Public Health WINS Is a Call to Arms as Well as a Roadmap for All Who Care About a Thriving, Healthy Nation

See also Sellers et al., p. 674.

Public health is at a crossroads. It can lead the nation once again in improving health outcomes and extending life expectancy, or it can continue down its current path and observe and document declines in quality and length of life. The choice is made stark in the findings from the Public Health Workforce Interests and Needs Survey (Public Health WINS) presented by Sellers et al. in this issue of *AJPH* (p. 674), which dramatically shows that our nation's public health workforce wants to embrace a Public Health 3.0 approach in its work but does not feel it has the skills and empowerment to take on that vision.

Public health is an essential part of our nation's infrastructure, even though that infrastructure is reflected primarily in human capital rather than bricks and mortar. The institutionalization of public health into a governmental resource that protects the public's health is responsible for the modern society, economic success, and quality of life that we have largely taken for granted in the United States. In 2017, life expectancy at birth was 78.6 years, double what it was a century ago.[1] This impressive progress is largely attributable to public health interventions in issues including sanitation, water quality, vaccines, smoking policy, and seat belts.

MODERNIZED PUBLIC HEALTH 3.0

This infrastructure is needed now more than ever as we confront declines in life expectancy for three years in a row for the first time in generations. The causes are complex, but they point to social drivers of health more than communicable or chronic disease.[2] We also continue to see significant disparities in health and mortality based on where people live.[3] More recently, the public's health is facing reemerging threats we thought we had tackled years ago, like measles and emerging pathogens, including those brought by climate change like the Zika virus.

To meet these new challenges, public health agencies around the country are embracing a modernized Public Health 3.0 approach.[4] They recognize that improving health outcomes requires public health leadership in catalyzing the health system to more formally partner across multiple sectors to address the social, environmental, and economic conditions that affect health and health equity.[5] At the same time, they are leveraging the fundamentals of public health practice to address ongoing and new communicable and chronic disease challenges, and they are also leveraging data in new ways to support more timely insights and actions.[6]

AN EMPOWERED WORKFORCE

Public Health 3.0's success is dependent on having a competent, committed workforce that is empowered and has the skills to adopt this modern approach to improving the nation's health. The 2017 Public Health WINS showed that large proportions of employees recognize that public health has a role in affecting health equity (85%), social support systems (75%), the K-12 (kindergarten to 12th grade) system (63%), the quality of housing (59%), the economy (56%), the built environment (55%), and the quality of transportation (53%). And yet, disappointingly, the survey also found that public health workers feel creativity is not rewarded and that they lack training in systems and strategic thinking, change management, and developing a vision for a healthy community.

The good news is that the workforce wants to implement a Public Health 3.0 approach. The challenge before us is to make sure we give that workforce the tools they need to do so (https://www.debeaumont.org/phwins).

Sellers et al. and a set of accompanying editorials in this issue provide additional insights into the key lessons and signals we should pay attention to in the results of their survey. Among the concerns raised are the unevenness of the diversity, capacity, and stability of the public health workforce by region. This is not surprising and reflects the unevenness of public health protection across the nation based on local funding. A recurring theme is a concern about losing the intellectual capital and experience of the workforce if they follow through with retirement in the coming years. The intention of many more experienced public health workers to retire signals an opportunity for advancement for those earlier in their public health career. This opportunity to advance may help with retention of top talent and support the transition to a workforce more abreast of current digital, partnership, and strategic approaches needed to protect the public's health in a 3.0 world. The expected turnover of staff is also an opportunity to enhance the diversity of the workforce. It is a

ABOUT THE AUTHORS

Karen B. DeSalvo, formerly acting assistant secretary for health at the US Department of Health and Human Services, Washington, DC, is currently professor of medicine and population health at the Austin Dell Medical School, University of Texas, Austin. Jeffrey Levi is professor of health policy and management at Milken Institute School of Public Health, George Washington University, Washington, DC.

Correspondence should be sent to Karen B. DeSalvo, 1701 Trinity, Austin, TX 78712 (e-mail: karen.desalvo@austin.utexas.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This editorial was accepted February 19, 2019.

doi: 10.2105/AJPH.2019.305047

reminder that training and professional development need to be available not only for leaders and the emerging workforce but also for midcareer staff.

New concepts such as health in all policies, cross-jurisdictional services sharing, and quality improvement are gaining awareness for a majority of the workforce. These concepts are central to the work approach of modern Public Health 3.0 departments. It is also exciting to see that awareness of these concepts is gaining ground in state and local health department workforces. The gap between awareness and impact highlights the need to provide robust and accessible training programs for the incumbent and emerging workforce. The responsibility for developing such programs falls to many, but the Association of Schools and Programs of Public Health and the training programs themselves need to ensure that the curricula for undergraduate and graduate public health trainees reflect the array of complex health issues they will have responsibility for, including those related to the social determinants of health.[1]

A PEOPLE- AND SKILL-INTENSIVE INFRASTRUCTURE

Public health is a people- and skill-intensive infrastructure. However, to do their work effectively and to continue to lean into emerging public health challenges, the public health workforce will need adequate resources. These are more than data and partnerships. As called for in Public Health 3.0, the public health infrastructure needs flexible, sustainable, and enhanced funding—not only to address crises, but to ensure strong foundational capabilities to protect the public every day. Given the concerns about public health workforce recruitment and retention in the articles in this issue of *AJPH*, we should recognize that we will not attract the best and brightest in public health training programs unless we are able to adequately compensate staff, ensure them job security, and provide them with the resources to do their work. The estimated gap in funding these foundational capabilities is only $12 per person per year, or an estimated $4.5 billion.[7] That's a relatively small investment to ensure the health of our nation.

CONCLUSION

A strengthened public health infrastructure, including a modernized workforce, is needed now more than ever in the United States to reverse the disturbing trends in life expectancy and to address more acute, equally concerning health threats here and across the globe. All people in America have the right to expect that a vibrant and modern public health infrastructure is supporting them every day. The results from Public Health WINS is a call to arms as well as a roadmap for all who care about a thriving, healthy nation. AJPH

Karen B. DeSalvo, MD, MPH, MSc
Jeffrey Levi, PhD

CONTRIBUTORS

Both authors contributed equally to this editorial.

CONFLICTS OF INTEREST

The authors have no conflicts to disclose.

REFERENCES

1. Murphy SL, Xu J, Kochanek KD, Arias E. Mortality in the United States, 2017. *NCHS Data Brief*. 2018;(328):1–8.

2. Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, et al. Trends and patterns of geographic variation in mortality from substance use disorders and intentional injuries among US counties, 1980–2014. *JAMA*. 2018;319(10):1013–1023.

3. Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001–2014. *JAMA*. 2016;315(16):1750–1766.

4. DeSalvo KB, Wang YC, Harris A, et al. Public Health 3.0: a call to action for public health to meet the challenges of the 21st century. *Prev Chronic Dis*. 2017;14:E78.

5. Koo D, O'Carroll PW, Harris A, DeSalvo KB. An environmental scan of recent initiatives incorporating social determinants in public health. *Prev Chronic Dis*. 2016;13:E86.

6. Bearnot B, Pearson JF, Rodriguez JA. Using publicly available data to understand the opioid overdose epidemic: geospatial distribution of discarded needles in Boston, Massachusetts. *Am J Public Health*. 2018;108(10):1355–1357.

7. Public Health Leadership Forum. Developing a financing system to support public health infrastructure. Available at: http://www.resolv.org/site-healthleadershipforum/files/2018/11/PHLF_developingafinancingsystemtosupportpublichealth.pdf. Accessed February 19, 2019.

Bringing Parenting Policies in Line With Evidence at US Schools of Public Health

See also Morain et al., p. 722.

Becoming a parent and sustaining a new life is challenging. It is also transformative, with the power to alter the trajectory of an individual, a family, or a community. In the field of public health, our research clearly indicates that investments in paid parental leave, breastfeeding, and high-quality childcare are necessary and worthwhile.[1] Indeed, the American Public Health Association (APHA) recognizes the public health detriments that stem from a lack of workplace-based protections for parents in the United States and the imperative for supportive policies, stating, "APHA supports breastfeeding, paid maternity leave, and workplace accommodations for mothers in the United States."[1] Schools of public health should be leaders in modeling such policies.

PARENTAL SUPPORT AT SCHOOLS OF PUBLIC HEALTH

An important new empirical study published in this issue of *AJPH* shows that our field is not

ABOUT THE AUTHOR

Katy B. Kozhimannil is with the Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis.

Correspondence should be sent to Katy B. Kozhimannil, PhD, MPA, Division of Health Policy and Management, University of Minnesota School of Public Health, 420 Delaware St SE, MMC 729, Minneapolis, MN 55455 (e-mail: kbk@umn.edu). Reprints can be ordered at http://www.ajph.org by clicking the "Reprints" link.

This editorial was accepted February 9, 2019.
doi: 10.2105/AJPH.2019.305027