



## Testimony Prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America – June 2013

### **Achieving Individual Health through Community Investment: A Perspective from King County, Washington**

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The United States spends more than any other developed country on health care, yet we rank toward the bottom of the pack on objective indicators, such as life expectancy.<sup>1</sup> All Americans—even those with health insurance, college education, and higher incomes—live sicker lives than people in other developed countries.<sup>2</sup>

What's behind our country's failure to create health? Some might point their finger at our national health care system, but that probably is not fair. Most of what affects health happens outside the walls of health clinics, is not “national” at all, and instead is a very local and community-based phenomenon.

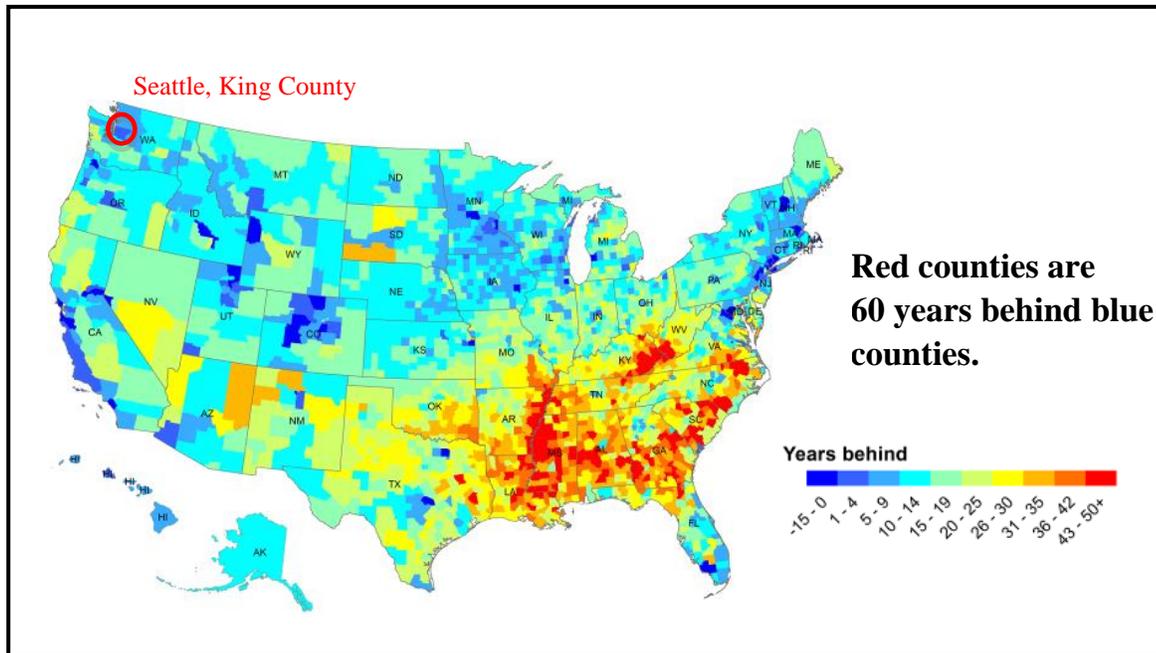
#### **Like Politics, All Health is Local**

The Institute for Health Metrics and Evaluation (IHME) recently analyzed the rate at which life expectancy has been increasing among the world's 10 best performing countries.<sup>3</sup> In 2007, the top 10 countries had an average life expectancy of 82 years. In contrast, the life expectancy in the United States was four years lower, 78 years—the same as these other countries had been *16 years earlier*. So, even if we could match the improvement trajectory of the best performing countries, it would take the U.S. at best 16 years to get to where the other countries are today.

Although disquieting, it turns out that focusing on our average national life expectancy masks the real underlying problem. IHME next imagined that each *county* in the United States was its own country and calculated how each county would fare relative to the top 10 performing countries (Figure 1). What immediately became clear is that our national average obscures the huge county-level differences in life expectancy that are the actual basis of our country's overall lag.

While some counties are doing as well or even better than the 10 top comparison countries, other counties, particularly in the southeast, are up to *50 years* behind. The solutions for our national problem seemingly need to be regional, with a special focus on the regions that are lagging the furthest behind.

**Figure 1.**  
**U.S. life expectancy by county compared to average of top 10 countries, 2007**

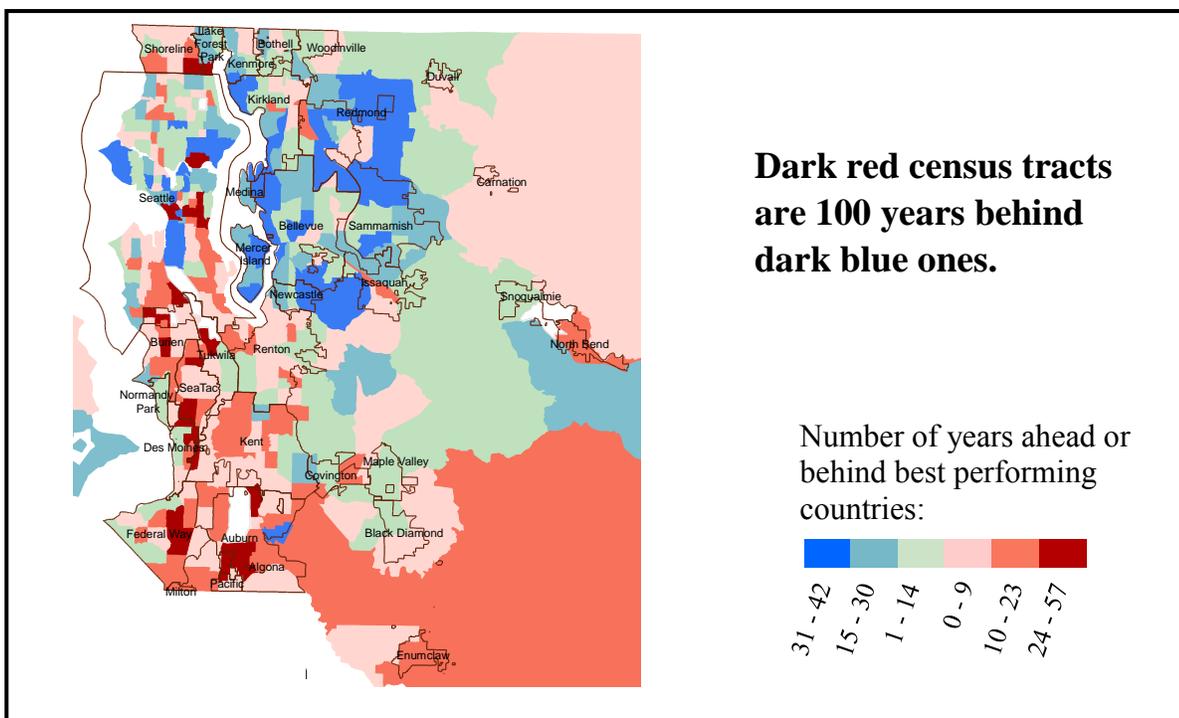


**Source:** Kulkarni, S. C., Levin-Rector, A., Ezzati, M., & Murray, C. J. (2011). Falling behind: Life expectancy in US counties from 2000 to 2007 in an international context. *Population Health Metrics*, 9(1).

However, even regional remedies may not be local enough. For example, take King County, Washington, home of Seattle and Starbucks. In IHME’s county-level analysis, King County fares well, only a couple years behind the top performing countries, reinforcing the region’s reputation as a place of great recreation opportunities, plentiful local food and a relatively robust economy. But, if we repeat the IHME county analysis at the census tract—if we imagine that each census tract in King County is its own country and calculate how each is doing relative to the best performing countries—it turns out that the county’s overall “good” average hides huge underlying disparities. While some census tracts in King County are as much as 40 years ahead of the best performing countries’ average life expectancy, there are others, not further than a bicycle ride away, that are almost 60 years behind. In fact, there is substantially more variation by census tract within King County than there is by county within the U.S. At the pace of best performing nations, it would take *100 years* for the census tract with lowest life expectancy in King County to catch up to where the highest ones already are today (Figure 2).

King County is not unique and all across the country, local neighborhoods with profoundly different health indicators are just a subway stop or freeway exit away from each other.<sup>4</sup> As a consequence, rather than national- or even regional-level investment strategies, the question that really needs to be asked is what should we be doing to improve health in specific and highly local neighborhoods, particularly in places that are lagging furthest behind?

**Figure 2.**  
**King County life expectancy by census tract compared to average of top 10 countries, 2010**



**Source:** Public Health-Seattle & King County analysis using methods from Kulkarni, S. C., Levin-Rector, A., Ezzati, M., & Murray, C. J. (2011). Falling behind: Life expectancy in US counties from 2000 to 2007 in an international context. *Population Health Metrics*, 9(1).

### Going Beyond the Walls of the Clinic

The reason for this profound difference in life expectancy by neighborhood is not a mystery. King County maps of health risk factors like obesity, tobacco use, physical inactivity and poverty vary by three- to ten-fold and look similar to each other and to the life expectancy map pictured above. Most deaths today result from diseases and conditions that are shaped by our social and environmental surroundings. Poor health almost any way you measure it is increasingly concentrated in the same locations, making it easy to identify which communities are making people unhealthy and underscoring the importance of place to health.

What makes these neighborhoods unhealthy? While the role of clinical health services is vital, medical care alone accounts for only about 10 percent of premature deaths.<sup>5</sup> Neighborhoods create ill health because of their intrinsic community characteristics. Houses and rental units are substandard and contaminated with mold and toxins like lead, streets aren't safe for walking to school or work because of crime or just a lack of sidewalks, and healthy food isn't easily available, though high-fat, sugar-loaded processed food is for sale at the corner convenience store.

Access to health care can't fix these problems. Instead, to improve health we need to look outside the walls of the clinic and focus on fixing the characteristics of local communities that underpin poor health. Tackling the social, economic and

physical infrastructure features of neighborhoods requires health leaders to consider new strategies and work with new partners. In King County, we are trying to use three interrelated principles to guide this approach.

***First, Deliberately Invest Community-Level Public Health Resources in Proportion to Need.***

Historically, public health resources usually have been evenly and “fairly” distributed geographically within jurisdictions at national, state, and local levels. In fact, competitive grants often result in preferential allocation to communities and organizations best resourced to compete. To improve overall health outcomes, however, allocating resources to communities with the most to gain holds the best potential to maximize overall return. We need to correct the mindset that larger investments in neighborhoods with the most challenges are in some way unfairly “disproportionate” to a more accurate and fair notion that these investments are *proportionate* to need.

For example, recently in Seattle, we allocated a two-year \$25 million federal stimulus grant, Communities Putting Prevention to Work (CPPW) to the specific Seattle and King County neighborhoods that had the highest rates of obesity and tobacco use. In communities where access to physical activity was limited, we worked with city government to develop walking and biking plans and worked with schools to improve physical education programs. Where it wasn’t easy to get healthy groceries, we made it easier for WIC recipients to shop at the local farmers market with electronic debit cards and worked with corner stores to sell fresh produce. Where smoking rates were high, we worked with housing authorities to create tobacco-free housing units and city parks departments to adopt smoke-free park rules. In total, we created access to healthy eating, active living and reduced tobacco exposure for 400,000 people in our poorest health communities.

***Second, Use Proven Global Health Strategies to Improve Health in Under-Resourced Communities.***

Poor health arising from community conditions in under-resourced areas is not a problem confined to the United States. Arguably, this same problem has been more effectively recognized and ameliorated through community-based strategies implemented well beyond our borders. As we consider ways to increase the level of investment in our poorest communities, we must also recognize that the nature of this investment may need to be qualitatively different from past efforts and that we could adopt and adapt strategies proven to improve health in under-resourced settings in other countries around the globe. Some examples of these strategies include employing community health workers, applying technology to leapfrog delivery barriers, expanding the use of public-private partnerships, linking health with economic development, and prioritizing community ownership and capacity building.<sup>6</sup>

Seattle is home to several global health organizations with tremendous expertise and resources committed to improving health in low-resourced countries. Locally, we have created a new partnership called *Global to Local (G2L)* consisting of Seattle’s global health institutions, a regional hospital system, a local community health center and our health department. Capitalized mainly by investment from the hospital system, we are piloting new community-based approaches in two of the least healthy and most ethnically diverse communities in our county. Through in-depth community discussions, including ongoing “community cafés,” residents and community leaders identify major health needs and related issues that affect health. Working with a small cadre of culturally diverse community health workers, residents then help develop and implement inexpensive solutions. Recent examples include:

- Responding to a community-identified desire for physical activity that respected the cultural needs of Muslim women by working with a local community center to offer single-gender exercise classes with child care;
- In partnership with AT&T, using mobile phone technology to assist in self-management of high risk, non-English speaking patients with diabetes who face transportation and financial barriers to seeking regular care; and

- Addressing underlying social concerns that often drive poor health outcomes by screening local community clinic patients, and referring them to volunteer college students who help them connect with food assistance, utilities assistance, and language training, among other services.<sup>7</sup>

### ***Third, Leverage the Health Care Financing Reform and Community Benefit Provisions of the Affordable Care Act to Make Community-Based Investment in Health in Neighborhoods Most in Need.***

Even with a commitment to invest according to need and to use low cost global health strategies, history tells us that the level of financing available for health-related community-based interventions places a very distant second to the amount of financing for health care for individuals. But, the Affordable Care Act and related health care finance reform may provide a new opportunity for leveraging community-based investments, particularly in our least healthy communities. In a future of capitated payment for individual health care, health care systems may find that remaining agnostic to the community from which their patients come weakens their bottom line. Instead, targeted investments in neighborhoods with the poorest health may begin to make both good health and good business sense.<sup>8</sup> The logic that individuals with significantly more complex health and social challenges benefit from intensive case-management to improve outcomes and reduce costs<sup>9</sup> may extend to comparable “hot-spotting case management” for under-resourced *neighborhoods*. Public health should capitalize on this opportunity to partner with hospitals, perhaps by leveraging the ACA’s new expectations for community benefit and encouraging investment in community-level improvements in the catchment area census tracts that have the worst health indicators.

In Seattle and King County, we are working with our hospital and health care systems to try and realize this potential. Our local health care systems see the value of collaborating on their community health needs assessments and community benefit requirements. Local government has directed us to identify high need neighborhoods and to convene community members and local organizations to identify strategies that build on the existing community resiliency and assets. The goal is to drive targeted investments to improve the community features that shape the health and well-being of residents. These investments include the development of community-based human services to address the underlying needs of the thousands of poor adults about to enter Medicaid, including homelessness, unemployment, childcare, and language barriers.

### **In Summary**

Underpinning the poor national health indicators of the United States is a more nuanced problem of profoundly local place-based health disparities. Only by directly confronting and correcting these disparities can we hope to see improvement in our overall national health and the indicators that measure it. The solution hinges on investment to improve the community-based policies, systems and environments responsible for producing poor health. To be successful, however, we must be willing to change our historical perspective on financing population-based public health and level the playing field by differentially investing in communities in proportion to their need. And we should take at least a couple of pages from the global health playbook, learning from the experiences of those who have been working for years devising strategies to improve health in poorly resourced communities beyond our borders. The ACA affords a unique opportunity to focus our health care system at least partly outside the walls of its clinic to leverage community benefit provisions and “hot spot” high need communities.

The time is also right to move this effort beyond just our health care and public health systems and to engage other natural partners in this work. The Robert Wood Johnson Foundation and others have made significant contributions to shifting the frame around health to encompass broader social conditions, creating and distributing tool kits, developing county health rankings, and building the evidence-basis with pilot tests and dissemination/scale-up approaches.<sup>10</sup> Community development corporations have remarkably overlapping goals with this work and banks have Community Reinvestment Act requirements to lend and invest in community development activities in the low- and moderate-income census tracts where

they have branches. Working together, there is no time like the present to collectively make communities become healthier places for U.S. residents to live, learn, work, and play.

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<sup>1</sup> Committee on Public Health Strategies to Improve Health, & Institute of Medicine. (2012). *For the public's health: Investing in a healthier future* The National Academies Press. Retrieved from [http://www.nap.edu/openbook.php?record\\_id=13268](http://www.nap.edu/openbook.php?record_id=13268)

<sup>2</sup> Steven H. Woolf, Laudan Aron, E., Panel on Understanding Cross-National Health Differences Among High-Income Countries, Committee on Population, Division of Behavioral, Social Sciences, et al. (2013). *U.S. health in international perspective: Shorter lives, poorer health* The National Academies Press. Retrieved from [http://www.nap.edu/openbook.php?record\\_id=13497](http://www.nap.edu/openbook.php?record_id=13497)

<sup>3</sup> Kulkarni, S. C., Levin-Rector, A., Ezzati, M., & Murray, C. J. (2011). Falling behind: Life expectancy in US counties from 2000 to 2007 in an international context. *Population Health Metrics*, 9(1). Comparison countries include Australia, Canada, Finland, France, Hong Kong, Iceland, Israel, Italy, Japan, Macao, Norway, Spain, Sweden and Switzerland.

<sup>4</sup> Robert Wood Johnson Foundation. (2009). *Commission to build a healthier America: Community: A short distance to large disparities in health*. Retrieved from <http://www.commissiononhealth.org/Community.aspx>

<sup>5</sup> Schroeder, S. A. (2007). Shattuck lecture. We can do better--improving the health of the American people. *The New England Journal of Medicine*, 357(12), 1221-1228.

<sup>6</sup> Public Health - Seattle & King County. (2010). *The global to local initiative: Improving health in south King County* Retrieved from <http://www.kingcounty.gov/healthservices/health/partnerships/G2L.aspx>

<sup>7</sup> Health Leads. *Our model: Solutions to challenges*. Retrieved from <https://healthleadsusa.org/what-we-do/our-model/>

<sup>8</sup> Brush, R. (2013). Can pay for success reduce asthma emergencies and reset a broken health care system? *Community Development Investment Review*, 9(1). Retrieved from [http://www.frbsf.org/publications/community/review/vol9\\_issue1/pay-for-success-reduce-asthma-emergencies-reset-broken-health-care-system.pdf](http://www.frbsf.org/publications/community/review/vol9_issue1/pay-for-success-reduce-asthma-emergencies-reset-broken-health-care-system.pdf)

<sup>9</sup> Gawande, A. (2011). The hot spotters. *New Yorker*, 86, 41.

<sup>10</sup> Robert Wood Johnson Foundation: Commission to Build a Healthier America, Roadmaps to Health, County Health Rankings and *A New way to talk about the social determinants of health*. (2010). Princeton, NJ: Robert Wood Johnson Foundation. Retrieved from <http://www.rwjf.org/en/research-publications/find-rwjf-research/2010/01/a-new-way-to-talk-about-the-social-determinants-of-health.html>