Michael Litterer
20:831:541:90 ECON FOR PA
Case Study – Healthcare: Solving Wrong Pocket Problems Related to Health Disparities
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Introduction:

In FY 2021, welfare programs, including Medicaid, cost the federal government 1.056 trillion dollars, representing 15% of the federal budget. Of the 1.056 trillion dollars of federal funding spent on welfare programs, 521 billion dollars was spent on Medicaid, and 535 billion was spent on thirteen other welfare programs such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children (WIC). (Aizer, Hoynes, & Lleras-Muney, 2022) These figures do not include state-level spending. Despite the US spending 16% of its GDP on health-related costs, compared to the 8% spent in comparable countries (Irene Papanicolas, 2019), the US has some of the poorest health outcomes globally. According to (Irene Papanicolas, 2019), the US "manages to spend substantially more than any other country while achieving some of the worst outcomes across high-income countries." (Irene Papanicolas, 2019) By applying the Framework for Analysis of Expenditure Policy (Stiglitz & Rosengard, 2015), this case study will propose a new program that reallocates current welfare-focused funding better to address the social care needs of the US population. This program design will address health more broadly, including all determinants of health, and solve the current "wrong pocket" (Roman, 2016) constraints impacting the existing federal funding model.

Program Summary:

The Whole-Person Care (WPC) Program is analyzed in this case study. The WPC Program will coordinate and enhance total cross-sector investments to create the capacity and systems required to address all health areas through the Medicaid care system. The WPC Program will establish healthcare providers as the single service point for all individuals' social and medical care needs. Providers can provide whole-person, patient-centered care by consolidating social services such as food, housing, and transportation into the existing healthcare system. The

enhanced access and coordination created by the WPC Program will more effectively address healthcare disparities and positively impact health for the entire population while increasing efficiencies.

The need for a program:

The United States faces a health crisis that directly impacts the economy. The main contributing factor to the health crisis is the growing health disparities among certain populations and the limited ability of healthcare to address all determinants of health. According to the Agency for Healthcare Research and Quality (AHRQ), "Healthcare disparities are differences in access to or availability of medical facilities and services and variation in rates of disease occurrence and disabilities between population groups defined by socioeconomic characteristics such as age, ethnicity, economic resources, or gender and populations identified geographically." ((AHRQ), 2022) Research continues to demonstrate that poor health and health disparities have a tremendous impact on the nation's economy. According to Deloitte Insights, "health inequities account for approximately 320 billion in annual health care spending signaling an unsustainable crisis for the industry. This figure could grow to 1 trillion or more if unaddressed by 2040." (Asif Dhar; Dr. Jay Bhatt; Neal Batra; Brian Rush, 2022)

A key indicator for measuring the country's health is life expectancy (LE). According to (Chandran et al., 2022), "the US LE has lagged behind other high-income countries for decades; the 2019 overall LE (prior to the COVID-19 pandemic) was 78.9 years, compared to the average among comparable countries of 82.6 years." (Chandran et al., 2022) Socioeconomic disparities are highlighted by the Healthy People 2030 Report, which states that "after 5 consecutive years in decline, the US poverty rate increased to 11.4 percent in 2020, or a total of 37.2 million people." (Promotion, 2022) Furthermore, Healthy People 2030 suggests that "unmet social needs, environmental factors, and barriers to accessing health care contribute to worse health outcomes for people with lower incomes." (Promotion, 2022) This helps to show a direct correlation between socioeconomic factors and health. According to an article from Cornell SC Johnson School of Business, "there is a strong and growing body of evidence showing that better health contributes to the more rapid growth of GDP per capita." (BECK, 2020) This evidence clarifies that health impacts the economy and that a poor economy only worsens poor health.

Market failures addressed by the program:

While the federal budget classifies Medicaid and the healthcare services it provides as part of the overall federal welfare budget, the services offered by non-Medicaid-related funding continue to be siloed and challenging to navigate. Overall, our welfare-funded programs need to be more cohesive and utilized. For most welfare-funded programs, families are eligible for multiple programs, including Medicaid, SNAP, and others. Despite this, research demonstrates that "among families receiving means-tested government assistance, Medicaid was the program with the highest participation rate (84.1 percent) and public assistance was the program with the lowest participation rate (7.0 percent)" (Statistics, 2018) This data supports that a large majority of families do not access all the supports and services available to them. In addition to the limited utilization of services, we also see the limited ability of healthcare to address the exact determinants of health that the underutilized programs attempt to address. The healthcare system is not designed to address whole-person, patient-centered healthcare. Numerous studies show that "medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population. The other 80 to 90 percent are sometimes broadly called the Social Determinants of Health (SDoH): health-related behaviors, socioeconomic factors, and environmental factors." (Magnan, 2017)

In an article from Health Affairs, the current failure within our welfare service structure explains that "high US healthcare spending is the result of low spending on social programs. The argument is based on evidence that low social spending leads to a population that is sicker, and it postulates that this sicker population not only has worse health outcomes but also uses more health care—which in turn leads to higher health care spending." (Irene Papanicolas, 2019) With the federal government spending over 500 billion dollars on welfare programs, an argument can be made that the issue is not solely attributed to low spending but is more of a "wrong pocket" issue. According to (S. Butler, 2018), "a wrong pocket problem arises when one organization or sector is best placed to make an investment, but it is another sector—another pocket—that benefits from the investment." (S. Butler, 2018) The WPC Program will address the "wrong pocket" challenges currently faced within the welfare-funded programs and, more broadly, the US economy. If the social care needs of the public represent 80-90% of a person's health, funding allocations should be reflective, and healthcare should be equipped to address all social care needs. An article from BMC Health Services suggests that the incorrect distribution of welfare funds "is compounded by government health

policy that tends to favor medical and pharmaceutical interventions, further contributing to distortions in the allocation of resources and inefficiencies in the management of chronic disease." (Watts & Segal, 2009) It should not be suggested that each federal welfare program alone represents a market failure. Instead, it should be understood that the funding structure is flawed, and the government is well-positioned to drive change in healthcare. (Stiglitz & Rosengard, 2015)

Alternatives to the program:

The WPC Program will shift the government's non-medical welfare funding intervention from public production to private production with government regulation to ensure healthcare acts in the desired way. (Stiglitz & Rosengard, 2015) Direct grants will initially provide funding as the healthcare business model transitions to a wellness-focused system. Government funding will eventually be provided through billing reimbursements and value-based arrangements with Medicaid and other payers. (Stiglitz & Rosengard, 2015) Social innovation strategies will also be utilized to find public-private partnership (PPP) opportunities. One possible PPP model that could be employed is the Community Hub model presented by (S. Butler & Diaz, 2016). Research demonstrates that increased social spending will decrease healthcare costs. The WPC Program's outcomes will result in redistributing current welfare spending. In a study by (WellSky, 2022), the analysis found that " a study cohort with resolved food needs showed that: Emergency department visits were reduced by 32%, Hospital admissions were reduced by 32%, Re-admissions were reduced by 30%, and Hospital costs were reduced 31%." (WellSky, 2022) The increased funding focus on food insecurity had a direct and inverse relation to healthcare spending, further supporting the concept proposed by the WPC Program.

Particular design features of the program:

Eligibility will be a crucial focus of the WPC Program. Currently, welfare program eligibility is primarily based on income. Research shows that SDoH impacts all income levels. As with all other medical practices, the need will be based on the actual assessed need of the person, not their income alone. The broadening of eligibility will have higher initial costs supported by phase one direct federal grants provided to healthcare providers. While the short-term spending on social care will increase, the long-term expenditures in medical care will be far less than the

long-term spending on universally available social care supports. (Stiglitz & Rosengard, 2015) The WPC Program will also improve data collection, increase utilization, drive the redesign of the current healthcare business model, and increase budget flexibility to facilitate the braiding and blending of public and private resources from multiple sectors and sources. (S. Butler & Diaz, 2016)

Private sector responses:

An additional benefit of the WPC Program will be the healthcare transformation created. Private insurance payers use Medicaid as a guide to healthcare policy. Once the WPC Program succeeds, the private healthcare sector will establish a "crowd-in" effect. (Stiglitz & Rosengard, 2015) Without the substantial change the WPC will foster, hospitals will continue to have "no financial incentive to spend hospital money to reduce the need for hospital services and hence reduce revenue." (S. M. Butler, 2017) In addition, due to the high healthcare costs of the current model, the WPC Program will have no "marginal" effect (Stiglitz & Rosengard, 2015) due to the cost savings this program will create. The WPC Program will help to "make it economically rational for hospitals to do less repairing and instead provide more non-medical services themselves, or partner with other institutions to improve health. That requires changing the payment rules for Medicare and Medicaid to allow hospitals to be reimbursed for delivering or organizing a wide range of non-medical services that have been demonstrated to improve health, including supportive housing. Private health insurance plans must also explore ways to reimburse non-medical services that improve health and reduce medical costs rather than just reimbursing medical services. If we take serious steps to pay for improved health in this way, rather than only for repairing people, we will begin to transform the business model of the American hospital." (S. M. Butler, 2017) This demonstrates the substantial improvements in the current public and private healthcare system that the WPC Program will initiate.

Efficiency consequences:

As outlined by (Stiglitz & Rosengard, 2015), due to the limited information consumers have concerning the cost of social and medical care as a product, efficiency consequences related to the WPC Program will be less of a concern. (Stiglitz & Rosengard, 2015) It can also be expected that there will be an "income effect" (Stiglitz & Rosengard, 2015) associated with the WPC Program with no "substitutional effect" (Stiglitz & Rosengard, 2015).

When a person's social care needs are addressed and covered by their health insurance, the money that person was spending can now be spent on other costs. The increased spending allows the person to be better off, thereby further increasing the health and prosperity of the individual, creating an income effect. The WPC will demonstrate similar cost savings similar to the comparison offered by (Stiglitz & Rosengard, 2015) related to the old government food stamp program and the new electronic benefits transfer program. (Stiglitz & Rosengard, 2015) The multiplier effect created by the WPC Program will carry exponential health benefits and further strengthen the economy in the long and short term.

Distributional consequences:

To address the concept of distributional consequences, or more simply put, "who benefits," it is best to consider the "wrong pocket" model. The Wrong Pocket Model described that "a central challenge to governments seeking to implement evidence-based prevention policies, programs, and practices is that the government body charged with implementing or expanding evidence-based practices pays the up-front costs of the initial investment, but likely does not receive compensating benefits in the near term, or possibly ever. There are three primary reasons this occurs, including because the benefits occur in the future, the benefits are real but small and occurring per capita, and because returns are hard to measure; as a result, evidence-based programs often are underfunded or remain on the shelf." (Roman, 2015) The WPC Program will have a long-run incidence of expenditure impact due to the long-term health improvements and the subsequent strengthening of the economy. (Stiglitz & Rosengard, 2015) The WPC Program will be universal, so while there might be a minimal progressive distribution effect, the program will benefit everyone equally. (Stiglitz & Rosengard, 2015)

Equity-efficiency trades off:

The WPC is expected to have a Pareto improvement (Stiglitz & Rosengard, 2015) based on the idea that the program will improve large groups of people without making others worse. While the WPC Program will increase spending through direct grants in the short term, long-term spending will represent a redistribution of the current funding allocations, not an increase in funding. This means that overall welfare expenditures will not increase; they

might decrease, eliminating the need for income redistribution. Increased social and medical care utilization will also be economic drivers in all associated industries. (Stiglitz & Rosengard, 2015)

Public policy objectives:

As mentioned earlier, a vital indicator of the health of a nation is life expectancy (LE). The objective of the WPC Program will be to increase LE without increasing the overall federal welfare budget. Additionally, objectives will include expanding the utilization of services from the current utilization levels. These clear objectives will allow the federal government to set the objectives of the WPC Program clearly and in advance. (Stiglitz & Rosengard, 2015) As suggested in a report by Brookings, programs like the WPC Program "will enable states, localities, and other jurisdictions to pool a portion of their discretionary funding…other federal agencies, such as HUD, should develop similar blended grant programs to make financing more flexible for hospital or school partnerships that address social determinants of health and create community value" (S. Butler & Diaz, 2016).

Political process:

In the wake of the COVID Pandemic, our nation's health and the large amounts of funding dedicated to healthcare are critical areas of focus. The current attention and demonstrated need to address our nation's health helps foster the political will necessary to pass legislation related to the WPC Program. In an article by JAMA, the author explains that "the COVID-19 pandemic provides an opportunity for clinicians, health systems, scientists, and policymakers to address social disparities, and thereby improve the health and well-being of all persons in the US for both known and future illnesses." (Lopez, Hart, & Katz, 2021)

The goals of the WPC Program can be simply explained to the average voter. Health includes medical care and many social aspects, such as where we live, what we eat, and how we behave. To address the whole person, we must equip healthcare with the tools to address all the determinants of health. If providers give patients prescriptions to manage their health, why shouldn't they also provide a prescription for food? The nation's overall health will increase by infusing social and medical care, resulting in a more robust economy. The WPC Program will require an initial investment to allow the healthcare market to adjust. However, once that is complete, overall spending on welfare programs will not increase and be more effective and efficient.

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