Schools of Public Health in Transition

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Background—Schools of Public Health

One of the interesting things about the schools of public health of the United States is that they vary a great deal. When you put their programs all together they present an interesting variegated tapestry that is important to keep in mind as we consider the impact of what we've referred to today as the New Federalism. First, I will try to sketch in the background of the efforts of schools of public health. Then I will discuss the major issues that face those who take the responsibility for educating professional people to function in the public health movement.

The New Federalism provides a severe test for the schools. It has shaken the schools of public health to the core. In the long run that is probably not a bad thing. I could almost wish that some of the other health profession schools could be shaken just as severely. Dissatisfaction and concern about the effectiveness of one's role are clearly useful, although they cause discomfort.

The notion of establishing organized programs of education in institutes or schools for hygiene and public health is not new. It was developed in the nineteenth century in Europe. In 1899 in Britain, legislation was passed that required medical officers of health to have a diploma in public health. In the United States the first school of public health was developed at Johns Hopkins in 1916, and quickly, by 1922, there were three other schools at Yale, Columbia, and Harvard. These first four schools were in private universities. There was a lull until the thirties when four more schools emerged, this time in state universities, Michigan, Minnesota, North Carolina, and the University of California at Berkeley. The development of more schools was sporadic thereafter; by 1960, there were twelve schools. Since 1960 six more have arisen. We now have eighteen schools in the U.S.A., one-third of which are state institutions.

Not only have the schools grown in number, but the size, scope, and productiveness of their effort has increased, particularly in recent years. The schools themselves vary tremendously in size and scope. This is a unique characteristic of schools of public health in this country. When you think of schools of law, dentistry, and medicine, you can be pretty sure of the number and kinds of departments, and you can be fairly certain about their organization. Schools of public health vary a great deal more in their scope and departmental organization. They all have the basic public health sciences of epidemiology and biostatistics, and they all have a program in health administration. Beyond those, there is a great variation. These schools are unique also because they function with an interdisciplinary base, largely because they appreciate that prevention, organization of services, and the kind of change in society to which they are committed cannot take place without adequate recognition of the diverse factors in society that influence the health of people.

Though the bulk of graduates are in fields of administration, health education, statistics, epidemiology, and the environment, there has been a great deal of specialization developed in these schools in the last decade. The research efforts of these schools, by and large, have a special focus. They are directed mainly toward the problems of prevalence, prevention, and control of disease and evaluating the effectiveness of programs. There is inadequate recognition of the fact, for example, that the basic understanding of the epidemiology of coronary disease has largely come from the work of epidemiologists in the schools of public health. The framework and techniques for studying the utilization of health services and for evaluating the quality of health services also comes primarily from the work done in schools of public health. The concept of the HMO (Health Maintenance Organization) which today is getting so much attention is based upon the fundamental public health concept of dealing with the health problems of a designated population on a direct and planned basis and organizing services that will be adequately preventive, curative, and constructive, all at the same time. There is inadequate recognition that this involves a series of principles which, in point of fact, can clearly be found in the literature written by public health practitioners largely out of schools of public health.

I have sketched in this general background as a basis for

moving to consider the kinds of issues we have to face in order to progress in public health.

The federal administration currently urges progress and innovation in public health but withdraws financial support at the same time. It talks about revenue sharing but sets up a framework for revenue sharing that makes it difficult to arrange for funds that are at the disposal of state and local agencies to be used either for education or direct human services.

Present-day emphasis, from many responsible quarters, is on decentralization of administration, the strengthening of preventive measures, and changes in the health services system which will lead more directly toward effectiveness and economy. These objectives cannot be put into practice without an adequate supply of appropriately trained professional people. The readily evident need for such personnel makes it difficult to understand present federal health manpower policy, especially as applied to the public health profession.

Public Health as a Movement

Before presenting a set of basic issues that I believe schools of public health must face, it will be helpful to define public health. The Milbank Commission believes that public health is the effort organized by society to protect, promote, and restore the health and the quality of life of the people. Public health needs to be thought of as a movement. Its success is dependent upon many programs, services, and institutions contributing to these efforts. Their nature, scope, and effectiveness are dependent upon the understanding and support of society.

Schools of public health started out to be the staff colleges (like West Point) for public health leadership in this country and the world. Then, as is perfectly natural with institutions and human beings, they tended to concentrate on the field that had been successful and they continued their relationships with the agencies that kept doing things and thinking things in the same way, while all around them the problems were changing. Even though, for example, our schools of public health gave leadership to research on chronic diseases, they took very little responsibility for informing the public that the problems were changing and for helping to

stimulate the organization of public health services so that these agencies could indeed be ready to adequately undertake new responsibilities.

The current questioning of the validity of schools of public health is paralleled, if not greatly exceeded, by similar reservations about state and local departments of health. Those in charge of our national policy, as well as the public generally, are dissatisfied with the effectiveness and efficiency of our health system. Tinkering appears to be the tendency; we just need to turn this off and turn that on and everything will change, whereas it seems to me that what's involved is the whole problem of priorities, emphasis, and the relationship between a certain quantity of effort and a predictable result. And if anything reflects the attitude and the skills of public health it is the ability to evaluate the nature of a risk and the predicted value of a proposed intervention.

The new problems that face us, in the fields of personal health services, the environment, and health behavior, need to be dealt with by employing the social sciences, by giving even greater emphasis to epidemiology and to biostatistics, by focusing on the human physiological and pathological aspects of the environment, and by clearly thinking with this public health point of view about the organization of personal health services.

With that background, let me suggest ten issues that need attention in terms of higher education in public health.

The Major Issues

First: What are or what will be the pressing public health needs of the coming decades, particularly in the United States? Pressing public health needs are not simply to contain the cost of a particular kind of effort but to evaluate the contribution of that effort, even at reduced cost, to the protection and restoration of the health of people. Let us distinguish between making people feel better, making them feel that they are being dealt with in a dignified way, and protecting their health and preventing disease—all, of course, being important human goals for our nation.

The second issue follows from the first: What is needed by way of research, manpower, and leadership to meet these pressing public health needs?

Third: What are the needs of professional people for continuing education and mid-career education? This has not been a field in which a license is required in order for people to be given major responsibility. People come to major public health responsibility by diverse routes. For these reasons, it is important to develop programs of continuing and mid-career education.

Fourth: What is the optimum organizational arrangement within the structure of higher education to meet the above needs? What is the best focus of organization? Is a school of public health necessary in order to prepare professionals for this wide range of activity? What are the advantages and disadvantages of various single educational programs unrelated to schools of public health, such as those in hospital or health administration in schools of business? What are the special problems of the interdisciplinary nature of the activities that need to be carried on? If, for example, the level of the social science component of schools of public health is compared with those disciplines in their home departments, there are at times striking contrasts to be noted. Sometimes the quality is high in the school of public health, and sometimes it is not. This raises questions about the kinds of necessary interaction universities can develop among academic units if those in applied fields are to get the theoretical nourishment they require.

Fifth: What is the optimum relationship between the faculty and field practice responsibility? It has been said that schools of public health are the only schools where faculty teach who do not practice their profession. In many quarters, there are serious reservations about the lack of continuous responsible involvement in field problems on the part of substantial portions of faculties of many of the schools.

Sixth: Schools of public health are a national and regional resource. This fact has implications for their programs, organization, and financing. Dr. Wegman pointed out that he would have great difficulty rationalizing his total budget to the legislature of his state when a substantial portion of the student body comes from other states. There are some long-standing examples of regional cooperative programs involving schools of public health. In these instances, there is an understanding that certain educational programs are very expensive and the states, therefore, cooperate in supporting them. There is room for much more development along these lines.

The seventh issue has to do with the diversity and wisdom of organized cooperation among the schools of public health. The eighteen schools are located in fifteen states. Each has strengths and weaknesses. For example, only a small number are strong in environmental sciences and engineering. The size and scope of the facilities and the intellectual resources needed to achieve that position of eminence are impressive. Another school that doesn't have such resources has the choice of saying, we're going to get there over the next ten or fifteen years, or instead, we're going to develop enough resources to be sure that all of our students can get an adequate orientation, and those who want to specialize in that field will go to a school that already has the resources and a first-class program. Biostatistics is another example. The major output of biostatistics comes from just two or three institutions. Are more such sources needed for advanced graduate education? There are basic educational resources that every school needs to have, but using these resources with a regional and national perspective for the preparation of professional leadership has much to be said for it.

The eighth issue deals with the contributions of schools of public health in terms of education, research, and service to the university in general, and vice versa. Two kinds of phenomena are evident with respect to administrative leadership in universities in the health sciences area. One is that while it used to be pretty much the general pattern that the vice president or the vice chancellor for health sciences was the person who had been, or continued as, the dean of the medical school, there are now more and more instances where that is not the case. This probably has some significance in terms of how universities currently view the health sciences activities on their campuses. Also, it has been my direct observation that when medical deans assume this position, they often change their views of priorities, needs, and opportunities rather sharply as a result of their exposure to the activities, needs, and potential of the other health profession schools on their campuses. There are, for example, recent instances in which the contribution of the professional activities in the school of public health are appreciated more than ever before, not only in the health sciences area, but on the campus generally. The social sciences are now beginning to appreciate what is available to them in this complicated area of human needs and human services, which

heretofore has been somewhat closed off to them. There is an unmistakable trend, in the universities which have academic health centers, aimed at uniting these health center activities with the rest of the university and thus creating one coordinated interacting campus.

Ninth is the special potential and problems of arranging interdisciplinary rather than multidisciplinary research, education, and service on a university campus. This is, in fact, not only a question of one school working with another school on the campus, but on occasion it involves the need for departments within a school of public health knowing about each other and working together much more closely.

Tenth, and last, is the responsibility of schools of public health for contributions to public understanding and public policy—the advocacy role. Public health is not a branch of something else; it is not a branch of medicine, dentistry, political science, or economics. It is an entity which is based on two things: knowledge about the problems, needs, and opportunities relating to the health of the public; and the commitment to do something about those problems and opportunities, which is so much a part of the heritage of public health. In this connection, we must recognize that one of our strongest potential allies is the public. If we have image problems today, it is to some degree because, in the last twenty or thirty years, our public health leaders have not taken the kind of role with the public that they took in the days when the most pressing problems were the ravages of communicable diseases. We must share with the public what we know about what remains to be done in public health and then, probably only then, will public health come closer to reaching its goals.

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