Public Health:

Filling Leadership Gaps in Health Promotion, Prevention and Care

An overview of ideas from the Harvard University Advanced Leadership Initiative Think Tank

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Introduction: The Think Tank Premise

The Advanced Leadership Initiative (ALI) at Harvard University is dedicated to educating and deploying a leadership force of experienced leaders who can address challenging national and global problems. An important part of the process is to stimulate discussion among experts and advocates about the gaps that can be filled by Advanced Leaders, including the Advanced Leadership Fellows at Harvard who are preparing to transition from their primary income-earning years to their next lives of service. Each year, ALI convenes three solution-finding workshops called Think Tanks to delve deeply into the nature of social problems, their potential solutions, the barriers to change, and the ways that Advanced Leaders can make a difference.

On March 26-28, 2009, roughly 200 public health leaders were convened to discuss where they were at and how to move forward, even as the debate over health care reform raged in the U.S. Congress. (Indeed, many session participants were deeply involved in negotiations over the reform.) The Think Tank was co-chaired by Howard Koh, Associate Dean of the Harvard School of Public Health and the newly appointed U.S. Assistant Secretary for Health, and Rosabeth Moss Kanter, Ernest L. Arbuckle Professor of Business Administration at Harvard Business School and ALI Faculty Chair and Director.

Despite spectacular advances in medical research and technology over the last century, public health improvements in developed and developing countries remain as challenging as ever, with new problems layering on top of old. On the one hand, health indicators such as life expectancy or maternal mortality in the developing world are equal to where they were at century ago in Europe and the United States. A major task in low-income countries is to create public health systems to improve population health which, if successful, create economic benefits for the poor. On the other hand, for the first time in history the life expectancy of children in the United States has fallen below that of their parents, given increases in incidences of cancer, heart disease, obesity, diabetes, and medical error. This has all come at a time when the population is aging, especially in Europe, and existing delivery systems have struggled to provide affordable access to care. Furthermore, globalization has created new threats of environmental change, bioterrorism, and epidemics which require international coordination to address.

Leaders gathered to discuss these issues, focusing less on medical practice and the delivery of acute care, though these are important pieces to the system, and more on the actions needed to reduce risk factors and improve public health at the population level. What can be done to lower the high rate of deaths from preventable diseases and medical errors? What is the best way to help individuals change lifestyles and end their addictions to junk food, alcohol, and tobacco? What do successful national health care systems look like, and how are they created? How can health care professionals, communities, and other stakeholders better collaborate? What specific leadership skills are needed to achieve better conditions and outcomes for citizens? In other words, leaders focused less on treating disease and more on systemic change in public health.

This report offers a narrative summary of the gaps identified during the event and highlights opportunities, both large and small, for improving national and global public health systems.

What Is Public Health?

While all may think that better health is a great thing, not everybody agrees on exactly what that would mean and for whom.

In 1948, the World Health Organization (WHO) defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." Building off that definition, Howard Koh offered a striking narrative example of the pervasive nature of public health:

> You wake up in the morning, and you open your eyes, and the air is clean to breathe. That's public health. Then, you turn on the water, and it's fluoridated. That's public health. You sit down for breakfast, and you're dying for the donuts, but you have the wheat toast. You get in your car to go to work [and] you put on your seatbelt, that's public health. Better yet, you ride your bike to work. That's public health. On your way to work, you have to drop your daughter off at daycare, and she needs to be vaccinated to start school. That's public health. You get to work, and it's smoke-free. That's public health. At work, you have chest pain, and an ambulance comes within minutes and takes you to the emergency department. That's public health. You get admitted to the hospital, and you get outstanding, high-quality care, and you get discharged with excellent follow-up in a short period of time. That's public health… Public health works for us 24 hours a day, seven days a week. And we don't really appreciate it until we don't have it anymore.

The public health domain is wide-ranging. It includes environmental health, eating habits, public safety, the need for exercise, child vaccinations, substance abuse, heart disease, disparities, lack of health insurance, lack of primary care providers, as well as issues related to the homeless, environmental hazards, and threats of epidemic flu and bioterrorism.

The public health system is a system of systems. It is more than the health care delivery system (or the sickness or disease care system, as some participants called it), which includes the doctors, nurses, hospitals, clinics, and other actors who deliver acute care. It also consists of the government public health infrastructure, academia, business, media, and the community. All work together – or not – to ensure the population's health. The government public health infrastructure guarantees hygiene and safety, such as safe drinking water, food quality, immunization, and emergency response. Universities train workers and perform research. Businesses create occupational settings, influence consumption, and impact the environment. Media shapes public opinion through the information and stories it offers, and communities shape the lifestyles of citizens through their social structure, interactions, and built infrastructure.

"These systems sound like giant obstacles and they are," Koh said. "But as my friend, William Sloane Coffin liked to say, 'Giant obstacles are brilliant opportunities, brilliantly disguised as giant obstacles.'"

Public Health Challenges in the 21st Century

As a system of systems, public health faces the twin challenge in the 21st century of becoming increasingly fragmented in an increasingly interconnected world. Some challenges divide developed and developing countries while others unite them.

Supply Driving Demand
Public health initiatives in Europe, the United States, and other developed countries over the past hundred years have been a resounding success. Life expectancy in the United Kingdom and the maternal mortality ratio in the United States a hundred years ago were the same as they are in Africa today. Lord Nigel Crisp, former Chief Executive of the National Health Service in the United Kingdom, argued that professionalism, science and technology, and commerce created these improvements. However, these drivers have become part of the problem as the supply of hospitals, clinics, universities, businesses, and clinicians now drive demand.

Medical Error
Medical errors have become the third leading cause of death in the United States, with roughly 300,000 people dying each year. Lucien Leape, Adjunct Professor of Health Policy in the Department of Health Policy Management at the Harvard School of Public Health, attributed the errors to four factors – practitioner arrogance; a secretive, inward-looking, opaque medical culture; poor leadership; and bad systems. "We have people being hurt by errors made by good people who are trying to do a good job. If you want to prevent errors," he said, "don't exhort [practitioners] to do better. Don't punish them when they make mistakes. Try to find out why they made the mistakes and change the system, so [they] will be less likely to happen."

Lack of Focus on Prevention
In ancient Greece, when physicians took the Hippocratic Oath, they swore to two gods – Asclepius, the God of Medicine and Hygea or Hygiene, the Goddess of Public Health. But in the 1960s, Hygea disappeared from view, argued Rear Admiral Susan Blumenthal, former Assistant Surgeon General of the United States and former Deputy Assistant Secretary for Women's Health. Of the $2 trillion comprising the U.S. health care budget, only a tiny percentage – 1 to 3 percent – goes toward prevention programs. There is plenty of room for innovation, she said, in mobilizing multiple sectors to promote health rather than just treating disease. But the barriers are many, said Donald Arthur, 2009 ALI Fellow and former Surgeon General of the U.S. Navy. The current financial incentive system values restorative care proving a negative event – that something has been presented – is difficult.

Fragmented Community-Level Data
"Just like all politics is local," said Deborah Klein Walker, Vice President of Abt Associates, "all public health is local." Although a community framework for the United States was laid out in the 1996 Institute of Medicine report ("Improving Health in the Community") and coalitions have formed to work on the issue, data remain fragmented. The Healthy People 2010 report has made a call for producing data on the ten leading health indicators for people at the community level, but commitments have not yet been met.

Research Silos
Although public health is a function of how people live and work, research continues in silos, focusing on immunization or maternal health alone, rather than understanding the holistic effects that childhood education has on economic productivity or that poverty has on biological development or that economic disparities have on disease. This is reinforced by a funding system that makes grants categorically by disease. According to Jack Shonkoff, Director of the Center on the Developing Child at Harvard University, academics could focus more on the study of systems to better understand how components relate to one another. A major challenge is to find a way to evaluate interventions intended to create systemic change.

Changing Lifestyles
The way people eat, sleep, work, interact, consume, and exercise is related to the rise in obesity, diabetes, and sexual disease. Changing these lifestyles is difficult and requires a combination of interventions. In part, it

is about providing information to citizens and better educating them about the consequences of their behaviors. However, it also requires changing the environments that lead to unhealthy lifestyles.

Health Disparities
Lifestyles are also connected to socio-economic differences, which correlate with health disparities. Diabetes, for example, is higher among the African-American and Latino population in the United States. Obesity correlates with income. Tackling the issue is a systemic challenge. The Health USA and National Disparities Board seek to address the problem. Issues also exist globally. However, some countries are uncomfortable recognizing the problem because it raises difficult political issues, especially in fragile or unstable national environments. Furthermore, the success of interventions is difficult to measure.

Global Disease Burden
Disparities also exist between countries in the form of global disease burden in developing countries. To help address the issue, the United Nations Millennium Declaration identified several health-related targets. The plan was for countries and development partners to work together to increase access to the resources needed to reduce poverty and hunger, and tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation. "Improving public health is one of the most powerful tools we have or means we have to empower people to lift themselves out of poverty," said Julio Frenk, former Minister of Health in Mexico and Dean of the Harvard School of Public Health. Furthermore, addressing the global disease burden requires hard choices about resource allocation. Money spent on coping with AIDS in Africa reduces resources for maternal health and child immunization

Systems Strengthening in the Developing World
If public health is a system of systems, then global public health is a system of systems of systems. However, many of these national systems, especially in the developing world, need strengthening. "The key difference between developed and developing communities," Julio Frenk explained, "has to do with the strength of the institutions. Institutions introduce certainty to transactions and articulate the incentives." However, aid donors do not yet act in a coordinated way to confront the problem, focusing instead on individual issues. Donald Berwick, President and CEO of the Institute for Healthcare Improvement, offered the example of 40 donors in Malawi attacking 40 different issues.

Transnational Issues
"Diseases know no boundaries; we're all in the same bath water," said Lord Nigel Crisp, former head of the United Kingdom's National Health Service. Potential epidemics such as SARS or the Bird Flu can move quickly among the world's populations. Furthermore, climate change, which touches upon issues of health security, will start to affect all and will have a global knock-on effect. Thomas Zeltner, former Vice Chairman of the Executive Board of the World Health Organization and Director-General of the Federal Office of Public Health of Switzerland, urged leaders to see these global health crises as integrated and warned that addressing transnational issues will demand enormous amounts of money. Crisp added: "Our ability to resist new diseases depends on world-wide vigilance, as well as cooperation and information-sharing and science. We're only as strong as our weakest link."

Global Shortage of Health Workers
The rise in health needs in the developed and developing world will create a global shortage of health workers. Norway, for example, estimates that it will need 30 percent more health workers. The lack of doctors in the developing world in places such as rural India and Africa is well known. Open questions include how to fill gaps, identify opportunities for training, and focus on the education of professionals in developing countries. Furthermore, human resources could be managed better. "We should be training people at tiered level," said Barry Bloom, former Dean of the Faculty and Professor at the Harvard School of Public Health. "People who cannot practice medicine in the United States or in Western Europe … could provide a tremendous amount of on-the-ground services."

Until now, most approaches to solving public health problems have focused on what Don Berwick calls "black box" strategies. They rely on markets, exhortation, or inspection alone. A reliance on markets requires little thought about how healthcare is delivered, the kinds of organizations needed for people to give better

care, or the use of existing or the creation of new knowledge. Rather, there is a faith that the market will solve these issues. Exhortation is even easier to rely on than markets. If the results are not there, push harder using force or fear. Inspection is a mechanism used by those who rely on markets or exhortation. Maintain transparency and accountability and change will occur. The United States, for example, has created a massive but inefficient inspection regime. However, these black box strategies create false choices, many of which would disappear if public health were viewed systemically.

If health is created in everyday life, then leading change requires the transformation of a system of systems. Berwick defined a system as "a set of interdependent elements that are interacting, or working together, to achieve a common aim, whether they know it, or not." In the pursuit of health, the elements of the system are highly non-linear and complex. Achieving better care and better health thus depends on seeing health systems as an integrated whole in need of redesign. "Systems change – the building of an integrated, interconnected, transparent system, like that used in the Mayo Clinics in which medical professionals can pull information together, measure results, and improve processes – is not just a better way forward," said Berwick, "It's the only way forward."

Government Policies and Programs

Though public health is a dispersed system of systems, government public health infrastructure plays a central role. Officials, from senior executives to department heads, face daunting challenges. Tasks differ by government system as different responsibilities fall on them. Regardless, they face three classes of leadership challenges: change the entire bureaucracy, set priorities and decide how to address them, and support innovators from within.

Reforming Entire Systems
Several former Ministers of Public Health, including Lord Nigel Crisp from the United Kingdom, Thomas Zeltner from Switzerland, Julio Frenk from Mexico, and Pablo Pulido from Venezuela, admitted feeling overwhelmed during their first days on the job, as did those heading government divisions. Where to begin? What are the priorities? How do you pick and choose? Cases from the the United Kingdom, an established healthcare system in a developed country, and Mexico, a system in need of strengthening in an emerging market, highlight leadership challenges and available solutions to systemic change.

United Kingdom
The United Kingdom's National Health Service (NHS) is the world's fourth largest organization, after the Chinese Red Army, the Indian Railways, and Wal-Mart. It sees a million patients every 36 hours and employs 1.3 million people. When Lord Nigel Crisp became Chief Executive of the NHS and Permanent Secretary at the Department of Public Health in 2000, he found a "deformed" system. The same factors that had contributed to the enormous gains in public health – professionalism, science and technology, commerce – had become detrimental. The supply of hospitals, clinics, universities, and businesses created demand rather than filling needs. Crisp tackled reform in three basic ways during his six years in office.

First, he took on the supply side by setting targets for improvement and driving out variations in hospitals. He put in stricter gateways for new drugs, affecting the pharmaceutical companies. "We weren't just going to accept what the commercial companies told us – that these drugs were going to be good for our system," he said. NHS also encouraged the move from pure academic research toward translational research, which allowed basic findings to be put to more efficient use in medical practice.

Second, he sought to change the system's incentives. The NHS had been both a payer and provider for services, so he separated the two and rerouted the payer system through general practitioners, making those closest to the patient responsible for buying treatment services from the hospitals. "This produced a big shift in power, because the primary care physicians could ensure that there were not duplicative tests, procedures, and medicines," Crisp said. On the provider side, he allowed private sector competition into the NHS hospitals, but retained the single payer system.

Third, he made massive new investment, not only in the major reforms but in additional programs, especially for prevention. Under Crisp's direction, the NHS also worked to change unhealthy behaviors through an "Expert Patient Program," offered to people with chronic diseases such as diabetes. After a number of years, people with such conditions become experts in their own care, ultimately reducing costs over the long-term.

Mexico
Like Crisp, Julio Frenk, Dean of the Harvard School of Public Health and Mexico's former Minister of Health, led the reform of his country's health system between 2000 and 2006. But the tasks and obstacles differed.

When Frenk assumed his role in Mexico, roughly 4 million families were going bankrupt every year because of their health costs (as is currently occurring in the U.S.). Over half did not have health insurance. As such, 52 percent of all health expenditures in the country were out of pocket at the point of service, which meant that the sickest people paid the most. To him, access to healthcare is a question of equity – it is a social right.

Three pillars guided the reform – a technical pillar (in the form of solid evidence about what the problem is and what works), a political pillar (selling ideas through clear, simple messages and effective communication), and an ethical pillar (visionary ideas derived from science, and ideals derived from values). "The most complex

challenge in health systems," he said, "is to nurture persons who can develop the strategic vision, the technical knowledge, the political skills, and the ethical orientations to lead the complex process of policy formulation and implementation."

Reform in Mexico began by making the problem visible, by providing the evidence to bring the issue's magnitude to public awareness. "For me, this is the most beautiful example of what I call making the power of ideas influence the ideas of power," he said. "By the process of research and analysis, we uncovered a reality that was absent from public awareness and made it the centerpiece of a major piece of legislation and reform." With evidence, he made the ethical case for reform, based on the argument that people cannot choose when to fall ill and that it is unfair that the state pays twice as more for the health of the affluent. Access to health care is a right.

In seeking to reform health systems, Frenk suggested different sets of tasks for Advanced Leaders. One set might focus on the technical core of health policy; their work would be to develop and train researchers who can absorb technical knowledge and generate evidence. Another set might seek to create a knowledge repository of reform experiments and experiences and develop a systematic process to evaluate new innovations in health care that in turn feed the repository. A third set might focus on "systematic development of skills in communications and negotiation" that could be shared with others.

However, leaders like Crisp and Frenk did not reform entire systems alone. Nor do systems change all at once. Change agents within the government or "intra-preneurs" tackle issues from within the organization.

Reforming Components of the System
A major challenge for public health leaders lies in identifying how to leverage dispersed public resources to solve unaddressed problems. Doing so requires them to seek new collaborations and partnerships both within and without government.

Environmental Health
When Ken Olden was serving as the Director of the National Institute of Environmental Health Sciences, he had a difficult time securing funding for new programs. During one meeting, a congressman bluntly told him that "nobody gives a damn about your Institute" because its investments were not aligned with the needs and the concerns of the American people. Olden took it as a wake-up call. He proceeded to change the culture of the Institute by getting everyone out of their suits and ties and putting them into communities to conduct on-the-ground research designed to discover what people needed in the form of more nutritious food, protection for children, and the cleaning of toxic waste sites. People did care about what the Institute was doing. Olden called the approach "community-based participatory research." Six years after his initial meeting with the congressman, the Institute's budget had doubled twice, making more resources and researchers available for communities to address important public health issues. The Institute developed a publication, *Environmental Health Perspective*, which became the field's leading journal, and other U.S. agencies outside the NIH have adopted the research model. "I'm very proud," Olden said, "but we would have never done that without community input."

Olden suggested that the model could help the NIH address three major problems: the effects of urbanization on health; increasing health disparities; and the aging of the population. (The latter, especially, will drive health care costs unless new research and programs address it.)

Women's Health
In 1990, a U.S. Governmental Accountability Office (GAO) report found that only 13 percent of the NIH's budget was spent on women's health, an alarming fact for Rear Admiral Susan Blumenthal when she became, in 1993, the country's first ever Deputy Assistant Secretary for Women's Health. Blumenthal and her colleagues set about building the first one-stop-shop, government-sponsored website on women's health. But the NIH and the Centers for Disease Control pushed back. "They were concerned that their public affairs budgets would be cut if they couldn't send out [their own] brochures," she said. To overcome interdepartmental resistance, Blumenthal's group built the website through the Department of Defense. Within a year, people began to understand the power of the Internet to disseminate information and they

worked across agencies to make the site work – the site eventually moved back to the Department of Health and Human Services. In the end, Blumenthal secured $4 billion in federal funding for women's health issues. She weaved a focus on women's health into multiple government agencies and managed to get women's health coordinators appointed to facilitate collaboration.

City-Wide Access to Care
When the mayor asked Sandra Hernandez, then head of the San Francisco Department of Public Health and current CEO and Director of the San Francisco Foundation, to find a way to cover every resident in the city and county of San Francisco with comprehensive healthcare within 100 days, she was stunned. The effort had already failed three times. "I took a deep breath," she said, "and thought, first, 'You're crazy.'" But she also believed that the time pressure could spur coordination among business, community, health care, and government interests to construct a local insurance plan for basic coverage. A major challenge lay in understanding how the dollars flowed in a complex, multimillion dollar public health system that incorporated programs for the poor, family planning, maternal and child wellness, and environmental health. In the process, she discovered that small business owners could not afford to cover their employees. Bringing them on board proved pivotal. Ultimately, her group designed a successful public HMO similar to Medicaid coverage. "It was adopted by the Board of Supervisors 11 votes to none," she said. "And the mayor signed it into law. Today, it is a fully functioning health-access program." Public health reform, even when led by government, does not come from government alone.

Crossing Boundaries, Collaborating for Solutions

Improvement in public health also requires stakeholders to understand the cross-cutting nature of problems – e.g. pain management, the holistic study of the child, sharing of best practices, patient safety – and collaborate for solutions.

Managing Pain through Complementary Medicine
Effective pain management is a critical problem in the U.S. health care delivery system. Roughly one in six people in the country suffer from chronic, disabling pain, with two-thirds of them having suffered for more than five years at an annual cost of $100 billion. However, there is institutional resistance to new approaches. "The shocking thing for me, as a cancer doctor by training, is that 40 percent of cancer patients in America die with pain that is not well-controlled," said Charles Denham, ALI Fellow and Chairman of the Texas Medical Institute of Technology (TMIT). Denham's organization is dedicated to driving the adoption of clinical solutions to patient well-being and healthcare performance improvement by collaborating with hospitals and businesses to combine the best of evidence-based conventional medicine with complementary care.

Penny George, Director and President of the Bravewell Collaborative, a philanthropic community dedicated to advancing integrative medicine and helping the field return to its roots in healing, has a first-hand understanding of pain management and complementary medicine issues following her own breast cancer diagnosis. The Bravewell Collaborative supports initiatives that promote wellness by emphasizing self-care, prevention, and the mind-body-spirit connection. In the latter half of 2003, the collaborative decided to invest in leading clinical centers of integrative medicine, which could serve as models for change in the larger health care delivery system. Representatives from the centers meet twice a year in pursuit of this goal. "We are part of something much bigger, which was a social movement challenging [medical practitioners] to re-think the reductionistic focus on disease and symptom management and pharmaceuticals," she said. "Instead, we felt they needed to see people as whole human beings, connected in mind, body, and spirit with internal resources of their own for recovering health." The Collaborative's goal is to make sure that integrative medicine is part of the national agenda for health care reform. "We're in the process of creating strategic partnerships with organizations that share a common desire to transform medicine and health care around wellness and prevention," she said.

Penny George offered a bit of advice for those who might want to learn from her experience. "Carefully managing the [collaborative] process is key," she said. It's necessary to clarify expectations and the ground rules on a regular basis. It's also essential for members to put ego and self-interest aside. "This is the hardest part," she said, "since it's sometimes difficult to know when you're being self-interested. It's important to fund strategic initiatives that are focused on long-term system drivers and choose those strategies carefully, yet to be open to opportunities when they do arise."

Rainbow Interventions and Well-being
"Basic health and well-being is really a matter of the way we live and the way we work," said Jack Shonkoff, Director of the Center on the Developing Child at Harvard University. Rather than focus on specific illnesses and siloed evidence about public health interventions, he called for a public health agenda that incorporated a rainbow of interventions known to affect health – from childhood education and the effects of poverty to new discoveries in molecular biology, genomics, and neuroscience. "The science base is getting stronger and stronger that a child's education is related to adult economic productivity, as it is to health," he said. "But this fact is still overlooked because academics are too focused on individual issues such as immunization or maternal health." Shonkoff's Center on the Developing Child seeks to enact this agenda, operating with the conviction that public health begins with childhood education. If successful, this knowledge revolution has implications for how people are currently treated (or not) in the current heath care system. New knowledge can lead to discoveries "about who gets sick more, who doesn't live as long, why diabetes is increasing more among poor people and people of color…we're learning more and more about the early childhood roots of the biology of adversity that are making us more or less likely to be healthy."

Sharing Global Best Practices: A Two-Way Street
The global sharing of best practices is a two-way street. ALI Fellow Pablo Pulido, founder of the Centro Medico Docente La Trinidad and former Secretary of Health and Social Welfare in Venezuela, noted that health practitioners in underdeveloped nations need to tap global information resources, and not just the latest scientific research from the developed world. In the developing world, there is a crying need for an easily accessible database of best practices in public health, in order to better manage critical problems such as maternity care and AIDS prevention. "Where can we find the critical information?" he asked. "Where is that repository where we can find the information and analyze what's going on?" In Venezuela, Pulido established a hospital in which doctors and students could review best practices in advance of an operation. A global information resource, he suggested, might also help health professionals identify key factors that affect public health. "We have to know poverty, we have to know employment. We have political circumstances," he said. "For the first time, we have data to produce real change." Pulido called for leaders who would know how to use such a public health information resource. "Where are these leaders?" he asked. "How do we identify them? How do we pick them up?"

On the other hand, the developing world has much to teach practitioners in developed countries. Lord Nigel Crisp, who, after his post at the U.K. National Health Service, has worked to strengthen health systems around the world, especially in Africa, observed that young health professionals have become increasingly interested in global health because it incorporates not only clinical knowledge but also elements of sociology, economics, and culture. He told the story of a young British doctor who, having noticed an increase in tuberculosis cases in Nottingham, traveled to Southern Ethiopia to learn more about the disease. The young doctor noticed that the Ethiopians had better clinical skills than he did. "He meant that they didn't look at the kit," Crisp said. "They had to actually look at [and] talk to the patient, look at the skin, and understand what was going on, clinically." Crisp urged leaders from developed countries to rethink the way they attempt to export ideas and ideologies about health and medicine. "At its worst, this is a vicious cycle of exploitation and arrogance. Or maybe, just a newer adaptation of colonialism. But what if it were the other way around?" he asked. "What if the nations of Europe and North America imported lessons from experiences in Africa, Asia, and South America? Could the vicious cycle become a virtuous circle of respect and mutual benefit?" By working with and learning from local people in institutions, he suggested, we could "train thousands more health workers and help transform lives."

Collaborating for Patient Safety
Medical error is the third leading cause of death in the United States – and it is preventable. The key, argued Lucian Leape, Adjunct Professor at the Harvard School of Public Health, is in fostering better collaboration and teamwork. It takes a team, for example, to insert a catheter without making any mistakes. "The nurses and the other people work with the doctor to make it happen. And you can't have a team," he said, "unless every member has respect for people who have different skills. They have to want to work together. And that's not the way we train our physicians. So we're talking about really changing, in a very fundamental way, how we train doctors and how we expect them to perform." Change begins with medical practitioners taking to heart the concept of professionalism. "The definition of professionalism is putting the patient's welfare above your own [and] taking responsibility for [one's own] competence," Leape said. He called for a movement to create a set of Commandments -"laws and regulations that say 'thou must follow all the safety rules,' 'thou must treat each other with respect,' 'thou must be a team player,' and 'thou shalt disclose to patients when you injure them.'" This type of advocacy and prevention is already applied to issues of disease.

Advocacy and Prevention of Disease

Disease cuts across populations. Preventing it requires not only multi-sector collaborations but bottom up efforts, said Robert Restuccia, Executive Director of Community Catalyst. Important drivers include not-for-profits that advocate for better polices and behavioral change.

For example, Jeff Levi, Executive Director of Trust for America's Health (TFAH) and former deputy director of the White House Office of National AIDS Policy, detailed TFAH's evidence-based advocacy model. The organization's stated purpose is to save lives "by protecting the health of every community and working to make disease prevention a national priority." They begin by translating hard data into a language accessible to the public and to policymakers. "We didn't just say, 'well, everyone just needs to be healthier.' We started talking about how a healthier population is a more economically competitive population," Levi explained. For example, TFAH collaborated with other organizations, such as the Urban Institute, to develop a return on investment (ROI) model for certain community interventions (e.g., smoking reduction, nutrition and physical activity) designed to make healthy choices easier. The work produced an ROI of $5.60 per person in reduced health care costs. "We actually dared to look at whether there was a return on investment if you did something about primary prevention in a community setting," he said. By making themselves a trusted source of information, they were better positioned to motivate lawmakers to support health-promoting legislation.

Successful advocacy and disease prevention efforts have also targeted heart disease and cancer in the United States and unsafe drinking water, child vaccinations, maternal mortality, and tobacco use internationally. Successes in each highlight challenges and opportunities.

Heart Disease
Heart disease is the leading cause of death in the United States, and risk factors are getting worse. With the rise in obesity and sedentary behaviors, the next generation of Americans, for the first time in history, will have a shorter lifespan than their parents. An explicit goal of the American Heart Association (AHA) is to reduce coronary heart disease, stroke, and risk. To address this issue, they launched the Alliance for a Healthier Generation, devoted to reducing childhood obesity. As a part of the initiative, the AHA brokered a deal with the beverage and snack food industries to change what was served and consumed in 4,300 participant schools in the U.S. "At the end of the first year of implementation, there was a 45 percent decrease in full-calorie drink sales and a 23 percent increase in water sales in schools nation-wide," reported Cass Wheeler, former CEO of the American Heart Association. The AHA also collaborated with national medical societies, leading insurers, and employers to offer comprehensive health benefits to children and families for prevention assessments and childhood obesity treatments. Finally, they worked with the Nickelodeon Channel to set up an interactive website and sign up a million children for the Go Health Challenge. The initiative sought to encourage children to live better by "making healthy lifestyles cool."

Cancer
After heart disease, cancer is the second-leading cause of death in the United States. In the face of this challenge, John Seffrin, CEO of the American Cancer Society (ACS), sought to transform his organization from a charity into a high-impact public health agency in the non-profit sector. This mission led to the resetting of organizational goals: (1) redouble the research portfolio with more prevention, public policy, intervention, and translational research; (2) bring cancer prevention into the realm of public policy everywhere; and 3) provide everyone access to quality healthcare. Advocacy is critical to achieving each of the three. In 2008, for example, 100,000 U.S. families declared bankruptcy as a result of a family member's cancer diagnosis. The ACS addressed the issue with a media campaign designed to help the public discern the link between the broken U.S. health system and cancer. It featured personal stories of cancer victims and the tag, "Are you insured? Are you covered? Are you sure?" "That program has been galvanizing to our organization," Seffrin said. The ACS has faced several challenges, including the coordination of millions of full-time volunteers, 7,000 professional staff, and 13 geographic divisions; communication with donors to raise millions of dollars; and pursuit of its advocacy goals without raising the eyebrows of the Internal Revenue Service. By creating a 501(c)4 organization called the American Cancer Society Cancer Action Network, the ACS was able to "do more advocacy than most other organizations."

Unsafe Water
Over a billion people in the world are still without safe water, and about 1.5 million children die each year because of water-borne diarrheal diseases. Companies that engage in corporate social responsibility efforts are making a difference. Keith M. Zook, Group Manager of Global Sustainability at Procter & Gamble, shared how the consumer goods giant has adopted the Millennium Goal challenge and made its PUR water purification product available at cost to NGOs through its Children's Safe Drinking Water (CSDW) initiative. The program has created roughly two billion liters of safe drinking water since its inception. However, Zook noted, widespread adoption of the product has been hampered by use behaviors and resistance from local water authorities.

Child Vaccination
An estimated six to seven million children die annually of preventable diseases. The problem has an effective solution. "Vaccines represent the most-effective medical intervention known to prevent death and disease," David Bloom, Chair of the Department of Economics and Demography at the Harvard School of Public Health, said. However, economic and political barriers make inoculation a formidable challenge. There is a real need for leaders, Bloom said, who can show heads of state and other government representatives how vaccinations directly improve their countries' economic prospects, as well as a need for leaders who can counter increasingly powerful anti-vaccine lobbies. Orin Levine, Executive Director of PneumoADIP (Pneumococcal Vaccines Accelerated Development and Introduction Plan) at Johns Hopkins University, described a "vicious cycle in which vaccine suppliers limit the number of doses that they manufacture because they don't see evidence of demand from developing countries. That keeps prices high, which keeps poor countries uncertain about demanding an expensive vaccine." A way to break out of this cycle, Levine said, is to put financing in place that shows a return on investment for vaccine suppliers, which in turn builds both demand and political will. In this way, vaccination against disease becomes important for governments and individuals.

Maternal Mortality
Roughly 536,000 women die each year in pregnancy or childbirth. The single most common cause of death is post-partum hemorrhage. The situation is exacerbated by the low status and voiceless position of poor women in developing countries. Uma R. Kotagal of Cincinnati Children's Hospital emphasized the importance of strengthening women politically and economically. Steven Schroeder, Distinguished Professor of Health and Health Care at the University of California, San Francisco and former President and CEO of the Robert Wood Johnson Foundation, noted that the best way to help poor women was to "focus on systems-strengthening, starting from the village health worker, all the way up to the delivery system." Participants listed several important steps for improving the lot of poor women in need of access to maternal care, including large-scale advocacy and global mobilization on their behalf; a strengthening of health delivery systems; cultural sensitivity and improved listening skills among health practitioners; training and recruitment of skilled workers; and the help of advanced leaders in framing new conversations with governments and local constituencies.

Tobacco Use
Perhaps one of the most intractable issues in global health is tobacco addiction, which has become more complicated with globalization. The tobacco industry has used the General Agreement on Tariffs and Trade (GATT) to force developing countries to allow the importation and marketing of American tobacco products. "Taking away the benefit that Philip Morris and other companies are getting from globalization and their ability to create this world oligopoly of tobacco is going to be very difficult," Berwick said. He suggested that agencies such as the International Monetary Fund and the World Bank begin by categorizing tobacco as a harmful, rather than a neutral product, and thus "take away the economic benefits to the multi-nationals for their plans to expand" – a move that would positively affect 100 million lives in the future. Richard Daynard, President of the Public Health Advocacy Institute, described how a project at Northeastern University (the Tobacco Products Liability Project and the Tobacco Control Resource Center) works with NGOs to monitor tobacco use. "To make tobacco control work in any particular country, you need both information…and to change social norms around smoking," he said.

Changing Individual Behaviors

"Health is created in everyday life, where we live, where we love, where we work, where we play, where we travel," Thomas Zeltner, Director of the Switzerland Federal Office of Public Health and a representative of the WHO, said. Leaders can seek to promote healthy behaviors either by giving people better information for making decisions or by changing the environment in which they live so that "the healthy choice is the easy choice." Zeltner cited evidence that changes in smoking, drinking, eating, and exercise can reduce chronic disease by as much as 30 percent in a population.

If people have better information about the products they are using or the consequences of their behaviors, then they may be more likely to make healthier choices. Shelly London, former Senior Vice President and Chief Communications Officer for AT&T and 2009 ALI Fellow, offered the example of how a radio program about non-invasive "gamma knife" surgery resulted in callers cancelling invasive surgeries to explore the new approach. Better information, she said, depends on a mix of communications between patients and doctors, advocates and the community, and advocates and the media.

Direct education from the government itself is one method. Pablo Pulido called for a bottom-up health education process that starts with educating the community. The government of Venezuela used a combination of video and public education to massively reduce the number of malaria infections among the indigenous population.

Effective messaging also helps. Sandra Hernandez observed that people respond more to positive messages about their health behavior rather than negative ones, citing the example of Kaiser Permanente's "Thrive" marketing campaign. It was designed to focus on everyday things that people can do to improve their health, with a dual goal: encourage switching to healthier lifestyles and use it to market Kaiser Permanente's services and programs, such as health and wellness classes. It is colorful and visual, includes billboards of fruits and vegetables, has kids running in parks, and gives a people-oriented wellness message. "The early returns on it are that it's been quite successful," Hernandez said. "[It is] a mind shift campaign."

Content embedding can increase awareness. After Jane Goody, star of the U.K. reality show *Big Brother*, received a diagnosis of cervical cancer in front of millions of viewers, the number of screening tests in Britain rose by 30 percent. John Whyte of the Discovery Channel offered lessons on how to sell media content. Don't just issue a press release or hold a conference and invite the media after the fact, he said, "If I want to do a show on heart disease or HIV, I have to find an angle that's going to get people interested in watching. The media are looking for folks that have a strong sense of content."

But more information is not necessarily better information. Gabriel Barbash, former Surgeon General to the State of Israel, observed that misleading information spread through the media can lead to a loss of credibility. "You have to be transparent; you have to be reliable in what you say; and you have to streamline information, even if the information is not telling good things," he said. Barbash argued that it could be beneficial to secure celebrity support, citing the example of actress Glenn Close's support for a diabetes initiative.

K. "Vish" Viswanath, Associate Professor at the Harvard School of Public Health and a member of the Board of Counselors for the Centers for Disease Control, highlighted the problem of information inequality. The explosion of evidence-based health information from various interest groups, coupled with the speed of distribution via the Internet, makes it difficult for practitioners to keep up. "The question is: Is it all good information?" he asked. "Is it is always relevant information? Is it always useful? What kind of a control can we exercise over this information [to avoid misinterpretation]?" Viswanath reminded the audience of the problem of rumor control. Conspiracy theories surround the use of vaccinations, or propagate the false notion among some people that being hit in the breast causes breast cancer. "We can't do anything about [disinformation], in terms of controlling it," he said. "What we have to do is accept it and decide what kind of platforms and solutions can we put in place to tackle the problems of misinformation." The challenge of disseminating accurate information is difficult, given that only 30 percent of those below the poverty line

have access to the Internet. This results in communication inequality. "The consequences are profound, because this also directly translates to knowledge they have about health."

Others suggested that changing behavior required a focus not only on information and incentives but on contextual and environmental factors. "Thinking that we can engineer individual behaviors through individual incentives is very, very small potatoes, to thinking about what does a community, or a society look like that can continue and improve its own health and healthcare," said Don Berwick.

Lord Nigel Crisp shared the insight. "We need to get rid of the notion that we behave rationally in patient terms or at least rationally in our sort of way of looking at it. How do we recognize in health the personal beliefs and wishes, family, community, culture, society?" Crisp said. "[W]e know these are the things that drive people's behavior." He continued: "In retrospect, I think our interventions [at the NHS] were too guided by economic ideas and not enough by our understanding of organizations, systems, and human beings."

Not all healthy behavior is conscious. Jack Shonkoff takes issue with the notion of blaming the unhealthy person for his or her actions. Such an attitude dismisses the contextual factors leading to unhealthy lifestyles thus absolving the need to pay for healthcare. The price of tobacco or access to healthy food or the building of parks all influence decisions. Sandra Hernandez noted that cities need to be redesigned to improve public health. "If we don't think about how we use and create urban spaces that promote safety and wellness, we'll continue to be in this conundrum of creating good evidence, but failing to make it applicable to our daily lives," she said.

The effects of these environments begin at birth. "Early childhood does not only influence learning but also long-term health. Health promotion and disease prevention is thus more than paying people to change individual behaviors," said Jack Shonkoff. Thomas Zeltner called for incorporating health education into early childhood education. "What children learn in these first four years can never be redone," and proper health education "has a great potential to reduce morbidity in later years and to reduce inequalities," he said.

However, there is a lack of funding for these initiatives, especially in the U.S. "There's a disproportionate investing in access to care, versus addressing social, behavioral, economic determinants of health. Until we, as a country, begin to make the policy decision for shifting resources from access in the medical care delivery system to public health and a health care system, I think we'll stay where we are on an international marketplace, as a waste of health improvement," said Dick Pettingill, CEO of Allina Hospitals & Clinics.

When individuals change tobacco, alcohol, and food use, the overall rate of chronic disease can drop. Unfortunately, industries may impede health improvement. Thomas Zeltner suggested that troublemakers can force large firms to take more responsibility for the health of their customers. He cited changes at Nestlé, which, facing public scorn due to unhealthy food products, found its marketing and recruiting efforts threatened. Yet there are also opportunities for collaboration. The American Heart Association has shown that it is possible to work with industry to reduce levels of coronary heart disease and improve health. "If you're setting about to change a culture and a behavior," noted Cass Wheeler, "you have to work effectively in unfamiliar settings."

Barry Bloom, Distinguished Service Professor at Harvard University and Joan L. and Julius H. Jacobson Professor of Public Health at the Harvard School of Public Health, saw learning from and partnerships with the private sector as vital, especially in low-income countries. "In a world where in the developing world, 76 percent of all healthcare dollars is private, not public, 70 percent of that is out of pocket, is there a role and how would you describe it for the private sector improving or helping to improve the public sector provision of all kinds of health services, in terms of innovation, efficiency outcomes, and consumer satisfaction?" Furthermore, public health professionals and academics could look more to business for help. "There's a huge amount that we know how to do, that's actually even off patent or cheap enough to do but we simply don't know how to get it out there," Bloom said. "If Unilever can deliver soap everywhere, the academic [world] can look to business for guidance in distributing much-needed medicine and other resources." But recognizing gaps and seizing opportunities takes leadership.

Leading for Change

"The single most complicated public health challenge is the need for leaders," said Marsha Jacobson, Executive Director of Leadership Initiatives for the Harvard School of Public Health, adding that leaders who understand the power of collaborative efforts are the keepers of the keys.

Participants offered several perspectives on good leadership. For Bill George, Professor of Management Practice at Harvard Business School and former CEO and Chairman of Medtronic, public health leadership is not about money, power, fame, and glory. Nor is it about telling people what to do. Rather, it is about accepting responsibility for employees, patients, customers, and others and ensuring that they align, empower, serve, and collaborate. For Sheila Burke, former Chief of Staff to former Senate Majority Leader Bob Dole, key skills include the following elements: identify issues and state a clear, articulated goal and statement of priorities; hold an unyielding commitment to a goal, and constantly reinforce it; pick the right time and place for action; commandeer resources; organize human assets to essentially address an issue; develop a plan; build a team, listen, manage, and respond to opponents; and negotiate and compromise where necessary, follow through, and be willing to learn from the past. Candace Lightner, founder of Mothers Against Drunk Driving (MADD), demanded to know what the next step for the provocateur was. "All right, I go to Congress," she said. "And tell them what?" She noted that it's important to follow up the demand for change with specific suggestions. Marshall Ganz, Lecturer in Public Policy at the Harvard Kennedy School of Government, emphasized strategic empowerment. Effective leaders may leverage "voluntary associations" that allow people to learn about and derive a common interest, combine resources in order to exercise power on behalf of those common interests, and motivate people to commit time, energy, and effort to making things happen.

Rosabeth Moss Kanter, ALI Faculty Chair and Director, observed that change does not occur in a linear way. Rather, it is like a wheel. To get it rolling, leaders must act on different spokes or fronts simultaneously to make a revolution. Components include a shared vision, education and training, champions and sponsors, quick wins and local innovations, measurable goals, and rewards and recognition.

Shared vision: It's important to set a shared vision, but a vision never really becomes shared "unless you get to the other end of the wheel to quick wins and local innovation." Change also occurs through storytelling rather than through a recitation of cold statistics. "People don't remember statistics, except maybe one or two memorable ones," she noted.

Education and training: Additionally, change occurs when people have the information and the tools they need to make a difference, particularly via the Internet. Information repositories can help people learn what's effective and what the best practices are.

Champions and sponsors: A leader champions, empowers, and develops other leaders who are sponsored to go out and lead a cause themselves. The champion may give support of various kinds – financial, political, emotional.

Quick wins and local innovations: These are the result of grassroots efforts that champions and sponsors can use to demonstrate how things can be different. Quick wins motivate people and groups to keep working on the problem and also help enlarge the circle of supporters.

Measurable goals: Change advances through a focus on concrete and achievable objectives, such as the Millennium Goals. For example, Kanter suggested setting a goal of saving 100,000 lives through the prevention of medical errors, and then progressively raising the goal. "Let's quantify it, let's measure it, let's show people progress."

Rewards and recognition: Awards provide a powerful inspiration to change behavior, as well as a challenge; they give people an opportunity to "stand up and feel really good." Students in medical schools, for example, might "love competing" for an award.

These elements were put in practice to advance the public service movement, Kanter said, citing the highly successful example of City Year, a grassroots organization with a mission to improve education in inner-city schools through a large network of young, eager volunteers who contribute a year of their lives to service. "City Year is a great story about change, starting with activists who helped create a grassroots movement for service and demonstration projects and then organized a tremendous campaign to get new legislation to scale up all their projects. That's a change story. With the Serve America Act a large number of people can be deployed for the causes you care about." National civilian service, she noted, is key to change because idealistic change agents inspire others to "think outside the building" as well as outside the establishments. "To go outside the establishments," she said, "you need to mobilize the people themselves and not just the professionals."

If viewed systemically, the initiatives featured at the Think Tank and the opportunities identified for future work all take on a piece of the public health system. "We're not going to take on the entrenched health care system ourselves," Kanter said. "We will ask our political leaders to do that. But we certainly can start burrowing underneath." And if multiple sectors can coordinate efforts, not only can they get change rolling, but they just may be able to complete a revolution.

Think Tank Agenda

Thursday, March 26

2:45 – 3:15 pm	Welcome by Rosabeth Moss Kanter
3:15 – 3:45 pm	Opening Remarks by Dr. Howard Koh
3:55 – 5:15 pm	Panel and Discussion: Public Health Challenges for the 21st Century Featuring: Arnold Epstein, Thomas Zeltner, Don Berwick, Pablo Pulido
5:45 – 6:45 pm	Leadership Challenges in the Global Health Agenda: The World Turned Upside Down Featuring: Lord Nigel Crisp
7:00 – 9:00 pm	Dinner and Group Discussion: Special Dimensions of Leadership in Public Health Featuring: Paula Johnson, Lucian Leape, Barry Bloom

Friday, March 27

8:30 – 9:15am	Lecture and Discussion: Leadership that Makes a Difference Featuring: Marshall Ganz
9:15 – 10:15 am	Panel: Creating Successful Collaborations Featuring: Jack P. Shonkoff, Julius B. Richmond, Charles Denham, Penny George, Sandra R. Hernández,
10:45 –11:45 am	Panel: Leveraging Government to Advance Public Health Featuring: Georges C. Benjamin, Kenneth Olden, Susan Blumenthal
11:45 am –12:45 pm	Concurrent Breakout Groups with the Morning Panelists Charles Denham/Penny George Kenneth Olden/Sandra R. Hernández Donald Arthur/Susan Blumenthal
1:00 – 2:15 pm	Lunch Speaker: Sheila P. Burke
2:30 – 3:00 pm	Plenary: Reports from the Morning's Breakout Groups Moderators: Jack Shonkoff and Georges Benjamin
3:00-3:45 pm	On-the-Ground Leadership Challenges in Public Health: Seeking Solutions to Four Challenging Problems Plenary Session: Introduction to the Four Topics with Steven A. Schroeder
3:45 – 5:15 pm	PHTT Concurrent Work Groups MDG5 – Maternal Health; Tobacco; Clean Water; Inoculation
5:30 – 6:15 pm	Plenary Session: Reports from the Work Groups
6:30 – 8:30 pm	Dinner: 20th Century Leadership to Transform Public Health Speaker: Bill George

Saturday, March 28

8:15 – 9:15 am	Panel: Improving Public Health through Effective Advocacy Featuring: Robert Restuccia, Jeff Levi, Cass Wheeler, John Seffrin
9:30 – 10:15 am	Lessons in Leadership from Health System Reform Julio Frenk, Dean of the Harvard School of Public Health.
10:30 – 11:30 am	Panel: The Impact of the Media and Public Opinion on Public Health Featuring: Shelly London, Gabriel (Gabi) Barbash, K. Vish Viswanath, John Whyte
11:30 am – 12:00 pm	Plenary Discussion: Reflections on What's Been Learned Speaker: Howard Koh
12:15 – 1:30 pm	Lunch and Concurrent Table Discussions with the Morning's Panelists

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