

Interview of Dr. Ken Warner, *Dean of the School of Public Health*

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Dr. Ken Warner has been Dean of the UM School of Public Health since 2005. He stumbled upon Public Health from a background in Economics, and his research since that career move has focused on preventing disease and promoting health through economic and policy measures with a focus on tobacco policy. He also worked to initiate and currently teaches the first and only undergraduate Public Health course (HMP 200: Introduction to Public Health).

How would you define public health?

Public health is the set of activities a society undertakes to monitor and improve the health of its collective membership. It has three distinguishing features: a focus on preventing disease & injury, the idea that the “patient” is the entire community (not individuals); and that the “provider” is society (and not individual professionals).

How do you work and interact with other health professionals?

I do this in all kinds of different ways. The people I work with are not all health professionals, but rather people oriented towards health. Tobacco control is the area I’ve worked in most of my career and I was the World Bank’s delegate to the negotiations that put the international tobacco control treaty together (known formally as the Framework Convention on Tobacco Control). That’s kind of at the 30,000 foot level. At the local level I work with folks at the Washtenaw County Department of Health. I also collaborate with senators and legislators in Lansing trying to pass the Smoke-Free Workplace Law. We work very closely with people in Washington, D.C. who are involved with tobacco control organizations. The list goes on...

Are there any roles you feel you’ve taken on as the dean that are very important or different to you?



I relate to a large number of people now about public health much more generally than what I’ve done in the past. People ask me questions about health care reform, and I will typically send them to one of my colleagues in Health Management and Policy who focuses on that subject. I get asked things as if I’m an expert on everything.

I certainly represent the school in many locations where we’re talking about big broad health issues, so a lot of my canned speeches will have references to the health reform debate for example, but I’m always personally leary of trying to over-represent my expertise.

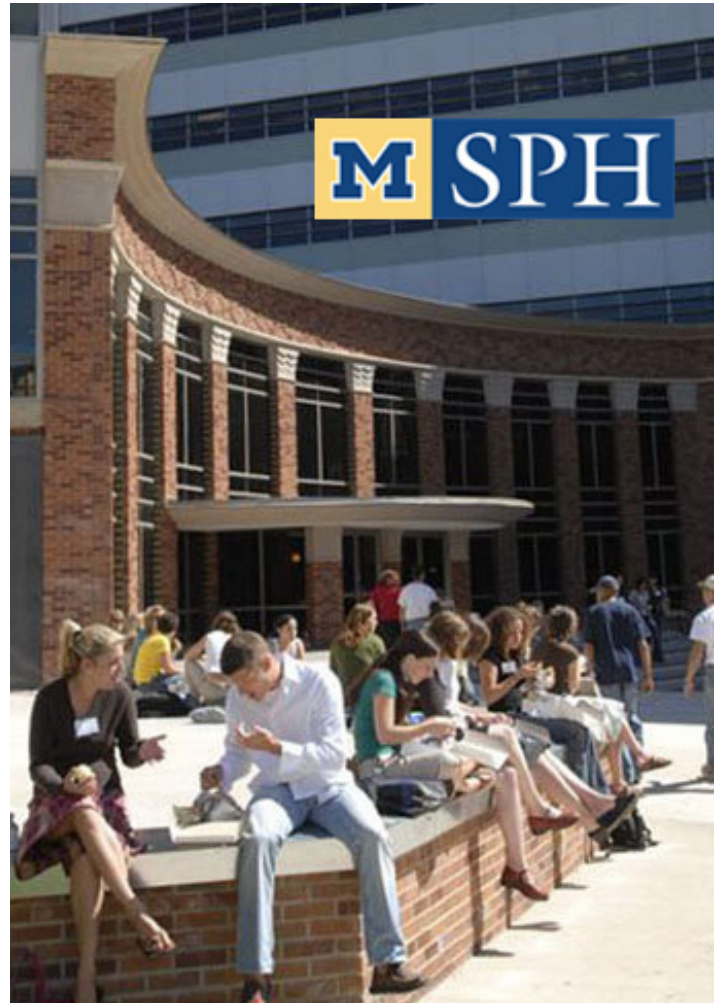
What does someone usually do with a master in public health degree?

Public health is a huge field – if you simply look at the names of our five departments: Health Behavior and Health Education, Health Management and Policy, Biostatistics, Epidemiology, and

Environmental Health Sciences, they themselves are sufficiently different to suggest the breadth of positions and jobs available. We have over 13,000 alums of the school, and they are all over the world doing all kinds of different things. The department I know best is Health Management and Policy. The single most common job that the graduates of this department are engaged in is management positions in health care systems. They typically start out at low to intermediate levels – they may be specifically working in hospitals, they may be working in the central office of large healthcare systems, frequently they’re working in a department within a hospital such as ambulatory care or physical medicine and rehabilitation – they’re getting their first professional experiences in hospital administration. We have a large number of people who work for consulting firms – they’re hired to deal with specific problems. A very large number of our graduates start out with a fellowship for one or two years. We have people who go work in Congress as aides to legislative committees; we have people who go work at the Centers for Disease Control and Prevention (CDC). The corporate sector also hires a lot of our graduates for health policy advice – some pharmaceutical companies in the past years have hired graduates of ours to evaluate new policies coming from Washington D.C. A quarter of our students are PhD students who go on to become researchers. The epidemiologists and biostatisticians do just as the name suggests, as do the health educators.

Coming from a background in economics, what attracted you to the field of public health, and what drew you into tobacco research?

I was in college when my sister developed a rare cancer, which she died from four years later at the age of 21. When I got into graduate school, I just felt kind of impotent about dealing with the situation. I was in economics, and I wanted to do something in health economics that was specifically related to cancer. So I did a dissertation that was related to the use of novel chemotherapies and how that was a quasimarket process, as opposed to the usual market process. When I was looking for



jobs after having spent eight years at all-male Ivy League schools, I decided I wanted to be at a really good, public co-educational research university. There were only three places I wanted to be: Berkeley, Michigan, or Wisconsin, which in those days were the top three. It turns out that there was a job available here at Michigan. Economics is a far more applied field than something such as literature; a lot of other fields exist because they’re intellectually and aesthetically important. Even with a field like economics that focuses on applied work, you’re still playing a pretty theoretical game – it’s basically a very mathematical game, you have to come up with the more sophisticated math models to “beat the other guy.” That’s what I was used to in graduate school, but when I got here I discovered people working on real world problems and it was kind of nifty. Here at the School of Public Health, what most people are doing is relevant to the real world. When I first got involved in tobacco policy research, I got some astonishing real world feedback, and I

was getting involved in things up the level of the Secretary of Health and Human Services. I was very young, just getting into this, and it was all very heady. That all derived from my research. Educationally, I appreciate that the public health students are a good group of people who want to make a difference in the world; they're not there to figure out a way to make a lot of money.

some work study research possibilities, though we typically want to give our own students priority for those. But also, if people are interested in particular areas they should come and talk to our faculty members over here.

Focusing on the specifics of your research career, can you tell us about your research with tobacco policy?

"It's got the technology of cigarette development, the sociology of smoking, the economics, politics, the biology. . . you name it, they're all there, they're all put together, and it's just endlessly fascinating, and I haven't gotten bored with it after 30 years."

Why did you feel it was important to establish the undergraduate class on public health?

First of all, public health is a field that most people do not understand or can easily define. It's not something like law or medicine – no one comes to college thinking 'I'm going to go into public health'. I thought the class could function simply as a device for exposing some undergraduates to the field. I thought and hoped it would be successful in helping to recruit students into the profession and some of them into our School of Public Health. I've been saying we ought to do this for a good twenty years. I finally decided it was time to put our collective money where my mouth has always been and do the class. It's been really fun, and it's a great group of people. We were worried we wouldn't get more than thirty people; we figured undergraduates don't look for public health courses, since all previous public health courses have been for graduate and professional students. All of sudden we started getting flooded with requests, and we filled up quickly. We ordered 140 textbooks and said that was a good place to stop. Next year if this goes well, and there's enough demand, we'll probably open The course up to more students.

How could an undergraduate become involved in public health research?

We have several faculty members here who have UROP students working with them, and that is probably the best way to do it. There are also

I got here in 1972 and I was very fortunate in 1975/76 to get something similar to a post-doctoral fellowship. It gave me the opportunity to go out to the National Bureau of Economic Research at Stanford University to work with Victor Fuchs, who is sort of the father of health economics. I spent a year out there continuing some of the work I had been doing on medical technology, and looking at changes in utilization of surgical procedures before and after the introduction of Medicare and Medicaid in 1965. We wanted to see how much more surgery we were seeing of various types after there was money available for it.

While I was there (having just quit smoking myself after having smoked about 10 years), I picked up a San Francisco Chronicle, and there was an article that stated "Anti-smokers have been wasting their breath." The article argued the anti-smoking campaign had been useless because adult per capita cigarette consumption was not any lower in 1974 than it had been in 1964, the start of the antismoking campaign. About a month later there was another article in the Chronicle, this time saying that a new government survey showed continuing declines in the percentage of adult American smokers. That struck me as inconsistent. I was just starting to get curious as to how to reconcile these when I happened to hear a seminar about automotive safety, during which I had one of those very rare epiphany moments. I thought "Aha! I know how to address the question now".

The comparison between where you were in '64 and where you were in '74 was the wrong

comparison. The right question to ask was, where would you have been in the 70s rather than where you are now. So I went back and looked at smoking patterns before '64 and basically did a time-series regression analysis projecting out where smoking would have been in 1974, including as factors some of the major anti-smoking events. It turned out that by that time, smoking would have been about 25% higher than it was had it not been for the antismoking campaign.

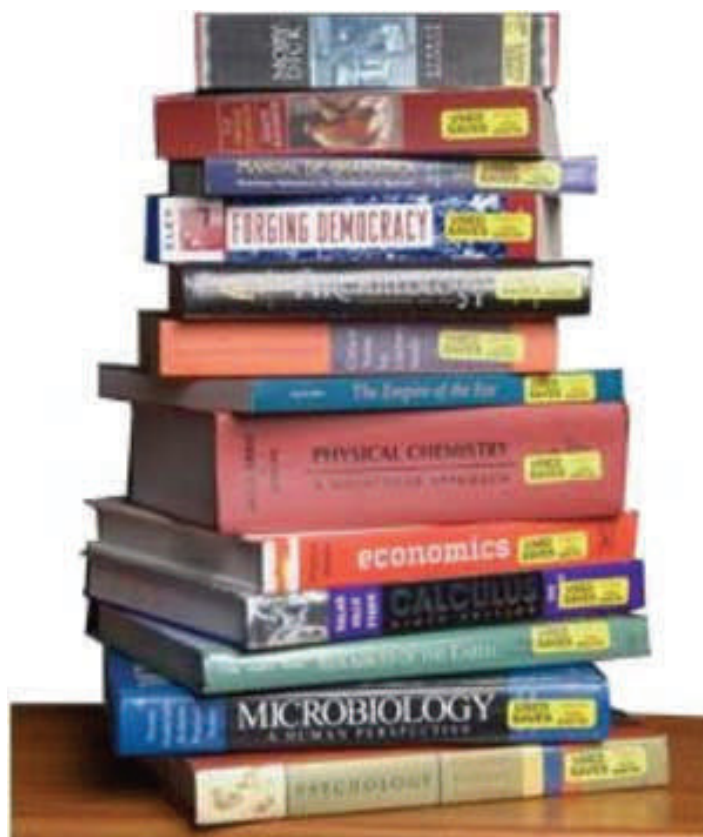
I published that in '77 and instantly got all kinds of reactions. Before I had gotten good reactions to my papers, but entirely from other academics. Here all of a sudden I received letters from the executive VP of the Tobacco Institute, congratulating me on discovering with publicly available data what they had known with their proprietary data for years. And then I get a phone call from the Secretary of Health and Human Services asking me to interview to direct the very first Office on Smoking and Health. I'm 30 years old or so, and all of a sudden all these wild things are happening. That made smoking seem a little more interesting than medical technology to me.

I thought when I started looking at medical technology that it was pretty hot stuff back then, but I got real bored with what I was doing with it. Then I thought, well here's this little piece of vegetable matter rolled up in a piece of paper with a little filter tip on the end of it, and it has really been endlessly fascinating. It's got the technology of cigarette development, the sociology of smoking, the economics, politics, the biology...you name it, they're all there, they're all put together, and it's just endlessly fascinating, and I haven't gotten bored with it after 30 years.

What has your current research been, and have there been any major changes in the direction of your research?

Since becoming the Dean I haven't had a whole lot of time for research unfortunately, but I am still continuing to do some of it. I have one colleague, who I'm working very closely with, David Mendez, on a project funded by the Bloomberg Project. We have to provide projections so that the

World Health Organization can come up with goals for target smoking levels around the world over the next 10, 15, 20 years. We got selected for this because many years ago we did some forecasting where we figured out what the rate of smoking would be if nothing changed from the initiation and cessation rates going on at the time, and the answer was that prevalence would drop gradually as more people quit than started, but then eventually prevalence would level off. We did this years ago, shortly after the Public Health Service had come



out with its Healthy People Objectives for the Nation which it does every 10 years. The objective for the nation they had in 2010, which they had set in the late '90s, was to get smoking prevalence down to 12% (from about 30% in those days). Using our model, we determined the only way that was going to happen is if we practically quadrupled the rate of quitting and got initiation down by $\frac{3}{4}$ or something, so we said this was never going to happen.

Of course we were the bad guys, but our argument was, the 12% target was not only unrealistic for 2010, it's unrealistic for 2020! And they've got themselves between a rock and hard place now

figuring out their goal for 2020, because the realistic one that's still a challenge would be no lower than 14%, but to say that would be 2 points higher than the goal they made for the previous decade. Anyway as a result of the attention from that work, the Bloomberg folks asked us to do something of that nature at the global level, and it's much much tougher. The data for smoking rates in developing countries are very very poor, so we have to be creative in how we're going about it.



Another issue I've been working for almost 15 years is tobacco harm reduction, like the e-cigarette, one of dozens of novel products. The whole question is, what do you do with these things? Do you regulate them? How do you study them to figure out whether they're really better for health or not? It's far more complicated than just evaluating the individual product and how it is used by the individual. You then have to ask yourself, how is it going to affect the public as a whole? Will it get kids to start using tobacco who will then become smokers who might not have? Will it get people who have quit smoking to go back to regular cigarettes? It's a very complicated set of issues but that's what I have been focusing most of my time on in the last 15 years or so, and it's the toughest problem in tobacco policy that I've run up against.

The issue of healthcare reform has been on the minds of Americans lately. How does public health play into healthcare reform?

First of all, nearly everyone in public health

would say we ought to have some kind of system that guarantees that every American is covered by some form of health insurance at a bare minimum. Keep in mind that the health reform we're looking at now is not going to do that – it's going to leave a large number of people without insurance. The second thing is that a vast majority of people in public health would argue that we should have a single payer system. We're spending a large percentage of our health care expenditures on the administration of the whole system. My wife runs Children's and Women's Hospitals here, and they have literally hundreds of different insurance plans they have to deal with. Think about trying to figure that out. I don't know how many people they have working on just getting paid, but there's a huge waste there. So what is the role of public health in health reform? President Obama has given more attention to the role of public health in health reform than any of his predecessors. There's a lot of discussion now on getting people to behave in ways that will make themselves healthier rather than having to rely on a healthcare system after they are already sick or injured. One of the bills includes a ten billion dollar public health fund. The level of interest in public health that this administration has been showing hasn't been seen for years.