**Sustaining Whole Health Investment CCRI Discussion Paper June 2023**

CCR makes two propositions. Increasing investment “upstream” in holistic wraparound programs of social services and primary care (behavioral, physical, and oral) will: (1) increase whole health/thriving for the vulnerable, and (2) decrease the current substantial payments for social failure (illness, corrections, et al). There is much evidence supporting the first; less data supports the second.

There are two ways to fund increased upstream investment. We can increase the budgets of individual social services and primary care, and then also pay for collaborative action to integrate individualized packages of those. This is what many other developed countries do. The United States has not attempted to do this in a significant way since the Great Society in the 1960s (and then temporarily increased investment in a range of individual services during the pandemic). The other approach is to focus on a defined group of people and “pay for success,” capturing some of the benefits and/or savings that accrue from such upstream investments in the vulnerable people and families. Those benefits and savings could range from lower expenditures on corrections, to projected lower spending on acute and specialist medical care, to improved productivity in local businesses, to improved educational results. In other words, they could be specifically defined savings such as those produced by ACOs today from health payors.

This second approach is fundamentally about investing, and being paid, for positive outcomes, rather than reimbursing for actions addressing failures. We invest enormous sums in sickness and social failure; we need but a fraction of that to achieve thriving. Yet this encounters some specific challenges:

1. Wrong Pocket. The benefits accrue to different organizations than those which produce them. Imagine if a group of primary care and social service groups formed a partnership, a Commons, and made upstream investments. If and when success was produced, they would not receive any of the downstream savings or productivity benefits. Those would go to others (e.g., savings by the jail system, savings by Medicaid/insurers, more productive workers for companies).
2. Timing. Unlike financing social failure, where payment occurs at the time of the service, these benefits typically will occur in the future, with different ones appearing in different amounts at different times. ROI for investments in kids can be huge, but they pay out over their lifetimes.
3. Upstream and Downstream Braiding. There needs to be an efficient method to aggregate the upstream investment in personalized family and individual packages (combining existing payments from primary care and social service sources with the increased investment to fund thriving and such a collaborative). Similarly, later benefits/savings come from multiple budgets (federal, state, local, and perhaps private). How can those be collected in a single Commons?
4. Risk. Even if a group of social service organizations, along with some health providers, figured out how to work together to produce much better outcomes, they are typically not in a position to assume the risk making the initial investment and then waiting to see if they achieve success before they get paid the extra costs they expended to produce those returns.

Shifting to investing comprehensively to achieve thriving from today’s system of reimbursing for fragmented actions addressing illness/social failure is extremely complicated. But it involves what every business faces when its leaders create a new business plan and seek investors. They are asking for investment now against uncertain returns in the future. We need to develop the data to prove our case.