berwick and colleagues assert that improving care and population health care are more than compatible with cost control—each of the three is essential to advancing the other two.[301]

In 2012, Carroll wrote otherwise—those efforts to improve access to care, to contain cost, or to boost quality or appropriateness of care must cause one or both of the others to worsen. For example, improving access must increase cost or compromise quality/appropriateness. He condemns those who believe otherwise as afraid of hard, "unavoidable truths." Or as politicians making lazy promises.[302]

Kissick described the trade-off differently in 1994. He wrote that the U.S. can't offer a rich mix of excellent-quality medical services for all people while containing costs. He refers to the mismatch between infinite clinical needs versus finite money and caregivers.[303]

No one should be surprised that pathology is remorseless, and resources are finite.

But so what?

The history of badly-designed access or quality improvements or cost containment efforts—the ones that, so far, have won political approval in the U.S.—supports the view that trade-offs are inevitable.

But Carroll and Kissick don't seem to acknowledge how much money and caregiver effort are wasted. And they don't seem to notice that other rich democracies spend about one-half as much as we do per person, give more care, and live longer.

Histories of health reforms in various rich democracies indicate that affordable care for all is financially unattainable absent cost controls. And effective cost controls are politically unattainable absent coverage for all people.

This suggests that well-designed reforms that are tested and implemented carefully, with solid political support, could boost access, contain cost, improve quality, and configure caregivers sensibly.

If about one-half of today's U.S. health care spending is wasted—as seems to be the case—the nation has ample room to radically boost coverage and quality, and support needed caregivers while containing spending. Dowd and McDonald are aware of the potential to recycle waste and think the barriers to doing so are political.[304] But their remedies are patient empowerment and market competition. That notion is debunked in chapter 4.

As chapter 3 now discusses, today's health spending is sufficient to finance affordable high-quality care for all Americans—sufficient to assure medical security for all. Even though it's not enough to assure immortality.

2. Not easy—just easier than any of the others

Spending this money more carefully will win a victory for competence and compassion, for efficacy and equity. And that will energize political will and liberate money to address the other determinants of better life.

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