Presented by Risa Lavizzo-Mourey, RWJF President and CEO September 10, 2008





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No one bears a heavier load, faces greater challenges, or is more important to the protection and promotion of health in America than you. My mother always told me that we are known by the company we keep—so today I am looking really good.

Where I work at the Robert Wood Johnson Foundation (RWJF), we think you are all-American heroes. We see how you put everything you have into the good health, safety and well-being of all Americans. We know that you do it against great odds, with limited resources and few champions, propped up by an infrastructure that is too fragile, in a field that is too fragmented and usually so far out of the public spotlight that no one pays attention until disaster strikes. We also know that while celebrities get on the news, it is the men and women like you who are making real history.

We are proud to be your partner in making public health history and in shaping public health's future. RWJF is absolutely committed to seeing that you get what you need to do your jobs:

- the political support you deserve;
- the policies you need;
- funding that is realistic and responsible;
- technologies and infrastructure that are cutting-edge; and
- the backing of an informed public that knows you and trusts you.

It is an ambitious list. It has to be if you are going to achieve your ultimate goal—a healthier America through a new public health, a new public health that is:

- accredited and accountable to the communities you serve
- performing to evidence-based standards of quality
- engaged in the political process and
- reliant on hard evidence to determine how best to improve performance.

It is a tough road you have chosen. You are not going alone. At RWJF, we are in this with you for as long as it takes, whatever it takes. Nothing we do is more important. Trust me. Nothing.

It is fitting that we are having this discussion at this time and in this place. Right here in Sacramento the storm tracks of seemingly unrelated crises have intersected in ways that expose the vulnerabilities of public health—and the health of the public.

For all you public health veterans, this is the story of your times. Remember this summer's TV images of California burning? More than 2,000 fires, a million acres destroyed at a cost of more than \$1 billion. So much smoke hung over the capital that it fouled the air. Some of you in nearby counties declared public health emergencies. You cautioned everyone to limit their outdoor activities. People with heart and lung problems were told to stay indoors.

And did you hear about Gov. Schwarzenegger? He couldn't even duck outside for a cigar in that famous smoking tent of his. Instead, he had to stay inside the capital, where a different kind of firestorm

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was raging. California has run out of money. The state has been without a budget since July 1. The budget gap is \$15.2 billion. And so far, there is no agreement how to close it.

It is the state's worst budget crisis in a generation. Thousands of state employees have been laid off; 200,000 had their pay cut. Medicaid is in trouble. Money for health and social services has disappeared. Community health clinics are losing \$1,000 a minute in uncompensated expenses. The safety net is torn and tattered. Governing has turned into a fight for survival. And oh, yeah, there is not even money left to fight any new forest fires.

California is not alone. More than half the states, along with the District of Columbia, are struggling with their own budget shortfalls. The estimated total for 2009 is a staggering \$47 billion. Options are limited. Many states are doing what California is doing—cutting Medicaid and public health.

Don't expect help from the federal government, either. The administration is shackled by its own deficit of \$482 billion. That is nearly half a trillion dollars; 10 times more than all the state deficits combined. Tack on the costs of war and an economy that is shaky at best—and the outlook is bleak.

You might ask what all this has to do with you. It has everything to do with you.

Here is what I mean. Five years ago today, at your meeting in Phoenix, Bill Foege spoke like a prophet when he told you that public health's worst dilemma was "resource allocation."

I would add that it is a 3-D dilemma. It has three dimensions:

- One: As Dr. Foege says, every public health decision and every resource decision is really a political decision.
- Two: Public health historically fails to close the resource sale with policy-makers and politicians.
- Three: Public health officials tend to be scientists at heart. Many of you have an innate aversion to politics.

Yet, you are the only ones who can make public health's case in the political arena. That is why, according to Foege, you cannot stay out of politics. We are not talking partisan, get-out-the-vote politics. No, we are telling you to leverage your stature as leaders to get the political system working for public health—and not against it.

It means changing how you do things. Change is hard. Most people instinctively resist it. But, let me ask you this: How is the old way of doing business working out for you? From where I sit, it looks like whenever public health knocks on the resource door, more often than not the possessors of power shut you out. Why is that? What's really going on? Some of the answer is in a story I have been saving for you today.

Back east—right when the California fires were at their worst—a group of health policy experts and Washington insiders sat around a conference table not far from the White House. They talked about the election and what it means for big issues like coverage, cost, Medicare and children's health insurance. Public health did not come up until late in the day, almost as an afterthought. What they said may be hard to take, but you need to hear it.

They spoke of public health as hardened in separate silos—federal, state, local—each distinct, disconnected and dysfunctional. They did not see you as you, as champions of the common good. Rather, as supplicants, hands out, complaining and bearing bad news, long on pleading and short on results

Those who know you actually winced when one D.C. insider said: "What a bunch of whiners. All they want is more money, but they never explain what they really do with it. Just fund CDC and

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community clinics."

The person talking is a real behind-the-scenes power broker, someone who wields tremendous influence at both ends of Pennsylvania Avenue over health policy, funding and legislation.

The message I want you to hear is that too many still don't get it. They don't know what they don't know. The danger is that what they don't know can hurt all of us.

The public, however, does know that something is terribly wrong. They are insecure, anxious, fearful. One of our national grantees, Trust for America's Health (TFAH), tracks public opinion on a range of public health issues, including preparedness. The most recent TFAH poll, conducted before Gustav or Hanna hit, found that:

- More than half the public-54 percent-feel that the United States is not as safe as before September 11, 2001.
- Among African Americans, the number jumps to 73 percent—something we need to pay close attention to.
- Large majorities fear that neither community nor country is prepared for emergencies like Katrina, pandemic flu or bioterrorism.

In a separate survey, the Harvard School of Public Health talked to people in high-risk coastal hurricane zones along the Gulf Coast, New Orleans, Florida and the Carolinas. The results, released in July, are provocative. A large segment of the population does not think you are going to be there when they need you. Roughly 40 percent do not trust the government to protect them if they evacuate in an emergency.

Obviously, these are matters of emergency preparedness that public health should resolve—if you had the resources. But you do not. And the public feels it.

I have to believe that this is one important reason 2 million people were so quick to evacuate this time as a hurricane approached Louisiana.

Here is the point. The people are telling us what they need—and what they expect—from public health. The larger message is that this is finally your time, the time, to change the discussion, to rebalance the equation, to establish a new public health.

We see two tightly connected pathways that will take you where you need to go. First, improve how you do what you do. Second, influence decisions affecting you by demonstrating the value of what you do.

Improving quality and performance is a very big deal at RWJF—and has been for nearly 30 years. For a long time, health care delivery systems were the target of our research and our testing of hypotheses. We have spent hundreds of millions of dollars gathering evidence about what works, testing and measuring solutions, building test pilots, and spreading successful models across the country. Along the way, we learned important lessons that directly apply to public health:

- We learned that quality means delivering the right programs and services to the right people the right way with the right outcomes.
- We learned that "systems" can be their own worst enemy–keeping capable professionals from doing what they are educated and trained to do.
- We learned that research is indispensable and that action without evidence is a waste of time, money and political capital.

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 We learned that simply trying harder does not work—but that changing systems, practices and policies does work.

Let's get real specific about what this means to you. Think how you would answer questions like these:

- How does the public know it is getting the best value for how you spend their money?
- Does it matter if Nevada spends only \$4 per capita on public health-and Hawaii spends \$152?
- What is the right course of action if the evidence says Nevada's outcomes are just as good as Hawaii's?
- When neighboring states or localities share the same public health problems, how can one choose to attack them, but the other doesn't have to?
- If a city, a county, a state and a territory all do the same thing—but each does it differently—how are we to measure what is effective and what is not?
- Should the public know how you measure up?
- Do you want the public to know how you measure up?

Now that is the hard one—letting the public see behind the curtain. Your impulse may be to keep the curtain closed. You may worry that the playing field is already tilted against you; that standards will not be fairly applied; that better-funded, better-staffed agencies in better-off communities will rate higher; that hard-pressed agencies with low-income, high-risk populations will be judged unfairly and punished accordingly; and that public scrutiny and accountability will hurt you more than any promised gain.

These are legitimate concerns. They raise important questions. Take heart. You are already coming up with your own answers. We see them in your actions and your outcomes.

Case in point—California's tobacco-control program. Though it began slowly 20 years ago, it is an impressive success. Smoking has declined 25 percent statewide, saving an estimated 50,000 lives by 2010. The state is saving billions of dollars, too; good news in bad budget times.

Two weeks ago, Stan Glantz and his colleagues at the University of California, San Francisco Medical School reported that by 2004 California's tobacco-control program had saved the state some \$86 billion in personal health care costs. That is a 50-to-1 return on a total program investment of only \$1.8 billion. This is a great story of how public health can transform the health trajectory of an entire population with a sound strategy and a willingness to stay the course.

In Genesee County, Mich., and the city of Flint, they have long struggled with a three-to-one disparity between the deaths of African-American and white infants. Right, Bobby?

Bobby Pestronk and his colleagues are smart and have been around a long time. They know that inequities in race, economics and resource distribution were harming the health of the community at least as much as the genes and lifestyle choices. They also knew that if they were going to take on socioeconomic contributors to infant mortality, that they would need help and funding.

With state and federal grants, they teamed up with local hospitals and community-based organizations to enhance baby care, educate the community and providers, and lower the level of racism as much as possible.

The results are dramatic. Black and white babies and their families both benefit. Between 2002 and

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2005, the African-American infant mortality rate dropped from 22 per 1,000 live births to 15. For white infants, it also dropped, from 9.9 to 6.3. The black-white disparity ratio also dropped from 3.6 to 2.4.

Taking on the social determinants of community health—a hallmark of the new public health.

Here is another case in point: In Colorado, trail-blazing legislation just signed into law is designed to improve the quality of public health services. The new law mandates that local, county and state officials work together to improve quality, even if it means sharing resources and responsibilities across jurisdictions. Collaboration, performance standards and resource allocation are key. Important elements include a public health information infrastructure, performance standards tied to outcomes, and resource allocation that realistically matches need.

Legislative advances like this are why Bill Foege says you cannot stay out of politics. How else do you think public health in Colorado pulled this off?

The old public health—working and worrying in anonymous obscurity—could never achieve a success like this. The new public health operates out front, in the full light of day, connecting the dots, building partnerships, and creating collaborative relationships that reach far into every corner of the community.

The new public health thrives on partnerships. The new public health does not for a minute presume that government can do it all on its own. The new public health taps into the very best leadership the larger community has to offer. The new public health includes leaders from government, business, community and faith-based organizations, health care, academia, even the news media. The new public health breaks out of its old silos; works with others; collaborates on preparedness, prevention, chronic disease, social inequities and economic disparities.

There is tremendous power in these cross-sector collaborations, in getting strange bedfellows to work together, accountable to one another and to their own constituencies. There is a side effect to all this collaboration. Each time you bring together leaders from other sectors, you widen your own base and you acquire new champions. Lord knows, we are going to need them.

Last year, I joined many of you at the NACCHO meeting in Columbus, Ohio. We talked about how hard it is to bust through the budget barriers without both a loyal constituency to help make your case, and good research to prove your point. Advocates and evidence go hand-in-hand.

The lack of convincing, compelling evidence has been public health's major stumbling block for many years. Until now, that is. Now you are able to build the evidence base you have been missing. Now you have the one thing that is certain to get the attention of the decision-makers. Now you can show them the money, show them the ROI—the return on their investment.

For example, the next time you sit down with your decision-makers, you can show them a direct cause and effect between what a community spends on public health and significant declines in infant mortality and preventable deaths as a result of new research conducted by Glen Mays and Sharla Smith at the University of Arkansas.

They used NACCHO data, collected from 2,900 local public health agencies. It is the most comprehensive look yet at the effect of local public health spending on population health. We funded the project and we have seen an early draft of their report. Mays and Smith matched—in exquisite detail—what communities spend on public health with rates of mortality among infants and deaths due to cardiovascular disease, diabetes and cancer. Then they asked: "Does More Money Matter?" The evidence conclusively said yes. For each 10 percent increase in public health spending, mortality rates fell from between 1.1 percent to a whopping 6.9 percent.

They also found that funding public health is a faster and cheaper way to lower mortality rates than beefing up local medical resources. For instance: Increasing public health spending in an average

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community by 10 percent, roughly \$300,000, can achieve a 3.2 percent reduction in cardiovascular mortality. To get the same outcome without relying on public health would take 14 new primary care physicians for every 10,000 in population. If you figure that the typical underpaid family doctor makes about \$176,000 a year, that's \$2.5 million in new spending. You do the math—\$2.5 million versus \$300,000. It's a no-brainer.

TFAH, Trust for America's Health, came out with another public health ROI study in July. This is truly groundbreaking. The study shows that even a small investment in community prevention can produce substantial savings in overall health care costs. The report shows that an annual investment of \$10 per person in community programs like increasing physical activity, improving nutrition and preventing smoking could save the country more than \$16 billion within five years.

This is a return of \$5.60 for every \$1 invested. Projected savings include \$5 billion for Medicare; \$1.9 billion for Medicaid; and \$9 billion for private payers.

I want to thank our partners TFAH; the New York Academy of Medicine; the California Endowment; and Prevention institute for these stunning results.

Here's what is important to remember: The ongoing national debate over health and health care usually focuses on just two factors—cost and coverage. The truth, however, is that there is much more to it—like prevention, preparedness, racial and ethnic disparities in resource allocation, and the social determinants of individual and community health.

With research—and the evidence it yields—you are better equipped to make a convincing argument for the new public health and for the fiscal and political commitment you need to do your jobs the way the American people expect and deserve.

I think you get the point. It is research that talks before the money walks. We are helping build a brand new field of "public health systems and services research" to provide you with a constant flow of reliable information. We stand shoulder-to-shoulder with ASTHO, NAACHO and NALBOH in this important work.

We are housing a data clearinghouse and analysis center at the University of Kentucky, with help from the National Library of Medicine. This will be the go-to source for the very best and latest data on what public health agencies are doing and learning. The goal is to supply you with all the proof you need to justify more resources—even now, when public dollars are so scarce.

What we are doing together 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, performance standards, advocacy, and a relentless reliance on research and evidence.

You are setting a course that will take the new public health—and the health of America—to new heights this century. You are heroes. You are, indeed, making history. Just think how, down the road, in grad school, the professors will be talking about what you did. Listening will be all those young hot shots who would like nothing better than to do the job you are doing now. They will ask how was it that you had the insight to see exactly what was needed, when it was needed, and the courage to act decisively and without hesitation. What a tough question. Insight is so hard to explain.

Let me try this way. We started out talking of wildfires. There is a story that forest firefighters tell that defines insight far better than any dictionary that I know of. It goes like this: More than half a century ago—Friday, August 5, 1949—Big Sky country of Montana was hot and dry, a tinder-box being stoked by 100-degree heat, high winds and 4 percent humidity. First-responders called it a red flag day.

About noon, a fire-spotter reported smoke rising from a remote canyon called Mann Gulch—that is right where the Rocky Mountains shoot up from the Great Plains. Parachute was the only way in. A

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rugged firefighter named Wag Dodge (I love that name) and 14 other smoke-jumpers were on the ground by 3:30 p.m.

It was like diving into an erupting volcano. Within minutes, a wall of flame 50 feet high and 100 yards wide was racing toward them at 700 feet a minute.

There was no way they could outrun it, though most tried. Wag Dodge, however, suddenly stopped in his tracks. He put a match to the tall grass around him, let the new fire burn and then threw himself face-down on the smoldering circle of ashes. The forest fire roared over like a freight train. A thin layer of air clung to the ground and gave him just enough oxygen. Dodge and one other lived; the rest died. Later, he could not explain where his idea came from. But he did say that he knew instantly and intuitively that it would work.

Today, almost 60 years later, neuroscientists call this the insight experience. It is what happens when we know exactly what to do—and we do it. These sudden make-it or break-it moments share a common dynamic.

First, there is the big problem that seems unsolvable. Nothing works. It is all impasse, gridlock. Next, there's a breakthrough, the big "A-Ha!"—a clarity when knowledge, experience and instinct click together like tumblers opening a lock. It is so palpable you feel it in every fiber of your body. With the "A-Ha!" comes the unshakeable confidence that this will work—that there is only one way forward and you know exactly what to do.

Bill Foege tells us the philosophy of public health is to find the truth. Ladies and gentlemen, this is your moment of truth. This is the "A-Ha!" moment for the new public health. Seize this moment. Face the flames. Strike the match. And turn to your future with the absolute certainty that this will work.

Review Risa Lavizzo-Mourey's presentations, commentaries, interviews and media briefings at the President's Corner of the RWJF Web site at www.rwjf.org.