Public Health Leadership and Management in the Era of Public Health 3.0

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In recent months, there has been a call to action for public health to "boldly expand the scope and reach of public health to address all factors that promote health and well-being including those related to economic development, education, transportation, food, environment, and housing."[1] This modernization, described as Public Health 3.0, would stretch the field beyond sanitation, epidemiology, and the recommendations from the Institute of Medicine's (IOM's) 1988 seminal report, *The Future of the Public's Health*.[2] In the era of Public Health 3.0, public health leaders work across sectors to address the social, environmental, and economic determinants of health. A report written by RESOLVE, with input from Robert Wood Johnson's Leadership Forum, further explains the future of public health and describes the role of local and state health departments as that of a *community chief health strategist*.[3] In this role, workers must be "…able to contribute to healthier communities" and federally aligned training programs are necessary to prepare workers to lead for collective impact.[3,4]

Importantly, these influential contributions recognize the leadership and management skills needed by the local and state public health workforce of the future. All too often, we focus on reducing disease-specific morbidity and mortality rather than the significant leadership and management skills needed to achieving the outcomes we desire most. In short, the challenge of creating a Public Health 3.0 workforce is less about subject matter expertise and the science of public health and more about building the leadership and management competencies of public health workers nationwide. To truly realize their roles as the community chief health strategists, more information is needed on how to better prepare our nation's more than 290 000 governmental public health workers in state and local health agencies nationwide for this new era of public health planning and strategy setting.[5]

The aforementioned 1988 IOM report set forth a similar forward-looking vision for the public health workforce. Following this report, core competencies were developed for public health generally and for specific disciplines within the field (eg, epidemiology, public health nursing, emergency preparedness). This led to expansive lists of needed skills, from which discerning priorities have proven difficult.

Along the lines of Public Health 2.0, most public health professionals identify more strongly with their specialty area or disease silo, often at the expense of a unified, consistent public health identity and shared vision required for Public Health 3.0. Given the limited resources available for public health, these unique interests often compete for legislative and public attention, as well as categorical funding. This competition discourages the creation of a unified set of strategic priorities based on community needs. Funding for workforce development follows this model, with the limited support available divided between competing interests, reducing the potential impact of those dollars and the availability of training and workforce development programs that are sorely needed. Categorical leadership development programs within public health reflect these divides. Attempts to "braid" or otherwise combine siloed work are often met with resistance by funding agencies and policy makers concerned about diluting the true intent of the investments or supplanting combined funds for other purposes in resource-strained local and state governments.

A specialized 2.0 workforce may perform specific programmatic work very well, but the workforce of today is not adequately prepared to address the Public Health 3.0 needs for crosscutting, multisector vision-setting and leadership in the future. There is a need for a much more concerted, coordinated effort to build foundational, high-performance skills. For

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example, leadership development and management skills along with policy development, communicating persuasively, and systems thinking are necessary for effective coalition building, collective impact, and facilitation of strategic discussions within and across sectors.[6] Regardless of our specialties, we must elevate these and similar skills to the same level as the core skills learned through our discipline-specific training and avoid competing with or replacing the skills our field has traditionally emphasized, rather, to complement our traditional skills allowing us to link perspectives and specialties from within public health to our partners in other disciplines such as transportation, agriculture, and housing. It will be these diverse connections and conversations that are the essence of the "chief health strategist" and Public Health 3.0.

Public health organizations and departments have developed and implemented various surveys to help improve their understanding of the workforce and identify workforce development needs. Although the information provided was invaluable, these efforts did not always gather individual worker perspectives across all of the categorically funded areas of public health, such as nursing, epidemiology, laboratory, maternal and child health, and environmental health. As a result, serious gaps remain in our understanding of public health workforce perspectives. While other fields, both private and public, have prioritized workforce development, a 25-year review conducted in 2012 found only 1 article on job satisfaction in governmental public health, which was limited to public health nurses. Other gaps included information on salary, workplace diversity, and the opinions, experiences, and attitudes of the public health workforce. Working separately, we may have identified a knowledge gap among a particular specialty, but we failed to capture if that need was widespread. Different methods, time frames, and content restricted our ability to combine or compare data.

In 2014, ASTHO and the de Beaumont Foundation partnered to address the gaps in our understanding of our workforce by fielding the first nationally representative survey to collect data from state health agency workers. The Public Health Workforce Interests and Needs Survey (PH WINS) provided first of its kind data on the public health workforce and allowed for cross-discipline, cross-state comparisons that were previously unavailable (Table).

With additional support from the de Beaumont Foundation, ASTHO engaged leaders throughout state health agencies and in the nation's largest cities to work together in a community of practice and shared learning to identify information-based workforce gaps as seen in their organizations' WINS data and develop strategies to improve these metrics.

With the success of PH WINS and the continuously evolving needs of the public health workforce, additional administrations of PH WINS (2017 and 2020) are planned. But, PH WINS is not just a data set. This survey represents the first major advancement and example of true alignment in our field, the potential to unite public health practitioners and researchers around the idea of an ongoing, centralized workforce assessment that can promote data-driven workforce planning throughout US health departments. By aligning behind a single, centralized assessment that can be tailored as appropriate and augmented when necessary, the time and support available for action increases, helping us reach the vision laid out by Public Health 3.0. But assessment is only one area. It is a great start, but we will need to develop other examples throughout the continuum of workforce development activities.

To realize the vision of Public Health 3.0 and fulfill the role of chief health strategists, the public health workforce should not be seen as something to develop within a specialty or silo but, rather, as a common good for the entire field of public health. Strategies and tactics of the past are not sufficient to meet the challenges of the future. We have the direction, but now we need to find the alignment between our priorities and constituencies to ensure the success of the entire public health workforce. To do this, we must

TABLE
Topic Areas Addressed in PH WINS (2014)

Workforce Preparedness for the Top Challenges It Will Face Over the Next 5 Years	Demographic characteristics of individual workers	Top training needs among various public health roles and program areas
Worker Perspectives on National Initiatives	Individual motivations to enter the field of public health	Factors contributing to job satisfaction
Aspects of the Workplace Environment Such As Morale and Job Satisfaction	The amount of turnover we expect to see in the next 5 y	Salary gaps by gender and race

Abbreviation: PH WINS, Public Health Workforce Interests and Needs Survey.

transition from individually focused to collectively focused leadership, which may be the first step needed on our path to Public Health 3.0.

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