The crescendo of seemingly intractable threats to our global well-being has prompted a call for more leaders in public health. Indeed, many highly motivated and well-intentioned individuals seem poised to respond. But as aspiring public health leaders prepare for action, there is a marked dearth of proven and tested teachings, models and frameworks to guide them. With relatively little public health literature on the topic, those hungry for leadership insights might understandably turn to the abundant lessons generated in the business, government, military and even sports sectors. However, such an approach not only overlooks the special nature of public health problems but also the unique opportunities that make leadership in public health a rich source of inspiration, frustration and fascination.

The special nature of public health problems

Public health problems pose special challenges. They are generally enormous in scale, stem from numerous and highly complex causes, play out in the public eye, impact a vast array of stakeholders and require unusually long-term solutions. The massive scope and complexity of such problems, including conditions such as uncontrolled childhood mortality, suboptimal maternal health, HIV/AIDS, cardiovascular disease and cancer, among others, affect millions worldwide. Furthermore, the health issues quickly trigger a host of other family, economic and social problems that ruin lives, erode communities and weaken countries.

Moreover, public health is always, by definition, ‘public’, often requiring its leaders to practice their craft ‘on stage’ in full view of admirers and critics alike. Multiple stakeholders demand and deserve transparency. The added dimension of media attention often magnifies tensions and complicates best efforts to conduct delicate and discrete negotiations among involved parties. Communicating about complex issues in these settings, particularly pertaining to long-term prevention, can be especially challenging.

The power to resolve or even address such enormous challenges usually lies well beyond the control of any single authority. Rather, sustainable solutions often demand broad societal level changes, requiring input not just from health experts but also from legal advisors, policymakers, ethicists and economists, among others. Other stakeholders can emerge from government agencies, non-government organizations, private companies, advocacy groups, religious leaders, philanthropies and local power brokers. This array of perspectives and opinions can lend a cacophony of voices to often sensitive and delicate decisions. In fact, vigorous disagreement on the goals or strategies required to solve far-reaching public health problems always characterizes the field. Sometimes, it is even difficult to gain consensus on defining the problem, much less determining a solution. Controversy, which may vary by context and culture, regularly accompanies questions regarding whether it is even ‘appropriate’ for government, the private sector, religious groups or others to be involved in potential solutions. Not surprisingly, the simultaneous collision of all these many dimensions often creates a sense of chaos.

The special opportunities of public health leadership

Leaders in public health are generally driven by a profound and fundamental sense of mission. A sense of purpose motivates them to leave the comfort of the sidelines and wade into controversy, despite the uncertainty of outcomes.
Many are ‘wounded healers’ \(^1\) who have suffered greatly but channel their pain into power for the common good. Their souls swell with both the passion and compassion of those who have seen suffering and want to stop it.

However, successful leaders must move beyond passion. In regularly tapping the realms of social strategy, political will and interpersonal skill, \(^1\) these individuals must also develop sophisticated, tactical leadership techniques that extend beyond running any single organization. \(^2\) The artful public health leader will be one who can function in an ambiguous arena without clear boundaries or hierarchies, using a chaotic context as a starting point for change. \(^1, 2\) Unlike in a corporate board room, public health rarely has a single desk where the buck stops. Absolutely essential, therefore, is the willingness and ability for the leader to be the team builder or even the unsung ‘backroom’ agent, forging and continually knitting together multiple, often unlikely, partners. \(^1, 2\)

Because of the relentlessly broad and interdisciplinary nature of the field, the leader must choreograph the seemingly limitless number of parties that may be distrustful competitors for scarce resources. Only by helping to identify a set of common goals where none may be readily apparent can one unite potentially unwilling partners and align a diverse set of viewpoints, objectives, resources and capabilities. Those expected to wield influence in this amorphous universe, often without formal authority, must hone the complex art of persuasion. \(^2\) In developing his or her coalition-building skills, the leader must demonstrate calm patience (at least outwardly) even in the midst of escalating problems and even be willing to make wrenching tradeoffs, if necessary. In short, an effective leader in this realm must model the value of interdependence, not independence. \(^1\)

Public health leaders understand that since quick fixes are rare, they must dedicate themselves to long-term, sustainable prevention that necessarily survives the tenure of any one individual or group. Immediate concerns are to secure ongoing funding, institutionalize procedures for constituent organizations and re-engage every new shift of players. However, even while putting in place complicated interventions for the present, public health leaders must also be actively recruiting those who will succeed them in the future.

We saw some of these principles put into practice through several of our own experiences in Massachusetts. One involved a unique public health initiative to close the gap between the need and the demand for donated organs. \(^3\) In our roles at that time as head of the state public health agency and a senior executive at the New England Organ Bank, we joined forces with CEO leaders of key hospital transplant centres to increase organ donation and decrease time for those on state waiting lists. \(^3\) After noting potentially valuable changes in hospital procedures to achieve these goals, but acknowledging the lack of any direct authority in the hospital-based transplant process, we aligned the state agency’s convening powers and the organ bank’s unique data-gathering capabilities to bring CEOs to the table.

Then, this energetic task force took off, collaboratively sharing statewide data, reviewing feedback about donation performance to individual hospitals, and collectively designing and implementing a unified intervention in a wide array of hospitals. The leadership group, initially composed of friendly competitors, became united as collaborators and in 18 months showed improvements in donations and significant increases in donation-related outcomes such as referral rates and consent rates. The initiative also served as a forerunner for a subsequent national programme. \(^3\) Nevertheless, sustainability was difficult, since turnover in the original group left few champions to keep the momentum going forward.

In a second example, in the early 1990s, Massachusetts served as a national leader in countering powerful tobacco industry influences. The state made history by being the second nationwide to pass a ballot initiative that levied an extra $0.25 tax per pack on cigarettes in order to fund a new statewide tobacco control programme. \(^4\) Passage required formation of a unique public health coalition that consisted of health experts, advocates, media experts, pollsters, lawyers, policymakers and thousands of grassroots volunteers. The tobacco industry fiercely resisted the tax hike and greatly outspent the coalition in terms of dollars and resources to fight it. Nevertheless, coalition leaders successfully leveraged this entourage of stakeholders to unite behind a tangible and visible campaign against the tobacco industry in a David versus Goliath struggle. \(^4, 5\)

After passage of the measure and subsequent launch of a statewide tobacco control programme, the ensuing decade saw the statewide adult per capita consumption of cigarettes decline by several times the rate seen in the rest of the country.

Although commitment to sustain the tobacco control program remains a major ongoing challenge, many states have subsequently used this model to advance similar programmes. Such efforts have received broad bipartisan support throughout much of the country. Furthermore, these experiences have generated critical data that led the Institute of Medicine \(^6\) and the World Health Organization \(^7\) to recommend such economic strategies as a key part of national and global tobacco control interventions.
Supporting future public health leaders

Aspiring public health leaders should not be left on their own to find guidance. Those with convening power can create new learning and teaching for the field by bringing together multiple parties, disseminating lessons learned from successful interventions and supporting those willing to take on the leadership challenge. Those who have successfully navigated these waters can share their insights as experienced change agents and coach those otherwise working in isolation, thereby providing another service in our service-oriented profession.

Academia is a natural place for such convening activity. In this spirit, the recently launched Harvard Advanced Leadership Initiative, an unprecedented collaboration of five Harvard graduate schools (Public Health, Government, Business, Law and Education) brings together accomplished senior leaders who are ready to become effective catalysts for innovative social change. An inaugural public health think tank, convening over 100 national and international leaders to explore concepts of advanced leadership in our field, has served as a starting point for growth. We hope to build on the lessons learned from this inaugural event to move public health leadership forward.

In short, public health requires its leaders to stretch their minds and souls in almost unimaginable ways. Public health has only recently begun to explore the potential of formal leadership education and training. Committing ourselves to furthering this worthy mission may well move us closer to realizing the World Health Organization’s goal of ‘the enjoyment of the highest attainable standard of health’ for every human being.

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References