

Investing in Health for Puerto Rico

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Thank you to Rose and Mariela for kicking us off so thoughtfully, and to the Fed, particularly Javier and Tony, for hosting this important discussion.

As a New Yorker, I am very familiar with a common Puerto Rican, Nuyoricán saying: “Yo soy boricua, pa que tu lo sepa!” It is said with so much pride, as it should be. And I know that *ser boricua*, to be Puerto Rican, has meant strength, endurance, resilience – even when resiliency feels inhumane for the circumstances. My question for all of us is this: what will it take for the identity of Puerto Rico – to be Puerto Rican – to become about *health*? ¿Qué se necesita para que la identidad de Puerto Rico, el ser boricua, se trate de *salud*?

And let me be clear. I do not come from New York City pretending to know all the answers. In fact, when I reflect on my tenure as the city’s health commissioner – through most of the pandemic – I have a feeling that may be familiar to all of you. I feel as though New York City has survived a catastrophic earthquake. One that claimed over 40,000 New Yorkers, 1 million lives in the United States, and over 15 million around the world. A gash in the fabric of our nation and our families, leaving 200,000 children without one of their caregivers. I know you have lived what I am talking about, whether a hurricane, an earthquake, a pandemic – or all of the above. For me, as I have taken stock of the rubble and the wreckage of COVID-19, I get the disconcerting feeling that other survivors seem to think it is just fine to carry on with their lives as before these giant shocks, or not to think about how to build structures that are less fragile when the ground shakes.

My argument to you is that we cannot accept this. We will dishonor the memory of all those we have lost if we simply snap back – or ignore the impetus for change. And that’s why we’re here today, to try to chart a different path forward, particularly for investment in health. It cannot be about Band-Aids, it has to be about bold ventures.

The starting point is a shared identity, a shared purpose, that lifts up health. The fact that you chose to be here today tells me that you believe in that purpose. We need you to light that candle in others, but even that is not enough. It will also require challenging three dialectics that have held us back. They are: health vs. the economy, cost vs. investment, and vicious cycles vs. virtuous cycles. The rest of my remarks will explore each of these briefly.

First is health vs. the economy. During the pandemic, as health commissioner, I saw how public health and the economy could be pitted against each other. And there were some times when tough decisions did indeed have to be made. I remember a patient of mine who asked me in May 2020, after that devastating first wave in New York City, when I thought the lockdown would end. A Colombian father of three, he worked in a restaurant and was growingly worried about money for food and rent. I remember feeling troubled — since he had high blood pressure and kidney disease, he was at higher risk for poor outcomes, and more likely to get infected

because of his job. But the economics of the lockdown brought its own challenges, particularly for his mental health.

But more often, health and the economy are NOT a zero-sum equation. We also saw during the pandemic how our entire economy is linked to a sufficient standard of public health. Vaccination helped bring back our economy and our schools over the course of 2021. Public health helps keep our food, water, and air safe, for commerce and for life, even when we are *not* in a global pandemic. And certain solutions, like community health workers, or *promotoras* provide a health workforce, economic resources, and jobs in one fell swoop.

Although health care is important when someone is sick and in duress, addressing the social determinants of health can help prevent that illness in the first place – and has intrinsic benefits, for example educational attainment, housing stability, and ability to work. Given that health is tightly linked to economic security, then, economic policy must be viewed as health policy. Paid sick leave during COVID-19 is a simple illustration of how economic policy and public health are synergistic, since it supports more people getting tested, isolation of cases, and quarantine of close contacts. And of course paid sick leave has health and economic benefits beyond COVID-19, such as for diabetes and mental health.

The second dialectic is cost vs. investment. Too often we talk about spending on health solely as a cost, rather than an investment. And the best argument for thinking about it as an investment is examining what the *return* on that investment is. Economic evaluations of dozens of public health programs consistently find significant returns on investment. We spent over \$2 billion on our COVID-19 vaccination campaign in New York City (that's billion with a B), which sounds like a lot of money. Until you look at the return on that investment, in terms of hospitalizations averted and economic productivity gained, not to mention the tens of thousands of lives saved. The bottom line was a return of about \$10 for every \$1 invested, according to an analysis we published with Yale University scientists. The return for other interventions is even greater – for example, society enjoys up to \$221 in savings for every \$1 invested in lead poisoning prevention programs for children. I know we have many investors in our audience, and I know you would kill for that return! But you can have it. The list of cost-effective interventions goes on: smoking cessation, community health workers, family planning services and influenza vaccinations. The argument is not that ALL public health programs are cost-saving or have this type of ROI – but rather that there are many that do, and that remain underinvested.

But let's bring this back to reality a bit. Even though the overall investment case is strong, actually channeling those investments is easier said than done. It requires creativity and also must surmount some well-established challenges, like the wrong-pocket problem and longer timeframes sometimes needed for return on investment. The "wrong pocket" problem refers to the fact that the entity making the investment fails to capture benefits that instead accrue to another entity. For instance, when a local health department funds a smoking cessation campaign, some of the financial returns on that investment (like lower medical costs) are

captured by health insurers. In addition, it takes time—sometimes several years—for some public health investments to generate savings.

Creative financing approaches are needed to surmount these challenges, and that's why there are partners from many different sectors in the room today, because it will require collaboration across those sectors. One example is the notion of a public health bond, which my colleague Dr. Suhas Gondi and I wrote about in a recent JAMA Health Forum essay. A public health bond is a financial transfer from a given payer to public health departments. The partnership would identify communities of interest and specific interventions with evidence-based potential to improve health and reduce expenditures. It is priced based on the costs of the interventions and the potential returns to the payer (eg, from lower health care spending). The specific mechanism – whether a public health bond or something else – is less important, but I hope you will hold onto the notion of creative financing helping to unlock dramatic return on investment.

The third dialectic is vicious cycles vs. virtuous cycles in health. This is something I think about a lot in my own clinical practice. There are negative feedback loops, like when someone gains weight, causing knee pain, which makes it difficult to exercise, which leads to more weight gain. But there can also be positive feedback loops, or virtuous cycles. I think about my homeless patient being placed in supportive housing, giving him not only the dignity of his own space, but also the stability to stop drinking and to take care of his diabetes.

My job as a doctor is to interrupt the vicious cycles, and to turn as many of them as possible into virtuous cycles. But equally this is our job at the population or policy level, when we think about how to best channel investment in health. Adopting this lens helps us remember that we are not just recovering from one hurricane, or one pandemic, but rather building an infrastructure for multiple crises spanning multiple generations. This is why, for example, we invested in a new family home visiting program in New York City, sending visiting nurses into the homes of first-time mothers in low-income families. The work was addressing the needs of the mother as well as the baby, providing services during a time of high stress, but also interrupting the intergenerational transmission of poverty and illness. Vicious cycles into virtuous cycles, through health investment.

So let me end on this note. Yesterday, I visited el centro medico, here in San Juan – I am grateful to Dr. Heriberto Marin Centeno, who hosted us at the school of public health. I found myself thinking about what was there on those 227 acres of land before the medical center, and what it must have taken to organize el centro medico in the first instance. I hope this convening is the catalyst for something just as special, and perhaps even the first step toward a Puerto Rican identity rooted in health. “*Yo soy boricua, pa que tu lo sepa!*” And everyone will know.

Thank you!