December 8, 2011

To Fix Health, Help the Poor

By ELIZABETH H. BRADLEY and LAUREN TAYLOR

New Haven

IT'S common knowledge that the United States spends more than any other country on health care but still ranks in the bottom half of industrialized countries in outcomes like life expectancy and infant mortality. Why are these other countries beating us if we spend so much more? The truth is that we may not be spending more — it all depends on what you count.

In our comparative study of 30 industrialized countries, published earlier this year in the journal BMJ Quality and Safety, we broadened the scope of traditional health care industry analyses to include spending on social services, like rent subsidies, employment-training programs, unemployment benefits, old-age pensions, family support and other services that can extend and improve life.

We studied 10 years' worth of data and found that if you counted the combined investment in health care and social services, the United States no longer spent the most money — far from it. In 2005, for example, the United States devoted only 29 percent of gross domestic product to health and social services combined, while countries like Sweden, France, the Netherlands, Belgium and Denmark dedicated 33 percent to 38 percent of their G.D.P. to the combination. We came in 10th.

What's more, America is one of only three industrialized countries to spend the majority of its health and social services budget on health care itself. For every dollar we spend on health care, we spend an additional 90 cents on social services. In our peer countries, for every dollar spent on health care, an additional $2 is spent on social services. So not only are we spending less, we're allocating our resources disproportionately on health care.

Our study found that countries with high health care spending relative to social spending had lower life expectancy and higher infant mortality than countries that favored social spending. While the stagnating life expectancy in the United States remains at 78 years, in many European countries it has leapt to well over 80 years, and several countries boast infant mortality rates approximately half of ours. In a national survey conducted by the Robert Wood Johnson Foundation, four out of five physicians agreed that unmet social needs led directly to worse health.

Unfortunately, instead of learning from countries like Sweden and France, we prefer the frantic

scramble to recover money from one part of the health care system only to reallocate it toward retreads of previously failed reforms. We pretend that the fresh schemes are innovative, but they are usually long on promises, short on details and often marked with an annoying acronym: H.M.O., F.S.A., A.C.O. and so forth.

It's time to think more broadly about where to find leverage for achieving a healthier society. One way would be to invest more heavily in social services. This may be difficult for many Americans to swallow as it suggests a potentially expanded role for government. Out of respect for individuals' rights, our current social programs are mostly opt-in, leaving holes for the undocumented, uneducated and unemployed to slip through cracks and become acutely ill. Emergency rooms, though, are not allowed to opt out of providing these people extraordinarily expensive medical treatment before discharging them back to wretched conditions and their inevitable return to the E.R.

The impact of sub-par social conditions on health has been well documented. Homelessness isn't typically thought of as a medical problem, but it often precludes good nutrition, personal hygiene and basic first aid, and it increases the risks of frostbite, leg ulcers, upper respiratory infections and trauma from muggings, beatings and rape. The Boston Health Care for the Homeless Program tracked the medical expenses of 119 chronically homeless people for several years. In one five-year period, the group accounted for 18,834 emergency room visits estimated to cost $12.7 million.

We can learn from the star pupils in our analysis. Other countries have created government ministries that marry health and social care. Earlier this year, the Department of Health in Britain released plans to create health and well-being boards comprising local government representatives, primary care physicians, hospital administrators, children and adult-services specialists and public health directors, who will coordinate care for their constituencies across the health and social care spectrum. We should think expansively about how to construct similar programs that enable much needed integration of these mutually dependent sectors. The Department of Veterans Affairs is leading the way, with programs called "stand downs" that simultaneously address the health and social needs of retired service members.

It is Americans' prerogative to continually vote down the encroachment of government programs on our free-market ideology, but recognizing the health effects of our disdain for comprehensive safety nets may well be the key to unraveling the "spend more, get less" paradox. Before we spend even more money, we should consider allocating it differently.

Elizabeth H. Bradley is professor of public health at Yale and faculty director of its Global Health Leadership Institute, where Lauren Taylor is a program manager.