Revisions in the 10 Essential Services Deserve a Comprehensive Implementation Strategy

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See also Benjamin, p. 542, and Castrucci, p. 598.

As the nation contemplates lessons from the COVID-19 pandemic, the role of public health is facing scrutiny. Unfortunately, as Brian Castrucci relates in this issue of *AJPH* (p. 598), surveys show a fundamental lack of agreement on what public health is. As a partial solution, Castrucci highlights the September 2020 release of a revised set of 1994's 10 Essential Services (TES) titled the "Common Framework Needed to Communicate About Public Health." The goal this title offers is consistent with the intentions of the original set: "(1) explain what public health is; (2) clarify the essential role of public health in the overall health system; and (3) provide accountability by linking public health performance to health outcomes."[1]

Castrucci states that an update is needed because the 1994 TES have grown "increasingly out of touch with current public health practice" and should "reflect new realities facing the field of public health" (p. 598). However, reforming the TES is only a first step in resolving these challenges.

Conflicts regarding the nature of public health go back at least to the 1915 Welch–Rose Report, which, like its medical counterpart the Flexner Report, established a framework for public health education. Debate was then between those who argued for biomedical research and those who argued for prioritizing administration.[2] Ironically, the recent amendments to the TES, which add a category addressing governance and appear to reduce the focus on research, seem reminiscent of this century-old debate.

Unfortunately, over the years the division between research and practice has become institutionalized. For example, the National Institutes of Health carries out research, frequently in collaboration with academic institutions, whereas the Centers for Disease Control and Prevention focuses on practice activities, including disease control, through a federal system reliant on state and local government public health agencies.

Herein lies the challenge. Although public health suffers from popular misunderstanding, this misunderstanding is reinforced by multiple constituencies that have institutionalized their own interpretation of public health. Academic tenure and promotion are tied to the Welch–Rose research model. Categorical funding and federalism promote the view that public health is a bureaucratic governmental system. Thus, in addition to amending the TES, public health leaders must institutionalize an inclusive approach to achieving the vision of another update, 2003's The Future of the Public's Health.[3]

Strategic examples already exist. Castrucci highlights the accreditation of health departments, and the state of Ohio has adopted this policy.[4] An approach to linking the academy to practice could be funding academic health departments so faculty can work with practitioners whom they might not otherwise have met. The inclusion of the TES in community health improvement planning through strategies like Accountable Communities for Health could also help institutionalize the TES.[5]

I was the director of the Iowa Department of Public Health when the TES were released and used them in policymaking. In the early 2000s, I directed our school's academic health department project that linked faculty with practitioners. I currently sit on the Public Health Accreditation Board. From these perspectives, I offer the concern that an update of the TES will not succeed better than its predecessor without complementary implementation across the entire spectrum of the population health enterprise. AJPH

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CONFLICTS OF INTEREST

The author has ne conflicts of interest to declare.

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