

# Leadership for the Public's Health Legacy of the Healthy Communities Movement

BY MARY PITTMAN

Over the last twenty-five years, the Healthy Communities Movement has played a prominent role in re-framing how health is perceived in the United States

The early days of the movement were led principally by people who were engaged in creating broader civic engagement and through the efforts of a small number of health care leaders who were trying to re-define the hospital's role within the community, particularly around community benefit requirements. These public health innovators played a strong role in developing many of the pilots that were executed in partnership with health systems and other providers over the subsequent years. Leading public health organizations engaged their communities in the planning and implementation of projects that were usually grant funded and focused on building specific areas of program expertise. There were few metrics or methods for designing healthy communities in this early period. However, the leaders who were engaged in redefining community health realized that metrics were necessary to measure their progress in whatever focus they had identified. Few of the early pilots were sustained after grant funding ended, but those that did thrive created a strong leadership capacity that facilitated partnering across organizations and sectors and attracted strong local support from government, philanthropy, and business.

## Healthy Communities: A Natural Outgrowth for Public Health

Early on, public health leaders recognized the potential for improving population health by engaging in healthy community work. Public health traditionally has been responsible for assessing, monitoring, and improving the health of the overall population in large health care market areas. Leaders such as David Satcher, MD, who served as the US Surgeon General and then director of the Centers for Disease Control and Prevention (CDC),

understood the power that organizing local communities could have on the health of the nation. He supported the launch of the Coalition for Healthy Cities and Communities and sponsored a convening at CDC in 1995. He pushed the participants to build on the work of public health but to reach outside the governmental sector to engage education, business, and faith-based organizations in the coalition's work. Public health providers have access to vital records and other sources of data critical to community assessments and monitoring community health metrics, which in turn inform other community leaders about strengths and needs of communities. Over the years, the ability and sophistication of public health to collect, analyze, and display data outside of vital statistics, data that capture the social determinants of health, has resulted in more comprehensive health assessments and has allowed for more targeted efforts to address disparities and health equity. As these issues have evolved, new tools and approaches for building healthy communities have crossed over to the fields of city planning and the built environment. Increasingly, leaders in public health are meeting with and collaborating with their professional colleagues in transportation, environmental services, parks and recreation, schools, and agriculture to address problems that cut across governmental agencies and sectors. Approaches such as Health in All Policies and Health Impact Assessments have solidified the methodologies and scientific basis for this new public health work. However, it has taken public health care crises to force the bloom of healthy communities.

## Early Driver for Healthy Communities: Learning from HIV

As a young professional in public health in San Francisco in the early 1980s, I witnessed the way the AIDS epidemic captured attention and focused efforts to improve community health in new ways. Public health had not experienced such an unknown, life-threatening disease in more than a century. All

of the tools of epidemiology, surveillance, laboratory testing, and prevention were turned on their head as new models had to be created to address this epidemic. Fortunately, the public health and clinical care system in San Francisco were integrated, and information and data were able to be exchanged in regular meetings. Further, the local health department leadership evolved from a top-down command-and-control model, which works well during a crisis, to a new, more community-oriented approach. Out of necessity, public health learned to partner with the community in new ways that contributed to new models of education, community planning and engagement, and care.

### **Healthy Communities: Growth by Crisis**

The lessons first learned from HIV were revisited several times over in the new millennium, starting in 2001. The post- 9/11 landscape, in which bioterrorism became an emerging and real threat to American communities, generated a growing awareness by both policy makers and the public that new leadership and an interconnected public health system were needed to respond. Just as the HIV epidemic created community sentinels for tracking the social aspects of the epidemic, the threat of bioterrorism required leaders to engage other sectors in tracking disease outbreaks and responding to threats such as the anthrax-laced letters. The science of public health was ready to address these challenges, but the leadership to fully implement the science required new skills and new roles at the local and state level.

Four years after 9/11, Hurricane Katrina again taxed the public health, health care, and public safety systems. Hurricane Katrina pinpointed the serious lack of interoperability and communications across public health, health care, National Guard, police, and other critical responders. It provided a wake-up call for how disconnected public health was from other key community service providers and decision makers. The challenge of determining who was in charge of what area and how joint decisions would be made led to the further development of new planning models for public health leaders. The new demands created by these health care crises highlighted how the underfunding that had plagued public health for several decades needed to be addressed in order to address emergency preparedness properly. One of the stark realities of Katrina was the lack of equity,

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access, and resources available to the low-income community most affected by the full force of the hurricane and years of neglected infrastructure in their community. Katrina focused the nation on these issues, and public health leaders helped reimagine what a healthy community would be while people from around the country lent a hand to help the displaced residents of New Orleans rebuild their community.

At the base of the current healthy community work is an acknowledgment that the social determinants of health—where one lives, works, plays, and interacts with faith and civic organizations—have a greater impact on how healthy you will be over your lifetime than how often you go to the doctor. Of course, this statement has to be qualified. There are many reasons why we want access to the best medical system possible when we need it. For instance, some people are born with genetic-related illness and disability that may need medical attention. Others develop conditions over their lifetimes requiring medical intervention. What we intend by our shorthand reference to the social determinants is that those things that provide the best possible start to life, that help individuals achieve their highest potential and that avoid preventable illness, should be our priority for creating healthy communities.

### **Public Health Leadership: The Challenge of Health Reform**

The current challenge facing public health leadership is to determine how to link the social determinants of health and the lessons from healthy communities with health reform. The key challenge is how to bridge the gap between the public health focus on preventing disease and creating a healthy environment with the need for preventive and restorative health care. There is a reference in the Affordable Care Act (ACA) to improving population health by focusing on the triple aim of better health, better

care, and lower cost, but the specific details on how to achieve these goals are left out of the legislation—and it is a good thing that they were. The ACA requires greater engagement by public health and community-based organizations in the largest social program created since Medicare. However, it will only be as effective as the level of engagement of public health leaders in its planning and implementation. It is exciting to see new models emerging with greater attention to investments in prevention and public health from savings in health care expenditures.

One of the biggest tasks facing public health is to partner across the clinical–social–public health sectors to create robust testing of the effective new health care models. The next challenge is to generate the long-underdeveloped evidence of the value of equitable healthy environments with engaged communities working for long-term health benefits. Leading in this manner requires new skills and an orientation of building healthy communities that are more equitable and sustainable. Healthy city and community leaders, such as Len Duhl, MD, pushed all of us to think what can be accomplished if we believe that everyone has a role to make the world a more just, equitable place to thrive, and now we have digital tools that make connecting community easier and our actions more transparent. By their nature, digital tools are democratizing data, facilitating organizing, and raising expectations of what we want our communities to be. It will be important to learn how public health can adapt to these new expectations and take a leading role.

Public health has evolved in its approach to building healthy communities: from community engagement, to a public health all-hazards focus, to building resilience and capacity and incorporating health in all policies. The health in all policies framework requires leaders to understand collaboration and how to apply new tools, such as health impact assessments and business models for return on investment. Recognizing the complexity and contextual nature of health, taking time to break it down so it is embraced and understood by all community leaders using new methods of integrating and displaying data, telling evidence-based stories, and engaging communities in the design and planning of research and programs—these approaches are shaping a new kind of public health professional and new models of public health leadership.

All social movements have to have a framework that can encompass the interests and viewpoints of the people involved. Periodically, they must assess the value and contribution that the movement is making to social change. The contributions that leaders of the healthy cities and communities movement have made in the past twenty-five years have had a profound effect and legacy that can be traced to many of our laws and approaches to community-based prevention and environmental change to build healthier communities in the United States.

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