Social determinants of health affect the distribution of individual-level social risks to health, such as food insecurity, housing instability, and inadequate transportation. \(^1\) Social risks worsen health, health care utilization, and health care costs. For these reasons, those in the health care system are increasingly seeking to help with social risks, often by working with social services agencies and community-based organizations—a strategy called multisector collaboration. Such assistance includes providing food through "food pharmacies" and meal delivery services, supportive housing programs, and nonemergency medical transportation. Although such work is promising, health care-involved social risk interventions frequently contain 2 unstated assumptions: that health care involvement is uniformly beneficial, and that such involvement should be financed by increasing capitated payments for those at greater social risk. In this Viewpoint, we discuss these assumptions, the benefits and drawbacks of health care’s involvement in social risk interventions, and proposals to finance such involvement.

### Should Health Care Organizations Be Involved in Delivering Social Care Interventions?

Directing funds to health care organizations to address social risks does not automatically translate into activities that effectively address those risks. Involving health care organizations may medicalize social problems, and suboptimal implementation may reduce effectiveness. High overhead expenditures in the health care sector may increase intervention costs, and health care organizations face opportunity costs if such initiatives detract from other clinical activities. Furthermore, the capacity, expertise, efficiency, and community relationships of health care organizations will vary considerably, so not all organizations may be able to implement social risk interventions well, even if some can. Therefore, the choice to involve health care organizations in addressing a particular social risk should be considered on a case-by-case basis.

A key question is whether intervention effectiveness and efficiency are better with or without involving health care organizations. Health care involvement may be useful for interventions closely tied to health care or those that benefit from clinical expertise. For example, medically tailored meal interventions can address patient-specific comorbidities, such as diabetes or end-stage kidney disease. \(^2\) Here, coordination between the clinical team and meal delivery organization may enable the intervention to be tailored to a patient’s specific disease state, biomarkers, and care plan. But for social risk interventions in which health care integration is not critical, such as federal nutrition programs that provide resources for people to purchase their own food, \(^3\) the rationale for involving health care organizations is less clear.

When deciding whether to involve health care organizations in addressing a particular social risk, decision makers need to consider both existing evidence about the likely effect of doing so \(^4\) and potential downsides of health care involvement. Having funds flow through health care organizations to provide social services could require complicated waivers or regulatory changes. \(^5\) Furthermore, some health care organizations do not have the capacity to implement such interventions, \(^6\) and social service organizations face substantial infrastructure costs to integrate into health care payment systems. Passing funds through health care may also divert money from community-based social service organizations. Finally, although multisector collaborative
approaches may be effective for mitigating the consequences of social risks for specific individuals, they typically do not address the underlying social determinants that produce those risks. For example, nonemergency medical transportation does not address the income inequality underlying barriers to affordable transportation.

Financing Social Care Interventions That Involve Health Care Organizations

For cases where health care involvement in social risk interventions is beneficial, there must be adequate financing to deliver interventions sustainably, including payment models to finance both capacity building and ongoing service delivery. If funding is insufficient for community-based organizations to develop the capacity to serve patients referred by health care organizations and provide ongoing support, multisector collaboration will falter. Indeed, many locations lack social service organizations to address identified needs, or existing organizations cannot serve all of those referred—sometimes called the “bridge to nowhere” problem.7

Which payment models can solve these problems? Many proposals seek to finance social risk interventions by providing higher capitated payments to health care organizations caring for individuals with greater social risks (social risk-adjusted capitated payments). Although this approach can be reasonable, it is only one of several options and can have downsides. Social risk-adjusted capitated payments are particularly useful for capacity building. Furthermore, they can provide health care organizations with the flexibility to address risks when it is difficult to specify in advance exactly how the funds should be expended. Yet capitated payments also introduce the possibility that funds may not be used as intended.8 When public funds are directed to private insurers as intermediaries between public agencies and patients (for example, in Medicare Advantage and Medicaid managed care), careful oversight is needed to ensure funds are actually spent to address social risks. Further, such risk adjustment could encourage health care systems or payers to present their patients as facing greater risks than they do in reality.8,9

Another payment option is fee-for-service payment for services that address social risks. This approach has the advantage of ensuring that funds are directed to financing the services intended. However, fee-for-service payments do not address capacity building, could promote overuse of social services, and pay for service provision but not desired outcomes.

Finally, a challenge facing performance-based payments is how to set performance targets that do not inadvertently penalize organizations caring for patients with greater social risks.10 Adjusting payments based on population or individual-level social risk may be one way to meet this challenge—a different use of social risk adjustment than that described above. But although social risk adjustment of performance-based payments could help shield organizations that disproportionately care for patients with social risks from financial penalties resulting from factors beyond their control, it could also remove some financial incentives to improve care. Because each payment approach has benefits and drawbacks, a mix of financing mechanisms will likely be needed, working in concert toward the overall goal—getting beneficial services to patients with social risks.

Conclusions

The US health care sector is actively debating its roles and responsibilities around providing and paying for interventions to address social risks. A key factor in deciding to involve health care organizations in such interventions is whether that involvement is likely to be beneficial for the people served. Benefit should not be assumed, and likelihood of benefit probably varies across patient conditions, types of health care organizations, and local social and health care contexts. Moreover, for multisector collaboration to work, health care organizations must have genuine
community-based partnerships that address community priorities in ways that earn trust by incorporating patient and community voices.

When health care involvement in social risk interventions is beneficial, financing should support both capacity building and delivery of social services. Applying a mix of funding mechanisms may offset some of the downsides that each individual mechanism presents. Payment approaches for social care interventions need to be contextualized in the broader conversation around health care’s role in addressing social risks. In some cases, improving health for those harmed by social risks may be best pursued entirely outside of the health care sector through social policy changes. But in other cases, using health care dollars to address social risks to health may be one part of a comprehensive strategy to improve population health and health equity.

ARTICLE INFORMATION
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