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JLN Editorial on Technical Sophistication of Public Health Agency Leadership

Note: this was initially drafted as a Letter to the Editor of Health Affairs in response to the Tilson, Beitch, and Gebbie “Infrastructure” papers in the July/August 2006 issue of Health Affairs. It was not submitted because it was 2.5 times the length allowed for a letter to the editor, but, still, somehow, not enough to be submitted as an independent paper. It has now been submitted to the Institute of Medicine as one of three papers relevant to the presentation to be made by JLN to the IOM Committee on Training Physicians for Public Health Careers at their October 5 meeting.

Tilson and Berkowitz, in the July/August 2006 issue of *Health Affairs*¹ note that the 1998 IOM Report² declared that our public health infrastructure was in “disarray” and that, now, eight years later – it is still in disarray. This paper and the two that follow (Beitsch³ and Gebbie⁴) discuss this state of disarray, and a variety of approaches by which it might be addressed.

I would like to add several observations and a proposed approach not considered in these three fine papers. My remarks will be limited to state and local governmental public health agencies – the heart of, but not the entire public health infrastructure.

The most critically important issue not addressed in any of these papers is the technical sophistication of the top-level leadership in these public health agencies. They all talk in general terms about the “workforce,” not addressing the critical importance of the technical, administrative and policy sophistication of the agency director and his or her inner circle – and the fact that these are the individuals who determine the qualifications needed for others within the agency.

There is no consistency to the professional qualifications of the agency director, and no information as to the qualifications of other members of the management team. Both ASTHO and NACCHO survey data⁵⁻⁷ show physicians, other health professionals, attorneys, non-health administrators and persons from a variety of other backgrounds heading up state and local public health agencies.

Herein lies the problem. Public health management and policy direction, if it is to be effective in meeting community needs is an exceedingly complex endeavor requiring both classroom training and supervised mentorship.

If, on a purely theoretical basis, one considers the ideal profile for the director or leadership team for a state and local public health agencies, one comes up with an individual or team that has a physician’s knowledge of human biology, the causation and natural history of health related conditions, and the efficacy of both preventive and therapeutic measures. In addition, one needs an in-depth understanding of epidemiology to enable scientifically valid analysis of local health-related issues, plus the management

and policy skills to manage and guide the public health agency and provide the community leadership envisioned in the IOM mandated “assessment, policy development and assessment” functions.²

There is, in fact, a group of individuals specifically trained, mentored and certified to do this work. I am referring to physicians, board certified in “General Preventive Medicine/Public Health” (GPM/PH) as their medical specialty. While there are in excess of 3000 such physicians in the United States, relatively few are employed in major leadership positions in state and local public health agencies because of local pressures by other physicians and by non-physicians for such positions, and a lack of clear national guidance as to the leadership needs of state and local public health agencies.

The difference between a physician securing an MPH degree, versus both the MPH and one-year public health practicum needed for board certification in GPH/PH is critical. A clinician securing an MPH degree is likely to come out with the impression that there is nothing of substance to public health management and policy skills – that they are simply a matter of “flying by the seat of one’s pants” – and doing what any reasonable person would do. Such physicians (and other clinicians) are also likely to fail to comprehend the difference between managing patients one at a time, and applying medical knowledge and skills on a population basis. The only practical way to address these problems is to have the clinician undertake real-life public health responsibilities, under the mentorship of a skilled supervisor. By this means the clinician can begin to appreciate the complexity of public health issues, the differences between clinical and public health collaboration and teamwork, and the kinds of benefits that can only be secured through teamwork and community orientation.

The available literature on the public health workforce^{8,9} is not helpful in that it does not separate physician roles within public health agency by type of role (policy/management, technical/epidemiologic, and clinical) and does not separately tabulate GPM/PH physicians from physicians with only an MPH, or without any public health training. Furthermore, none of these studies^{8,9} relates the technical qualifications of agency leadership to objective measures of agency performance.

Both voluntary and mandatory accreditation of public health agencies has been under active discussion since at least the mid 1970’s. It seems clear, in retrospect, that the “disarray” in our public health infrastructure declared by the 1988 IOM report² was clearly apparent by then. During that period, the federal government initiated what is now a long series of reports dealing with health department standards, guidelines and goals. The accreditation discussions, then and now, have been stymied by the same considerations – 1) if one set the standards high enough to be meaningful, few public health agencies would meet them; 2) If one watered them down to the level that most agencies could meet them – they would be functionally meaningless; and 3) Then-current (and now-current) public health agency leadership, as represented in both ASTHO and NACCHO will never concur on guidelines that suggest that current leadership individuals or teams do not have the skills and ability needed to properly strengthen our public health infrastructure.

An alternate approach is required if we are to dramatically reduce or eliminate the “disarray” in our public health infrastructure. The first element would have to consist of educating state and local appointing authorities to the knowledge, skills and abilities needed by public health agency leaders if the full range community needs are to be effectively met. The second element will involve identifying the qualifications that meet these needs. The third will be to assure that the training “pipeline” is configured to meet these needs.

Moving in this direction would also set the stage by which the studies can then be done to refine our impressions of the technical and leadership skills needed within our public health infrastructure if this infrastructure is to meet our collective needs for public health protections, services and policy guidance.

The most obvious set of qualifications to meet these needs is physician board certification in GPM/PH. The most obvious place to provide the needed mentorship will be within teaching health departments – a number of which already exist, and others of which could be developed within just a few years.

Not all state and local health directors need be physicians board certified in GPM/PH. One can easily imagine leadership teams where the agency director is not such a physician, provided that the director recognizes the need for GPM/PH guidance when dealing with major policy and management decisions. There are also large numbers of very small public health agencies where it would be impractical to hire GPM/PH physicians in a full-time policy/management capacity. In those cases, the leadership and policy guidance would have to be provided by or through the state public health agency. Since GPM/PH physicians are also capable of covering epidemiology/disease control and clinical roles – it is often possible to hire a single GPM/PH physician to play multiple roles within the agency – most commonly (in smaller local agencies) as both Director and clinic doctor.

Transition to higher levels of public health leadership can and should proceed within a three to ten year period. With state public health agency directors having a mean tenure of less than two years, and local health directors with a mean tenure of approximately six years – there is plenty of opportunity for creative change. This transition period is long enough to provide the time needed to expand and create anew the residency/practicum programs needed to generate the physician and other manpower needed to meet these expanded public health job marketplace needs.

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