Transcript of the Socially Determined Podcast

"Applying an Economic Lens to the Social Determinants of Health" with Len Nichols, the Director of the Center for Health Policy Research and Ethics (CHPRE) and a Professor of Health Policy at George Mason University

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ANNOUNCER:

Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, Board President of the National Association of Chronic Disease Directors. Dr. Gabriel Kaplan interviews Dr. Len Nichols, the Director of the Center for Health Policy Research and Ethics and a professor of health policy at George Mason University. Together they discuss the economics of public health and how an economic lens can help public health professionals address the social determinants of health. Thank you for joining us. Enjoy the program.

DR. GABRIEL KAPLAN:

Hello everybody and thanks for joining us today. Today we're having a conversation with Dr. Len Nichols. Dr. Nichols has been the director of the Center for Health Policy Research and Ethics professor of health policy at George Mason University since March of 2010.

He has been intimately involved in health care reform debates, policy development, and communication with the media and policymakers for 25 years, and has served as a senior adviser for Health Policy at the Office of Management and Budget in the Clinton administration. Since that time he has testified frequently before Congress and state legislatures, published extensively, and spoken to a wide range of hospital associations, hospital systems, physicians groups, sports directors and Health Policy Leadership Forums across the country.

Recently he's become focused on how payment models may be used to incentivize sustainable investments and the social determinants of health. And that's what we would like to talk to him about today. Dr. Nichols received his PhD in economics from the University of Illinois in 1980 and his B.A. from Hendrix College in Conway, Arkansas and his M.A. in economics from the University of Arkansas in Fayetteville. He lives in Arlington, Virginia with his wife Nora Super of the Milken Institute. Dr. Nichols, thank you for joining us.

DR. LEN NICHOLS:

Glad to be here Gabe.

DR. KAPLAN:

So I wondered if you could begin by telling our audience how you came to be interested in the economics of public health prevention and in the social determinants of health in particular.

DR. NICHOLS:
Well you know that's a good question because I certainly didn't spend most of my career doing that. But about two years ago I had three multi-year grants that were winding down and I'm approaching, in fact have now reached, Medicare eligibility myself.

So I was thinking, you know, I probably have one more big effort left in me and I happened to see my now co-author Lauren Taylor give a talk at a conference about social determinants and I was so impressed with her and with her command of this fascinating field I basically walked up to her and said, I know you don't know me and I don't know this stuff, but if you'll teach me social determinants I will find us an economic model to incentivize investment upstream. Because it seemed obvious from her talk and everything I've read since, we as a nation and communities across our country underinvest in social determinants, so the problem was how to discover a way to incentivize more investment in that.

And that's what I set out to do and somehow managed to do it. The other big reason to take it on is that it's one of the very few areas where you can actually simultaneously try to do something about health care costs, which everyone agrees are too high, and our endemic and systematic inequalities in our, in our nation and certainly in our health care system, and access to care and well-being. So it's a wonderfully fruitful area to get into.

DR. KAPLAN:
Yeah, I like the way you put that because I think one of the things that's so remarkable and wonderful to me about conversations around the social determinants of health is they really are an example of a policy issue in which we can provide benefits to everyone. When we make investments in these kinds of issues and when we also address inequality, it's true that everyone's going to benefit. In your writing you say that social determinants of health are examples of public goods problem. For our listeners who aren't economists, can you explain what this means and why it makes public sector and social solutions both challenging and necessary?

DR. NICHOLS:
Sure. You know when you think about social determinants of health as you know certainly, Gabe, maybe not all your listeners do, it has to do with those things outside the health care system that affect our health. And you think about all of us, housing certainly does, food we have access to, do we live in a safe neighborhood, can we exercise? Do we have a social network so that we're not alone? Do we have a proper understanding of what health professionals tell us? Do we have the right health literacy, etc. All these things matter. And when you think about people who don't have, let's just concentrate on housing for the moment. For the homeless, giving them housing would be an example of giving them something most of us take for granted, and it would certainly benefit that one person.

But turns out—and this is where the literature and evaluation is so interesting—providing housing and supportive services to people who are homeless and also have serious mental illness, or maybe they have substance use disorder, or maybe they have chronic conditions which are quite common of course among people who are forced to live outside, those folks, turns out when you give them housing, the benefits of that housing actually flow to more than them. It flows to health plans if they're covered in a Medicaid expansion state, it flows to hospitals who may have been treating them in lots of ways that are more expensive than otherwise and then maybe taking up a bed that could have been used on a more profitable patient. So there are lots of different people

downstream that could benefit from the intervention and that's why we think about it as a public good. A public good is something that benefits a whole bunch of people and the fundamental problem of public good, the national classic example is national defense. You know it protects all of us. No one will voluntarily contribute, I'll give you this much for the Defense Department, so we have to tax ourselves.

And so public goods create a problem that we call a free rider problem because people can benefit from the activity even if they don't contribute. Well, in the social determinant case, those different stakeholders downstream who would benefit from the provision of the housing can't capture the full benefit of that, of that gain and so they end up not investing in it, and that's why we underinvest in general. So the point of our model is to try to figure out how to make it clear all stakeholders could benefit if they organize themselves in a particular way.

DR. KAPLAN:

It's fascinating. You mentioned your co-author Lauren Taylor. How has the work of Elizabeth Bradley, who I believe Lauren has worked closely with, and others influenced your thinking in this area?

DR. NICHOLS:

Well that's right. Elizabeth was the person who really started our focus as a profession of health services researchers thinking about social determinants spending. She discovered that countries that spend more on social services tended to spend less than the United States anyway on health care. That's not hard, we're an outlier in health care—we spend way more than everybody else. But it turns out in particular in the study she did covering the 1995-2005 period, the United States also spent a lot less on social services than other countries. So we spend more on health care, less on social, and she looked in general and saw a number of examples where that seemed to be true and just raised the question: Maybe these things are related. So she did some pathbreaking statistical work showing that the ratio of social spending to health spending is predictive of things like life expectancy and infant mortality, real specific health outcomes that reflect the health of a population. So you could not have a person make a bigger impact than Elizabeth Bradley had. Lauren turned out to be an undergraduate at Yale when Elizabeth was doing this pathbreaking work, and later co-wrote a book with Elizabeth as well. So yes, Elizabeth started this field in a serious way.

DR. KAPLAN:

Can you explain for our listeners what the wrong pocket problem is and why it's so integral to understanding why our health care system underinvests in prevention?

DR. NICHOLS:

So really good question. Wrong pocket has to do with thinking about a situation where someone might spend money upstream and someone else would benefit. A classic example is a child who has asthma and maybe the child lives in a low-income housing situation. And so what they really need is an air conditioner and to have their carpets professionally cleaned, but they can't do that. Medicaid cannot pay for that. And so what happens instead is the kid keeps getting sick and keeps having exacerbations going into the E.D., maybe even being hospitalized, which Medicaid will pay for, but it would be way cheaper to clean the carpet, right, and put an air conditioner in a

window. So the wrong pocket problem is Medicaid can't do it, other people could put the air conditioner in there but they don't benefit from the Medicaid savings, so it has to do with the person who would pay for it can't benefit from it. That's exactly why we want to devise a better way to collaborate on the spending and the benefits sharing.

DR. KAPLAN:
We see that so often in healthcare, especially with our fragmented system where people are moving among different plans throughout their life and then of course they transition onto Medicare later in life. We see this with diabetes prevention in the chronic disease field where investments by private payers or by state Medicaid plans in diabetes prevention can reap savings for the Medicare program, but they can't capture it themselves and so it leads them to underinvest in those kinds of prevention strategies like the Diabetes Prevention Program that can prevent an individual who's prediabetic and at very high risk from developing those kinds of complications that come down the road. So it's endemic and it's interesting that this is really another example of that at work.

So what have you learned from your work and how does the model that you and Lauren Taylor have put together to fix the systemic problem of funding and executing interventions that address the social determinants of health and provide benefits to numerous people who maybe are unwilling to reveal that they're willing to make an investment to realize some savings there.

DR. NICHOLS:
So you know Gabe, I'd say the main thing we learned is that it's possible. It's possible to construct an incentive structure where indeed stakeholders who would benefit from a collaborative investment upstream might be persuaded to put their money on the table and actually execute the intervention. So that's number one. Our model essentially builds on a very simple principle and that is, if you think about a situation where an intervention—let's again say housing, or transportation, or food, is going to end up benefiting multiple stakeholders. In those situations, what you need to do is figure out what does each person or each stakeholder organization willing to pay, to accomplish the objective to get the person the services that are going to benefit them ultimately, and how to sort of capture that willingness to pay in a way that will tell the group, is it worth doing. And so the model sets up a mechanism and there are a couple of features that have to be present.

One of them is a notion of a trusted broker. A trusted broker is someone, typically you imagine a local philanthropy, maybe a United Way, maybe a local health department, maybe in some places it could even be a local academic if they were trusted enough; someone that the stakeholders around the table who could benefit from the intervention would be willing to tell, I'm willing to pay "X" to solve this problem. They would never typically reveal what they're willing to pay to solve this problem, this common public good problem, to their competitors because they'd rather have that other hospital or that other health plan do the contribution. But if they could be persuaded to reveal it to this trusted broker, who would keep the information obviously private and take the bids, if you will, from all of the stakeholders around the table, add them up, if the sum of the bids exceed the cost of the project, then you've got a value worth doing. You've got an economic value of the activity.

Then what the trusted broker could do with a little help from folks like us is assign prices so that if you think about it, the sum of the bids exceed the costs. Well then every single person could have a price assigned to them that would be less than their bid. And in that way guarantee them a return on investment—they would get a benefit back bigger than what they paid. And that self-interest would then be linked to continuing the project forever.

And that's really why we think it could be sustainable in the long run. So the model essentially marshals the self-interest of the stakeholders around the table and creates a mechanism whereby money can be collected spent down-, upstream, and then the benefits flow back to everybody and it keeps going forever because their self-interest is driving it.

DR. KAPLAN:

That's fascinating. So you mentioned this notion of a trusted broker in your model and you did mention that it could be perhaps a local health department. Most of our listeners are staff at state health departments working in chronic disease programs. And do you think the level of intervention needs to be locally grounded in a community, or is there a possibility that perhaps in some places state health departments might be able to play that role of the trusted broker?

DR. NICHOLS:

So certainly we would want state health departments to be involved. A, because they tend to be much more aware of kind of how things connect together and certainly if one state had one place that was doing this they would want to spread that knowledge later if it turned out to work and it's imaginable. And I certainly have seen people in the real world who could play this role. It's imaginable that the state people would have enough trust they could indeed play this role in various places. But our fundamental concept is that the stakeholders around the table are much more likely to be local because the population we're intervening with is definitely going to be local and the flow of benefit.

Be it monetary in some cases or even non-monetary, you know Gabe, there are people who care about the homeless and care about people getting food and care about people getting transportation to get the services that they need, even if they don't benefit financially. So you could have a non-financial benefit as well. But yes, state health departments—A, should be aware of and involved in the planning, and perhaps in some cases they could walk right in and play this trusted broker role absolutely, totally depends entirely on the credibility and trust that's been earned long before we arrive.

DR. KAPLAN:

That's great. Can you give us any examples of this work nationally and maybe communities that have read your article in Health Affairs, heard about this model and are trying to engage in this way?

DR. NICHOLS:

Well you know we haven't yet implemented it anywhere. We are now funded by the Commonwealth Fund, the Episcopal Health Foundation from Texas, the Missouri Foundation for

Health and the California HealthCare Foundation. So we've got a range of local and national funders and we are doing what they call a feasibility study, which is kind of like a learning collaborative. We're teaching the model to all newcomers for free through our series. We've had two in July; they're archived. You can still catch them if you'd like to catch up. We'll do two more in September and then we will do a deep dive and investigate which communities that are participating and seem to be the most likely candidates for successful implementation. And we'll do site visits to them in the the last part of ’19 and early ’20, and then we expect that some of them will want to do it, and we'll help them write proposals to get funding for the technical assistance to implement this thing.

At the moment I can't tell you for sure who's going to do it. I can tell you that our last webinar we had people from 28 different states, from 144 different zip codes, from 88 different counties, from Anchorage, Alaska to Lawrence, Massachusetts. From San Diego, California to Tidewater, Virginia. I mean, I gotta say, I've been overwhelmed at the response to this thing. Usually when you write a paper in economics you get like four emails and the first one says you should resign and coach football, and the second, you should have used a different data set, and a third one says you should have used this new mathematical proof.

We had 20 communities come to us within a month that basically said, can we do this here and no one is quite ready today, it is complex, and you need to have some technical assistance to make it work. But a lot of different coalitions exist around the country that are perfectly good candidates to do it over the next year or two years. Let me just say there are a couple of reasons these coalitions exist.

Number one: readmissions penalties in the ACA. Hospital A is penalized if a patient discharged from their hospital is hospitalized within 30 days in a different hospital. And that simple fact of the way A, people actually behave, and B, the penalty was structured, has led to hospital collaboration in some cases, Gabe, for the first time in various communities around the country.

There is even a coalition in Kansas City that's made a 501(c)3 for the purpose of helping hospitals coordinate and collaborate on this on this front. Number two: the opioid crisis, sadly, that brought criminal justice family services and emergency room people all in the same room. Once you get in a locked zone, spread around the solution to all their problems lies upstream; the solution has to do with significant services being given to the family, typically not just the addict but the whole family, right.

And so that put those sectors, if you will, imagine a coalition, collaborators around the table—my stakeholder table—it put them in the room. The third thing is Medicaid expansion, because Medicaid expansion basically in those states that did it, now cover, it means that many of the homeless population actually are insured for the first time ever and they're covered by a Medicaid managed care organization. And those organizations are highly focused on the fact that suddenly these homeless folks are now costing them money.

Well, turns out, they've been scouring literature and they're ahead of the game in figuring out how to identify them, how to find them, how to find which ones could benefit from services. And so you've got these three different sources for the collaborative activity going on and what our model really has done is catalyzed a vision of how to finance the collaborative activity in a way that no one's been able to figure out before.

DR. KAPLAN:
But what I love about all of this is, when you follow the news and when you look at the political dialogue going on today, and when you see the scale and breadth of the kinds of social and economic problems that we face as a society, it's easy to hang your head and feel that public health is going to fall so far down in the pecking order that our needs would never perhaps, you know, ever surface to be responded to. And what I love about this approach is it's so filled with optimism.

And it identifies so many opportunities to bring together people who have an interest in sitting at the table together. And it highlights that some policy changes, like payment reform and Medicaid expansion, have these unanticipated benefits because of the way they change people's incentives to now have conversations about these things for the first time. I think you see this a lot in conferences where you now see hospital systems going to conferences and talking about the social determinants of health and recognizing that this is as much a part of their business model for the future as the next MRI machine they're going to buy.

DR. NICHOLS:
Absolutely, same is true for health plans. And it is it is invigorating. Gabe, you know the notion of, as you say that to be blunt about the broken politics at the national level, at the local level, it doesn't matter how they vote—red, blue, green, or yellow. Everybody wants their community to work—where they live, and work, and play, and pray—and that's what's exciting about this, because there is no partisanship when it comes to trying to work together in these ways. And that is a breath of fresh air in all our lives.

DR. KAPLAN:
What's interesting to me also about this conversation, we earlier in this series had a conversation with Massachusetts which has a certificate of need program that they've used to leverage and incentivize hospitals and health systems that want to make investments in their infrastructure to make similar investments in the community and particularly in addressing some of the social needs and challenges that communities are facing.

Also in North Carolina—within our series we've had conversations with them—they have worked to seek an 1115 waiver from the federal government so that they can cover with their Medicaid program some of these social determinants of health issues such as a month's worth of housing.

And I think what it really underscores is that this landscape is changing so rapidly we are very quickly going from an environment in which I think many people in chronic disease felt like they would never be able to move into these upstream arenas, and now seeing opportunities that are sort of breaking out all over the place where they can connect their work to it and play a leadership role and advance some of this at their state.

DR. NICHOLS:
I agree it's exciting. And you know, I would just get back on the on the non-partisan nature of all this. You know some people in our country have always wanted government to spend less money and other people have always wanted to get more services to people—well, this is an area where you can do both because you could spend less in total by redirecting some of the

money that is now spent in health care upstream and thereby reducing net spending overall, and that is win-win across the political spectrum.

DR. KAPLAN:
Well thank you so much for your time today, Dr. Nichols. This is really such exciting work. And it's obviously pathbreaking and has found a resonant chord in communities across the country and in circles where people have been talking about these issues and challenges for almost a decade now. And really lays out an opportunity, and a model, and a framework for thinking about how we roll up our sleeves and begin to do this work. So thank you for your leadership on this, and for laying these ideas out there and playing such an important intellectual broker role in all of this.

DR. NICHOLS:

Well thank you for doing what you're doing and spreading the word and pulling together all these interesting speakers every week. So thank you Gabe, I appreciate the time. Thank you so much.

ANNOUNCER:
Thank you for listening to Socially Determined, a podcast brought to you by The National Association of Chronic Disease Directors. Please visit www.chronicdisease.org to listen to more podcast like this one.

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