



**PUBLIC HEALTH LEADERSHIP
IN THE 21ST CENTURY**

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INTRODUCTION

Leadership in public health requires stretching the mind and soul in almost unimaginable ways. Living the dynamic tension of health as “part individual good served by medicine and part public good secured by public health activities” (Institute of Medicine, 2003a) represents a privilege and an awesome responsibility. Upholding the health of others requires complementing a foundation in science with skills in government, policy, media, economics, sociology, ethics and other dimensions. To survive and thrive, public health leaders must practice the “tactics of the transcendent” (Parks, 2005).

Many lament that public health today suffers from a leadership void. In fact, the hunger for leadership has only deepened amidst the wide array of fresh challenges in the intensely globalized context of the 21st century. The public health conundrums of last century, such as cardiovascular disease, cancer, and substance abuse, have already been complicated by a new century featuring “unthinkable and unspeakable acts” such as bioterrorism and anthrax (Mitroff, 2004). Moreover, major public health advances have dramatically extended the quantity and quality of life for many, but by no means for all. Glaring disparities between rich and poor have sparked ethical debates and moral outrage about how best to deploy limited health resources in a time of limitless health challenges.

We live in “volatile times in an increasingly morally ambiguous world” (Parks, 2005). To advance public health, several landmark reports from the Institute of Medicine (IOM) (Institute of Medicine, 2003a, 2003b; Institute of Medicine. Committee for the Study of the Future of Public Health, 1988) recommend reinvigorated leadership training to bolster this fragile field, saying “Today, the need for leaders is too great to leave their emergence to chance.” In this paper, we first explore the ever dynamic and increasingly interdisciplinary nature of public health, a field dimly understood by too many. Then, we highlight some key leadership themes that have particular relevance to public health. Finally, we summarize some specific efforts to advance public health leadership education at the national, state and local level, with special emphasis on the community.

I. UNDERSTANDING PUBLIC HEALTH

Public health, defined by the IOM as “fulfilling society’s interest in assuring conditions in which people can be healthy” (Institute of Medicine, 2003a), has led to dramatic improvements in people’s lives. As a prominent example, from 1900 through 2002, U.S. life expectancy at birth rose from 48 to 75 years (men) and from 51 to 80 years (women) (National Center for Health Statistics, 2005). The U.S. Centers for Disease Control and Prevention (CDC) has attributed a substantial portion of this improvement in mortality and morbidity to the “Ten Great Public Health Achievements” of the century, namely vaccination, motor vehicle safety, safer workplaces, control of infectious diseases, decline in deaths from coronary heart disease and stroke, safer and healthier foods, healthier mothers and babies, family planning, fluoridation of drinking water, and recognition of tobacco use as a health hazard (Centers for Disease Control and Prevention (CDC), 1999). Such achievements exemplify not only the benefits of treatment but also the power of prevention.

Yet, despite these strides, America and the world continue to fall far short of optimal physical and emotional well-being. In the U.S., the Department of Health and Human Services (DHHS) has promoted the *Healthy People 2010* blueprint for health objectives for the nation (U.S. Department of Health and Human Services, 2000). Achieving at least some of the objectives for the 10 leading health indicators (physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health,

injury and violence, environmental quality, immunization and access to health care) could prevent up to half of 2.4 million annual deaths. Furthermore, in 2000, the global community set forth the historic *Millennium Development Goals*, establishing eight sets of benchmarks to be reached by 2015. The World Health Organization (WHO) has assumed international leadership with respect to the three goals specifically related to health: 1) to reduce death during pregnancy and childbirth; 2) to reduce child mortality; and 3) to combat major communicable diseases, particularly HIV/AIDS and malaria. An overriding objective, that relates to all eight benchmarks, is to eradicate extreme poverty and hunger (World Health Organization, 2006).

Reaching these goals requires substantial and sustained societal understanding and support. Yet such support is often erratic or not forthcoming, as the field remains chronically undervalued, underappreciated and, not frequently, under siege. In fact, in 1999, when a national telephone survey asked “When you hear the term ‘public health’ what do you think of?,” 57% of respondents could not define it as either protecting the population from disease or programs that promote healthy living conditions for everyone (Centers for Disease Control and Prevention (CDC), 2000).

To illustrate the challenges (Institute of Medicine, 2003b), first consider the sharp, well-defined image of the health care professional—that is, one who heals individual patients. Patients and providers alike fully understand the common agenda and what constitutes success. As part of a personal service ethic to heal and cure, the clinician employs a narrow range of focused interventions, such as medications or surgery (Institute of Medicine, 2003b). Traditionally educated in the biologic sciences, the clinician must meet well-defined standards in clinical training, licensing and certification in order to serve. In contrast, consider the blurry image of the public health practitioner (Turnock, 2004)—that is, the professional who prevents disease among populations. As part of a public service ethic, this professional employs a wide array of broad interventions that may have medical, legal, or regulatory overtones. Such interventions can be concrete, such as immunizations or food inspection. Other interventions may be broad, such as promulgations to uphold environmental safety standards or to enforce isolation and quarantine, in efforts to achieve the greatest good for the greatest number. Consensus on what constitutes success may be elusive, especially since society places disproportionately greater attention to spectacular biomedical advances rather than everyday prevention (Institute of Medicine, 2003a). Furthermore many such practitioners are trained on the job, not necessarily in a school of public health.

In this context, leaders must contend with a vast, multifactorial universe constantly in evolution. Those accepting the leadership challenge in public health must understand and respect the seven unique features of the field described by Turnock (Turnock, 2004):

A) Social Justice Philosophy

Public health promotes the common good. The preamble to the Constitution of the World Health Organization notes that “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” (H. Koh, Tavares & Pavlos, 2003). Promoting these rights requires fairness in the distribution of the responsibilities and benefits of health. But growing research has documented that “within countries and within regions, the divisions between rich and poor, health and disease remain sharp” (Bloom, 2005). For example, in the poorest nations, half the children die before age five. But even a country as wealthy as the United States also features striking disparities, one example

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being that about 88% of white men in the U.S. reach age 65 but only 76% of African American men do (Bloom, 2005). Such disparities prompt one expert to conclude that “this huge loss of life, reflecting the very different social and economic circumstances in which people live, stands as a stark abuse of human rights” (Wilkinson, 2005).

Promoting public health also raises provocative ethical questions about just approaches to improve social outcomes. In the face of limited seasonal influenza vaccine, how justifiable are new guidelines recommending that certain subpopulations have higher priority for immunization? What policy changes are required to eliminate disparities in U.S. infant mortality rates, which remain over twice as high in black mothers compared to white mothers? How much of a public health budget should be spent on nursing home care for elders as opposed to vaccinations for children? Such issues trouble public health leaders and indeed all in the field (Northouse, 2004).

B) Grounding in Data and the Sciences

Some would define public health as “science in the service to society.” Public health assessments and interventions, grounded in medical data, involve many other fields of science as well. Whereas the public traditionally supports and understands the nature of the medical and physical sciences, it is less familiar with the social sciences such as anthropology, sociology, and psychology. Even epidemiology, the bedrock of public health science, is not well understood or appreciated by many. Moreover, while national surveillance systems are well established for areas such as vital statistics (births, deaths) and cancer, robust data and monitoring systems are lacking for many other areas such as asthma or autism. Sustaining public funding for such systems to monitor public health trends remains a never ending challenge. Meanwhile, when leaders are asked to craft “reasonable” public health recommendations, the lack of definitive data in so many areas, leaves the field susceptible to more subjective influences.

C) Dynamic, Ever Expanding Agenda

Public health in the early 20th century focused primarily on issues such as infectious diseases, and the health needs of mothers and infants. Later, the agenda expanded to include chronic disease epidemics, such as cancer and cardiovascular disease. Still other issues such as tobacco addiction and substance abuse, mental illness, teen pregnancy, long term care, HIV/AIDS, diabetes, health care reform, rising health care costs, and covering the uninsured added to a growing list. Now, the 21st century has already proven to be the era of global emergency preparedness, with deadly pathogens seemingly only a plane flight away.

Moreover, experts have traditionally divided health issues into those pertaining to “developing” versus “developed” countries, but such distinctions have blurred in the context of shifting demographics. The dynamic flux of the public health agenda includes the aging of populations, rural groups moving to urban areas, and women bearing fewer children. Furthermore, countries undergoing rapid economic expansion, such as India and China, are now confronting public health challenges (such as obesity and type II diabetes) similar to the United States (Bloom, 2005). In fact, some experts project that if left unchecked, the U.S. obesity epidemic may cause the steady rise in life expectancy during the past two centuries to come to an end (Olshansky, et al., 2005).

D) Link with Government

Public health requires an intimate knowledge of working either in or with government. In meeting its multitude of responsibilities to the public, government implements policies to influence health or directly provide programs and services (Turnock, 2004). As one major example, government funded health insur-

ance (such as Medicare, Medicaid, military, and the State Children’s Health Insurance Plan) covers about 30% of the U.S. population (“Census Bureau Home Page”). Furthermore, government supports medical and public health research (through agencies such as the National Institutes of Health [NIH] with its \$29 billion dollar budget) and also enforces safety standards in areas ranging from sewage and water systems to drug safety. In addition, government can promote health messages through social marketing campaigns and enforce isolation and quarantine of individuals in the face of an epidemic. When public health interventions potentially limit personal and property rights on behalf of community needs, tensions inevitably erupt. Furthermore, leaders understand that their decisions may upset the delicate balance between regulation and free enterprise or between federal, state and local authorities (Turnock, 2004). As this balance of rights and freedoms vary by region, culture and country, what constitutes a “reasonable” public health intervention in one setting may be viewed as completely unreasonable in another.

E) Use of Prevention as a Prime Strategy

Public health acknowledges the primacy of prevention. For example, prevention of substance abuse, especially tobacco addiction, could potentially save millions of lives (Koh, et al., 2005). But success with prevention is not visible and therefore never fully appreciated. Prevention sounds easy, but it’s not. Too often, “an ounce of prevention—is a ton of work” (Koh, et al., 1993). Nevertheless, over centuries, public health professionals have documented the value of prevention resulting in reduced death and suffering. Or as Professor June Osborn once noted “If we do preventive medicine and public health right, then nothing happens and it is very boring. We should all be praying for boredom” (Coates & Collins, 1998).

F) Inherently Political Nature

Every part of society has a stake in public health. The multiplicity of stakeholders commonly leads to differences in values and perspectives with respect to “the ends to be achieved and the means for achieving those ends.” The question of whose responsibility it is to promote health often result in a “collision of worlds” (Parks, 2005). Inherently, then, this milieu is one of politics, first defined in Plato’s dialogues as “the pursuit and exercise of power—in the interest of those who pursue and exercise it” (Tucker, 1995). Others define politics as “the way people decide who gets what, when, where, how and why...” (McDonough, 2000).

Many enter public health as passionate advocates, making deep commitments to prevent the suffering that they or their families have personally experienced. Those seeking to address unacceptable wrongs may have heightened expectations and demands on leaders and those in authority, particularly government officials. This introduces many added dimensions of emotion. Advocates are often absolutely passionate about what they believe—and oftentimes they will not rest until everyone else agrees with them. In this context, advocates must be careful not to let passions blind them to the passions of others. Leading in this universe at times requires “orchestrating the conflict” (Heifetz, 1994; Parks, 2005).

G) Uncommon Culture and Bond

Today, a “typical” public health meeting may feature doctors, nurses, occupational therapists, social workers, government officials, business leaders, advocates, payers, providers, researchers, media experts, sanitarians and of course, concerned members of the lay public. After 9/11, such meetings are more likely to include police, fire, and emergency medical services personnel. This diversity of perspectives creates a rich uncommon culture that links professionals from diverse backgrounds with common goals.

The common link of these professionals is the three core functions of assessment (e.g., monitor health status and identify community health problems), policy development (e.g., inform, education mobilize community partnerships and empower people) and assurance. Table 1 summarizes the three core functions and ten essential services that constitute the fundamental mission of the field. Public health leaders live this mission daily, as noted below.

TABLE 1

THE THREE CORE PUBLIC HEALTH FUNCTIONS OF PUBLIC HEALTH
Assessment and monitoring of the health of communities and populations at risk to identify health problems and priorities;
Formulating public policies, in collaboration with community and government leaders, designed to solve identified local and national health problems and priorities;
Assuring that all populations have access to appropriate and cost-effective care, including health promotion and disease prevention services, and evaluation of the effectiveness of that care.

THE TEN ESSENTIAL PUBLIC HEALTH SERVICES*
Monitor health status to identify community health problems
Diagnose and investigate health problems and health hazards in the community
Inform, educate, and empower people about health issues
Mobilize community partnerships to identify and solve health problems
Develop policies and plans that support individual and community health efforts
Enforce laws and regulations that protect health and ensure safety
Link people to needed personal health services and assure the provision of health care when otherwise unavailable
Assure a competent public health and personal health care workforce
Evaluate effectiveness, accessibility, and quality of personal and population-based health services
Research for new insights and innovative solutions to health problems

* From the Association of Schools of Public Health. Adopted: Fall 1994, Source: Public Health Functions Steering Committee, Members (July 1995): American Public Health Association, Association of Schools of Public Health, Association of State and Territorial Health Officials, Environmental Council of the States, National Association of County and City Health Officials, National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Program Directors, Public Health Foundation, U.S. Public Health Service—*Agency for Health Care Policy and Research, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office of the Assistant Secretary for Health Substance Abuse and Mental Health Services Administration.*

II. UNDERSTANDING THE DIMENSIONS OF PUBLIC HEALTH LEADERSHIP

The increasingly volatile context of public health only fuels the hunger for authority figures to provide reassurance for our hopes and fears (Parks, 2005). In public health, we often seek ready answers from those with formal authority—for instance, heads of health agencies at the international, national, state, or local level. Such public figures may include the Director General of the WHO, the Secretary of the U.S. Department of Health and Human Services, the U.S. Surgeon General, and/or state health officials/commissioners. When those authority figures fall short of meeting expectations and demands, the public may be left feeling disconnected and unempowered. However, it is virtually impossible for any one person to master fully all the intricate dimensions of science, policy, budgets, programs, and press involved in this whirlwind. The modern model of leadership for public health will unlikely be the CEO with easy answers (Heifetz, 1994) but rather, the individual will more likely model what Block refers to as “the servant leader” (Block, 1996). Such an individual can join disparate voices together and foster change through open collaboration, while heeding Harry Truman’s words that “You can accomplish anything in life, provided you do not mind who gets the credit.”

The servant leader model of public health leadership involves at least seven competencies. Such a leader must:

A) Acknowledge the Unfamiliar and the Ambiguous

Public health leaders regularly encounter the unfamiliar. New challenges, such as Hurricane Katrina and SARS (Severe Acute Respiratory Syndrome), force a painful and powerful examination of what is often taken for granted. The U.S. anthrax attacks in the Fall 2001 forced an awkward merger of public health, emergency management, law enforcement and postal service investigators in creating a new post 9/11 public health infrastructure. Now, with the world nervously eyeing increases in human cases of H5N1 avian influenza in Asia and Europe, the possibility of a pandemic has exposed major gaps in worldwide surveillance, disease control, resources (such as vaccine and antiviral medications) and an overall lack of a sound public health infrastructure required to save lives.

Ambiguity is always one’s companion in public health, a field characterized by partial knowledge and uncertain outcomes. Rarely blessed with the luxury of rigorous studies with defined end points, leaders often find themselves intervening in the midst of public pressure based on minimal or incomplete data. In the classic public health example of over 150 years ago, Dr. John Snow reviewed death records of London residents who died from cholera and documented that most deceased persons had lived near and drank water from the Broad Street pump (Centers for Disease Control and Prevention, 2004). Removal of the pump handle prevented additional cholera deaths, supporting Snow’s unpopular theory that cholera was a waterborne disease. In fact the exact cause of cholera, *Vibrio cholerae*, was not identified for another three decades (Centers for Disease Control and Prevention, 2004).

Unlike Snow, today’s public health leaders rarely enjoy the benefits of a single dramatic intervention. They find themselves leading because they reject the status quo and demand change in an ambiguous world. An artful leader lives within the web of complexity, and senses potential creative opportunities and innovations as hidden issues surface and ripen (Parks, 2005). Such servant leaders may not necessarily seek a specific outcome. They rarely shrink from chaos, but rather, see it as an ally, and a starting point for change. In the words of Bridges, “Chaos is not a mess, but rather a primal state of pure energy to which

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the person returns for every true new beginning” (Bridges, 2003). Instead of being paralyzed by the breadth of concerns, leaders can focus on “their own circle of influence” which expands with attention (Covey, 1990). As that circle of influence evolves, one’s confidence grows, enabling an ability to address even more of the circle of concerns.

This ambiguous environment requires adaptive work, one part of the three types of work noted by Heifetz (as noted here with some examples from the medical world). In this model, Type I: Technical work is where the problem is clear and requires a “technical expert” who implements a clear solution (e.g., a patient with a broken bone finds the doctor who fixes the problem). In Type II: Technical and adaptive work, the problem definition is clear but the solution requires learning and shared responsibility of both the technical expert and the stakeholder (e.g., a patient with heart disease may need to change his way of life with respect to diet, exercise, cigarette addiction or stress. To change, the doctor offers broad solutions while the patient must also implement new priorities).

Public health usually finds itself wrestling with Type III: Adaptive work: the problem definition is not clear and technical fixes are not readily available. The situation calls for leadership that induces learning when even the health professional does not have a ready solution in mind. Learning is required to both define the problem and implement a solution. In situations such as creating health coverage systems to cover the uninsured, defining the appropriate parameters for genetic testing, eliminating homelessness, or preventing violence, authorities will face enormous pressure to “...offer more certainty and better promises.” (Heifetz, 1994; Parks, 2005). In response, such authorities “sometimes fake the remedy or take action that avoids the issue by skirting it...” (Heifetz, 1994; Parks, 2005).

Leadership in such instances may mean “giving the work back to the group” and “disappointing people at a rate they can bear” (Heifetz, 1994; Parks, 2005). Or, as McGriff has said, “Blessed are the flexible for they shall not be bent out of shape” (*Leadership Digest*, 2006). In such circumstances, one may need to humbly acknowledge Tolstoy’s belief that certain questions are put to human beings not so much that they should answer them but that they should spend a lifetime wrestling with them. Taking people out of the familiar promotes the growth of leaders to act as instruments of change.

B) Cultivate the Higher Value of Interdependence

In public health, the traditional leadership trait of fierce independence must give way to the higher value of fierce interdependence. In explaining this point, we contrast again the traditional medical leader and a modern day public health leader. The surgeon leader in an operating room practices his / her craft in a hierarchical manner, complete with a stream of doctor’s orders. This lead surgeon possesses all the requisite technical knowledge, expertise and skill to direct the team. However, in public health, the leader is more like the symphony maestro capable of playing perhaps several instruments but who must coordinate and blend the melodies of dozens more. Ideally, this servant leader focuses on results, not attention, all the while challenging himself and others. Such servant leaders create the space where others can be invited in.

Cultivating interdependence means understanding that at some level, everything is interrelated. One set of actions may trigger ripples of repercussions. Developing systems of care for intravenous drug users may reduce rates of other diseases (such as HIV and Hepatitis C) or improve conditions (such as homelessness, joblessness, domestic violence, or crime). Preventing the closure of a financially troubled hospital may not only save jobs there but also prevent diversion of ambulance traffic to busy neighboring emergency departments. An increase in cigarette taxes may not only decrease smoking rates but also provide funding for children’s health insurance.

C) Recognize Crisis Leadership as an Evolving Part of Public Health

We have entered an era where disasters have become the norm. Recent decades have given witness to such “normal accidents” including Three Mile Island (1979), the worst nuclear accident in U.S. history, the methylisocyanate gas release in Bhopal (1984) that left 3800 dead, and, more recently, Hurricane Katrina (Mitroff, 2004). Mitroff observes that “...one of the worst outcomes of a crisis is the collapse of fundamental assumptions about the world” (Mitroff, 2004). Surely this sentiment applies to the post 9/11 anthrax attacks where unknown perpetrators used the postal system to spread disease, and to Hurricane Katrina which literally submerged a city, while blowing the cover off health disparities affecting primarily poor, African American populations.

In the latter instance, tremendous media attention focused on the overwhelming recent inefficacy of the U.S. Federal Emergency Management Agency (FEMA) and its Director Michael Brown. Many articles lamented his inadequate training and performance in this national emergency, undoubtedly meeting Kellerman’s description of “bad leadership,” the dark side of the human condition (Kellerman, 2004).

Nevertheless, public health leaders should be mindful that the Director’s performance was only one manifestation of systems issues affecting public health in general and the growing pains of the new Department of Homeland Security (DHS) in particular. Public health planning for the unthinkable now means promoting systematic preparedness that cuts across all dimensions of society. In fact, as part of the new agenda for public health, DHS and DHHS are two major federal agencies striving to integrate preparedness efforts for such low probability, high consequence events.

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Crisis leadership today means fostering a new global interdependence that involves merging activities and reporting systems. As examples of such adaptive work, preparing for pandemic influenza involves international coordination of culling of poultry in rural parts of Asia and Europe, as well as attention to worldwide vaccine and antiviral drug development and distribution. Meanwhile attention to bolstering surveillance and “surge capacity” of medical staff, space and supplies, establishing fair guidelines for use of limited resources, and promoting optimal risk communication to regain the trust of an anxious public are all part of rejuvenating a global public health system to protect people in a time of crisis.

D) Understand the “Public” Part of Public Health Leadership

By definition, public health is public. Keohane notes that “the leader is always on duty, always on stage and anything she does is inescapably interpreted not as a private action, but as representing the organization itself” (Keohane, 2005). Bennis also warns of the trials and tribulations of being “on stage,” noting “You have to learn how to do the job in public, subjected to unsettling scrutiny of your every word and act, a situation that’s profoundly unnerving...Like it or not, as a new leader you are always on stage, and everything about you is fair game for comment, criticism, and interpretation (or misinterpretation). Your dress, your spouse, your table manners, your diction, your wit, your friends, your children, your children’s table manners—all will be inspected, dissected, and judged” (Bennis, 2004). At times, even the most trivial aspect of a leader’s profile seems worthy of a media attention. A recent newspaper article comparing the business suits of current NIH Director Dr. Elias Zerhouni to the more rumpled wardrobe of his predecessor is a poignant example of Bennis’s warnings (Harris, 2005).

Such scrutiny can be especially intense in public health, where so many differing passionate factions clash with conflicting expectations. Promoting change for many can represent costly loss for some. As a result, critics may “go after your character, your competence, or your family” in the hopes of leaving the leader marginalized or neutralized (Parks, 2005). In those times, leaders gain resolve from the words of David Gergen who has commented, “The toughest steel goes through the hottest fire” (Gergen, 2000).

Like the symphony maestro, the leader searches for the right dynamics and balance to emerge from unsettling cacophony. In fact, the maestro leader performing before an audience may oscillate from being the focus of intense attention to being rendered almost invisible. Focusing on the product and not the individual, s/he is content to set the tempo and tone, confident that the music will soon to flourish and flow.

E) Honor the Community

Healthy People 2010 states “the health of the individual is almost inseparable from the health of the larger community and that the health of every community...determines the overall health status of the Nation” (U.S. Department of Health and Human Services, 2000). Demonstrating honor and respect of community must be among the first actions of any new leader. In public health, a community can be defined in a multitude of ways. For some, it is one’s neighborhood, city, town, state, or country. For others, it is a group of professionals or committed volunteers focused on a particular disease area (cancer, heart disease, women’s health, HIV, for example). For still others, the community represents the globe. In a recent *U.S. News and World Report*, Drs. Paul Farmer and Jim Kim were honored as international public health leaders for improving the health of the global community through work in controlling HIV and tuberculosis (*U.S. News & World Report*, 2005).

Building community requires special commitment in a time of declining social capital where people are often “bowling alone” (Putnam, 2000). One way to envision a healthier community is through “scenario planning” promoted by The Shell Company. Scenario planning crystallizes mutual understanding of how today’s decisions, resulting from uncertain yet important driving forces, may affect the future. This group process, which creates a number of diverging stories about the future, serves also to minimize the expectation that identifying just the right leader will solve these challenging problems. It also reinforces the notion of the servant leader without ego. Typically, the scenario planning process is as follows:

- identify people who will contribute a wide range of perspectives
- conduct comprehensive interviews/workshop about how participants envision future shifts in society, economics, politics, and technology
- cluster or group these views into connected patterns and draw up a list of priorities (best ideas)
- sketch out pictures of the future based on these priorities (stories, rough scenarios)
- further develop detailed impact scenarios (determine how each scenario will affect the organization)
- identify early warning signals (indicative for a given scenario to unfold)
- monitor, evaluate and review scenarios

As one prominent example, in 1991, the “Mont Fleur Scenario” project energized South Africa during their tumultuous transition away from apartheid. The project assembled 22 prominent leaders from across South African society (including community activists, conservative politicians, African National Congress officials, trade unionists, academics, establishment economists, and corporate executives) to develop a set of alternative scenarios about the country’s future. The group settled on four possible scenarios, based on the norms that long defined their culture, and crafted a common awareness of the early

warning signals. Scenario planning engendered a common commitment to avoid potential problems and united many factions to learn more about the complexities of the situation. This powerful tool helped these “servant leaders” ensure that they were not bowling alone.

F) Nurture the Spirit

Public health leadership is fundamentally a matter of the soul, being awakened from within. The mission of preventing human suffering involves profound spirituality, defined by Coffin as “living the ordinary life extraordinarily well” (Coffin). Embracing the broader purpose of this mission for every community in an era of globalization requires both passion (to suffer) and compassion (to suffer with). Resonating with one’s inner passion and compassion can motivate a leader to be “alive in pain.” As Nouwen has noted “the great illusion of leadership is to think that man (and woman) can be led out of the desert by someone who has never been there” (Nouwen, 1972). Furthermore, he observes that “...the way out is the way in, that only by entering into communion with human suffering can relief be found” (Nouwen, 1972).

Not surprisingly, many public health leaders have been personally touched by the suffering they are struggling to prevent. Such figures have encouraged the “personal to become public” (Quinn, 2000). Quoting Block, Quinn writes: “Allowing the personal to become public is the act of responsibility that initiates cultural change and reforms organizations. Our need for privacy and fear of the personal are primary reasons why organizational change is more rhetoric than reality. Real change comes from our willingness to own our vulnerability, confess our failures, and acknowledge that many of our stories do not have a happy ending.” So, for example, Wendy J. Hamilton, former national president of Mothers Against Drunk Driving (MADD) was launched into activism through the tragedy of her family’s three separate drunk driving crashes (“Mothers Against Drunk Driving,” 2006). The late actor Christopher Reeve, who played Superman in action movies until a tragic accident reduced him to quadriplegic status, used the remaining years of his life to advocate for the rights of the disabled. Tobacco company executive Jeffrey Wigand, fired after trying to change the system from within, turned whistleblower to expose that the industry had long known that its product was addictive. Compassion frequently requires confrontation. All these leaders, after suffering a personal tragedy, identified the threads in their lives that represented their authentic core. Instead of turning inward and lingering in their pain, they focused outward to turn “pain into power.”

Nouwen has written that such individuals are “wounded healers,” who use their own pain as motivation to help prevent suffering for others. He relates the Talmud parable of such healers as “sitting among the poor covered with wounds. The others unbind all their wounds at the same time and then bind them up again. But he unbinds one at a time and binds it up again saying to himself, ‘Perhaps I shall be needed: if so I must always be ready’...” (Nouwen, 1972).

Spirituality for public health leaders also means understanding the fundamental question “Who tells you who you are?” For too many, the answer lies in the reassurance of external trappings, such as status, salary, or titles to bolster self-worth. Some even are defined by their enemies—that is, what they are against, as opposed to what they are for. In the policy world of government, many are asked to demonstrate their loyalty to authority figures to validate their value and self-identity. In such settings, one commonly encounters those who scramble to gain power through proximity, or in Gergen’s famous line “nothing propinqs like propinquity” (Gergen, 2000). But Coffin reminds us that if power is a requirement for self-identity, loss of power leads to loss of self (Coffin, 2001). Leaders may do better to focus on expressing oneself, not proving oneself. This helps one bear the inevitable slings and arrows of service and, in the words of Gergen, “absorb the punishment without surrendering your soul”(Gergen, 2000).

G) Hone Succinct, Concrete Communication

Public health leaders spend their careers trying to explain the complexity of their field to others. Clarifying the hazy image of prevention necessitates succinct, concrete communication that can cut through the fog. Such a task is complicated in a new century where communication channels proliferate at an accelerating pace. Gone are the days where media communications meant working with three major television networks. In the age where technology encourages personalized entertainment and information, the proliferation of web-based sites for information and dialogue has ironically led to fragmentation of audiences. Those communicating have less control about dissemination and interpretation of the message, an important issue in our increasingly diverse society (Viswanath, 2006).

Communicating public health through the mass media also requires understanding the different goals of the two fields. Atkin, Wallack and others summarize some of these differences (Nelson, 2002). The mass media reflects society and aims to entertain or inform, while public health promotes social change. Media usually address short term personal concerns, while public health addresses long term societal concerns. Mass media tends to provide certain answers while public health acknowledges uncertainty, realizing that conclusions can change.

To meet these challenges, effective prevention messages require concrete appeals to the proverbial man on the street. Sample messages could include:

- “Good health is a fragile gift, granted moment by moment.”
- “When prevention works, we live free from the bonds of HIV/AIDS. When prevention works, we live free from the bonds of tobacco addiction.”
- “When public health works, we enjoy the gift of seeing our children grow up to have children of their own.”
- “Public health protects not only every life but also every day of every life.”
- “Public health is dedicated to ‘saving lives, millions at a time’ (Johns Hopkins Bloomberg School of Public Health, 2004).”
- “Health care matters to all of us some of the time, (but) public health matters to all of us all of the time” (Koop, 1991).

III. TEACHING AND EDUCATION OF PUBLIC HEALTH LEADERSHIP IN THE UNITED STATES

Over the past several decades, public health leadership education in the United States has expanded at the national, state and local levels. Such training, augmented by lessons learned in leadership education in other sectors, may begin to fill the hunger and the void in these uncertain times. The programs noted below represent the beginning of a growing field.

A) National Education and Training

1) *Association of Schools of Public Health (ASPH) Competency Model Development in Leadership*

The nation’s public health schools have recognized leadership education as a critical priority. To this end, the Association of Schools of Public Health (ASPH) has promoted a Core MPH (Master of Public Health) Competency Model Development to establish uniform leadership competencies for students. While traditional public health fields (such as biostatistics and epidemiology) have previously established core competencies, defining them in the field of leadership breaks new ground. Establishing such competencies could provide the basis for long overdue national credentialing for public health professionals.

2) *National Public Health Leadership Institutes*

Since 1991, the Centers for Disease Control (CDC) have funded public health leadership institutes for state and regional based programs. These programs, formed through academic and practice collaborations among public health schools and state health departments, train approximately 1000 individuals annually. In 1994, the CDC, through a cooperative agreement with ASPH, established a Public Health Leadership Development Network managed by the Saint Louis University School of Public Health. The Network supports annual conferences, projects and publications (Rowitz, 2001; Wright, et al., 2000). From this initiative, Wright, et al. have published four major sets of competencies (core transformational competencies, political competencies, transorganizational competencies and team building competencies) as the major core of public health leadership training (Wright, et al., 2000). Recently these institutes and others have incorporated crisis leadership training through CDC-funded academic Centers for Public Health Preparedness and through a National Preparedness Leadership Initiative. Meanwhile, a National Center of Healthcare Leadership has promoted a competency model concerning transformation, execution and people (National Center for Healthcare Leadership, 2004).

B) State Education and Training

The high level of turnover in public health leadership at the state level, where the average tenure of health officials (i.e., state health directors or commissioners of public health) lasts only two years, seriously hampers continuity of operations. To counter this constant erosion, the Robert Wood Johnson Foundation began the State Health Leadership Initiative (SHLI) which is administered by the National Governors Association (“State Public Health.org,” 2006). Since its inception in 1999, the SHLI has not only created guides for governors / appointing authorities regarding the optimal selection and retention of state health officials, but also published orientation materials to help officials transition into these often turbulent jobs. In addition, in collaboration with the national Association of State and Territorial Health Officials and Harvard University’s Kennedy School of Government, the SHLI hosts leadership trainings that emphasize personalized skill building assessment and feedback. SHLI graduates point to improved confidence and enhanced professional growth resulting from this training.

C) Local Education and Training

As public health is firmly grounded in the local community, special educational efforts are required for grassroots leadership. Recently, the Blue Cross Blue Shield of Massachusetts Foundation launched an innovative Community Health Leadership Institute for those who serve the low income uninsured in the state. Planning and implementation of the Institute embodied the themes of collaborative leadership and adaptive work mentioned above. The organizers used the heavy input of a community advisory council of over 20 state leaders (representing advocacy groups, community based organizations, community health centers, state and city government) to plan a unique leadership curriculum for not-for-profit organizations serving the low income uninsured. The process led to the creation of a series of modules that included three key themes: learning to see one’s self as a leader, developing others, and creating change in the system through collaboration.

The organizers promote collaborative leadership, emphasizing personal development to identify the unique threads that define the leader within. Additional content includes working with the media and working with boards. The Institute is a 17-day residential program that began in October 2005 and continues each month until June 2006 with a highly experiential curriculum, including classroom work, peer-to-peer exchanges and collaborative learning. One measure of the Institute’s success will be an increased network of collaborative leaders involving many stakeholders in addressing the adaptive work issues facing health care leaders and consumers.

IV. CONCLUSION

The new public health leaders of the 21st century will be those who can mobilize, and motivate to the higher purpose of upholding the health of others. Promoting the power of prevention for all people in a global community requires special attention to the ambiguous and interdependent nature of our new world. Promoting routine prevention while preparing for the unthinkable remains part of the job. Emerging leaders must tap into their unique talents, passion and compassion to promote a mission of health for all in every community. As has been said:

“Go to the people
Learn from them,
Love, them,
Start with what they know,
Build on what they have,
But of best leaders,
When their task is accomplished,
Their work is done, the people will remark
‘We have done it ourselves’” (Levy, 1998).

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