



**National Public Health
Partnership - Secretariat**

Level 12, 589 Collins St
Melbourne 3000

GPO Box 4057
Melbourne 3001

Telephone
(03) 9616 1515
Facsimile
(03) 9616 1500

Summary of Workshop to Scope an Australian Public Health Leadership Program for the National Public Health Partnership

Sydney, 25 February 2000

Summary

This paper draws from the discussions auspiced by the National Public Health Partnership (NPHP) Group initially to examine the needs, issues and options for a public health leadership program in Australia, and then to consider a framework for the design and implementation of a National Public Health Leadership Enhancement Program. In particular, the paper reports on the material considered at the 'Workshop on Leadership Enhancement' convened by the NPHP on 25 February 1999 and outcomes of the Workshop.

The principal conclusions are:

- There is a need for and strong commitment to a systematic and structured approach to the development of public health leadership in Australia.
- A number of models for leadership programs exist.
- There is general agreement that the most promising among these is the approach used by the CDC-UC (Centres for Disease Control – University of California) Public Health Leadership Institute, although several programs active in Australia provide extremely useful models and lessons.
- However, any model would have to be adapted to the size, dispersion and structure of Australia's market of public health professionals.
- The design and implementation of the programs should be staged so that the design commences immediately under the umbrella of the NPHP, and the consideration of who implements it done as a separate step.

The major recommendations are:

- A two-year National Public Health Leadership Program should be agreed as an initial approach with an annual intake of 50 people at senior level, commencing in year 2001.
- NPHP should identify modifications to the CDC-UC model necessary to design a model responsive to Australia's circumstances and needs.
- NPHP should auspice and develop but not implement the program.

1. Public Health Leadership Initiative – Current Status

An Australian national public health leadership initiative has been on the National Public Health Partnership (NPHP) Group agenda for over one year. The initiative responds to the perception that public health professionals are often thrust into positions of leadership but may not have had the opportunity to develop the requisite skills, competencies, personal attributes and resources to respond effectively to the challenges of public health leadership.

At present separate, parallel initiatives to develop public health leadership are under way in a number of jurisdictions including Victoria, New South Wales, Western Australia and the Northern Territory. In previous discussions a range of varying perspectives and issues had emerged, leading the NPHP Group to recommend the preparation of a Scoping Document setting out a national approach consistent with Australia-wide need and local circumstances.

To that end, the NPHP convened a workshop in late February 2000 aimed at identifying a generally supported approach, and at generating consensus to move the national initiative to the next step – the formalisation of a national public health leadership approach and program.

The one-day workshop was held in Sydney. The agenda and list of participants are attached.

2. The Elements of Leadership Development

The meaning of public health leadership

The introductory session of the workshop produced rich description of the distinctive definition of public health leadership. Leadership in public health requires:

- a distinctive advocacy and community role that differs from the roles of other leaders;
- personal as well as organisational insight;



- a capacity to scan the environment and compellingly synthesise the most important features and their public health implications;
- that public health leaders embody a value system that people can identify with, and that inspires them to action;
- the capacity to integrate actions, visualise the future, and bring people along in pursuit of that vision;
- strategy and foresight;
- accountability of word and deed that matches the values of the communities whose interests are represented by the public health leader; and
- a thorough grasp of the unique complexities of public health.

Experience over nearly a decade of public health leadership development in the USA has generated a profile of public health leadership as:

- collaborative – working in tandem with the community;
- reflective;
- contextual;
- comprising a set of qualities that can be learned;
- having a skill set – especially communications skills – reflecting the primary importance of sending effective public health messages;
- embodying a shared vision;
- an openness to continuous learning and to different perspectives;
- risk-taking combined with necessary validation to back up the courage that effective public health leaders must demonstrate; and
- the capacity to broker across sectors, including public health, health care, business and education.

There is general consensus that the distinct imperatives of public health generate the need for a distinct leadership response amongst public health professionals. That distinctive leadership response in turn implies a distinct approach to leadership development. Questions persist about the specific dynamics and processes by which people acquire the skills and attributes of leadership, especially the process of developing an embodied capacity, such as 'judgment'. One of the challenging aspects of leadership development is avoiding a simplistic definition of leadership capacity. The processes of acquiring qualities like 'judgment' and 'insight' are complex.



The experience of the US National Public Health Leadership Institute was instructive: at a national level that program sets specific, personally-tailored objectives within each of a series of 'objective' areas. A competency framework is more likely to be applied at the State and Local level, where Institutes of Leadership can set more relevant and specified objectives. It is also at this local level that credentialing works best, again because the relevant, specific and innovative are better applied in more local contexts.

3. Models of Leadership Development

Two national leadership programs were examined for their relevance to the National Public Health Leadership Enhancement Initiative: The CDC/UC Public Health Leadership Institute and the Health Leaders Network (previously the Australia New Zealand Health Management Network).

The CDC/UC Public Health Leadership Institute

The CDC/UC Public Health Leadership Institute (PHLI) was founded to develop public sector leaders in public health in the US. It began as a consortium among four US schools of public health and has evolved into an 'academic' NGO. This richness of perspectives enabled it to develop for a specific organisational context in which 'transformational leadership' is required: public health.

Over the years the Institute has evolved in response to opportunities and needs. Examples include the acceptance of non-synchronous as well as synchronous learning; learning by internet as well as distance learning; and very little 'contact' work. The development of public health leadership is now housed in one of several 'Centres' of the Institute.

Among the trends and issues that have led to the growth and development of the leadership program are:

- growing acceptance of, and interest in, adult learning, especially learning from one's peers;
- a need to support leaders when they 're-enter' organisations after leadership training;
- the development of the leadership program as a 'virtual organisation' – with 'faculty' across the US in the public and private sector and in universities;
- high use of the internet and teleconferencing.

As the PHLI has expanded and grown in reputation, participants are increasingly the senior person reporting to the Chief Health Officer, as well as the Chief Health



Officers themselves. State and local programs have developed the reach of the National PHLI further, and involve:

- academics (up to 3 in each intake)
- 'invited' scholars
- top level leaders from the US managed care sector; and
- representatives of large foundations.

Participation in the program is quite competitive. The program, which revolves around 'learning communities', has evolved to incorporate a 360 degree focus on:

- the public health leader as an individual
- her/his organisation
- the community.

The PHLI has been funded for periods of 4–5 years renewable.

One of the challenges facing the program is the difficulty of evaluating its impact, and in particular, quantifying the impact of the program on participants. This has become increasingly important as competition to host the PHLI grows, and the funding for the program will be up for renewal. The PHLI has developed a series of proxy indicators that it has offered to the Australian national program.

Among the issues that the Director of the PHLI raised for the Australian initiative are:

- **The breadth of the Australian leadership initiative:** it is much wider than the US initiative because it aims to integrate government, NGOs and broader community sectors (education, etc.), consistent with the Australian model of 'community' leadership in public health.
- **The limited number of very senior professional public health leaders in Australia;**
- **The limited funding** likely to be available for the initiative.

One of the ways that the US-based National PHLI addresses the financial shortfall is by cross-subsidising the PHLI's core costs with dues from the large NPHLI alumni society.



Lessons Learned from Health Leadership Programs

Lessons from the CDC/UDC Program:

- The programs must entail transformational leadership – not ‘learning about’ leadership.
- In the US program, 2 face-to-face sessions of at least 4 days each – ‘core learning events’ – have been necessary – public health leaders tend to need at least 4 days to relax and engage effectively in transformational leadership activities.
- Bringing back some ‘alumni’ to serve as ‘practice faculty’ is valuable.
- A single person responsible for designing each of the 3 modules (with varying faculty teaching each module) provides a more cohesive module, and avoids the limitations of a single person documenting and teaching only what they know.
- The training and the alumni network are equally essential.
- Varying levels of financial support for program participation can breed resentment but at the same time make participation more equitable.
- Faculty usually need to be trained in how to use the internet.
- The program must generate written ‘lessons learned’ and disseminate the documented impacts of the program in order to ensure funding. And the program should obtain earmarked funding to document/evaluate impact.
- The program must use numerous learning techniques, with the overall aim of being highly interactive and participatory. Methods include anecdotes, case studies, lectures, problem-solving exercises, in carefully structured 3-hour sessions.

Lessons learned from the Australia–New Zealand Health Leaders Network Program:

- Managers balk at paying the travel costs involved in bringing senior health staff together – even though its value is undisputed.
- Case studies are less effective as teaching tools than considering immediate, live issues and problems.



- Coaching and mentoring is a vital part of the leadership development process.
- 'Chatham house rules' are essential so people can speak freely and ensure privacy.

4. Aims and Implementation Issues: Ensuring that the Model of Public Health Leadership Meets the Needs of Varied Target Groups

The aim of the Australian National Public Health Leadership Program (NPHLP)

The aim of the Australian NPHLP program would be:

A two-year initiative sponsored by the National Public Health Partnership that would:

- form a human resources capacity at a national level that can be built on at the jurisdiction level in different ways;
- be aimed at the whole scope of public health;
- link with the community, and have a consumer focus, encouraging diversity in participants so as to avoid 'silos'; and
- be national in scope and public health specific – that is, aimed at public health people rather than generic or even health care leadership.

Priority participants in the Australian National Public Health Leadership Program

Priority would be given to:

- Section heads of public health divisions within government departments of public health, at the central and regional levels
- health professionals Key local government people
- Selected participants from non-government organisations
- Some other
- People in the community health sector who are not necessarily identified as 'public health' professionals.

Additional aims



Infuse some public health leadership elements in the program of the Health Leaders Network, and in selected Masters of Public Health programs

Implementation Issues

- The NPHP brings to the initiative an endorsement that can be a valuable form of validation. However, the NPHP cannot 'do it all', especially at the State level, where experience elsewhere shows it is preferable for the program to be picked up by local organisations.
- Ensure that the first national cohort is a strategic selection of public health professionals, producing leaders who have an impact on their jurisdictions as a consequence of completing the program.
- Define a broad target group for the life of the program.
- Identify state-based finance that enables the States to invest in people who have a long-term relationship with the communities they represent, and who may come from these communities.
- Ensure that the course content addresses the critical issues facing public health leaders in Australia today.
- The program needs to address wider issues concerning public health, such as globalisation and how it is creating 'winners' and 'losers'; the impact of urbanisation on poverty. (Note: in the CDC/UC program these issues are addressed in lunchtime roundtables.)
- Ensure that the curriculum is developed for the aims of the program in Australia today.

5. Conclusions

- There is consensus on the need for a National Public Health Leadership Program, and agreement that it should start as soon as possible.
- There was agreement that the NPHP should take the lead in launching the program.
- Initial activities should be restricted to building National capacity, creating an impact and demand for programs that can later be implemented at the State level, in different forms according to circumstances.



- The initial program should aim to train approximately 50 senior people per year over 2 years.
- Designing and preparing to commence the program will take at best 8 months from the start of program development – with a staffed program – until the first group goes through.
- Options for implementation include an existing leadership program in a related field and a consortium of universities. However, the program should not be based in a university, to encourage buy-in from the wide range of supporters needed.



Appendix

Public Health Leadership Workshop Agenda and Participants

**National Public Health Partnership
Leadership Enhancement Program**

Workshop

Friday, 25 February 2000

Venue:

**Conference Room, Level 11
NSW Health Department
73 Miller Street
North Sydney**

Time:

9.30am – 4pm

PROGRAM

- Background and workshop objectives
- Presentations
 - o CDC/UC Public Health Leadership Institute
 - o ANZ Health Management Network
 - o States on training initiatives in public health
- Delineation of:
 - o purpose
 - o target group
 - o nature and structure of learning activities
 - o program content
 - o approaches to sustaining program benefits
- Scoping paper:
 - o structure and content
 - o recommendations
 - o process for finalising

Conclusion



Participants in Scoping Workshop on Public Health Leadership Program

Sydney, 25 February 2000

Participant	Position	Organisation
Dr Andrew Wilson (Chair)	Chief Health Officer	NSW Health Department
Ms Carol Woltring	Director	CDC/UC National Public Health Leadership Institute
Ms Cathy Wall	Director Health Workforce Unit	ONHMRC Commonwealth Department of Health and Aged Care
Assoc Prof David Legge	School of Public Health Academic Coordinator VPHTS	La Trobe University
Mr Alan Philp	Director Development and Support Public Health Division	WA Health Department
Mr Brian Corcoran	First Assistant Secretary Population Health Division	Commonwealth Department of Health and Aged Care
Dr Lyn Madden	Public Health Training and Development Branch	NSW Health Department
Assoc Prof Don Stewart	School of Public Health	Queensland University of Technology
Dr Jennifer Alexander	Executive Director	Australia New Zealand Health Management Network
Ms Jan Norton	Assistant Director Public Health Division	Department of Human Services, Victoria
Prof Vivian Lin	Executive Officer	NPHP Secretariat
Mr Joseph O'Reilly	Chair NPHP Advisory Group	c/- NPHP Secretariat
Dr Abby Bloom	Managing Director	Health Innovations International Pty Ltd
Ms Karen Roger		

