NEW PERSPECTIVES

The Battle for the Public's Health

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We are losing the battle for the public's health. This, in spite of our daily devotion to the cause. The statistics are grim. We are number 38 in the world in life expectancy, yet we spend the most. Preterm birth has increased by a third in the past few decades, and by 2030 more than 40% of our population will be obese. It really matters that we get this right. Not because health is the endpoint, but because it allows people to fulfill their every potential.

We are losing this battle for the public's health because we are going about it all wrong. We are spending enormous intellectual and financial capital on the health care industry in the hopes that this will improve the public's health. But health care is the wrong tool. Health care only impacts at best 20% of someone's health. The other 80% includes determinants such as the built environment, access to fresh foods, behaviors, educational opportunity, and housing. Yes, we are trying to creep over to the other 80%—behavior and where people live, learn, work, and play—through health care, but it isn't possible in the current framework. Health care, though heavily funded, is inherently designed in a sickness framework. Its business model is predicated, ultimately, on caring for people who aren't healthy. The incentive is for the public's health to be poor. This generally leads to a better bottom line, better educational opportunity, and better research opportunity.

Is public health the right tool for improving the public's health? It is accountable to the entire public—not just the patients seeking care. Its business model is not entirely predicated on sickness. But I believe that as is, it is ill equipped to improve the public's health. It is still grounded in antiquated laws and structures better designed to tackle yellow fever than obesity or violence. There is dramatic variability in funding, form, function, reporting, and capability across the nation. Public health is using outdated data for decision making. And it is programmatically focused with limited opportunity for cross-pollination or innovation within programs or with other sectors. It is also dramatically underfunded. Only 3% of the US health budget is directed at public health. This equates to $251 compared to the $8,086 spent on health care. And the funding continues to decline. It is the "general medicine" of government: big responsibility and little money.

To make matters worse, the two systems, health care and public health, who together may have the tools and expertise to improve the public's health, often exist in isolation and often don't coordinate, much less cooperate. The reasons for this are many but include the lack of a shared legal framework, vocabulary, agenda, strategy, and workforce development. And there is distrust perhaps because of the regulatory nature of public health. But without major change and a significant shift towards meaningful integration, we will not be able to use those tools to win this battle for the public's health.

I have seen these worlds intimately, from both sides, as I have experienced or directed their dismantling and rebuilding. I completed my residency at our public hospital in New Orleans (commonly called Charity Hospital). I learned to deliver great quality care but learned less about the context in which people were struggling to be healthy. Following the care plan was a low-priority issue when the patient had a shaky employment situation, was reliant on undependable public transportation, marginally literate, and living in poor-quality housing in an unsafe neighborhood. The outcomes for that patient's diabetes would be suboptimal. The health care system wasn't meeting the needs. My approach was to make the health care system work better for patients trying to improve their diabetes. And I often lost the battle.

And then Hurricane Katrina came in August 2005. Katrina wrought flooding on New Orleans that kept a landmass the size of the Island of Manhattan under several feet of water for weeks. Katrina dismantled everything—including our health care infrastructure. It was horrific, with 1,800 dead and more than 200,000 homes flooded.

But it was also an unprecedented opportunity to step back and take stock about whether the health care system we had built was improving the public's health. Of course it was not. Louisiana had poor health status at high cost compared to other states in the nation. Like most of the rest of the country, we were pouring our resources into hospitals and emergency rooms rather than preventing illness. And, like most in the nation, we were in full swing transforming our health system into one that could do more than affect a mere 20% of the public's health.

Our immediate response to those in need after Katrina laid the foundation for a more patient-centered primary care infrastructure that considered the social determinants of health for everyone we served. We went to the street and delivered what care was needed to those left behind and those first responders helping them. What evolved naturally was a medical

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home version of primary care determined to meet the patients where they were. This meant working in teams, incorporating mental health services, and considering the context of the patient's health—housing, safety, job security, social support. Yes, this meant medical homes—but medical homes able to address the social determinants.

From those street-based urgent care stations serving as makeshift medical homes grew a collection of 80 clinical sites serving 200,000 people in the area in a year. This high-quality network boasts dozens of NCQA patient-centered medical homes and care that in external evaluations is deemed accessible and high quality by people who are more challenged by health and social issues than the average American.

This new health care system, devoted to winning the battle for the public's health, grew rapidly out of necessity and deliberate action. It grew in to a health care model more able to improve the public's health because it was unfettered by the typical constraints of health care. We had flexible funding that supported care and not just services. We were able to push the envelope of what primary care could do for the public's health by embedding legal aid services, onsite community gardens, lay health workers, and street-level outreach to high-risk patients in the delivery system.

Participating in crafting this better health system was personally very rewarding for me. It was an opportunity to imagine health care at its best and also able to address the 80% of people's health not directly impacted by health care.

As health care and payers embrace meaningful payment for the medical home and for population care, health care will be able to do more in prevention and primary care. This also became more of a problem when the flexible funding ended and we were forced into a more traditional model where we were reimbursed for services and not able to provide care.

But it was frustrating to me that we were still just mostly patching people. We were identifying diabetes and treating it. Yes, we were trying to push the envelope. We created a map to give to our patients with information about where to get fresh food in the community, but I needed to better understand how the fresh food got there in the first place.

And so, when our remarkable new mayor, Mitch Landrieu, invited me to join him as the health commissioner, I jumped to public health and government hoping to understand all those levers that might improve the public's health.

It should come as no surprise that, like our health care system, our New Orleans health department was severely broken. But years of neglect and a lack of focus did not destroy the health department. Like so many things in our city, the hurricane did not cause the problem but brought it out in to the open and forced us to face it, to fix it.

They were trying to be health care and improve the public's health with a tool designed to respond to sickness and able to influence only 20% of people's health. The health department was not focusing on environmental systemic factors that could improve the public's health. There were no internal controls, business infrastructure, no budget—just a series of disconnected ledgers and accounts. No human resource policies or expectations. No vision, no strategy. No playbook. A debris field. We were spending the majority of our budget on a poor-quality inefficient version of primary care, which distracted the health department from being a neutral convener around health care access.

We have been aggressively cutting, reorganizing, and rebuilding. This meant a 43% budget reduction and a reduction of force by about 30 people. Most of this came through the elimination of the primary care service line. This allows us to move away from direct services as a means of improving the public's health and toward the essential public health functions—assessment, assurance, policymaking.

Everyone is talking about doing more with less or the same with less. I found sufficient waste in our system allowing us in some ways to do more with less. But our health department, like most in the United States, is underfunded to do this work. In New Orleans we have $1.7 million or $5.10 per person in non-program funds to spend. This includes overhead and salaries for me and the core staff. It is what we have on the margin for innovation.

It is not an isolated phenomenon. We are undertaking this transformation of our health department at an amazing time in public health. Just as health care is undergoing transformation, so is public health all across America. Public health has realized it is losing the battle for the public's health and must make change to reverse course. Public health, like health care, has to restructure itself at its very foundation. This involves building a stronger business and operational infrastructure, focusing more on outcomes, and building bridges with

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other sectors critical to impacting the social determinants of health.

To turn this tide, we need to quickly make changes in how we are thinking about improving public health and be willing to let go of old ways. That while we are simultaneously making a new way. Much in the way we did for health care after Katrina, and much in the way we are now doing it with our health department in New Orleans. It doesn't always take a catastrophe, but it does take will. And imagination.

But to really make an impact on the public's health, we are going to need to partner with many sectors. Health care is a natural, valuable, and wealthy partner—and one that is meant to have the same ultimate goal of health. Moving forward, we need to move public health and health care along the continuum from working in isolation, to integration where it makes sense. To get there, we will need to develop a common agenda to improve the public's health, integrate public health and medical education and workforce development, and leverage health care data to inform public health policymaking.

Significant adjustments to the funding and financial reward situation of health care and public health are in order. These will of course be harder changes but are critical. Both will need to focus on eliminating redundancy of effort and waste aggressively. Public health will require a significant increase in investment. The Institute of Medicine has called for a doubling of funding. For health care, funding and payments should be predicated upon broader community health rather than just the health of a patient population.

Time is running out for us—whether you are worried about our nation's financial situation, the public's health, or both. We simply must stop using our old tools to solve this. They aren't working, and we are losing.

Let's forge the power of your brains and brawn to reform and realign the health care system and public health to turn the tide. The public's health is in your hands. I have every confidence in you. *SGIM*