Leading Public Health
A Competency Framework

James W. Begun, PhD
Jan K. Malcolm

Leading Public Health is intended to equip current and aspiring public health leaders with the knowledge and competencies they need to mobilize people, organizations, and communities to successfully tackle tough public health challenges. Designed specifically for graduate students and practitioners of public health, the book highlights the aspects of leadership unique to this field. Building on several existing competency-based models, the book focuses on preparing public health professionals to invigorate bold(er) pursuit of population health, engage diverse others in public health initiatives, effectively wield power, prepare for surprise in public health work, and drive for execution and continuous improvement in public health programs and organizations. It is based on research from leadership theory and practice and combines the viewpoint of a prominent scholar with that of a seasoned practitioner.

Based on the premise that public health as a field is undervalued in health policy and practice, the book addresses the need for more informed and proactive public health leadership and describes the values, traits, and knowledge that undergird such leadership. At its heart are detailed examinations of 25 specific competencies required for effective public health leadership. Written in accessible and engaging language, the book includes 19 case studies and multiple examples from public health practice to demonstrate the successful application of leadership competencies. With an eye to the future, the book also includes content on emerging public health challenges, complexity science, innovation, resilience, quality improvement, and leading during unexpected events.

Key Features:
• Empowers public health students and practitioners with leadership knowledge and competencies
• Examines 25 specific competencies required for effective public health leadership
• Combines the expertise of an academic and a practicing health care leader
• Provides abundant case examples from public health practice
• Presents leadership development as a lifelong process
Leading Public Health
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Leading Public Health

A Competency Framework

James W. Begun, PhD
Jan K. Malcolm
JB: To the bold change makers and progress makers in public health—thank you for your leadership.

JM: To the wonderful professionals, past and present, at the Minnesota Department of Health and in local health departments all over Minnesota. Your skill and dedication to protecting and improving the health of Minnesotans inspire me and made me a passionate advocate for this field. This book is also dedicated to the staff and leadership of the Robert Wood Johnson Foundation who have done so much to advance the public’s health. I am proud to have such colleagues and friends.
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Preface

This book is a current, compact guide to the values and traits, knowledge, and competencies needed by public health professionals to mobilize people, organizations, and communities to effectively tackle tough public health challenges. To our knowledge, it is the only competency-based leadership book designed specifically for students and practitioners in public health, highlighting those aspects of leadership unique to this field.

We wrote this book to empower students and practitioners of public health with knowledge and with a framework for self-development. In doing so, we anticipate that readers and the field as a whole will make progress toward achieving a more powerful position in health policy and practice. As a result, the individuals and populations we all serve will have improved chances for healthy lives. We firmly believe that what is good for public health as a field is good for the public’s health.

The book comes at an important time. The evidence base for a social determinants framework for health policy and practice is strong and ever-cumulating, and it is harder and harder for politicians, community leaders, business leaders, leaders of philanthropic organizations, and others to ignore the evidence. There is growing appreciation for the “systems perspective” that public health embraces, both within academia and the policy and practice sectors. Now is the time to press for bolder public health action.

Leadership development in public health has a checkered past; it has performed well for a select group of “emerging leaders” or “leaders,”
usually working in the public sector, but with less attention to the field as a whole. We believe that everyone who belongs to the field of public health can perform leadership activities. Indeed, leadership education should be offered in public health educational curricula, for all specialties, including epidemiology, biostatistics, environmental health, and other specialties whose sponsors do not traditionally consider leadership development to be part of the core education.

Accordingly, we intend this book to be accessible to a wide range of entry-level and inexperienced leaders. We think that experienced leaders as well will find the framework to be a useful way to understand and build on their own experiences.

The genesis of this book comes from our joint teaching of leadership courses to diverse groups of public health students, including many students from countries other than the United States and from a variety of public health specialties. The book focuses on leadership in the context of the United States, but most of the competencies apply across the globe.

We write with two qualitatively different voices—one (JB) academic and research-based, one (JM) practical and experience-based. We find this combination of academic and practitioner to work well in teaching leadership, because it enables theory and research to be linked to application and application to be linked to theory and research. We have not tried to homogenize the two voices in the book. Particularly, Chapter 3 (“Values and Traits of Public Health Leaders”) and the five chapters of Section III, Competencies for Public Health Leadership, are purposely written with a more subjective and normative voice. We think the chapters “speak” to the reader better that way. To further emphasize application of the material, 19 cases of leaders or leading organizations in action are presented throughout the book.

We look forward to a new era in the improvement of population health, and the significant contributions of public health leaders at all levels to those improvements. Nationally and globally, the work of public health has never been more critical. We hope this book gives public health leaders—both current and future—a framework for thinking about the attributes and acts of leadership that can elevate the importance and impact of public health programs and organizations.
Acknowledgments

This book would not have been initiated or completed without the assistance and support of many friends and colleagues. Thanks to Tony Kovner of New York University for his early support of this project. Katie White (University of Minnesota) and Ken White (University of Virginia) provided suggestions for improvement of the original outline for the book. At Springer Publishing, Sheri W. Sussman was an early proponent and flexible partner on this project.

An important contributor to this book is Linda M. Kahn. She is a master of public health (MPH) candidate in the Executive Program in Public Health Practice at the University of Minnesota, School of Public Health. Linda transitioned into graduate studies following more than two decades of experience in health care administration, where she led management analysis and reporting teams at academic health centers and in management and technology consulting. Her area of concentration is community health care system integration through public and health policy focused on community health, social connectedness, health equity, and access, especially in underserved communities.

Our association with Linda began in fall, 2012, when Linda was a student in our Public Health Leadership course. She then served as a research assistant who contributed well beyond our expectations. Linda is a valued colleague, a superb editor and writer, and a joy to work with. She made primary contributions to almost all of the In Practice cases in the book, as well as several other inserts and editing. The book would not be nearly as strong and as engaging without her contributions.
Other students and research assistants who contributed to this book include Katie French, Luqman Lawal, Samantha Mills, Ngozi Njoku, Pearl Ometan, Brooke Vagts, and Elliott Wortham. We thank all of the students in our Public Health Leadership courses for energizing us and for sharpening the content of the book.

Within the University of Minnesota School of Public Health, champions for leadership content in the graduate curriculum include Mary Ellen Nerney, Sandra Potthoff, Donna McAlpine, and John Finnegan, Jr. We appreciate their efforts.

Anne Barry, Aggie Leitheiser, Ruth Mickelsen, Lowell Kruse, Mary Selecky, and Nicole Lurie all served as fountains of wisdom on their respective areas of expertise. We are grateful to them for sharing their knowledge and experience with us.

Jim Begun thanks his (extended) family—Jean, Michael, Mitch, Stephanie, Blythe, and Murray—for filling his life with joy, wonder, and hope for the next generations of leaders.

Jan Malcolm thanks Kris for constant support and for putting up with the piles of paper all over the house, and Nancy for always telling her she could do anything, even write a book.
Share

Leading Public Health: A Competency Framework
A first step in any social or organizational transformation is making the case for change. In Chapter 1 (“Why Leadership? Why Now?”) we make the case that public health is undervalued in policy and practice arenas. Public health offers the best hope for cost-effective and value-adding solutions to intractable population health challenges in the United States and around the globe. The social determinants model developed by the field provides a foundation for stronger public health leadership. Performing leadership activities effectively can leverage the impact of every public health practitioner and advance the power and influence of public health.

In Chapter 2, “A Framework for Public Health Leadership,” we introduce a framework for the book based on the values, traits, knowledge base, and competencies of effective public health leaders. The framework builds on four complementary perspectives on leadership (servant leadership, complexity leadership, integrative leadership, and adaptive leadership) and several existing competency frameworks for public health. Seven key values and seven traits of effective public health leaders are forwarded. Five competency sets, comprised of five competencies each, form the basis for leadership development: invigorate bold(er) pursuit of population health; engage diverse others; effectively wield power; prepare for surprise; and drive for execution and continuous improvement.
Public health is undervalued and underutilized in relation to its capacity to improve the health and well-being of individuals and populations. In this chapter, we weigh the gap between public health’s potential and its current contribution. Stronger leadership from public health professionals can reduce that gap and accelerate improvement in the health and well-being of individuals and populations.

PAST SUCCESSES, FUTURE OPPORTUNITIES

The field of public health has made enormous contributions to human welfare. For example, public health interventions have been credited with adding 25 of the 30 years of average lifespan gained in the 20th century in the United States (Bunker, Frazier, & Mosteller, 1994). Vaccinations, motor...
vehicle safety, safer workplaces, control of infectious diseases, safer food, fluoridation, and regulation of tobacco are among the public health interventions responsible for these and other improvements in the quality and length of lives (Centers for Disease Control and Prevention, 1999).

Around the globe, the results of public health work are equally compelling. Cholera, typhoid, smallpox, and polio are among the infectious diseases that have been largely controlled by improvements in sanitation, water and food safety, improved nutrition and living standards, and vaccines (Schlipköter & Flahault, 2010). Simple screening programs can drastically reduce death rates from cancer. Rapid investigation of disease outbreaks has saved untold lives. Prevention and recovery efforts directed at natural disasters such as tsunamis continue to improve with learning and experience.

Public Health Challenges

The need for enhanced contributions from public health is increased by the fact that public health challenges are growing, not diminishing. Nearly 2.4 million children around the world die each year from vaccine-preventable diseases (Schlipköter & Flahault, 2010, p. 92). Efforts to control HIV/AIDS, malaria, and several other diseases continue to struggle. As some disease sources are controlled, other problematic diseases emerge, due to the complex interaction of animal species, expanding human populations, changes in technology, and environmental conditions, among other causes. Complex new health challenges, deriving from resource depletion and climate change, are looming. Chronic food shortages, natural disasters, population growth, wars, and epidemics will continue to challenge the public health sector in some countries, while obesity and addiction will plague others. People are living longer, leading to aging populations with more chronic disease load. Technologies to keep people alive are improving, adding to the cost of providing care. Some would add the impact of modern culture, particularly individualism and materialism, on well-being as substantial public health problems (Hanlon, Carlisle, Hannah, & Lyon, 2012).

Global inequities in health outcomes are a particular challenge of the future. Marmot (2005) notes that huge differences in life expectancy among countries (for example, a difference of 48 years between Sierra Leone and Japan) and within countries (for example, a difference of 20 years between the most- and least-advantaged populations in the United States) are not inevitable. Large inequities in income within and between countries are associated with a host of health outcomes.
and challenges, including mental health, infant mortality, violence, obesity, and life expectancy (Wilkinson & Pickett, 2009). The Rio Political Declaration on Social Determinants of Health, endorsed by the World Health Organization (WHO) in 2012, explicitly targets inequity within and between countries in the distribution of power, money, and resources as a health challenge (WHO, 2013c).

In the United States, cost, quality, and access problems continue to vex the health care delivery sector. Residents of the United States pay twice as much or more and have significantly worse population health statistics than many people in the world, with the situation worsening since 1990. For example, among 34 Organization for Economic Co-operation and Development (OECD) countries, the U.S. rank for life expectancy at birth fell from 20th to 27th between 1990 and 2010 (U.S. Burden of Disease Collaborators, 2013). In many countries around the globe, health services are taking increasing proportions of national budgets, as the availability of new and expensive drugs and medical technology and consumer demand continue to grow. If not contained, government spending on health will rise to 14% of Gross Domestic Product over the next 50 years on average in the OECD nations, from 6% in 2010 (OECD, 2013).

The budget situation is particularly dire in the United States, with Medicare and Medicaid programs continually labeled as unsustainable in their current forms, and driving much of the ongoing budget deficits in federal and state governments. The conclusion of Harvey Fineberg, MD, President of the Institute of Medicine, is stark: “Despite a level of health expenditures that would have seemed unthinkable a generation ago, the health of the U.S. population has improved only gradually and has fallen behind the pace of progress in many other wealthy nations” (Fineberg, 2013b, p. 585). Inequities in health based on race, ethnicity, and economics persist in the United States. For example, infants born to black women are 1.5 to 3 times more likely to die than infants born to women of other races/ethnicities (Centers for Disease Control and Prevention, 2011).

Table 1.1 summarizes the wide range of public health challenges facing society in the future, with an emphasis on issues that have emerged in recent decades. Given the range and impact of the health and cost challenges faced in the United States and around the globe, the need for effective public health solutions has never been greater.

Public Health Solutions

What does public health have to offer? What are public health “solutions” to the challenges listed in Table 1.1?
TABLE 1.1
Future Public Health Challenges

<table>
<thead>
<tr>
<th>CONVENTIONAL CHALLENGES</th>
<th>RECENT AND EMERGING CHALLENGES</th>
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<tbody>
<tr>
<td>• Infectious diseases—prevention</td>
<td>• Access to personal health care services</td>
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<td>• Water quality and sanitation</td>
<td>• Life expectancy</td>
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<td>• Nutrition and hunger</td>
<td>– Maternal mortality</td>
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<td>– Infant/child mortality</td>
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<td>• Epidemics and pandemics</td>
<td>• Early childhood education and kindergarten readiness</td>
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<td>• Food safety</td>
<td>• Mental health</td>
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<td></td>
<td>– Availability of preventive services</td>
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<td></td>
<td>– Institutional care capacity and competency—hospitals, prisons, schools</td>
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<td></td>
<td>– Community support services</td>
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<td></td>
<td>• Physical activity, obesity</td>
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<td></td>
<td>– Physical, behavioral, social, and environmental factors causing obesity</td>
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<td>• Oral health</td>
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<td></td>
<td>– Lifelong access to oral care</td>
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<td></td>
<td>– School-based dental sealant programs for children, especially in underserved communities</td>
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<td></td>
<td>• Weapons of mass destruction—chemical, nuclear</td>
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<td></td>
<td>• Substance abuse</td>
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<td></td>
<td>• Bioterrorism</td>
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(continued)
An expansive view of the field of public health has been widely adopted in recent decades by many public health professionals and governments. This expansive view has been referred to by such terms (with some distinctions among the terms) as the synthetic model, ecological model, multilevel framework, social determinants model, and New Public Health (Braveman, Egerter, & Mockenhaupt, 2011; Fielding, Teutsch, & Breslow, 2010; Kaplan, 2004; Tarlov, 1999; Tulchinsky & Varavikova, 2010; U.S. DHHS, 2011; WHO, 2013c). We generally use the term “social determinants model” to refer to this broader perspective in this book. An example of the perspective is provided in Figure 1.1, which displays the framework of the U.S. government’s Healthy People 2020 program. At the individual level, genetics, biology, and behavior all play a role in health. The social environment, which includes economic and social conditions in communities, and the physical environment, which includes chemical pollution and natural threats to health, join individual-level factors and “health services” as determinants of health outcomes. Historically, health policy in the United States and many other countries has focused on individual-level health determinants and interventions, while the Healthy People 2020 framework argues for an expansion of emphasis on health-enhancing social and
physical environments (U.S. DHHS, 2011). A similar framework guides the World Health Organization’s practices (WHO, 2013b), as well as those of many governments (see Figure 1.2). One popular framework is Frieden’s five-tier health impact pyramid (Frieden, 2010). The base of the pyramid consists of “socioeconomic factors”—the first tier and the root driver of health outcomes, followed in tier 2 by the “context” of health decisions and protective interventions at the second level. Only then do preventive interventions (tier 3) and clinical interventions (tier 4) enter in the pyramid, followed at the top (tier 5) by counseling and education. In general, the social determinants model challenges the “medicalization” of health status problems, which leads to neglect of social and economic causes of health vulnerability and disparities (Lantz, Lichtenstein, & Pollack, 2007).

Another popular social determinants framework was developed by the University of Wisconsin Population Health Institute (2013). In that model, causes of variation in health outcomes are allocated among four categories: health behaviors (30%), clinical care (20%), social and economic factors (40%), and the physical environment (10%). Social and economic factors include education, employment, income, community safety, and family and social support.

The social determinants framework for public health has implications for the definition of “public health solutions” to improving individual and population health. This broader, bolder, and more powerful

FIGURE 1.1 Conceptual framework of Healthy People 2020.
view links public health to social services and social policy. Researchers found that the United States is one of only three industrialized countries to spend the majority of its health and social services budget on health care, versus social services, with negative effects on health indicators (Bradley, Elkins, Herrin, & Ebel, 2011). The Health in All Policies movement suggests that decision makers (public and private) in all sectors that influence health, such as transportation, agriculture, land use, housing, public safety, and education, consider the effects of their policies on health outcomes. The U.S. Institute of Medicine and a variety of public health associations in the United States recommend the approach to more fully address social determinants of health (Institute of Medicine, 2011a; National Association of County & City Health Officials, 2013c). The recommendations of the WHO Commission on Social Determinants of Health illustrate the broad range of public health solutions as applied to global public health problems (WHO, 2008). The Commission’s recommendations for improving health equity are as follows:

1. Improve the conditions of daily life.
2. Tackle the inequitable distribution of power, money, and resources.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

The recommendations reflect serious consideration of all levels of public health solutions to drive improvements in health outcomes.

Population health, defined as “the health outcomes of a group of individuals, including the distribution of such outcomes within the group” (Kindig & Stoddart, 2003, p. 381) is viewed by many as demarcating the domain of a broader public health. Kindig and Stoddart argue that “a hallmark of the field of population health is significant attention to the multiple determinants of such health outcomes. . . . These determinants include medical care, public health interventions, aspects of the social environment (income, education, employment, social support, culture) and of the physical environment (urban design, clean air and water), genetics, and individual behavior” [italics in original] as well as their interactions (Kindig & Stoddart, 2003, p. 381).

Referring back to the Frieden health impact pyramid (described above), tiers in the pyramid can be characterized by “ease of change.” The levels at the top require the least political commitment and, one might argue, the least “leadership” on the part of public health to achieve. As observed by Gostin and colleagues, the broader vision of public health is politically charged, as it shines a light on the poor condition of public health agencies; requires a transition to an intersectoral public health system; promotes the adoption of bold changes in physical, social, and economic conditions; and requires a values shift toward collective interest (Gostin, Boufford, & Martinez, 2004). The lower levels at the base of the pyramid, despite their impact on population health, are not within government’s appropriate sphere of action, in the opinion of powerful elites (Frieden, 2010, p. 591) and those who advocate for a narrow role for public health (Epstein, 2003).

Similarly, a health care system organization applying the University of Wisconsin Population Health Institute framework classified the socioeconomic and environmental factors as under “limited control” of the organization, compared to the “shared control” over health behaviors and “high control” over clinical care (May, 2013b).

In all of these frameworks, public health solutions involve far more than health care. The broad vision for public health requires integration of public health into the education of clinical care providers and into clinical care practice, a long-standing position of many in the history of public health (Lurie & Fremont, 2009; Sava, Armitage, & Kaufman, 2013).
The broad and bold vision for public health reflects a complex systems approach, depicting that determinants of health are embedded within larger systems (or contexts) that affect them. The systems approach includes an understanding of root causation, tracing problems far back in the causal chain. In this sense, the public health approach is a long-term perspective, accompanied by diagnosis of the deepest underlying roots of issues.

In summary, there is growing, strong, and pervasive support for the social determinants of health approach to public health, which has been documented in the literature (Braveman, Egerter, & Williams, 2011). It is time that such intellectual and evidence-based movement be accompanied by broader social and political action. In Practice cases 1.1 and 1.2 illustrate examples of public and private organizations that are adopting a broader view of public health action. They detail efforts of the New Orleans Health Department and two private health care delivery systems in Minnesota to expand their services to more directly address social determinants.

IN PRACTICE 1.1

TACKLING SOCIAL DETERMINANTS OF HEALTH DISPARITIES: NEW ORLEANS HEALTH DEPARTMENT

Undertaking the challenge of reducing deeply engrained socioeconomic and health disparities is not an enviable job for any public or private organization. This would seem especially true in a major metropolitan city that survived one of the worst series of natural disasters and delayed recovery efforts in recent U.S. history. The New Orleans Health Department (NOHD), however, took on this ponderous task and earned recognition in 2013 by the Robert Wood Johnson Foundation (RWJF) as an inaugural “Roadmaps to Health” winner for its “outstanding community partnerships. . . . which are helping residents live healthier lives” (City of New Orleans, 2013, para. 1).

An Epic Storm Followed by a Chaotic Response

Hurricane Katrina hit southeast Louisiana—including Orleans Parish and the City of New Orleans—on August 29, 2005, arriving as a Category 4 hurricane. Katrina’s winds and water surge produced one of the most devastating natural disasters in U.S. history, with thousands killed, injured, displaced, or dispersed from an area of the country already plagued by persistent socioeconomic and health disparities. By most accounts, failures at every level of government occurred in the aftermath of Katrina; according to LaFronza and Burke (2007, p. 4), “Truthfully, everything broke down; governments, private sector organizations, and individuals were ill-prepared to respond in a timely manner.” But the issues ran deeper than preparedness and...
response, as New Orleans already faced severe problems prior to Katrina: “. . . social forces that created an economically divided New Orleans emerged from years of inadequate policy, attention, and concern. . . . Katrina more clearly uncovered many social ills that were omnipresent but perhaps lurking just beneath the surface” (LaFronza & Burke, 2007, p. 7).

Recognizing That Place Matters for Health

As part of its long-term recovery efforts, New Orleans used the community health assessment process to bring together cross-sector leaders and community members. This collaborative effort identified poverty as a major determinant of residents’ health, especially childhood poverty. Poverty impacts health in the extreme: as deficits, such as lack of access to affordable food, housing, and health care; and as excesses, including rates of infant mortality and morbidity, obesity, and unemployment higher than the national average. Those living in the poorest neighborhoods experience a 25-year lower life expectancy compared with those in the wealthiest neighborhoods (NOHD, 2013).

These findings are supported by research published by the Joint Center for Political and Economic Studies (2012, p. 1), which found that in Orleans Parish, “people living in neighborhoods characterized by poor housing, inadequate schools, polluted environments, insufficient transportation, and lack of safety typically have significantly poorer health than people living in neighborhoods that don’t suffer from these characteristics.” Historic patterns of discrimination resulted in residential segregation, with environmental conditions in specific neighborhoods creating the fundamental causes of health inequities across different racial, ethnic, and socioeconomic groups. While not unique to Orleans Parish and New Orleans, segregation based on these demographic characteristics has been substantial and persistent.

Addressing Persistent Social Determinants Through Cross-Sector Partnerships

Using accreditation guidelines developed by the Public Health Accreditation Board (PHAB), NOHD has focused its post-Katrina efforts on implementing a prevention and public health model. This “modern public health agency” approach replaces its previous “broken and outmoded” clinical care model. Through a collective of cross-sector partners—including schools, businesses, health care and nonprofit organizations, and government agencies—the city moved quickly from being “a place where we were treating the consequences of poor health decisions and the impacts of social determinants of health . . . into a place where we’re upstream and we can prevent it” by working across sectors, according to Dr. Karen DeSalvo, Health Commissioner for the City of New Orleans (RWJF, 2013a, paras. 5–6).

A primary factor in New Orleans’ success has been this collaborative approach to improving population health. With all sectors involved in decision making, diverse partners have represented and considered the breadth of social determinants in new policies. Dr. DeSalvo cited the success of the approach: “As we rebuild our
roads, buildings, parks, and playgrounds, we are thinking about not only health from a physical activity and a nutritional standpoint, but also mental health and addressing those chronic disease needs that communities have” (RWJF, 2013a, paras. 7–8).

In the aftermath of Katrina, clinical care has also been improved to address the needs of the most vulnerable in the city. Examples include community-based health care access points for uninsured, underinsured, and low-income patients; electronic medical records across the health care system; and the Greater New Orleans Health Information Exchange to share clinical data for the improvement of population health (RWJF, 2013a, para. 12). Along with community health programs focused on wellness, fitness, healthy food access, school-based gardening and education, and urban farming, New Orleans is undertaking an intentional “work-in-process” approach to its ongoing experiment with a new approach to public health.

“Health in All Things” as a National Model of Community Wellness

One of NOHD’s goals in the wake of its post-Katrina efforts is PHAB accreditation; it received funding as an accreditation support initiative site and submitted its accreditation application in May 2013 (National Association of County & City Health Officials, 2013d). Hurricane Katrina is viewed as a catalyst that exposed, not created, the effects of deep and persistent socioeconomic and health disparities in New Orleans. As Dr. DeSalvo stated, “Our challenges are great, but so is our opportunity. . . . as we seek to establish New Orleans as a model for community health improvement for the nation” (DeSalvo, 2013, para. 4), as well as “a rallying cry for all of us to come together and find a way to solve those problems as a community” (RWJF, 2013a, para. 18). LaFronza and Burke (2007, p. 7) put it this way: “In a post-Katrina environment, there are new opportunities to recreate institutions and organizations, and restructure the interactions among them.” Given its efforts and progress to date, NOHD is demonstrating that a public agency can be a public health leader by engaging all sectors of the community to overcome disparities and adversity through an attitude and practice of “health in all things.”

IN PRACTICE 1.2

TACKLING SOCIAL DETERMINANTS THROUGH HEALTH SYSTEM–COMMUNITY COLLABORATION

With clinical care accounting for only 20% of the health factors impacting health in the United States (University of Wisconsin Population Health Institute, 2013), the role of health care delivery systems in improving population health may be questioned. Yet health systems hold a unique place in the communities they serve and their influence can be far-reaching to members of the community and the communities at large. In Minneapolis and Saint Paul, Minnesota—the Twin Cities—two large health systems are collaborating with their communities to impact the
lives and health of those they serve. While these providers are not unique in their approach to population health, HealthPartners and Allina Health are demonstrating organizational leadership that has captured national interest in their commitment to improving community health.

A critical feature of programs offered by both HealthPartners and Allina Health is the focus across the life course. The health systems partner with local community organizations such as schools, media, and a variety of service providers. Together they develop and deliver programs and resources that are valuable to all ages, especially those early and late in life.

Early Lessons in Healthy, Active Living to Young Community Members

Isham, Zimmerman, Kindig, and Hornseth (2013, pp. 1448–1449) describe the partnership between HealthPartners, schools, and Radio Disney to form the yumPower School Challenge. Part of an evidence-based, integrated healthy eating campaign, the program’s goal is to increase healthy eating behaviors in school-aged children. Elementary students from participating urban and suburban school districts voluntarily track fruit and vegetable consumption, a key indicator in childhood of future health outcomes. Representing predominantly low-income households from public school districts in the Twin Cities, students and parents, along with teachers, administrators, and nutrition staff, all engage in learning about healthy eating. HealthPartners contributed funding of the initiative and engagement of its leaders to collectively improve community health results.

Allina Health offers similar school-focused initiatives to instill lifelong health behaviors in young children. One program is Health Powered Kids™ (HPK; Allina, 2013a, p. 12), which provides online curricula for children ages 3 to 14. The focus of HPK is empowering students to make healthier choices about eating, exercise, keeping clean, and managing stress, including fruit and vegetable consumption and physical activity ideas for home and classroom. Resources are made available for free to a wide-reaching audience, including elementary schools, home-schooled families, daycare providers, individuals, and community organizations, such as local Girl Scout and YMCA participants. In addition, School Health Connections™ and Neighborhood Health Connections™ (Allina, 2013a, pp. 6–8) provide grants to elementary school and community organizations, respectively, to support healthy activities that increase healthy, active lifestyles; build health literacy; and increase social connectedness. Allina’s partnership with Free Bikes for Kidz (FB4K), a Minneapolis-based nonprofit organization, has provided thousands of new and gently used bikes and helmets to promote active play and physical activity along with bike safety for children from low-income and underserved families.

Community Health Programs for Life

Both health systems offer programs to support individuals and families to stay healthy and understand health conditions and health decision making. By promoting health and wellness programs delivered online and in person, health systems reach diverse community members with resources that are meaningful to them.
For example, Allina Health has invested in the Heart of New Ulm Project to improve cardiovascular health for residents living in New Ulm, Minnesota; the work of the Cultural Wellness Center profiled in Chapter 6; and the Healthy Communities Partnership, a health screening and assessment initiative with 13 communities (Allina, 2013b). HealthPartners, which operates half the mental health beds in the eastern Twin Cities, has collaborated in partnerships on a growing number of topics related to mental health, including education, advocacy, and reduction of stigma. The “Make It OK” campaign is geared toward increasing awareness about and comfort in individual and community discussions about mental illness (Isham et al., 2013). Each of these programs allows the health system to work with and provide resources to patients, stakeholders, government leaders, businesses, and organizations in its communities on vital issues facing the varied needs of community members.

Support and Care to Face End-of-Life Issues

HealthPartners and Allina Health also address end-of-life issues within their communities. Allina is undertaking the Robina LifeCourse™ study, which is developing improved ways to allow those with serious illness to choose how to live their lives by collaborating with their entire health care team, including care providers, social service and support practitioners, and care guides (Allina, 2013c). HealthPartners is one of the partners in the Honoring Choices Minnesota initiative (Isham et al., 2013, p. 1449), which aims to improve end-of-life care. Through Honoring Choices, community leaders and health care providers work together to share information with patients and community members to raise awareness about the options and importance of advanced care decisions and directives.

Competing Health Systems Can Collaborate, Too

HealthPartners and Allina Health are working collaboratively to address community health in the Twin Cities. In 2010, the competing health systems launched the Northwest Metro Alliance to improve the care of over 300,000 people in the northwestern suburbs, including over 27,000 patients with HealthPartners insurance who receive their health care at HealthPartners and Allina facilities in the northwest metro (HealthPartners, 2013, p. 2). The partnership was developed as a long-term collaboration to achieve the “Triple Aim” of health care—high-quality care, exceptional patient experience, and affordability—by targeting cost and care improvements, optimizing available care networks and specialty services, and preventing duplicative services or capital projects in the service area, thus serving as an Accountable Care Organization (ACO) “learning lab” (HealthPartners & Allina Hospitals & Clinics, n.d., p. 1).

Focusing on providing health care services together across the community allows the Northwest Metro Alliance to reduce care fragmentation and provide better care across the inpatient and outpatient care continuum. One initiative involves improved prescribing of generic medications and reduced variation in prescribing to improve cost and quality, with an increase from 75% generic utilization in 2009 to
87% utilization in 2012, representing a $3.4 million reduction in prescription spending (HealthPartners, 2013, p. 1). Community outreach through the Northwest Metro Alliance resulted in over 9,000 people completing health assessments at community events and local settings, such as schools and employers, in 2012, with 87% of participants receiving counseling on health improvement activities (HealthPartners, 2013, p. 2). Electronic health information sharing is a key strategy of the Northwest Metro Alliance, which allows Allina and HealthPartners to use data-based analyses to target initiatives toward the population and individuals served in the region and better address the “Triple Aims” across the care continuum (HealthPartners & Allina Hospitals & Clinics, n.d., pp. 2–4).

Health and wellness are critical goals of health care delivery systems and communities. Consumer and societal demands for more value from health care services are pressuring health care delivery organizations to integrate more fully with public health practice (Zismer, 2013). By partnering together through cross-sector collaborations, participants impact the lives of their community members to a greater extent throughout the life course. HealthPartners and Allina Health are providing leadership, innovative program ideas, and funding to their communities to strengthen the bond and outcomes of community health and health care. In the end, these collaborations benefit patients, their families, and communities, as well as the health systems.

Value of Public Health Solutions

The American Public Health Association in 2013 adopted “public health is ROI” as one of its tag lines. ROI refers to return on investment. Simply put, public health solutions at the bottom of the Frieden pyramid, to use one example, often provide higher levels of performance improvement per unit of cost than those higher on the pyramid. Maximum value means producing the highest output with the least resources. The greatest value comes from changes at the bottom of the pyramid. Public health interventions often meet that criterion. They are wiser investments for societies with scarce resources. Whether explicitly or implicitly, the proportionately greater investments other countries make in housing, education, transportation, and income security may well be part of the reason they outperform the United States in population health measures, at far lower spending on medical care.

The Gap

All of the past accomplishments of public health are a source of pride and positive energy in the public health community. The future challenges indicate that public health will be a prominent fixture in the betterment
of society in the future. The ability of public health to contribute more to societal gain has been documented in public policy tomes issued by the Institute of Medicine several times in the United States (Institute of Medicine, 1988, 2003a, 2012).

However, the fact that the recommendations of Institute of Medicine and other groups have been repeated and have been largely unheeded is troubling (Tomes, 2008). Public health’s influence in current health care policy and funding debates is much less than it should be, given the evidence of its potential. The mismatch between the amount of resources devoted to public health and the influences of public health approaches on ultimate health status outcomes ought to frustrate and be a rallying cry for strengthened public health leadership at all levels.

In the United States, government public health activities comprised 2.9% of national health expenditures in 2011 (Centers for Medicare and Medicaid Services, 2012). Many have observed that the “field of public health has long been the poor relation of medicine” (Hemenway, 2010, p. 1657). Despite its contributions to social welfare in the United States, public health operates largely at the margins of health policy. The share of national health spending devoted to public health activities in the United States pales in comparison to spending on medical research and attention to reorganization of the system to deliver care for illnesses that are preventable. Fineberg (2013a, p. 85) describes the “paradox of disease prevention” as the fact that prevention is celebrated in principle, but resisted in practice. Reasons for this include the long-term nature of solutions, the diffuseness of the beneficiaries in contrast to the clearly identifiable beneficiaries of clinical health care, the relative lack of drama of prevention, opposition from commercial interests and personal beliefs, and the invisibility of public health leaders and organizations. Public health solutions require change in institutions that are powerful and inertial or opposed to more investment in public health solutions. Such conditions add up to a disconcerting underinvestment in public health (Hemenway, 2010).

WHAT IS LEADERSHIP?

The potential for public health solutions to improve lives, save lives, and save money for the health sector is huge. The realization of this potential depends on persuading stakeholders—governments, opinion shapers, and economic elites—of the value of public health solutions. Political will, funding, initiative, and training are needed “to maintain and develop the gains achieved in the past century and to transmit the
latest knowledge and technology to many parts of the world where preventable deaths measure in the hundreds of thousands” (Schlipköter & Flahault, p. 110).

To transform both the influence and impact of public health, public health leaders need to be increasingly competent in challenging and moving people and organizations, with more urgency and success than they have had in the past. This will not happen unless public health practitioners commit to leadership activities and have the competencies to perform them.

Leadership can be defined at a variety of levels (for example, individual, team, organization, community, or society) in a variety of ways (for example, as a personal trait, a process, or a system function). In Chapter 2, we systematically examine the different ways to conceive of leadership, and we derive the definition of leadership used in this book: Leadership is the practice of mobilizing people, organizations, and communities to effectively tackle tough public health challenges. Many different individuals mobilize others to address public health challenges. Next, we consider the pool of individuals who can practice public health leadership.

**Who Is a Public Health Leader?**

Public health is a full-time professional pursuit for a core of approximately 500,000 individuals who provide one or more of the essential public health services, regardless of discipline or work. These individuals hold positions as administrators, biostatisticians, environmental engineers, health educators, public health nurses, physicians, or veterinarians, to name a few public health roles (Evashwick, 2013; Morrissey, 2011; U. S. DHHS, 2000). They are the backbone of the public health practice community. In the United States, a large majority (85%) is employed in governmental public health agencies, including nearly 3,000 local health departments, 56 state and tribal agencies, and the many federal agencies responsible for public health, such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), and the National Institutes of Health (NIH). The remaining 15% of the public health workforce in the United States is employed at nonprofit organizations, academic and research institutions, medical groups and hospitals, and private for-profit companies. The workforce encompasses many others not included in the 500,000 figure, such as those responsible for occupational safety and health in industry, unions, and government; those involved in population-focused
health education and community programs in voluntary organizations and health care systems; and those reducing environmental hazards (Gebbie, Merrill, & Tilson, 2002). A broader definition of public health professional is “a person educated in public health or a related discipline who is employed to improve health through a population focus” (Institute of Medicine, 2003b, p. 4). Due to the diversity and scope of public health work settings, and the absence of funding for enumeration efforts, the exact size and composition of the public health workforce in the United States remain uncertain (Morrissey, 2011).

Public health leaders function in all sectors of the economy of the United States and most other countries: public, private for-profit, and private not-for-profit. In fact, a complexity of most public health leadership work is that it typically spans all three sectors. Heifetz, Grashow, and Linsky (2009, p. 53) provide an apt summary of relevant differences among the three sectors:

1. Private, not-for-profit sector: mission driven, consensus decision making
2. Private, for-profit sector: profit driven, competitive environment
3. Public sector: risk averse, security oriented, insulated from marketplace competition

Those who practice leadership in public health must be prepared to work with other individuals and groups in all three sectors, requiring a degree of flexibility and openness not needed in more bounded leadership settings. In fact, observers increasingly note that leaders who can move easily among the business, government, and social spheres are needed to solve society’s most vexing problems (Lovegrove & Thomas, 2013).

In addition to crossing sectors, public health leaders function at all levels of organizations, programs, and communities. Public health workers at the lowest levels of organizational hierarchy can enact leadership competencies in their work with the teams and projects to which they are assigned. They can contribute to mobilizing others through their positive influence on others and on the output of their teams and projects. Their behavior can be “leader-ful” or not. People who serve in staff or volunteer positions may not define themselves as leaders, but the “leader” role is not reserved to those with position power in organizations, programs, and communities (Komives, Wagner, & Associates, 2009). People can lead by role modeling the changes they support, by telling their own stories, by raising questions, as well as by working to change organizational and social cultures, policies, and practices.
In the broadest sense, public health is a social movement that encompasses many times the formal public health workforce (Turnock, 2012, p. 11). Some leaders will hold full-time jobs in related fields and will perform public health leadership functions only as members of task forces or other collaboratives. Some leaders will enter and leave the field of public health as they change roles. Local activists may function as public health leaders in their “after-work” time, working as volunteers to organize neighborhoods or communities to pursue public health interventions. Corporate executives may do the same through service on boards of not-for-profit public health organizations. All of these people need the competencies of public health leadership.

For example, former Mayor Michael Bloomberg of New York City (2001–2013) is a modern public health leader (see In Practice 7.2 in Chapter 7). Yet, his career has been largely as a business leader and public official. Governor Jesse Ventura, with whom author JM worked as Minnesota Health Commissioner, championed public health issues and approaches that surprised many. Examples of his administration’s approach are included in several chapters of this book. In his prior work life, Governor Ventura was a professional wrestler and a Navy Seal, among other jobs. These leaders are important because they leverage the impact of public health. Without public officials and others who adopt public health solutions, public health would be a more insulated clan of technicians and scientists.

**THE TIME IS NOW**

There are several reasons why more effective leadership can have a growing impact on the health of individuals and populations at this particular point in the evolution of public health.

**Evidence-Based Knowledge on Leadership Is Growing**

The knowledge base for leadership has advanced significantly in recent years. In the not-so-distant past, successful leaders were the primary sources of wisdom for future leaders, often writing their own accolades and suggesting that others follow their guidelines. While their advice largely was heart-felt and honest, it often failed to transfer to settings other than their relatively unique ones, and to apply in a world that was rapidly changing.

In place of personal testimony of successful leaders, more systematic collection of experiences and more scientific study of leadership
effectiveness in different contexts have arisen. Examples of the “collections of experiences” include the work of Kouzes and Posner (2012b) and Collins (2001a, 2011). Recognition of the importance of context for leadership is reflected in such work as Hickman (2010).

Academic study and associated scientific research on the topic of leadership, while still relatively young, have added to the possibility that evidence-based leadership is now more than a dream.

Another important recent development has been application of the concept of competency in the fields of education and training. Competency models provide an anchor for translating knowledge to action, and public health has taken a strong position of leadership and support in the competency development movement. Several competency models for public health leadership and for diverse segments of public health work have emerged via consensus development of leadership competencies over the past two decades, as well as novel efforts to train public health leaders. Key examples of these competency models are reviewed in Chapter 2.

As a result, there is a foundation of knowledge to guide public health leaders that is stronger than ever. There are substantial bodies of accumulated knowledge about leadership that are (1) generic (shared across public and private sectors) and (2) customized to public health. Public health practitioners and students need to attain that knowledge and the skills to apply the knowledge. This book attempts to provide that foundational direction for those who choose to live a life of leadership.

**Leadership Leverages Individual Contribution**

Why pursue leadership as an individual? Leadership creates value for individuals and for society because it multiplies the effect an individual can have on the world. It makes individual lives more productive on many dimensions and thus, for many, more fulfilling. Leadership feeds the need to “be all that you can be” for many individuals.

This enhanced productivity of individual public health practitioners (through leadership) pays dividends to the profession of public health. Those who support professionalization of the field of public health note the need for practitioners and academics to convince elites, particularly those with power in the policy sphere, of the value of public health knowledge (Evashwick, Begun, & Finnegan, 2013). A more energized and proactive public health workforce creates the opportunity for a more respected and powerful role for public health practitioners. A vision for the future would be for the next U.S. Institute of Medicine
report on the future of public health to marvel at the increase in the influence and effectiveness of the public health sector in driving better health outcomes and helping to solve some of the greatest economic and human challenges faced by the nation.

**Leadership Can Be Learned**

Leadership is learnable, through mastery of its competencies. Leadership competencies are easier for some to learn. Indeed, they seem natural for a few, because some leadership competencies (for example, inspiring others) are easier to master for those with specific personality traits and values that are difficult to “learn” and are hard to change. But there are few, if any, who cannot learn to be effective leaders, regardless of their starting point. Values can and do change with learning. Leadership behavior can be exhibited by all personality types. Being timid, for example, is no excuse to avoid leadership activity, though it makes leadership harder to undertake on one’s own. At the same time, those who find leadership competencies easier to attain can still benefit by being intentional about improving those competencies. Current public health leaders and future leaders can continuously learn new knowledge and skills.

Still, proactive pursuit of leadership competencies is not easy or natural for many. It requires forethought and hard work. We comment more on the requirements for learning in Chapter 4 (on knowledge for public health) and in Chapter 10 (on lifelong learning).

**Leadership Differs From Management**

It is useful analytically to separate the concept of leadership from another common term that also describes the work of organizing and directing individuals, teams, organizations, communities, and societies—management. The two concepts have much in common, but there is value in separating the concepts of leadership and management (Taylor, 2012, pp. 2–5). Education and practice in leadership can add meaning and impact to both management and non-management careers.

Management means getting things done, as does leadership. Critically, though, leadership works through mobilizing others in situations and to a depth that requires tools not necessarily possessed by managers. Managers rely on authority in order to mobilize others; leaders inspire others through discovering common purpose and passion. A common adage asserts that management refers to *doing things
leadership refers to *doing the right things*. This adage reflects the importance of values and choice in mobilizing others. Management involves realism and execution. Leadership combines realism with idealism and execution with inspiration.

Other distinctions between management and leadership include the notion that managers focus on efficiency (doing the most with the least), while leaders focus on effectiveness (goal attainment). This distinction relates to the shorter-term and operational focus of management compared with the longer-term and strategic focus of leadership. Often, the distinction between managers and leaders in organizations is based on position in a hierarchy. Those at higher levels (leaders) have more control over resources and decisions related to vision, mission, and strategy.

Ideally, managers would have the competencies of leaders, and leaders would have the competencies of managers. In practice, there is substantial overlap. Many good managers have the potential for greater impact by becoming good leaders, and good leaders are made even better by being good managers. For this reason, the leadership competencies in this book include some elements of effective management, but the competencies go well beyond effective management.

**Resources Are There; Somebody Will Get Them**

Resources devoted to population health exist in all societies. Access to basic health care services, including many preventive measures, is a basic right in most countries for that reason. Governments recognize the value of a healthy population, and individuals sacrifice almost anything to achieve health. Some would argue that the absence of abundant resources devoted specifically to public health is an insurmountable problem in the sense that public health leaders can ask, but they will not get. But the distribution of resources within the health sector is subject to change, as is the distribution of resources devoted to health versus other sectors, like defense. As noted above, public health could improve on the allocation of (1) health sector resources to public health versus medical care and (2) societal resources to social and welfare services relative to health services. As well, the allocation of resources to the health and social services sector versus other sectors, such as defense, is a political decision.

Proponents of medical care expenditures and solutions are both allies and competitors of public health, in regard to changing the balance of resource allocation. They are allies because they are often in the best position to help argue for increasing the “total size of the pie”—increasing
resources to the health sector, including public health. They may join in arguing for giving a bigger piece of the pie to public health. But proponents of medical care solutions may at the same time be competitors for a share of limited and scarce resource.

Leadership Is Not for Everyone

Leadership activities and roles are not for everyone, despite the fact that everyone has the potential to perform leadership competencies. Some individuals do not find leadership activities and roles rewarding, preferring careers in which they are not responsible directly for influencing others to take action on public health challenges. Their activities and roles are just as important to the profession as leadership activities and roles, and they often contribute to achieving the goals of leadership (“mobilizing people, organizations, and communities to effectively tackle tough public health challenges”) in other ways. A public health researcher contributes by adding to the evidence base for public health interventions. A public health teacher contributes by educating new generations of practitioners. Public health practitioners in any specialty contribute by doing their jobs conscientiously, both helping to apply public health solutions and serving as role models for colleagues.

Leadership in the form of full-time, public, or high-profile activity, utilizing the full range of leadership competencies, is not easy. It exposes individuals to failure and disappointment. It pushes individuals outside of their comfort zones. It does not guarantee personal success, happiness, wealth, promotion, or respect. Leadership is not for everyone.

Leadership Is Only Part of the Solution

The “romance of leadership” is the tendency to assign too much causal attribution to the actions of leaders on the outcomes (both positive and negative) of organized systems (Meindl, Ehrlich, & Dukerich, 1985). This tendency derives from our desire to assign causation in general and to cope with uncertainty, with leaders being a simple and easily identifiable answer to the question, “Why did things work (or not work)?” The romance of leadership causes many people to ascribe magical powers to leaders and leadership. Leaders do not have magic wands. Their ability to exert influence is constrained by the receptiveness of the cultural, social, and political structures and conditions that they attempt to influence. Systems thinking and public health thinking emphasize the
causal supremacy of underlying social, cultural, economic, and political conditions.

Several forces will continue to limit the influence of public health leaders. First is the role of private corporations in the political systems of governments, particularly in the United States. Private corporations lobby for policies that often conflict with a public health approach. Lobbies for the tobacco, food, and chemical industries have resources to influence legislation that promotes sale of their products. Medical equipment manufacturing and pharmaceutical companies are in a similar position with regard to emphasizing intervention rather than prevention of illness. As we have noted, the proponents of clinical care, to the extent that they argue for resources that could otherwise go to public health, are another powerful force limiting public health success.

Second, strong cultural forces reinforce investment in short-term intervention for health problems rather than long-term, public health solutions. Societal culture supports the allure of heroic intervention to cure disease after it appears, rather than preventing it. The popularity of television shows about medical detective work and emergency room and inpatient hospital care are examples of this popularity.

Third, much of public health is provided by publicly funded organizations that are expected to “do their job” and avoid taking controversial stands on policy issues. They are not expected to be advocates for transformational change, but bureaucrats who administer programs paid for by others (taxpayers). Even among legislators and administrators who are “pro-public health,” there are legitimately different views about the proper role of government versus individual freedoms and responsibilities. There is an ethical and legal argument for constraining the role of public health largely to the control of communicable diseases (Epstein, 2003).

Finally, corruption, nepotism, authoritarianism, and other human and organizational “bad behavior” challenge not only public health but most public policy initiatives and constrain the influence of leaders driven by the general good. Many potential public health leaders are constrained by their position in organizations that are not well led.

While recognizing that leadership alone will not drive change and effectiveness, a source of optimism is that the notion of “leaders” used here (and increasingly in other settings) refers to all of us, rather than one individual at the head of a program, organization, or community. The power of “all of us” as leaders is much stronger than the power of a single, formal leader. Second, if underlying conditions and environments are to be changed, leaders should try to shape that change rather than leaving it to other forces (like nature, resource scarcity, religious
belief, technological change, and the host of forces driving the future of our societies and cultures). Leadership can affect all levels of the frameworks proposed by Frieden and others discussed above. Indeed, only leadership can affect all the moving parts of pieces of the complex systems that determine population health. Public health is fundamentally about making change, and since making change requires leadership, greater public health effectiveness requires greater leadership effectiveness.

CONCLUSION

We define leadership in public health as mobilizing people, organizations, and communities to effectively tackle tough public health challenges. The time is ripe for a radical expansion of public health leadership. Public health has a proven track record and growing evidence base for the creation of value in the use of scarce resources. Past solutions dependent on a narrow model of health problem causation have fallen far short of expectations. Challenges that require value-driven, long-term fixes continue to multiply.

It has been said that radical change is most likely under conditions of crisis, consensus, or bold leadership. A health care crisis exists around cost, quality, and access. There is growing consensus that supports a social determinants model of causation. A renewed push to mobilize people, organizations, and communities to tackle tough public health challenges can ensure that the upcoming decades demonstrate wiser use of scarce resources to improve population health.