JAMA Forum: How “Wrong Pockets” Hurt Health

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Every month about 30 researchers, policy makers, and practitioners from 4 different sectors—health, education, housing, and social services—meet at the Brookings Institution in Washington, DC. We discuss policy reforms that would boost collaboration between sectors to improve the health of households and communities. We are especially interested in “social determinants”—nonmedical social factors affecting health.

The focus of a discussion might be children’s mental health, housing conditions, or aging. But whatever the topic, it is never long before someone raises an example of a “wrong pocket problem” undercutting the incentives for collaboration. 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. As any economist would point out, when a potential investor incurs the cost but cannot capture the generated value, there will be underinvestment.

Wrong Pockets vs Social Determinants

This issue is important in health care because the research literature increasingly emphasizes the importance of nonmedical factors in health. For instance, the absence of quality medical care appears to account for perhaps 20% of avoidable deaths and genetics another 20%. But social, behavioral, and environmental factors may account for as much as 60%.

The wrong pocket problem reduces optimal investment in nonmedical factors that would improve health outcomes. Examples abound. For instance, according to the Centers for Disease Control and Prevention, more than 800 000 people—disproportionately elderly—are hospitalized annually because of falls, costing the health system about $50 billion. Many of these falls result from uneven steps, loose rugs, bathrooms lacking features optimal for elderly individuals, and other home hazards. Spending money on home safety could sharply reduce medical costs and improve lives. But the housing agencies or private landlords who would foot the bill would see none of those savings as a return on their investment, so there is little financial incentive to make changes for health reasons.

Other examples include patients who miss appointments or fail to pick up prescriptions for want of adequate bus transportation, and children whose mental health deteriorates for lack of family counseling. In each case, investment in a nonmedical service sector would produce health savings or improvements, but the wrong pocket problem gets in the way.

Four Necessary Steps

What should be done to address this pervasive problem? Action is needed on several fronts.

One critical step is to expand and refine the research demonstrating the relationship between social investments and improved health outcomes. It is hard to make the case for health-related spending in a nonmedical sector without studies showing the potential return on investment. In some areas, such as housing, there is a substantial body of literature on the health benefits. In other areas, however, such as the health payoff of many antipoverty strategies, we need more analysis. We also need more organizations to catalog studies and make the findings available to state and local governments.

A second needed action is to break down silos between government agency budgets, so the prospect of crossover benefits becomes more influential in government budgeting. This is already happening to some degree. For instance, more than two-thirds of the states now have children's cabinets. With varying degrees of effectiveness, these bodies coordinate data and budgets across agencies to enhance the health and welfare of children. Maryland is a leader in this by also creating county-level local management boards, designed specifically to blend and braid funding across sectors.

There are proposals to create similar financial intermediaries across the nation. Tennessee dedicated a pool of resources to support an interdepartmental approach to adverse childhood experiences. Several counties and cities are taking similar steps to coordinate agency budgets to mitigate wrong pocket disincentives. At the federal level, the Department of Housing and Urban Development and the Department of Health and Human Services have also established a number of effective partnerships to tackle such issues as homelessness and asthma.

These initiatives are very helpful but they are not the norm. Far more budget coordination is needed.

A promising third strategy is, in effect, to bring all the pockets into the same budget process by creating bodies dedicated to enhancing health rather than only providing medical services. In this way, the full cross-sector value of investments is incorporated into the business model, by bringing in-house the investment and spending decisions for their enrollees that currently are made in other sectors. With such a business model in place, it is possible that the hospital or clinic of the future could evolve into a "mall" for a wide range of health-related services, such as housing, social services, and parenting education.

Medicaid managed care organizations (MCOs), Medicare Advantage plans, and similar health plans are well positioned for such a model because they receive capitated payments to keep enrollees healthy and have the financial incentive to do that creatively and well. They have a strong motivation to address social determinants that will pay off in reduced medical costs. And many already do. CareSource, for instance, covers some transportation costs for its Medicaid members. Significantly, the MCO's JobConnect program helps adult Medicaid members with employment training, transportation assistance, childcare, and other services so they can obtain and keep jobs—knowing that with stable employment comes reduced stress and better general health.

For managed care plans to overcome the wrong pocket problem, however, they must be permitted to devote a portion of their capitated payments to nonmedical services—which federal rules have made difficult in the past. Fortunately, these rules are slowly easing. For instance, Medicaid MCOs can now devote funds to a range of nonmedical services. Meanwhile Medicare Advantage plans have just won statutory and regulatory flexibility to offer their members a range of support services, such as delivered meals, transportation, and bathroom safety devices. Though controversial in some quarters, these are

important steps. But much more flexibility is still needed if managed care is to be able to focus on the determinants of good health, not just on medical care.

A fourth step is to test new organizational models that would mitigate the wrong pocket problem by creating procedures for the costs and benefits of cross-sector collaboration to be identified and built into decision making. Auditing firm KPMG is helping health organizations do this. Meanwhile, Len Nichols, PhD, and Lauren Taylor, MDiv, MPH, recently made an intriguing contribution by approaching the problem as a classic example of the need to find ways to fund public goods and to address "free riders" who reap benefits without investing in activities that actually generate those benefits. Drawing on an economic model designed to address these issues, they propose an organized bidding process within communities in which stakeholders would have to offer to share the investment cost. This process would be managed by the type of trusted intermediary that is already a common feature of successful collaborations.

The increasing attention to the nonmedical social factors in health is important for constructing a future system that enhances health, rather than one focused only on fixing medical problems. But for our system to evolve in this way, we need to address perverse incentives and deficiencies in health care's business model. The wrong pocket problem is one of the most troublesome of these. It is time to address it.

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