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Changing Landscape of Global Public Health
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Thank you, Dean Fried—for your welcome, and for your leadership of the Mailman School… which, along with its precursor, the DeLamar Institute of Public Health, has been pioneering the frontiers of public health for more than 90 years.

And I must also salute you for last night's tribute to Allan Rosenfield. Anyone who was lucky enough to know Allan knows he possessed not just a brilliant mind but also a wonderful character. And *all* of us know what a difference he made to so many lives worldwide … especially for mothers in developing countries – the too often forgotten M in MCH.

We've gathered today to talk about the changing landscape of global public health… and to create a vision for public health leadership in the 21st century.

But I'd like to start by taking us back to the start of the *20th century*… to remind ourselves of the distance we've traveled, and the spirit that brought us this far.

In the early 1900s, health challenges were among the greatest burdens to society – even in the United States.

I don't have to remind this audience that in those times, medicine was more of an art than science. Bloodletting was still a commonplace treatment. Diseases like TB and typhoid ran rampant. Antibiotics were still unimagined.

And rural areas suffered devastating illnesses of their own—such as hookworm, an insidious, debilitating disease that ravaged poor communities.

Hookworm was a consequence of primitive plumbing… poor soil and water treatment… and lack of footwear.

But the disease was more than an individual affliction; it was a *community* affliction.

It sapped victims' energy, leaving them unable to learn or to work… contributing to Southern states' impoverishment at the start of the 20th century.

And then, 101 years ago this week, a revolutionary change got under way.

On October 26, 1909… thanks to a million dollar gift from John D. Rockefeller… the Rockefeller Sanitary Commission for the Eradication of Hookworm was established. Over a

five-year period from 1910 to 1914, a team of doctors, nurses, and health officials led a vigorous public health campaign to eliminate this scourge of the poor.

Education was considered as important a part of the campaign as was treatment. Public school systems and the press were enlisted, alongside medical professionals. The effort led to the eradication of hookworm, one of the great public health accomplishments.

This winning formula of scientific innovation plus strategic implementation was captured in the Welch-Rose report of 1915… and helped inspire, in 1916, the Rockefeller Foundation's establishment of the world's first school of public health at the Johns Hopkins University… as well as our support for medical-education reform, through the work of Abraham Flexner.

My predecessors didn't use the word innovation; they called their work "scientific philanthropy." But innovation was their game. It was bold and daring, intrepid, and risk-taking.

And they weren't alone.

Take Dr. Sara Josephine Baker, a physician here in New York City, who was appointed director of the city's new Bureau of Child Hygiene in 1908. She developed programs for midwife training, basic hygiene, and preventive care. She created the Little Mothers Leagues, to teach young girls how to properly care for infant siblings. She promoted health education in immigrant neighborhoods… distributed milk to children… and created a school health program that was copied in 35 states.

By the time she retired in 1923, New York City had the lowest infant mortality rate of any major American metropolis. And consider: For the vast majority of Dr. Baker's career, American women didn't even have the right to vote.

Talk about bold and daring!

Of course, today, much has changed.

We've seen many public health advances in the last century:

- life expectancy doubled;
- Infant and maternal mortality are declining throughout the world; and
- Eight of every ten people living in countries where poverty is decreasing.

And yet, significant challenges persist, that test our approaches, our focus and our resources.

Our work on the old problems remains unfinished. Take the hookworm example again. While hookworm has been effectively "unhooked" in much of the developed world, the disease remains the world's leading cause of anemia and protein malnutrition … afflicting an estimated 740 million people in developing nations.

Or, take child mortality. A baby girl born in New York today can expect to live until 82—the highest life expectancy in recorded city history.[i] Dr. Baker would be thrilled! And yet, today, a baby girl born in Sierra Leone can only hope to make it to her 40s. These kinds of disparities exist not only among countries but *within* them—reflecting the persistence of economic and social inequities that tend to hurt most those who are the most vulnerable.

Meanwhile, as global lifestyles evolve, new challenges are creating new stresses. Obesity is reaching epidemic proportions and non communicable diseases are rising dramatically. Even in developing countries, we see the impact of behavior and lifestyle such as increased tobacco use, poor diet, and obesity.

The health services needed for all these growing burdens are not accessible in many places in the world… or they are paid for out-of-pocket… which means the consequences of a medical crisis can be financially catastrophic.

Add it all up and it seems that global public health is ready for another "revolutionary idea."

At the Rockefeller Foundation, we're doing our best to reignite that bold spirit of progress.

In looking systemically at global health, we and others have found that, despite impressive vertical efforts against priority problems such as TB, HIV, and malaria, "health <u>systems</u>" are ailing and weak. Symptoms take the form of poor stewardship… dysfunctional service delivery… and inequitable financing… and are especially acute in developing countries, where nearly 10 million children die every year from largely addressable causes.

As U.S. AID Administrator Raj Shah has said, "Visit any African country and you're likely to find a health system organized around diseases and interventions, not the actual patients. You'll find separate clinics in separate places for AIDS, for children's health, family planning and advanced obstetric care. Not only is that bad for the patients, but it is strikingly inefficient for taxpayers. And in many cases, we have ourselves to blame."[ii]

And let's be honest: When it comes to health care access and health care quality, we know the discrepancies that burden the poor are not limited to <u>developing</u> countries. While global spending on health has increased to some $7 trillion annually, access to affordable, quality services has not—including here in the United States.

Yet, new technologies and demographic, epidemiologic, and economic shifts are transforming health systems around the world. There <u>is</u> a window of opportunity to promote strategies that steer this transformation toward better health outcomes and financial protection.

That's why Rockefeller has made "transforming health systems" our next revolutionary goal, around which we'll help promote much-needed innovation… broker robust partnerships… and find sustainable, scalable solutions.

Improving human resources and bolstering specific health services are critical to this enterprise. To that end, we're supporting governments with the technology, talent, tools, and training to become better stewards of their national health systems, and improve planning, financing, and quality of services.

But that won't be enough. To measurably improve the health status and financial resilience of the poor, we also need to transform health financing at the country level.

Consider this:

Beyond the perils of disease, more than 150 million individuals worldwide face catastrophic healthcare expenditures… and, as a result, approximately 25 million households are pushed into poverty every year.

High out-of-pocket expenditures also prompt parents to withdraw children from school, using education fees to cover medical costs.

The world's <u>poorest</u> people pay the <u>highest</u> percentages of their wealth for health. The World Bank reports that in low-income countries, out-of-pocket spending accounts for 93 percent of private spending, and more than 60 percent of total health spending.

And while, on average, only 5 percent of people fall ill in a given year, the lack of health insurance and effective social protection programs means that these people pay the lion's share of the national health spending bill.

We are convinced that an indispensible ingredient of strengthening health systems is working toward universal health <u>coverage</u>, defined as "access to appropriate health services for all, at an affordable cost." So I'm happy to see the transformation of health systems and achieving universal equity in health care is one of the key tracks of this conference.

Even in lower-income countries, universal health coverage is not merely laudable but possible.

Just look at Ghana, which invested approximately $115 million over six years to establish their new system, boosting coverage from 40 percent to 70 percent of the population.

Or Andhra Pradesh in India, which invested $60 million over a three-year period of reform, during which time coverage was extended from 10 percent to 85 percent of the population.

In both cases the additional investment amounted to 2.5 percent of the total health expenditure for several years. The result? A plummet in out-of-pocket expenditures, from nearly 60 percent to only 30 percent of the total.

The Rockefeller Foundation believes the international community should share and learn from successes like these.

We're facilitating cross-border learning through a "Joint Learning Network on Universal Health Coverage." Earlier this year, we brought together health officials from Ghana, Vietnam, Rwanda, India, Indonesia, and the Philippines for a workshop in Delhi, to trade best practices and new ideas for implementing universal health coverage.

We're supporting new research on the global macroeconomics of universal health coverage and comparative health systems analyses.

And we've convened a "Global Task Force on Universal Health Coverage," made up of national and multilateral leaders, in an effort to share and align institutional efforts on universal health care in low- and middle-income countries.

But, as countries renegotiate their social contracts for health, I believe schools of public health have an important opportunity to lead and to innovate.

After all, universal health coverage will depend on good ideas, research, and robust science… as well as the capacity-building to support its implementation. These ideas and initiatives will not be born out of biomedical laboratories; rather, they will emerge from the field of public health. And who better to drive that endeavor than institutions of learning like yours… with your expertise in health economics, policy, and services… and your commitment to social justice?

So, given our convening by one of the world's premier schools of public health… and the fact that this gathering represents some of the sharpest and most innovative minds in the field… let me challenge you all to be as bold and intrepid as the times demand—and to ask yourselves:

What revolutionary contribution will schools of public health make… in 2010… in the decade ahead… and in the century still unfolding?

Society's needs and demands are taking shape in new opportunities—including the Global Strategy for Women's and Children's Health, with pledges of more than $40 billion over the next five years… and President Obama's $63 billion Global Health Initiative, which aims to partner with countries to improve health outcomes through strengthened health systems.

The Global Fund for AIDS, TB and Malaria is trying to become a more holistic vehicle to support health systems as well.

And under the leadership of Francis Collins, the NIH, has listed health sector reform among his top five priorities. With the United States accounting for half of the world's total funding for health research, changes at the NIH can help to drive health systems research at global level. But this could mean merely more clinical trials under the banner of comparative effectiveness, unless experts and advocates like all of you here drive efforts to expand the scope.

You have the leadership platforms to make the most of these opportunities, and mobilize real social change.

Assert that leadership to ensure that the principles and services that public health stands for are incorporated in the blueprints for global health in the 21st century.

And let's take inspiration from the example of Allan Rosenfield, who would have been so energized to see all of you here today.

I remember reading a story about Allan, as his own health was failing. It described him lying on his office couch with a machine pushing air into his lungs… and his determination to keep working as hard and as long as he had left.

In his words, "There's so much to do."[iii]

He was right. So let's do it.

Thank you very much.

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[i] http://www.nydailynews.com/lifestyle/health/2010/01/26/2010-01-26_new_york_city_has_highest_life_expectancy_in_recorded_history_data.html
[ii] http://www.usaid.gov/press/speeches/2010/sp100629.html
[iii] "Frail and Ill, but Still Focused on Global Health," NYT, June 12, 2006.