

Keynote Address at 2009 Keeneland Public Health Systems & Services Research Conference

Presented by Michelle A. Larkin



Robert Wood Johnson Foundation

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KEYNOTE ADDRESS

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Thanks, Steve, for that very generous introduction. You know how to make a newcomer feel welcome. Now I know from Jim Marks how much basketball means to you and to the Kentucky faithful. And now that you've lured Coach Calipari to the University of Kentucky—condolences to our friends from Memphis—we at the Robert Wood Johnson Foundation (RWJF) are also hopeful that Kentucky basketball will resume its rightful place in the NCAA Final Four in 2010. I'd also like to salute Bill Hacker, Commissioner of the state of Kentucky's Public Health Department, Michael Karpf, the university's executive Vice President for *Health Affairs* and Carolyn Clancy from Agency for Healthcare Research and Quality. I really appreciate your breaking free from busy schedules to be with us this evening.

It's a privilege for me to be here. I mean that very sincerely. It's an honor to be keynoting the conference. But I also mean it in this sense—and I think it applies to all of us in this room today: It's a privilege—a privilege and also a tremendous opportunity—to be part of the public health movement at this moment in history.

I use that term “movement” purposefully.

We are moving. We are gaining momentum and solidarity as a profession. We are moving with a vigor and focus that was still in the offing a year ago as this conference was inaugurated.

Public health has a venerable tradition and a storied list of accomplishments. But we have begun to speak of a new paradigm. A new day has dawned and if I have a message this evening: Our time has come, and with it comes great opportunities and equally great responsibilities. Seize both!!

One opportunity is this very conference. Along with the conviviality—and I, for one, have no plans to miss out on that—it's an opportunity to network, to swap ideas, begin new relationships to break out of the silos in which our work sometimes confines us—because that kind of cross-pollination is so vital to the new public health. Think about it. These relationships matter. This conference is also about sharing the passion that gets us out of bed each morning to do this important and meaningful work.

So much has happened in the year since the first Keeneland Conference: The global economy has swooned—“collapsed” is not too harsh a word for it. In the past year, America concluded a presidential campaign in which both candidates—the liberal and the conservative—acknowledged the need for health reform and disagreed only on the details. Imagine that: It was only an election ago that calls for revamping America's approach to health were dismissed as socialist ravings. Corporate America wouldn't stand for it. Now it's corporate America begging for change. The consensus view also encompasses this irrefutable fact that: While figuring out how to extend coverage and improve the quality of care, America must rein in its out-of-control health care costs or it will fall only farther and farther behind.

Very simply: Our present approach is unsustainable. We have no choice but to shift dollars from the treatment of disease to its prevention—from chronic care to building wellness.

As Gov. Kathleen Sebelius's nomination hearings got under way last week in Congress, we were reminded of just how grim the situation has become. Forty-six million Americans without coverage—and

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this at a time when health premiums over the past nine years have doubled, a rise that outstrips inflation by 300 percent! By the estimate of Medicare's own trustees, the program's unfunded liability over the long term is 85 trillion dollars. That's with a T—\$85 trillion!

America is spending twice as much on health care—let me repeat that: twice as much—as any other nation. And yet key health measures—infant mortality, life expectancy, diabetes, obesity—are actually worsening. In infant mortality we now rank 25th—below Korea and the Czech Republic. The next generation looks to be the first in American history whose health will be worse than their parents'. It is a time, in other words, when the public health perspective—our expertise—has never been more urgently in demand.

Clearly, decisions have to be made—and made soon—that are hugely important. Many will hinge on dollars and cents and the value of those investments. Now, more than ever, we have the chance to make our case that an ounce of prevention is worth a pound of cure. The question is, are we ready to make that case?

What evidence do we have about organization, finance, governance, infrastructure and how they impact return on investment (ROI)? Is regionalization of services the way to go? How might comparative effectiveness play out in prevention and public health? How best to marry the vigor and creativity of the private sector with the rigor and expertise of governmental public health and the energy and persistence of community advocates?

I'm asking these questions, not hinting rhetorically at preconceptions of my own. These are the questions our profession exists to answer, particularly those of us in services and systems research. Suddenly, we are no longer perceived as health care's red-headed stepchild—at least not by policy people who really know the score. But let me be blunt: We have only just begun to earn that respect as a field. The achievements of public health in the past century are staggering: A near doubling of life expectancy; the conquest of old and lethal scourges such as tuberculosis, diarrheal diseases. And more recently a big pushback against tobacco use, a push for seatbelts, physical activity and access to fresh, healthy food.

Under the new public health paradigm, we are obliged to come up with the hard numbers that back up gut instinct.

We are building the evidence for public health practice and policy—building the science: We are becoming more sophisticated researchers—blending epidemiology, economics, law, and the social sciences to answer complex questions. We can demonstrate—we can prove—the impact of our policy recommendations. We can quantify ROI.

I urge you to use these tools.

As just one example, a Trust for America's Health report that we helped fund provides some stats you can use like a bludgeon in your dealings with government bean counters! An investment of \$10 per person a year in community prevention programs like smoking cessation, improved nutrition and more exercise was shown to yield \$2.8 billion annually in health care savings in just two years. That rises to \$16 billion in five years—more than a five-to-one return on investment. Who wouldn't like to see that kind of return on our 401K plans right now?

The American economic crisis is, at last, being perceived—correctly—as a crisis not limited to certain esoteric practices among Wall Street investment banks and hedge funds. It is perceived—again, correctly—as systemic. Meaningful remedies will require reshaping federal and state spending priorities for decades to come. None of those priorities is more urgent than the reform of American health care and the allocations that have shaped it—and distorted it.

At \$2.4 trillion a year, health care is our nation's largest industry—bigger than defense. It comprises 17 percent of our national economy with runaway impacts on the nation's financial security in the years

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ahead. Seventeen percent is a big number, but get ready for this: By 2025—a mere 16 years away—unless we get on top of the trend, health care spending is expected to comprise 25 percent of America's gross domestic product, the Congressional Budget Office warns. Today, the federal budget in its entirety is only 20 percent of GDP.

And the impacts aren't limited to financial security alone: How about national security? There's the threat of disaster, of pandemics that Dr. Hacker and his colleagues must prepare for. And there are other reminders in our midst. How about the growing percentage of military age young men and women who are simply too obese to serve? How about the flight of American jobs overseas because homeland corporations simply can't manage to shoulder health insurance costs? General Motors now spends more on health care than on steel. And, don't dismiss GM's problem as peculiar to an old-guard corporate behemoth. Even Starbucks is spending more on health care than on coffee!

The retooling—the reining in and more intelligent allocation of health care dollars—will not be limited to clinical practice, though clinical practice will surely be affected. It will require a continuing commitment to the evidence-based research that identifies best practices, the research that spots inequities and waste, the research that conclusively demonstrates the value and impact of wellness and prevention strategies.

That wasted money, by the way, is a staggering sum—and thus a golden opportunity for us. It's estimated at \$800 billion annually—nearly one in three health care dollars. That comes to more than the bank bailout plan. Every year! Redeploying those dollars more intelligently is a key to our future both as a profession and as a nation. It's what we do as public health professionals. It's what we fund at RWJF. Our goal is to make this thinking mainstream. To be sure that effectiveness is mindful of cost-effectiveness. To determine what interventions—prevention or treatment—give us the best value.

The Obama administration seems to get it. The stimulus package includes \$1 billion for public health research and programs, prevention programs at the community level prominent among them. That's a hearty affirmation of our profession's critical role. But the sword of public funding cuts both ways. We have to be realistic about that. Budgets at the state and local level continue to hemorrhage public health jobs and dollars because of the economic downturn.

In the near term, this is hugely challenging. I make no bones about it. Longer term, it's the opportunity of our professional lifetimes.

Very simply, the era of eternally rising health care costs is over. Kaput. Finito. Done. It has to be. The old—alas, still operative—model of medical reimbursement has rewarded doctors and hospitals for maximizing the number of procedures. It has been a system, in other words, that feeds on—and in a perverse way rewards—sickness. Think about this: 95 cents of every health care dollar still goes to treating illness. Meanwhile, 2 cents of that health care dollar, 2 cents—a pittance—supports wellness.

Where we are going—as the stimulus package but also common sense dictates—is toward a system that changes all that. And our profession must show the way. Where we are going is toward a system that rewards the quality of performance over the volume of performance. Towards a system that rewards health care professionals for keeping people well and for more effectively managing chronic conditions, should they develop. These chronic conditions now eat up a huge percentage of our health care spending—shoving wellness care into the back seat. We must move towards a system that supports health where we live, where we learn, where we work and where we play—making it easier for us, for everyone to make healthier choices

OK. Fine and dandy, the skeptic responds: Reward quality care; be suspicious of volume care. But where does quality lie? What is the quality of performance?? What is the proper level of funding for public health? What are the prevention practices and policies that provide the greatest return on public

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investment? And over what time span?

Again, these are not rhetorical questions. They cut to the heart of our agenda, as a profession and a field. Answering these questions is the research that RWJF embraces and that public health professionals and researchers in this room have begun to explore.

How do we avoid duplication of services and reduce costs—to better serve hard-to-reach and economically strapped communities? Do we get more bang for the buck by regionalizing public health? Or does reform lie in optimizing budget allocations within the existing infrastructure of public health departments? What are the most promising financing mechanisms for public health? What's the right balance of public and private initiatives as we explore those financing options on a national scale?

I realize that the answers to these questions are going to be complex and nuanced. They are going to require cross-disciplinary teamwork, but that is another great strength of the new approach to public health—more so now than ever, as challenges cry out for holistic solutions. We are learning to climb out of our bunkers. We are learning to combine the wisdom of epidemiology with lessons from mass marketing and politics. At RWJF we are funding a new program that brings legal experts to the table alongside public health professionals. We're tackling vexing questions about the impact of law, statutes and regulations on health. The program will explore a broad range of issues—from the safety of our food supply to the capacity of public health departments to respond to the next health emergency. This is one example of the holistic thinking that I'm talking about.

Obesity? Tobacco use? They're the one-two punch when it comes to preventable causes of death and disease. Smoking rates are still too high, but they're way down from a generation ago—an extraordinary achievement. Obesity, on the other hand, is an epidemic that is surging, with horrifying repercussions ahead. When you factor in the resulting diabetes, stroke, cardiovascular disease and associated cancers, obesity's price tag reads \$117 billion. Every year. A terrible scourge—and a pivotal challenge (perhaps a defining moment) for public health.

But how best to combat it? The road back from America as a couch potato patch may not be a road at all: it may be a bicycle path; it may be light rail and a vigorous walk to the train station.

A tall order? Sure it is. But I draw inspiration from the great South African leader Nelson Mandela who chided doubters with an eight-word adage, "Some things seem impossible until they are done."

Thirty years ago, significant inroads against tobacco use seemed impossible. Its economic and political allies were too entrenched; smoke and cigarettes were part of the very fabric of American life and culture; they were an inextricable part of what we saw as glamorous, sophisticated, status quo. Today, cigarette use has plunged, smokers are in a minority, and Big Tobacco has been obliged to admit the deadliness of its products and finance the campaign that curtails their use. And no April Fooling, but right here in Kentucky, tobacco country, a 30 cent tobacco tax increase went into effect on April 1. It's a policy that will prevent an estimated 16,000 Kentucky kids from starting to smoke. The savings? \$14 billion in health care costs within five years.

We can lament that our nation finds itself buffeted by a perfect storm of converging crises: runaway health costs; a collapsed financial system; a national infrastructure disintegrating after too many decades of neglect. But when the right solutions are holistic, these convergences—catastrophic as some of them seem—are also opportunities. An opportunity to move past piecemeal solutions toward the kind of deep and trenchant overhaul that will hasten the patient's return to health. And that patient, good people, is us—our nation, our profession, ourselves.

We're in the spotlight, as never before. Washington is looking to us to show the way back from the verge of ruinous health care costs, and the beacon that we must shine ahead in our search for new ways of thinking, new practices and new policies, is not a warm and fuzzy feeling for holistic approaches but

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the hard numbers that confirm or refute the assumptions implicit in public health policy shifts. It means measuring the disparities that offend common sense. That sets an agenda. It also means measuring outcomes achieved as we address those disparities. That's where you come in—with answers; answers buttressed with hard numbers and reinforced with outcome measurements that are just as exact.

Galileo put it succinctly. Galileo—a scientist so farsighted he was accused of heresy—said, “Measure what is measurable and make measurable what is not so.”

Let that be our mantra. Measurement. Numbers. Evidence. Without them, no policy recommendation can be truly persuasive. They're the weapons at our command, just as, for a prior generation of public health professionals, the weapon was the hypodermic needle, the inoculation chart, the campaigns to upgrade public sanitation. The results were staggeringly impressive. They will not be less so now.

My colleague and yours, Jim Marks, pointed me toward a study he saw recently. It noted that a sedentary 50-year-old man who smokes and is overweight has a 58 percent chance of developing diabetes or cardiovascular disease by the time he's 65. Snuff out the cigarettes and convince him to slim down and get a little exercise—and the chances of onset for those conditions drops to 13 percent—a whopping 75 percent decline. As Jim says: If we had a drug that guaranteed those results, we'd put it in the water.

Well, we don't have that drug. But here's the point: We don't need that drug. Don't take my word for it. What we do need is the evidence-based research that corroborates each facet of a more holistic approach.

It's your hunch and mine—it's also certainly our hope, that there's a return on investments in public health—that we're worth more than the 2 cents out of health care dollar. But are we? Does more money buy better health?

That was the question that drove an extraordinary body of research compiled by Glen Mays and Sharla Smith at the University of Arkansas—work that RWJF was proud to support. Mays and Smith pulled together data collected from 2,900 public health agencies. With precision, they measured what communities spend on public health and then checked that number against mortality rates among infants and deaths due to cardiovascular disease, cancer and diabetes.

The cause and effect turned out to be direct and definitive. Money matters and it matters a lot: For each 10 percent increase in public health spending, mortality rates fell within a range extending from 1.1 percent to a whopping 6.9 percent.

Here's something else they found: Investments in public health programs are a faster and also a cheaper way to lower mortality rates than pumping additional money into medical approaches. For instance: Upping a community's public health budget by 10 percent comes to \$300,000 on average and achieves a 3.2 percent reduction in cardiovascular mortality. To get the same outcome through a medical spending strategy would take hiring 14 primary care doctors for every 10,000 residents. If you lowball those family practice salaries and pay each of those doctors \$176,000, that's \$2.5 million. You do the math: \$2.5 million vs. \$300,000. That study will be published soon—right, Glen? As soon as it is, I urge you to dig in.

It also gives me particular pleasure to be able to mention the clearinghouse for public health data and analysis—right here at this extraordinary university. The University of Kentucky, the National Library of Medicine and RWJF combined resources to create the nation's most comprehensive public health data bank. Think of it as the Fort Knox of public health data—to mention another repository of national treasure based in Kentucky.

This clearinghouse is intended to be the go-to source for the best, most up-to-date data on public health programs and research. It will serve you as an arsenal—a place where you can arm yourself with the

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proof you need in arguing for the cost-effectiveness of public health—even at a time when dollars are scarce—especially at a time when dollars are scarce. Because when dollars are short, it is that much more imperative that they not be wasted.

OK: You get the message. Measurement is our mantra, provided there's follow-through and those measurements infuse well-considered practices and policies. Follow through that requires persuasive advocacy that we are proud to support. It's no longer enough to rely on hunches and wishful thinking. Does that mean I disparage the deeply humanitarian impulses that brought so many of us into the field? That desire to serve and to help?

I am no stranger to those impulses. They were behind my decision to make a somewhat wrenching career shift of my own, a decision to look beyond patient-by-patient work as an oncology nurse, go back to school—first for a degree in health policy and then law degree. It was a move from helping one person at a time to serving the broader population that public health work reaches. Let me confess that this impulse, this change, was not based on hard evidence. It was based on a hunch and a hope: That public health work could also fulfill a young woman's yearning to be on the side of justice, to attack disparities in the way health care—and health itself—is distributed across the American social spectrum. Because disparities in health—whether they cut across class, geography, race, ethnicity, gender or income levels—are injustices to overcome. That is what rescues our measurements from abstraction and aridity. That is what makes room in our profession for the passion that is at its heart.

It's gratifying work. I'm glad that I yielded to a hunch in moving into public health, but I recognize that practitioners and policy-makers need more than a hunch. They need the evidence you provide to make hard decisions about how best to invest limited resources to protect and promote health.

The late, great Lewis Thomas, Ph.D., put it this way, "Hunches and intuitive impressions are essential for getting the work started. But it is only through the quality of the numbers at the end that the truth can be told."

You are discovering that truth by building the evidence for public health services, systems and policies. You are determining what must be done to make public health better.

As RWJF's president Risa Lavizzo-Mourey, M.D., M.B.A., put it in an address to public health officials from all over the country: "What we are doing together," she said, "is nothing less than creating a new field of public health study, practice and innovation. It is literally a new public health, firmly set on a fresh foundation of accreditation, quality improvement, accountability, advocacy and a relentless reliance on research and evidence."

We have a window of opportunity to make a difference at this historic time in health reform—to advance the new public health. We need to work smarter, work more collaboratively and produce results quicker in order to take advantage of that opportunity. We view all of you as partners in the new public health.

Thank you for the work that you have done and will do. And thank you for the truth that you will continue to tell.