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Building a Culture of Health

A New Imperative for Business

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ISSN 2192-3698 ISSN 2192-3701 (electronic)
SpringerBriefs in Public Health
ISBN 978-3-319-43722-4 ISBN 978-3-319-43723-1 (eBook)
DOI 10.1007/978-3-319-43723-1

Library of Congress Control Number: 2016948733

Printed on acid-free paper

This Springer imprint is published by Springer Nature
The registered company is Springer International Publishing AG Switzerland

Dedicated to the Robert Wood Johnson Foundation
"Our goal is to help raise the health of everyone in the United States to the level that a great nation deserves, by placing well-being at the center of every aspect of life."

Preface

Every company, knowingly or unknowingly, impacts public health, and it does so in four ways: through the healthfulness and safety of the products and services it sells (Consumer Health); through the efforts it makes to insure the safety and well-being of not only direct employees but also workers in its supply chain (Employee Health); through investments it makes to improve health and safety in the communities where it does business (Community Health); and through the impact of its operations on the environment, through carbon emissions and water use, for example (Environmental Health). In these four ways, every company lays down a population health footprint. The net impact of the footprint can—and should—be measured. A company that incorporates a Culture of Health in its mission and daily decision-making will not only seek to make its net impact on public health as positive as possible, but will also create business opportunities for itself in doing so.

In April 2016, a conference was convened at Harvard Business School, in partnership with the Harvard T.H. Chan School of Public Health (represented by Professor Howard Koh) and the Robert Wood Johnson Foundation (represented by Executive Vice President Jim Marks). The title of the conference was the same as this book: Building a Culture of Health: A New Imperative for Business. The 300 attendees included around 60 % from the private sector, 20 % from the not-for-profit sector and from government, and 20 % from academia. Panels discussed Consumer Health, Employee Health, Community Health, and Environmental Health. Concluding sessions addressed how to connect the dots, measure a company's overall population health footprint and implement a culture of health in a company. The consensus at the conference was that this is a useful starting point—there is much more work that must be done to fundamentally reframe how business thinks and acts in the realm of public health.

This book, and the examples of company best practices that are included, draw from the conference proceedings. As such, we are deeply grateful for the ideas generated by the participants and for the partnership of the co-sponsors that made the conference possible. The Harvard Business School Division of Faculty Research and Development funded the by-invitation-only conference; we thank Dean Nitin Nohria for his support of our cross-disciplinary and cross-sector initiative.

In addition, we wish to thank colleagues who reviewed earlier drafts of portions of the manuscript: Professors Jose Alvarez and Walter Willett (Community Health); Professors Kate Baicker and Robert Huckman (Employee Health); Professors Howard K. Koh and V. Kasturi Rangan (Community Health); and Professors Rebecca Henderson, Eileen McNeely, and Jack Spengler (Environmental Health).

Finally, we acknowledge the help and efficiency of Elaine Shaffer who worked closely with our editor at Springer, Janet Kim, to move our manuscript through to publication.

Boston, MA, USA — John A. Quelch
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June 2016

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Building a Culture of Health

Every company, large and small, impacted health in four main ways. First, through the healthfulness and safety of the products and services it sold. Second, through its attention to employee health and well-being in its work practices and benefits. Third, through contributions to the broader communities in which it operated. And, fourth, through the environmental impacts of its operations.

Consider, for example, ride-sharing companies. By 2016, Uber, Lyft, and other ride-sharing companies were growing rapidly, conveniently connecting passengers who needed rides with nearby drivers—all through simple apps on their passengers' smartphones. These companies were not "healthcare" companies in a traditional sense.

However, they affected health in both positive and negative ways. In 2015, Uber produced a report in partnership with the non-profit organization, Mothers Against Drunk Driving ("MADD"). The report highlighted how drunk-driving crashes fell 6.5 % among drivers under 30 in California markets after Uber launched; what's more, 93 % of people surveyed would recommend Uber "as a safer way home to a friend who had been drinking."[1] Chariot, a ride-sharing company announced in 2016, was created in an effort to make rides safer for women by allowing only female drivers and female passengers.[2]

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[1] MADD, "New Report from MADD, Uber Reveals Ridesharing Services Important Innovation to Reduce Drunk Driving," *MADD website,* January 27, 2015, http://www.madd.org/media-center/press-releases/2015/new-report-from-madd-uber.html?referrer=https://www.google.com/, accessed March, 2016.

[2] WMAR staff, "Women-only ride sharing app offers Uber alternative," *ABC 2 WMAR Baltimore,* http://www.abc2news.com/news/in-focus/women-only-ride-sharing-app-offers-uber-alternative, accessed April, 2016.

J.A. Quelch, E.C. Boudreau, *Building a Culture of Health*, SpringerBriefs in Public Health, DOI 10.1007/978-3-319-43723-1_1

While the ride-sharing apps provided new—and potentially safer—ways for consumers to travel, their health effects were not all necessarily positive. Around the same time, Uber found itself in the middle of an employee vs. independent contractor[3] debate, prompting questions about whether Uber drivers deserved employee benefits such as health insurance. Having health insurance was directly related to healthcare access, and those with health insurance enjoyed better health outcomes.[4]

Because Uber's drivers used their own cars to provide rides and created their own schedules, Uber considered its drivers to be independent contractors, rather than employees. Uber maintained that the company was "merely an app that connect[ed] drivers and passengers—with no control over the hours its drivers work[ed]."[5] However, in 2015, a California court ruled that a prior Uber driver was in fact an employee.[6] The issue remained contentious, as the ruling did not apply beyond the driver who initiated the case.[7] Complicating the employee health debate further, there were also potential health benefits that independent contractors enjoyed, such as the flexibility to decide when, where, and how long to work and the ability to work for multiple companies—potentially factors that could reduce stress.[8,9] Therefore, it was difficult to assess the overall impact that ride-sharing companies had on employee or contractor health.

Assessing their net impact on community and environmental health was equally challenging. In 2014, both Lyft and Uber announced that they were releasing new passenger-pooling ride options that offered riders cheaper fares if they shared their vehicle with other passengers traveling along a similar route. One *TIME* article stated, "multiple people sharing a single ride to a common destination is a simple act that has the potential to reduce CO_2 emissions, ease traffic, lessen fossil fuel dependency, reduce stress on commuters, and even drive down rents in dense cities."[10]

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[3] For employees, businesses were required to withhold income taxes, withhold and pay Social Security and Medicare taxes, and pay unemployment tax on paid wages. Businesses did not have to withhold or pay taxes on payments to independent contractors, and they did not have to offer them benefits like health insurance, paid time off, or overtime. In effect, hiring independent contractors was often much less costly for employers than hiring employees.

[4] Benjamin D. Sommers, MD, PhD; Sharon K. Long, PhD; and Katherine Baicker, PhD, "Changes in Mortality After Massachusetts Health Care Reform: A Quasi-experimental Study," *Annals of Internal Medicine*, 2014;160(9):585–593, doi:10.7326/M13-2275, accessed April 2016.

[5] Mike Isaac and Natasha Singer, "California Says Uber Drive is Employee, not a Contractor," *The New York Times,* June, 17, 2015, http://www.nytimes.com/2015/06/18/business/uber-contests-california-labor-ruling-that-says-drivers-should-be-employees.html, accessed October, 2015.

[6] Mike Isaac and Natasha Singer, "California Says Uber Drive is Employee, not a Contractor," *The New York Times,* June, 17, 2015, http://www.nytimes.com/2015/06/18/business/uber-contests-california-labor-ruling-that-says-drivers-should-be-employees.html, accessed October, 2015.

[7] Mike Isaac and Natasha Singer, "California Says Uber Drive is Employee, not a Contractor," *The New York Times,* June, 17, 2015, http://www.nytimes.com/2015/06/18/business/uber-contests-california-labor-ruling-that-says-drivers-should-be-employees.html, accessed October, 2015.

[8] Ibid.

[9] Jeanne Sahadi, "When an independent contractor is really an employee," *CNN Money,* July, 16, 2015, http://money.cnn.com/2015/07/16/pf/independent-contractors-employees/, accessed October, 2015.

[10] Katy Steinmetz, "How Uber and Lyft Are Trying to Solve America's Carpooling Problem," *Time,* June 23,2015, http://time.com/3923031/uber-lyft-carpooling/, accessed April, 2016.

Ride-sharing might thereby improve the health of the surrounding communities and reduce fossil fuel emissions—a boon for environmental health.[11] Further, there was potential for ride-sharing companies to reduce the number of consumers who found it necessary to own car, which would positively impact the environment and conserve resources.

However, the overall impact of these services on both community and environmental health remained elusive, as there was little information on what alternative transportation consumers were substituting (e.g., personal vehicles, public transportation, and taxi cabs).[12] Though sharing vehicles had the potential to decrease traffic congestion and emissions, passengers switching from walking to their destinations or taking new trips that would not have occurred otherwise would boost CO_2 emissions.

While the net impact of ride-sharing companies on public health was hard to measure, the industry illustrated that all companies—even those that did not seem at all health-related—had significant, multifaceted impacts on public health. It was also clear that companies could have both positive and negative effects on health and most corporations did not fully understand the potential influence they held. The objective here is twofold: first, to highlight how corporations wittingly and unwittingly enhance and detract from public health; and second, to showcase why it is critical—now more than ever—for corporations to prioritize building cultures of health as part of their missions and values.

Background

Health was an issue of global importance. Health status at an individual level profoundly affected quality of life, and at a population level, it affected a wide range of socioeconomic issues, in turn impacting many facets of everyday life.[13] Research by the Harvard T.H. Chan School of Public Health and the John F. Kennedy School of Government had shown that good population health improved the economy in five ways: financial protection; education; productivity; capital investments; and the demographic dividend. (See Exhibit 1.1 for detailed descriptions of each; see Exhibit 1.2 for a framework connecting health and poverty alleviation.)

Exhibit 1.1: How Good Health Reduces Poverty

1. **Financial protection**: Removing financial barriers to access enables the use of health services when needed, and helps at-risk households avert impoverishing expenditures and poverty.

[11] Ibid.

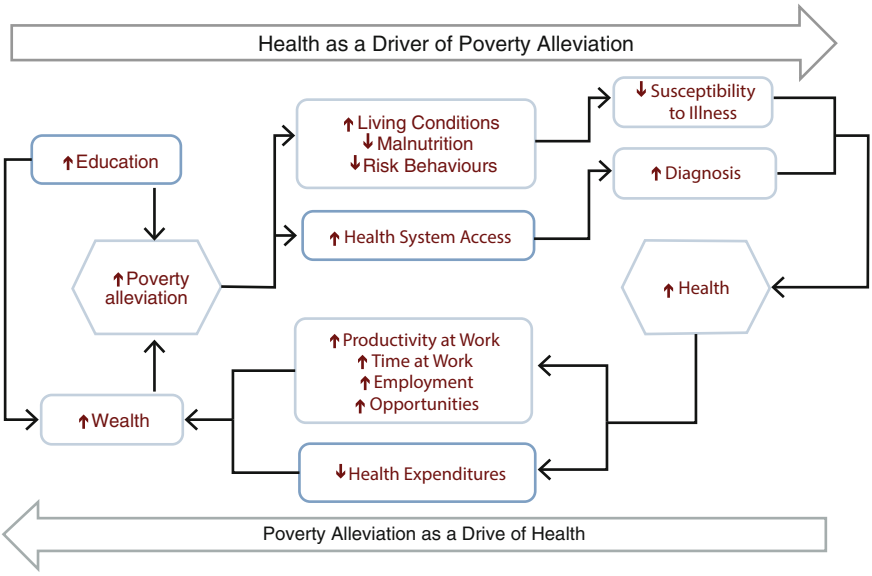
[12] Ibid.

[13] Health Poverty Action, "Key Facts: Poverty and Poor Health," *Health Poverty Action website*, https://www.healthpovertyaction.org/info-and-resources/the-cycle-of-poverty-and-poor-health/key-facts/, accessed May 2016.

2. **Education**: The prospect of longer, healthier lives induces people to invest more in their human capital, as they are better able to realize future long-term gains in employment and income.
3. **Productivity:** Productivity is enhanced through contribution of better health to increased worker capacity, lower rates of absenteeism, and less workforce turnover.
4. **Capital investments**: Heightened longevity in lifespan and higher incomes mean people save more for retirement—boosting the economy-wide capital available for increased investments.
5. **The demographic dividend**: With the right conditions in place, changes in population age structure with growing and educated work force creates the opportunity for economic growth.

Source: Rifat Atun, Claire Chaumont, Joseph R Fitchett, Annie Haakenstad, Donald Kaberuka, "Poverty Alleviation and the Economic Benefits of Investing in Health," *Forum for Finance Ministers 2016*, accessed at https://cdn2.sph.harvard.edu/wp-content/uploads/sites/61/2015/09/L-MLIH_Health-economic-growth-and--development_Atun-and-Kaberuka_4-11-16.pdf, accessed May, 2016.

Exhibit 1.2: Connections Between Health and Poverty



Source: Rifat Atun, Claire Chaumont, Joseph R Fitchett, Annie Haakenstad, Donald Kaberuka, "Poverty Alleviation and the Economic Benefits of Investing in Health," *Forum for Finance Ministers 2016*, accessed at https://cdn2.sph.harvard.edu/wp-content/uploads/sites/61/2015/09/L-MLIH_Health-economic-growth-and--development_Atun-and-Kaberuka_4-11-16.pdf, accessed May, 2016.

By the 2000s, international efforts to improve public health had achieved considerable success. Life expectancy at birth had increased worldwide—rising in the US,

for example, from around 47 in 1900 to nearly 79 in 2013.[14,15] This dramatic increase was largely due to improvements in living conditions (e.g., sanitation, hygiene, housing, and education) and medical advances (e.g., vaccines and antibiotics).[16] Early to mid-life mortality was so reduced that, by the second half of the twentieth century, there was little room for further improvement.[17] A 2011 report by the National Institutes of Health stated, "The dramatic increase in average life expectancy during the twentieth century ranks as one of society's greatest achievements."[18]

Nevertheless, several significant public health challenges remained. These included:

Rising non-communicable diseases: Despite a decrease in the prevalence of infectious diseases, the prevalence of non-communicable diseases (e.g., cardiovascular disease, cancer, diabetes, and chronic respiratory disease) was increasing.[19] According to the Centers for Disease Control and Prevention (CDC), non-communicable diseases were responsible for more than 75 % of deaths worldwide in 2016.[20] Non-communicable diseases were largely caused by modifiable risk factors (e.g., tobacco use, alcohol consumption, unhealthy diet, and insufficient physical activity). The World Health Organization (WHO) estimated that 80 % of premature heart disease, stroke, and diabetes could be prevented.[21]

Aging populations: Populations around the world were rapidly aging as people continued to live longer.[22] By 2050, the US population aged 65 and older was projected to reach 83.7 million, almost double the 43.1 million in 2012.[23] Growth in the elderly

[14] CDC, "Table 22: Life expectancy at birth, at 65 years of age, and at 75 years of age, by race and sex: United States, selected years 1900–2007, *CDC website,* http://www.cdc.gov/nchs/data/hus/2010/022.pdf, accessed April, 2016.

[15] Jiaquan Xu, Sherry L. Murphy, Kenneth D. Kochanek, M.A., Brigham A. Bastian, "Deaths, Final Data for 2013," *National Vital Statistics Reports,* volume 64, Number 2, February 16, 2016, http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_02.pdf, accessed April, 2016.

[16] Rosabeth Moss Kanter, Howard Koh, Pamela Yatsko, "The State of U.S. Public Health: Challenges and Trends," HBS No. 316-001 (Boston: Harvard Business School Publishing, 2015).

[17] Ibid.

[18] National Institute on Aging, "Health and Aging: Living Longer," *U.S. Department of Health and Human Services,* 2011, https://www.nia.nih.gov/research/publication/global-health-and-aging/living-longer, accessed April, 2016.

[19] World Health Organization, "Noncommunicable diseases (NCD)," *WHO website,* http://www.who.int/gho/ncd/en/, access April, 2016.

[20] Centers for Disease Control and Prevention (CDC), "CDC Global Noncommunicable Diseases (NCDs)," CDC website, http://www.cdc.gov/globalhealth/healthprotection/ncd/, accessed May, 2016.

[21] World Health Organization, "Noncommunicable diseases (NCD)," *WHO website,* http://www.who.int/gho/ncd/en/, access April, 2016.

[22] World Health Organization, "Ageing and life-course," *WHO website,* http://www.who.int/ageing/en/, accessed April, 2016.

[23] Jennifer M. Ortman, Victoria A. Velkoff, and Howard Hogan, "An Aging Nation: The Older Population in the United States," *Census.gov website,* May 2014, https://www.census.gov/prod/2014pubs/p25-1140.pdf, accessed April, 2016.

population increased demand for health services and raised policy questions around the continuing financial viability of social security programs.[24]

Increasing costs: In 2013, health expenditures[25] totaled ~17% of the US gross domestic product (GDP) and ~10% of the worldwide GDP.[26] Healthcare costs increased throughout the 2000s due to faster-than-general inflation increases in the prices of drugs, medical devices, and hospital care.[27] As health costs increased, many in the US questioned the sustainability of government-funded health programs for the elderly and poor, Medicare and Medicaid, at current levels.[28]

Health and income disparities: Many, diverse factors affected the health of individuals and broader populations. Some of these elements were controllable by the individual, but many were not. Although average life expectancy had increased worldwide, it varied significantly across the world.[29] Further, these differences existed not only between countries, but also within them.[30] There was no biological reason for these differences and experts largely attributed them to social and environmental factors, such as income inequality and healthcare access disparities.[31]

According to the University of Wisconsin Population Health Institute, healthy behaviors determined 39% of a population's health, while 12% was attributable to health care and fully 50% depended on social and economic factors.[32] Research by Robert Putnam showed an increasing opportunity divide between richer and poorer

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[24] Ibid.

[25] Total health expenditure was the sum of public and private health expenditure. It covered the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.

[26] The World Bank, "Data: Health expenditure, total (% of GDP)." *The World Bank website,* http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS, accessed April, 2016.

[27] Mike Patton, "U.S. Health Care Costs Rise Faster Than Inflation," *Forbes,* June 29, 2015, http://www.forbes.com/sites/mikepatton/2015/06/29/u-s-health-care-costs-rise-faster-than-inflation/#3665589f6ad2, accessed April, 2016.

[28] Kimberly Leonard, "Are Medicare and Medicaid Sustainable?" *U.S. News,* April 15, 2015, http://www.usnews.com/news/articles/2015/04/15/are-medicare-and-medicaid-sustainable, accessed April, 2016.

[29] Central Intelligence Agency, "The World Factbook," *CIA website,* 2015 Est., https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html, accessed April, 2016.

[30] World Health Organization: Commission on Social Determinants of Health, "Closing the gap in a generation," *WHO website,* http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf, accessed April, 2016.

[31] The World Health Organization, Commission on Social Determinants of Health, "closing the gap in a generation: Health equity through action on the social determinants of health," 2008, http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf, p. 26, accessed November, 2015.

[32] Bridget C. Booske, Jessica K. Athens, David A. Kindig, Hyojun Park, Patrick L. Remingtom, "Country Health Rankings Working Paper: DIFFERENT PERSPECTIVES FOR ASSIGNING WEIGHTS TO DETERMINANTS OF HEALTH, *University of Wisconsin Population Health Institute,* February 2010, https://uwphi.pophealth.wisc.edu/publications/other/different-perspectives-for-assigning-weights-to-determinants-of-health.pdf, accessed April, 2016.

children in the US.[33] Children from higher income households typically had greater access to social support, healthcare, and extracurricular activities, which led to significantly better outcomes over time versus those for children from lower income households.[34]

Public and Social Sector Responses

Efforts to address these concerns were sponsored by governments, non-profit organizations, and international agencies. In 2000, the United Nations (UN) announced the Millennium Development Goals (MDGs), a set of eight goals that were focused on reducing extreme poverty worldwide between 2000 and 2015.[35] Five of the goals were directly related to health (see Table 1.1 for the MDGs). In 2015, Ban Ki-moon Secretary-General of the UN discussed the significant but incomplete outcomes from the MDGs, stating:

> The MDGs helped to lift more than one billion people out of extreme poverty, to make inroads against hunger, to enable more girls to attend school than ever before and to protect our planet. They generated new and innovative partnerships, galvanized public opinion and showed the immense value of setting ambitious goals…Yet for all the remarkable gains, I am keenly aware that inequalities persist and that progress has been uneven. The world's poor remain overwhelmingly concentrated in some parts of the world.[36]

Table 1.1 Millennium development goals

Goal	Description
1	Eradicate extreme poverty and hunger
2	Achieve universal primary education
3	Promote gender equality and empower women
4	Reduce child mortality
5	Improve maternal health
6	Combat HIV/AIDs, malaria and other diseases
7	Ensure environmental sustainability
8	Global partnership for development

Source: Adapted from UN, "Millennium Development Goals," *UN website,* http://www.un.org/millenniumgoals/bkgd.shtml, accessed April, 2016

[33] Robert Putnam, "Crumbling American Dreams," *The New York Times,* August 3, 2013, http://opinionator.blogs.nytimes.com/2013/08/03/crumbling-american-dreams/?_r=0, accessed May, 2016.

[34] Michael Jonas, "Opportunity gap," *CommonWealth Magazine,* October 13, 2015, http://commonwealthmagazine.org/economy/opportunity-gap/, accessed December 2015.

[35] UN, "The Millennium Development Goals Report 2015, *Un website,* http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf, accessed May, 2016.

[36] Ibid.