

# looking forward



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The careers outlined in this book represent a small window into the enormous world of public health, where wonderful opportunities abound. The experts profiled here never cease to impress, amaze and inspire me, as I hope they do you. Many of them say their careers were determined as much by chance as by intent. Mine certainly has been! But I have always subscribed to the aphorism that serendipity favors the prepared mind. In fact, a theme that recurs in many of the chapters in this guide is how important it is to be prepared to face the multiple challenges of our field.

A second recurring theme is that the education of the past is but a preparation for the present and a forecast to the future, which is another way of saying that a career in public health is a career of lifetime learning.

Consider what we did not know and how quickly we learned about infectious diseases such as HIV/AIDS, whose discovery and early responses have been detailed by Dr. James Curran. Or consider West Nile virus, discovered in New York State for the first time in 1999, which we read of in detail from Dr. Dale Morse. The international and global health chapter in this book describes the direct connection between iodine and a child's IQ and how providing sufficient iodine in a child's diet can alleviate potential problems. But learning and applying what we've learned do not always work in tandem. In her discussion of global HIV/AIDS, Dr. Helene Gayle points out the power of education, but explains how the work of health care providers is critical to giving prevention a fair chance.

The current public health climate is exhilarating in part because its challenges present so many fresh opportunities. Many of these challenges arose in the immediate aftermath of the terrorist attacks of 2001. Since then, the public has been troubled by the emergence of bioterrorist weapons, and public health issues have been thrust into the limelight. When legislators used the words "public health infrastructure" when they talked to the press about the solutions to our nation's lack of preparedness, many of this volume's contributors knew an important corner had been turned. The September 11



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disaster also prompted national, state and local legislators to recognize the value of the public health systems in their states or municipalities. More and more they insist that these systems provide leadership, guidance and protection for their citizens. As these demands continue to evolve, public health agencies and organizations must raise funding to keep pace. The infrastructure proposals delineated throughout this book recognize the need for sustained federal appropriations and state and local contributions, to build and maintain public health resources.

Tip O’Neill, late Speaker of the U.S. House of Representatives from Cambridge, Massachusetts, once famously said, “All politics is local.” My personal variant of that aphorism is “all public health begins at home.” Locally, every community needs its own identifiable public health system, including health information databases with qualified personnel to run them. The informatics network is critical to a solid and effective infrastructure. Public health officials can no longer afford to learn about unfolding public health disasters and emergencies by watching cable news networks. What we know at the national level must immediately be available at the state and local levels, and that means instant bi-directional telecommunications — a database in every community’s health department connecting directly to the state health department and the nation’s public health nerve center, the Centers for Disease Control and Prevention (CDC) in Atlanta.

The workforce is an essential — perhaps the most essential — part of any infrastructure dependent on people. When considering what it will take to provide a workforce that delivers on the promises for the decade ahead, several matters become clear. First, as the population ages, public health services will expand and as they do, so will the number of jobs at all levels. Competitive salaries will be needed to keep public health careers on a level playing field with other occupations. Second, we need well-trained people with strong skills to fill those positions as they develop. Health professionals, including nurses, social workers, nutritionists, administrators, educators, pharmacists and physicians, should exhibit competencies not always provided by schools of public health or even public health certificate programs of the past. To this end, there is a movement afoot to consider developing separate public health credentials, parallel to what we see in our educational system. For example, someone wishing to teach biology can have a PhD in biology but still not be allowed in the classroom without a teacher’s certificate. The

same holds true in public health as well; an MD might not be well prepared for the public health challenges ahead. As you have read in Dr. Gebbie's chapter, a separate credentialing mechanism is being considered, designed to ensure that anyone who practices in public health demonstrates professional competence not only in his or her specialty, but also in the core essentials of public health.

A natural conceptual leap from credentialing for public health professionals is accreditation of community health agencies. The "National Public Health System Performance Standards," which were designed to evaluate the way communities deploy essential health services, have actually provided communities with a great opportunity for self-assessment. Might a national group such as the Joint Commission of Accreditation of Health Care Organizations (JCAHO) tweak these same standards to accredit communities, provided these communities demonstrate, through application of the public health system standards, that they are adequately protecting the health of the people?

Unacceptable disparities in health status among underserved subgroups of our population persist. For the infrastructure to work at maximum effectiveness to serve us all, and particularly to help us all address and overcome disparities, we need to capitalize on the potential for diversity in this profession. The positive lessons learned in the divisive '60s and '70s are that the workforce is stronger for its differences. Still, in this profession, many cultural and ethnic groups are underrepresented. We must make a strong effort to recruit a culturally balanced workforce to create an effective public health system. This principle especially applies to leadership positions. Leadership in the public health community must be developed from a large and culturally mixed pool of potential supervisors and directors, and that means involving and mentoring, in the integral workings of every facet of the profession, any qualified and promising people who request such assistance.

Two initiatives should be mentioned that I believe give us a preview of things to come in public health. The first, Public Health Grand Rounds, is a demonstration project jointly sponsored by the CDC and the University of North Carolina School of Public Health. In Public Health Grand Rounds, the "patient" is the community and the "condition" is a public health issue confronting the community, such as an epidemic, higher percentage of low-birth weight newborns or prevalent drug abuse.<sup>1</sup> The Grand Rounds team

visits communities where a public health situation has occurred, interviews those who were involved in addressing it to learn the lessons they have learned, and creates a learning case study video. The video is then broadcast and web-cast live and nationwide from a studio at the CDC to thousands of viewers, who are generally in their local communities and watch the program

in groups. The world's leading experts on the subject critique the case, and viewers are encouraged to call in or fax their questions. The implications for the lifetime learner in public health of the future are exciting to think about.



The second initiative is the public health law program at the CDC, designed to improve the understanding of the interaction between law and public health and to strengthen

the legal foundation for public health practice. There is a clear consensus that the archaic public health codes developed by every state over the past decades must be reviewed, aligned, and, as needed, refreshed in an on-going nationwide coordinated process.

Solutions to the public health challenges we face will be reached only if we choose to anticipate the problems of tomorrow. What sorts of problems? Antibiotic resistance, obesity and other epidemic chronic diseases, deterioration of our environment and barriers to medical care are some. Others we cannot always specify, such as the possibility of a major infectious disease emergence similar to the West Nile virus, or even the unpredictability of climate and weather, or disasters, natural or, tragically, man-made.

With a surveillance system properly tuned, a response system properly prepared and a support system regularly refreshed, we can face these challenges. These and other tools to address these situations will be available to you as never before. But in all our excitement about the future, let us not forget the enormous progress of preventive medicine over the past 50 years, which makes it possible for someone like myself — a guy in his 60s — to anticipate another 20 years of productive public health work. This opportunity for me and for a healthier America exists as a result of the insights,



leadership and resources of my contemporaries. But it's up to the next generation, those of you who are currently working toward degrees, to now step up to the helm. I'm personally looking forward to seeing you there.

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1 <http://www.publichealthgrandrounds.unc.edu>