STRATEGIC HEALTH CARE

DR. BRAVEMAN AND DR. GOTTLIEB DISCUSS THE SOCIAL DETERMINANTS OF HEALTH

Washington, D.C.

Thursday, January 7, 2021

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P R O C E E D I N G S

MR. OOSTRA: Hello, my name is Randy Oostra President and CEO ProMedica. I'm pleased to welcome you to this eight-part series of healthcare reform discussions with nationally recognized health policy experts. These interviews will discuss Medicare policy including healthcare pricing, long-term care, and the social determinants of health. This series is part of ongoing two-year effort by more than a dozen hospital CEOs from around the U.S. to urge Congress to take up significant healthcare policy reform legislation largely by calling for the creation of a national commission on healthcare reform.

It is our intent that these policy reforms discussed during these interviews demonstrate our desire for substantive national reform. Moreover, that these interviews help to further inform congressional members and committee staff as they work to craft legislation to improve healthcare delivery and financing during the next Congress. Our motivation is straightforward. Well before the onset of the COVID-19 pandemic, we were adamant that race, age, and/or economic circumstances

should not be defined as preexisting conditions, nor do we accept the premise that Americans should be resigned to live shorter lives in poorer health.

We invite you to listen to or to read the transcripts of all eight interviews. If you'd like to provide comment, you can do so via the contact information we noted at the conclusion of these interviews.

MR. INTROCASO: Welcome to this series of eight interviews concerning federal healthcare policy reform. I'm the host David Introcaso. With me to discuss social determinants of health are Dr. Paula Braveman and Dr. Laura Gottlieb, both professors of family and community medicine, at the School of Medicine at the University of California in San Francisco. Dr. Braveman and Dr. Gottlieb, welcome.

DR. BRAVEMAN: Thank you.

MR. INTROCASO: Dr. Braveman and Dr. Gottlieb's bios are posted with this interview's audio file and transcript. On background, despite the fact the U.S. vastly outspends all other countries on healthcare, the country ranks near last or last in

access, affordability and outcomes, and this holds true even for white, educated, insured, and upper-income Americans. What largely explains this higher spending - poor health paradox are the social determinants of health generally defined as education, economic circumstances, food, security, housing, and social environmental and related exposures.

Where people live, work, and socialize determines approximately 60 percent of their health status whereas medical care accounts for approximately 10 percent. Despite the essential role social determinant's play, the U.S. has the lowest ratio of healthcare spending and social services spending in the OECD. For every dollar spent on healthcare, the U.S. spends one dollar on social services. Across the remaining 36 OECD countries, the ratio averages one dollar on healthcare to $2.50 on social services.

Two related points deserve note.First concerning economic circumstances, the U.S. suffers extreme income and wealth inequality. The U.S. has the fifth highest OECD Gini coefficient, and the top 0.1 percent of the U.S. population holds roughly the same share of wealth

as the bottom 90 percent. Second, as for the healthcare industry's investment in social determinants, a study published in February 2020 found that among 57 health systems that include 957 hospitals, or 1/6th of all U.S. hospitals, researchers found that they collectively invested only 2.5 billion in social determinants programming over atwo-year period or just 4 percent of their overall community benefit spending.

With me again to discuss social determinants policy are the University of San Francisco's Dr. Paula Braveman and Dr. Laura Gottlieb.

So with that as background or introduction, Paula and Laura, let me begin by asking just a general overview question that is: What's your general assessment of how we've addressed social determinants of health?

DR. BRAVEMAN: I think that you have -- this is Paula -- I think that you, David, have already cited some of the key evidence, you know, in the answer to that question. We are not doing well on the social determinants of health, and one very major piece of evidence for that is the fact that we -- although we

spend more on medical care than any other country on the face of the earth, but we consistently rank at the bottom or near the bottom among peer countries, and by peer countries, I'm referring to countries that are relatively high income and industrialized, and actually referring to democracies as well.

And I think that how striking that fact is has to be people to raise questions about, you know, what are we doing in relation to the social determinants of health, you know, that might explain that paradox of spending more than anybody on healthcare and yet having worse health. And it's very important to keep in mind that there have been very major scientific advances in the last 10 to 20 years that really have demonstrated scientifically the important crucial role that the social determinants of health play.

And just among the highlights among that I think that are important in understanding -- again understanding this paradox of spending more and having poor health that there have been -- some of the most striking advances have been those in neuroscience that have indicated about how social factors like income and

education and wealth and stress and racism actually get into the body.

And we have learned, and neuroscience has taught us that chronic stress is very likely a major contributor to both socioeconomic and racial or ethnic disparities in health. We've learned that childhood experiences, childhood social circumstances shape adults' health, and we have started to understand the biology of all of these.

We've understood -- started to understand how racism shapes health through pathways both that involve the living conditions and also pathways that directly involve stress, and the toll that chronic stress can take, and how that leads -- you know, what we've learned about the biology of that, how chronic stress actually leads to inflammation and to immune system dysregulation, you know, both of which lead to chronic disease.

What we've also learned the whole science of epigenetics have come up, and it's I think the most eloquent statement and concise statement about what epigenetics means is one by Professor Stern, a professor

emeritis from UC Davis that she said that genes load the gun, but the environment pulls the trigger, and I think that really sums it up.

So the science is there. I think that's a very important thing for people to understand that we're in a different situation now talking about the social determinants of health and how important they are than we were 20, 30 years ago.

MR. INTROCASO: Okay, thank you. So you reminded me of, you know, the phrase here on this per your point is allostatic load, so thank you for that. Laura, would you like to make a comment?

DR. GOTTLIEB: You know, Paula is really a national expert on this, so I don't know that I have a lot more to contribute. I think that this leads really, you know, to the next question, which is very much about, well, you know, if we have these 50 years of that, you know, increasingly strong consistent compelling evidence saying that social factors influence health, what has the healthcare system mobilized to do about it, and, you know, that is -- that's where Paula's and my work intersects, and where our team has, you

know, been focusing and increasing the amount of energy.

So, you know, on that front, I would just say that, you know, we've taken that 50 years of evidence, and then now with they're coupled with this increased attention value-based pair, and value-based care is modeled that the healthcare system is now saying: Oh, maybe we should be doing something about social determinants, and it's not that people weren't interested or weren't aware of that evidence as it was emerging that it was just much more piecemeal and much kind of less systemic or strategic.

And now I think really in the last decade we've been seeing health as some say: Gosh, you know, where's value-based care? We're going to be on the hook for this, and we can't be as siloed in kind of the traditional wheelhouse of medicine as we have been, as we've been pigeonholed before. So now we're seeing this sort of growing cross of health professional organizations that has been endorsed and a wide vein really of healthcare actions on social conditions of the strategy for improving both individual and population health.

MR. INTROCASO: Okay, thank you, and we will obviously get to the response, what it's been and what it -- where it should be or how it should evolve. Before I go there, I did purposely mention in my intro the income inequality or economic inequality issue, so let me push down on that. I did note, Paula, you had a short piece in via RWJF, "Wealth Matters for Health Equity" September 1, 2018, but that aside, because of course we know wealth is correlated to health.

I noted again economic inequality in the opening. Though the consequences of economic inequality are glaring, and one might phrase it or think about it in context of, and I'm sure you're well aware of the phrase "depths of despair." The problem receives extremely little discussion in health policy circles, and by organized medicine. In fact, I -- the AMA as an example of the ladder has interestingly said nothing about increasing the minimum wage which you are probably aware has not been raised -- the federal minimum has not been raised since '09. It's not indexed.

And, of course, it would be an important step to addressing racial inequality and health equity. So

my question is for you: Why have we not seen, and/or might we begin to see more emphasis in healthcare policy circles related to addressing the effects, just economic inequality, per se, and its effects on population health?

DR. BRAVEMAN: Well, you know, it's very interesting that both -- that economic inequality translates into a lot of people having -- living in poor conditions, and are living in the circumstances that we know are not good for their health, and those circumstances would include inadequate childcare and inadequate housing, and inadequate nutrition, and a daily struggle to cope with the everyday challenges while being faced with having inadequate resources, and so it's not just a theoretical thing, you know, a relative thing, the economic inequality.

There are, you know, too many people who are living in unhealthy environments, unhealthy physical and social environments that are under the control of social policy, but it's also very interesting and sad at the same time that economic inequality, there's very good reason to believe that that exacerbates one of the major

reasons, I think, that explains why we have such relatively low social service spending to medical care spending, and that's a profound lack of social solidarity and a lack of social cohesion, and, you know, scholars I think have laid this out pretty convincingly how it is that economic inequality can lead to greater -- to less social solidarity, to less social cohesion, and it's a vicious circle because then you also have less push for humane social policies for everyone.

And so I think -- I mean connected with that, the lack of social solidarity is the issue of racism, and I think in looking at what could explain why we have such a low ratio of social service spending to healthcare spending that it is very likely that -- and a lot has been written about this by many scholars, that racism has played a very important role in that why are we different from all of these other industrialized, you know, high-income countries, and many scholars have concluded that our racism has divided us and has made so that the majority who are more enfranchised and who have more power do not vote for programs that are going to help the disadvantaged because they see that the

disadvantaged represented by people of other racial and ethnic groups.

And so I think that the issue of racism and general social cohesion and social solidarity are really important here. I think the other -- you know, another major issue when we look at the causes what could explain, you know, the low social service spending in the U.S., and why the healthcare sector is not investing more in the social determinants of health which is that we have a huge for-profit healthcare industry, and it's a very powerful lobby, and that that's part of why there has been the success in getting more and more spending for healthcare, but that's a very important part of the scenario that's -- it's very difficult to deal with but must be dealt with, so I think that the -- you know, the low social service spending which may also just reframe it as low-investment in the social determinants of health.

Also I think the other big issue here are the silos, and Laura referred to that in passing in what she said, so I would just underscore that, that the way it's set up right now, you know, health is not the

responsibility of the healthcare sector that because the social determinants of health are such critical determinants, such critical factors that they are not under the control of the healthcare industry and the healthcare industry, you know, it should not be surprising that they have not felt responsible.

It's perhaps more remarkable that they have -- that there has been increasing interest shown by the healthcare sector, but we have these silos so that the one -- so if it's the healthcare sector, and let's just even include the public sector in this, if the healthcare sector invests in the social determinants of health, it doesn't get the credit. You know, the incentives are perverse. You know, the credit will go elsewhere, and that is that these silos in our government structure or, you know, it's in the structure, the general economic and social and political structure these silos I think have also have been and will continue to be a big obstacle to seeing investments in the social determinants of health including by the healthcare sector.

MR. INTROCASO: Thank you. Laura, did you

have a comment?

DR. GOTTLIEB: No, I just -- and to Paula's points about the wide range of reasons, lack of investment in social conditions in the United States and for addressing income inequality are so deep, and, you know, it's a particularly poignant time to be talking about them on the day after the Capitol was, you know, attacked by a mob because I think it just sort of lays bare these issues, you know, racism and lack of social cohesion and solidarity that are really sort of the fundamentally -- the causes of, you know, why we aren't investing.

Yes, why we aren't investing in health but also why are we not investing in health -- excuse me, in education or in employment or in other strategies for people to, you know, have equal opportunity, and, yes, I just -- how I really appreciated that, your take on the sort of range of reasons.

MR. INTROCASO: So --

DR. BRAVEMAN: And I appreciate you bringing in the issue of the attempted coup yesterday.

MR. INTROCASO: Yes.

DR. GOTTLIEB: Yes.

MR. INTROCASO: Yes. Yes. That part of the -- there are numerous other confounding factors least of which is because we spend so much on healthcare, pushing 4 trillion, it certainly crowds out other public spending, and when you said education, that was my immediate thought: Well, education -- if you look at state rather than federal levels certainly and the state budgets, too, when state Medicaid budgets are ever increasing, that crowds out spending or compromises state spending on education.

Let's go to the responses, and, Laura, you made note of we're moving into -- and per Paula's comment about perverse incentives, we're moving towards models generically termed "pay for performance" where as opposed to just fee for service or fee for volume. You're well aware that under the Affordable Care Act, we've started the program of Affordable Care organizations or Accountable Care rather organizations, the Medicare Shared Savings Program, MSSP, and they're incented to reduce their benchmark spending more or less any way they can, and so if they can address, for

example, the typical food security of course, housing stability, transportation or more common social issues, they can reduce clinical or medical spending, and we have seen when you address social determinants, for example, you can reduce or limit hospital readmissions for example.

So how do you think these models have progressed or are progressing again because now there's an incentive to incorporate or dovetail clinical care with social service supports, and moreover beyond the Medicare program of course we've seen this just by way of setup into this question is the Medicaid program?

The Medicaid program supports social determinant programming through waivers at the federal level and then states increasingly are requiring their Medicaid managed care organizations under contract to address -- in fact, all states Medicaid programs require the transportation services, and then from there it breaks down a lot of it is just encouraging MCOs to provide other services, so really we see more of this in the Medicaid space but increasingly in Medicare, but how do you see these progressing?

DR. GOTTLIEB: You know, this is another example where the question is very timely. Just today CMS actually issued a new saying health officers whether that this specifically clarifies some of the confusion that there has been around this sort of how you can use Medicaid and ship dollars specifically to support social determinants of

health-related services and so forth, and so this is hot off of the presses, but, you know, seven years ago or I think -- I can't remember when we did -- our first project was the state Medicaid agencies asking them what they thought they were allowed to pay for.

Well, we heard from the state Medicaid agencies at the time was we -- or actually, first we heard it from the Medicaid Managed Care Organizations was we don't really know, and then when we heard from the state Managed Care agents -- the state Medicaid agencies was: Well, we're not really sure, and we may like try to authorize something for our -- the managed care organizations under our -- you know, in our state, but we're not really sure if CMS is going to approve it, and now we're finally seeing CMS offer some much more

detailed items saying what's allowed and what's not allowed. So, yes, you're right.

In Medicaid there's been more flexibility than traditionally there has been in Medicare, although even in Medicare under the current Care Act in 2018 allows them more flexibility to support non-primarily health-related services. So, I mean, I can through some of the examples, you know, that are included in that letter, but you're right, it's mostly under waivers but there also is a lot of flexibility in case management and targeted case management support.

There is a range of social determinants related work that can come under long-term support for these services and community-based services programs. There is, you know, the health home activities. A lot of the 1115 demonstrations are enabling things like, you know, recurrent cleaning services, housing transition support which includes like one-time expenses for just like down payments. And then you mentioned medical transportation, but there's actually a lot of activity now around non-medical transportation and not (inaudible) in Medicaid and in Medicare.

So I think we're seeing a lot more flexibility. One of the major impediments so far or barriers so far to adoption has been this sort of ongoing confusion about what's allowed, and hopefully this new letter is going to really help, and even, you know, under that 2018 change to the Medicare Advantage supplemental benefits flexibilities, you know, you're not really going to see the changes until, you know, the process of what benefits are allowed or approved.

It just takes so long that we're not really going to see those changes until 2021, so, you know, we did some interviews with the (inaudible) or around 60 plan leaders from 31 different Medicare Advantage Plans, and a lot of them said: Yes, we're thinking about it, we're talking about it, we're including it in next year's plan, but they just weren't yet sure of, well, what should we be doing. And to be fair, like part of that is just hasn't (inaudible) what will be allowed, and then part of that is some lack of data and evidence about exactly which interventions are the most impactful, and so that we're learning a lot as we go.

MR. INTROCASO: Thank you. I'm glad you

mentioned MA, Medicare Advantage plans, of course because as you noted there was regulatory reform to what's supplemental benefits expansion CMS was authorizing, and I smiled when you noted because there was a lot of confusion over what was in and what was out relative to what expansion would allow for in MA. Let me -- I do have to -- I'd be remiss.

This is always sort of the crux of the matter, and that's the question other than sort of regulatory confusion or uncertainty, this always comes down to largely appropriately the question of ROI, or what's the Return on Investment, and you both would know much better than I would, but I do have at least some awareness that the research is somewhat mixed although maybe I'm being optimistic, but there is research that does show that there is a return because the argument you'll hear is, we don't know or uncertain, you know, how far we should go down this road because whether it's remunerative, so what's your understanding of the extent to which investments made in social determinants by providers does provide for them a return on their investment?

DR. BRAVEMAN: Well, I'm glad this issue came up. The fact is that the impact of many social determinants of health is not evidenced often for decades, and sometimes it's for generations, and it is impossible really to do a randomized clinical trial, so if that's the standard for evidence that you've got RCT reveals about the effectiveness of an intervention, you're never going to have it, almost never going to have it. You know, there are other study designs and methodologies that are rigorous.

RCTs aren't the only one, but that's part of the uphill battle, I think, is, you know, a recognition that, you know, the gold standard of the RCT is just it's not going to make it because the results show up much later. So for example with, you know, I brought up the issue of, you know, how neuroscience has traced out how it is that stress damages health.

Well, the way that it damages health doesn't show up often for decades, and so some of the most powerful social determinants are those experienced during childhood, and if, you know, you want to measure the effect of those during childhood, you know, you're

not necessarily going to see something. It's looking, you know, at that person's fifth decade of life, their fifth or sixth decade of life, and their premature mortality, you know, from processes that now -- I mean, we understand them, but, you know, I think there needs to be more discussion about, you know, so what is and what are the standards for the evidence.

And another obstacle is that there hasn't been enough investment to study the impact of the social determinant of health, and an investment in developing methodologies, creative methodologies that can yield rigorous studies; studies that are rigorous, yet not RCTs. Yes, I wrote a paper with some colleagues a while ago. The title was "When do we know enough to act on the social determinants of health?" And it was really, you know, a discussion of these issues.

MR. INTROCASO: Mm-hmm.

DR. BRAVEMAN: But we do need evidence. Just because you can't run an RCT or something doesn't mean that you can just, you know, throw out all the evidence, and for example, to do what the mob did yesterday at the Capitol building, and, you know, they weren't troubled

by evidence, so we want evidence. There always has to be evidence and critical thinking, and vigorous science, that there is some creativity that's needed because of this issue that the action of many of the social determinants in health does not manifest for decades.

MR. INTROCASO: Yes, Paula, I appreciate your mentioning childhood because this is the CDC's Adverse Childhood Experiences, a study that they've run longitudinally, and of course we do know that children who suffer, for example, childhood sexual abuse that manifests throughout their adult lives in pronounced and profound ways certainly.

Let me ask: Laura, since you addressed the Medicaid program I'd be curious to ask how are Medicaid program officers or state or federal Medicaid policymakers thinking about this issue if for no other reason how do they prioritize budgets or spending between and amongst the numerous social determinants?

DR. GOTTLIEB: Mm-hmm. So first, I agree with Paula. I think that there is, you know, the way we currently study impacts in many ways doesn't enable us to adequately capture the impact of intervention that,

you know, take a much longer time to manifest. At the same time, I think we are seeing a growing cross of studies that are showing that housing is both and cost effective. I just don't want to undermine that (inaudible) argument here, and that healthy nutritious meals are cost-effective.

We have very much a nice little group of studies that are showing that. There are some that are sort of multi-domain studies that are great evidence now from the group at University of Pennsylvania around the impact of community health workers that are really sort of helping people on a lot of different domains and showing that the ROI of that is very impressive, so, you know, people are turning to those few studies that do exist that suggest that there is in some cases an immediate ROI.

I think there's some big questions remaining around for which patients, you know, when we look at the utilization pyramid of, you know, the top one percent that use X number of resources, and then that sort of rising risk people that are sort of the 5 to 10 or 15 percent depending on where you, you know, put your lines

on your pyramid as people who use up resources in the healthcare system versus the sort of bottom 80 to 85 percent, and maybe that different types of interventions are relevant to different groups of those, and it may be that we're not going to move the needle necessarily for the top one percent, but maybe we could really make a dent in that rising risk group with some of these social risk-related interventions.

And then there's just one other point that I think is worth mentioning here which is, you know a lot of the interventions that we're talking about in Medicaid and in Medicare are really focused on concrete tangible modifiable social risks, but they're not really focused necessarily on community level social determinants kind of more upstream social and structural factors that then lead to these more downstream social risk factors.

And what we tried to do in the National Academy of the Medicine workforce that came out of -- gosh -- it's even the lost year of 2020, it now feels so long -- it didn't feel so long ago, but now it feels so long ago -- it came out in September of 2019 integrating

social (inaudible) into healthcare deliveries and improve the nation's health was to say healthcare systems not only could be acting on those sort of immediate tangible social risks, but they also could be making community level investments that might be more impractical on not only sort of the availability of social resources at the community level, but also more broadly impact structural and social determinants in communities.

And that was -- we actually have also seen some movement both in Medicare and Medicaid although more specifically in Medicaid where people are using, for instance, their first-year rent contracts to say: Hey, there should be a cap on Medicaid capitation payments to, you know, minimum threshold where like a certain number of dollars need to be spent on social determinants related intervention, or that Medicaid organization should be sure to have a social determinant related strategic plan including reinvesting in community health.

So I think that there -- you know, there may be a limit on the return investment on these like

individual patient level intervention, but we probably -- and we need to -- I'm not even going to say "probably". We need to figure out a way to study what the impacts are of reinvesting at a community level, and, you know, in some ways it's a way of just redirecting dollars from healthcare into, you know, where -- I think Paula makes that important distinction between healthcare policy and health policy and it's a way of saying: Hey, some of those healthcare dollars could be reinvested in the health policy or health investment that could be much more impactful on.

That was a long-winded way of saying that I think the return-on-investment argument is very complicated, and we need to be looking at it and much more dynamically.

MR. INTROCASO: Yes --

DR. BRAVEMAN: And I just want to say I am so glad that you clarified, though, Laura, that in spite of the -- it's true that it's difficult to study the impact of the social determinants of health, but in spite of that, there is a growing body of evidence that gives us a lot of information that we can act on now. And I also

think your point about looking -- the need to look about investments at the community level and not just the individual level, it's a very important one also.

MR. INTROCASO: Thank you. My last question is, and I'm citing this is -- you may be vaguely aware or know this, this was a RAND Europe 2016 synthesis study, and it drew some conclusions that we would find obvious. The U.S. has consistently spent much less on social programs in the gap between health and social spending, and the U.S. has widened over time, some other more sort of obvious conclusions, but two I found particularly interesting: One, they drew the conclusion that the association between health outcomes and social spending is stronger in countries with higher income inequality, i.e., social spending is particularly important in countries with greater income inequality such as the U.S., and they also found based on their review of the literature that the most consistent association between health outcomes and social spending is found in old age spending or spending on seniors.

And then thirdly, they found a stronger association between with better health outcomes for

public social spending versus private social spending. so that would argue that, say for example, the Medicaid and Medicare programs which of course is public spending should beef up their budget for or spend more on social determinants, or again social spending. My question is: How would you flesh-out or provide details of policymakers rather to how they can address increase social spending in the Medicaid and Medicare programs? Could these be loans; would it just be a budgetary line item; would it be enhancements to pay for performance models; how would we functionally do this?

DR. GOTTLIEB: I'll jump in, and, Paula, maybe you can help me flush it out, but I do think that this, you know, the opportunity in value-based payment models to really an expensive (inaudible) systems to invest in what works for seniors particularly is a real opportunity. So, yes, I do think we need to continue this move towards value-based payment models in healthcare systems.

You know, we had a big push. CMS thought they'd be much further along than where they are right now, in large part because of the incredible pushback

that they got from the for-profit healthcare industry, and then in part because of service. You know, it's hard to make these kinds of changes, but I think that the commitment is still there, and it's a, you know, bipartisan commitment as for as value-based payment models, and I think we've seen some, you know, pretty extraordinary effects of programs like the PACE model in seniors where they actually, you know, do provide things like housing transition expenses, and non-medical transportation, and support would actually be the daily living, and, you know, case management.

And that's about the great example of where paying first social care for seniors including care that addresses socialized relation in some of sort of around loneliness that can affect all (inaudible) for seniors actually really pays off. So I think investing in things like the PACE model that particularly because it is a value-based payment model is a perfect opportunity.

MR. INTROCASO: Thank you. Paula, do you have a comment?

DR. BRAVEMAN: No. No, I don't think I have anything to add except perhaps the notion -- I feel

ambivalent about the notion of the healthcare sector being given funding to address social determinant of health at the community level because I wonder whether that it means to be that -- you know, that investment needs to go elsewhere, not -- the healthcare sector is just too invested in healthcare and the individual model, and there should be some other sector that would, you know, for -- if it's essentially community development just -- I feel ambivalent.

On the one hand, I like the idea, and I think that evidence tells us that for a lot of the issues, it is an investment at the community level, but that's going to be necessary community level at the policy level. It's not going to be solved at the individual level. So, you know, shining a light on that I think is helpful, but on the other hand, I just have that concern about maybe it's better in some other sector, not the healthcare sector.

MR. INTROCASO: Well, that is a very fair --

DR. GOTTLIEB: May be. I think it's hopefully a -- I'm sorry. I was just going to say, David, that I think it's at both ends. I think the healthcare sector

can do some, and I think Paula's really right, that this is -- there -- you know, we need to separate a health policy from healthcare policy. There's some that the healthcare sector can do.

MR. INTROCASO: No, that's a very fair point, and I genuinely appreciate your making that point, Paula, that in many ways, per your earlier point, this is really community development, or should be community development monies, and it may be sufficiently a distinct or apart from what's certainly we know traditionally the healthcare industry has done which is very, you know, obviously clinically intensive.

So with that, Paula and Laura, we're at about our time for this discussion, so I do want to say I'm genuinely appreciative for it. We probably tried to cover too much ground here, but it's certainly a good overview of where we are, I think, and in fact I think you'd both agree that we have a long way to go in however or whomever addresses social determinants and factoring them into improving health status in population health. So with that, thank you both.

DR. GOTTLIEB: Okay. Thank you so much,

David, for reaching out, and, Paula, it's always so much fun to learn from you in things like this.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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