CHAPTER 3

The Six Levels of Leadership

Learning Objectives

- Describe the six levels of leadership.
- Learn strategies that enhance personal leadership.
- Understand the AIM Leadership Model.
- Determine the reasons and benefits for creating teams.
- Describe the importance of knowledge management.
- Discover how public health leaders work at the community level.
- Understand the factors that help in community-building where collaboration exists.
- Master the eight steps in building a coalition.
- Describe how leaders can make a mark on the public health profession.

A leader is a person who inspires others to action and guides their undertakings. These others can be members of a team, employees of an agency, or heads of groups that have formed a coalition, an alliance, or a partnership, for example. In other words, leaders in public health, as in other arenas, operate on different levels. The major difficulty in conceptualizing what leadership is relates to the fact that we live in an ever-changing world that demands that leaders adapt to these changes in a continuous way. Each day leaders face new technical challenges for which solutions must be found. These challenges require more than the usual solutions tied to an authoritative position or to the standard operating procedures of an organization or community. The events of September 11, 2001, show us that the world has changed. Heifetz and Linsky pointed out that these adaptive challenges require solutions that are innovative, perhaps experimental, and create new forms of adjustment.[1] Adaptive change may require a change in attitude, values, and behavior or a new interpretation of events.

It is also important to understand what entices people into leadership roles. Over the past 25 years, there has been a strong belief that leadership can be taught. Many public health leadership programs have come into being with the goal of training public health professionals to be better leaders with the belief that leadership is one of the key dimensions in building a stronger public health system. Parks has stated that there are important explanations of why people want to be leaders.[2] She calls these explanations "hungers" and discusses five of them as follows:

1. Hunger to contribute and make society better
2. Hunger to be in an authority position
3. Hunger to implement and explore systems issues
4. Hunger to show others how to adapt to change
5. Hunger to demonstrate moral courage on behalf of the "common good"

This chapter first discusses the abilities that public health leaders need at any level, including the personal level (i.e., when dealing with another individual one on one), then goes on to consider the particular abilities and strategies they put to use in heading a team, heading an agency, working on a community collaboration activity, shifting our perspective to the global level, or guiding their profession toward improvement. As we proceed, it is important to remember that each of the six levels of leadership provides a foundation

PUBLIC HEALTH HEROES AND VILLAINS 3-1 Dr. C. Everett Koop, a Public Health Hero

Dr. C. Everett Koop is one of the most well-known surgeon generals in U.S. history and also one of the most controversial. In 1982, President Reagan nominated Dr. Koop for the position of surgeon general. It was believed by the administration that the conservative evangelicals who supported Reagan would be happy with the Koop nomination. His conservative prolife credentials upset many in Congress. Many liberal women's groups, medical groups, and public health groups called on Congress not to approve the nomination. Although critics did admit that Dr. Koop was an excellent surgeon, they argued that he did not have appropriate public health credentials or experience.

Once confirmed, Dr. Koop surprised many of his advocates as well as critics. During his tenure, which lasted until 1989, he did not let politics interfere with his work on many public health issues. He showed his leadership abilities in many different areas as he went from one health problem area to another. Tobacco issues ranked high on Koop's public health agenda. He took on the tobacco industry in a fight to have warning labels put on tobacco products. He won. He worked to have smoking prohibited in public buildings and related places. In 1984, he was able to convince Congress to pass a bill requiring cigarette ads to include the health warning labels. His office issued a report in 1988 pointing to scientific evidence that nicotine was addictive. As of 2016, the impact of Koop's work still continues in the area of prevention of tobacco use.

The Reagan administration was slow to recognize the critical nature of the growing AIDS (acquired immune deficiency syndrome) epidemic. Once he was able, Koop wrote the official policy on AIDS and by the end of 1988, his office sent AIDS information to every household in America. Even though Koop thought the AIDS crisis was an important public health concern, he was criticized by gay activists for the way he targeted gay sex in his comments. Koop did say that the use of condoms was a preventive measure. He did pursue his comments on the crisis in spite of any criticism he might get. This is a clear leadership stance.

Koop also addressed abortion. Although he was antiabortion, he was not willing to say that abortions performed by qualified physicians were a health risk to women who chose to terminate their pregnancies, He supported the rights of newborns and children with disabilities.

for the next level. It is almost like going up a flight of stairs; we need to go up the first stair before going to the second stair. Skipping a stair might trip us up. A very good example of an individual who was able to move between the various leadership levels with very few obvious problems was our next public health hero—the former Surgeon General of the United States, C. Everett Koop.

LEADERSHIP AT THE PERSONAL LEVEL

This section considers some of the prerequisites for being an effective public health leader at any level. These prerequisites include a commitment to social justice, an understanding of democracy, an understanding of the political process, communication skills, mentoring skills, decision-making skills, and the ability to balance work and life outside work. There are at least nine learning strategies that will enhance personal leadership development activities:

1. Lifelong multidisciplinary learning
2. Systems thinking and complexity
3. Reading
4. Exploring the arts
5. Creativity
6. Family–work balance
7. Retreats and reflection
8. Experiential learning
9. Promoting a culture of health for our communities

Values

Public health leaders, to be fully effective, must be committed to the values that characterize public health, especially social justice. However, they should be careful not to let the social justice agenda prevent them from doing the tasks that need to be done. Furthermore, social justice is a broad concept and encompasses a range of different issues. The predominant social justice issue of concern to almost all public health leaders is equity in access to care. However, no consensus exists that, for instance, there should be a radical redistribution of wealth in the society at large.

A commitment to a value such as equity in access to care entails a willingness to challenge the political status quo and act as an advocate for the public health agenda. Leaders are supporters of organizational and community values and should be on the front lines in attempts to make public health practices and policies conform to these values. Leaders also must be at the front line if values need to be changed, modified, or reinterpreted.

Politics and Governance

Public health leaders need to understand the political system of the location in which their activities take place. In this country, they must understand how the American version of democracy works at the local, state, and national levels and how to influence the political process. As an example, the author, on a visit to the office of a public health professional in a state health department, noticed *The Federalist Papers* and de Tocqueville's *Democracy in America* on the shelf. The public health leader said that he often referred to these books for guidance in making decisions.

One question that arises is whether there is a difference between government (or governance, the activity of governing) and politics. Governance, in large part, consists of administering programs and adjusting them to fit policies developed as part of the political process.[3] Unfortunately, these policies are sometimes not founded on the best available evidence but instead reflect the personal concerns (including the desire to get reelected) of the politicians who vote them into existence. Several years ago, I talked to a state legislator about having a school of public health supply data on specific health issues and social determinants of health of interest to the legislator. He refused the offer, because, according to him, he did not need data to make his decisions. (As someone has pointed out, politicians have "spin doctors," whereas government agencies have "spokespeople."[4] That says something about the difference between politics and government.)

Public health agencies are government agencies, and public health leaders are implementers of policies set by politicians. This creates interesting possibilities for a partnership between the political and governmental sectors. Leadership theories often focus exclusively on organizational tasks, such as setting organizational policies and motivating the workforce, but public health leaders should develop the skills necessary for working with elected officials. Their role is to use the values, mission, vision, and goals and objectives of their agency to clarify public health issues and ensure that the policies created to deal with these issues will have a good chance of being effective.

Communication and Empowerment

The AIM Leadership Model is based on the idea that leaders have to learn to take action, learn how to influence the field, and be motivated by the process.[5] According to the model, the five building blocks of effective personal leadership are communication, the empowerment of followers, a focus on key issues, linkage to others, and life balance. Each of these building blocks is affected by leadership style and practices as well as the systems approach to organizational change.

Good communication skills are critical. Effective communication has several aspects, including slowing the thought processes, increasing understanding, testing conclusions, listening constructively, getting to the essence of things, and exploring areas of disagreement.[6] In addition, gender differences, racial or ethnic differences, and age differences can affect whether messages are received as intended.[7] Leaders need to understand all the factors that influence communication so they can synthesize public health information into effective messages.

Leaders, in trying to empower work and community associates, often act as their mentors. Interaction between leaders and constituents is critical,[8] and leaders need to empower "followers" in ways that give them the chance to be more effective as well as to develop their own leadership skills. Followers are themselves people with exceptional talents, and according to one study, 80 percent of the effectiveness of a project is due to the followers and only 20 percent to the leadership (80/20 rule).[9]

Leading and Following

Followers in one situation become leaders in another, and many public health practitioners see themselves in both leadership and follower roles. Public health practitioners who work for public health agencies see themselves as professionals first and even leaders in their profession, but those who are part of a traditional public bureaucracy are frequently expected to be less leaders than followers, which can create a contentious work environment.

Members of a board of health often see themselves as powerful individuals and therefore as natural leaders. Health administrators also see themselves as leaders rather than followers. This may lead to conflict. For example, a health administrator addressing a group of public health professionals in a leadership program said that it was his job to protect board members from gossip and controversies. A local board of health president who was in the training program said that if the health administrator kept information hidden from board members, someone in the community would give

them the information instead. Board members need information and lose trust in health administrators who hold back information.

Another board of health president pointed out that the administrator of the health department was his employee, because he could fire the administrator and recommend cutting the local health department budget. This shows how important it is for the board of health members and the public health administrator to develop an understanding that they are partners. In this regard, governance has an important role to play.[10] A governance public health framework should include mechanisms for organizing values, carrying out the public health mission, formulating goals and objectives, developing realistic action plans, resolving conflicting agendas, determining the need for structural change, improving the relationship between the board and the health department, and developing mechanisms to share governance with the appropriate governmental body. As one public health leader stated:

> To create effective governing boards, we must examine our values and determine why our boards need to exist. Once we discover our common purpose, we can develop skills and processes to improve our effectiveness. Boards and administrators need a shared vision, commitment, and leadership to make goals a reality. As public health leaders, it is our job to develop boards that are a part of our leadership teams and join us in creating healthy communities.[11(p.11)]

Agenda Setting

Public health leaders should learn about and use the systems approach to organizational change and the public health core functions model to ensure that their agencies' agendas are tied to the core functions of public health. In addition, they must master the art and science of public health. Leaders are the grand integrators of science and practice, and part of their job is to explain public health issues to health professional associates and community partners.

Leaders should acquire agenda-setting skills. An organization needs to prioritize the problems that it is facing and create action plans that deal with the largest problems first. Rogers and Dearing[13] developed a model for agenda setting that included the creation of a media agenda, a public agenda, and a policy agenda. The fact that public health leadership practice takes place in a government setting means that community and political realities affect the agenda-setting process. Also influencing the process are gatekeepers, the media, and spectacular news stories (e.g., a story about children becoming ill after eating in a fast-food restaurant).

Barriers to Effectiveness

In 1988, the Institute of Medicine issued a report stating that the public health system in the United States was in disarray.[14] The report listed a number of barriers that reduce the ability of public health leaders to be effective, including the following:

- A lack of a consensus on the content of the public health mission
- Inadequate capacity to carry out the essential public health functions of assessment, policy development, and assurance of services
- Disjointed decision making uninformed by the necessary data and knowledge
- Inequities in the distribution of services and the benefits of public health
- Disharmony between the technical and political aspects of decisions
- Rapid turnover of leaders
- An inadequate relationship between public health and the medical profession
- Organizational fragmentation
- Problems in relationships between layers of government
- An inadequate development of necessary knowledge across the full array of public health needs
- A poor public image of public health, inhibiting necessary support
- Special problems that unduly limit the financial resources available to public health

Without question, the public health system in the United States needs to become more effective, and public health leaders will be at the forefront of attempts at reform.[15] One problem is that public health agencies are dealing with more complex problems today, and the complexity of problems in the areas of infectious diseases and chronic diseases will probably continue to increase. Therefore, organizational stability may not be possible to achieve. In addition, public health professionals come from different disciplines with different approaches to problem solving, which leads to professional disagreements.[16] Only through collaboration will effective problem solving and decision making occur.

In a speech before the Illinois Public Health Leadership Institute in 1992, George Pickett said that public health leaders need to increase their skills transorganizationally;

that is, they need to be able to understand and communicate with others in community sectors with values and priorities different from theirs. Public health leaders are often deficient in collaboration skills,[17] and consequently they are sometimes prevented from cooperating effectively with leaders from important sectors, such as the business community and the religious community. Fortunately, obstacles to cooperation are becoming less frequent.

It should be noted that, in general, leaders who are extremely effective tend to be key players in rather than reactors to the change going on around them.[18] Effective leaders, when confronted with a problem, typically consider a wide range of options and seem to know how to select the important factors first. They also think in terms of win–win and try to arrange it so all parties are winners in a dispute. They are good listeners who try to understand others and their perspectives before trying to make themselves understood. They are excellent synthesizers who try to foster cooperation and collaboration. Finally, they constantly renew themselves through training, education, exercise, values clarification, and so on.

Leadership Style

Public health leaders need to develop an appropriate leadership style. Autocratic and directive styles work best when the leader structures the tasks and the workers are willing to do what the leader asks. In public health, the democratic style seems to work better.[19] Participative forms of leadership, in which staff members are involved in the problem-solving process, facilitate the building of a consensus and the acceptance by the staff of the decisions reached. Collaboration should be viewed as a creative process the goal of which is to discover new approaches and new solutions for old problems.[20]

Dealing with Diversity

Professional diversity in public health brings its own set of problems.[21] Practitioners from different professions view public health differently. Public health leaders need to look at public health in its totality and develop strategies for integrating the different approaches. Public health leaders need to confront not only professional diversity but gender, race, ethnic, and age diversity. For example, the so-called glass ceiling for women still exists,[22] and therefore public health leaders must conscientiously promote gender equality. The first step is to gather the data necessary to determine whether gender inequalities exist and, if so, where they exist. The next step is to hire a consultant to evaluate the agency's environment and its receptiveness to gender equality. The third step is to use a benchmarking process (comparing the agency with the best agencies, not the average ones) to identify best practices for achieving gender equality and taking full advantage of the skills that women bring into the workplace. The final step, so to speak, is to prepare oneself for a backlash.

Diversity encompasses gender, age, race, ethnicity, sexual orientation, work and family issues, education, work experiences, tenure within the agency or organization, personality, risk tolerance, geographic region, and religion.[23] A unified diversity enhancement program for public health professionals and clients may be difficult to construct because of the different issues that are prominent in each diversity category.

One way for public health leaders to deal with diversity issues is to empower staff so that they become advocates for themselves. It is important to understand how human beings in our society act and what needs they have. In his classic work *Motivation and Personality*, Maslow defined a hierarchy of needs.[24] At the most basic level, individuals want their physiological needs met. Second in order of importance are their safety needs. In other words, issues of job security and amount of income are critical for most people. Next come social needs, including the need for recognition by colleagues. One level up, people want to experience a sense of self-esteem. They want to take pride in their work and hence want to be empowered to do a good job. A professional who works well and without the need of much direction will usually be allowed the freedom to design his or her own activities, an almost sure way of increasing self-esteem. Finally, people have a need for self-actualization—the ability to make personal dreams become reality.

Balancing Work and Play

Work has a tendency to take up most of a leader's waking hours, and family life can suffer as a result. O'Neil called this dilemma the paradox of success.[25] In his view, the myth of success is that success offers complete fulfillment, is tied to how much money is made, and increases freedom. In fact, success causes a constant craving for more success and hence can lead to a kind of bondage. Factors that can help a leader keep a balance between work life and private life include self-knowledge, managing conflicting pressures, and maintaining a concern for how others feel.[26]

Women seem to be proficient at balancing personal and professional interests. For working women with a family, work and home are full-time jobs that they typically seem to handle equally well. At work, women, by redesigning their positions and demanding employee training and development, are helping to break traditional organizational molds.[27]

They are also helping to break down the barriers between home and work by pushing for flextime, child care, and family leave.

This section raised and discussed many issues related to personal leadership development. Following is a list of leadership strategies that can be used to increase one's leadership skills and abilities:

- Be a value role model. Live the values that the community espouses.
- Understand the democratic process and how it affects the public health system.
- Translate political policy into action.
- Improve communication skills.
- Be a mentor to others.
- Learn to follow when appropriate.
- Be partners with the agency's governing board.
- Learn agenda-setting skills.
- Address barriers to effective public health practice.
- Explore community partnerships.
- Be creative in finding new funding sources.
- Balance work and family.
- Increase leadership opportunities for others.

At the personal level, leaders struggle with the issue of how they spend their time and on what. **Exercise 3-1** is a quick exercise on how you use your time, including how much of your work time is spent on management activities and how much on leadership activities.

EXERCISE 3-1 Only 100 Percent

Purpose: to define how much time is spent on management activities in contrast to leadership activities

Key Concepts: management, leadership, time, organizational needs

Procedure: Pick an organization for which you have a leadership role. Using 100 percentage points, how many points would you give to your management activities for the organization and how many points for your leadership activities. If you are spending more time on management activities than you are spending on leadership activities, how would you reduce your management activities and increase your leadership activities? Discuss these strategies with the class or workshop as a whole.

LEADERSHIP AT THE TEAM LEVEL

Public health leaders do not work alone. Public health practice is a group activity. Therefore, among the most important skills a leader can possess are those that are necessary for building and maintaining teams and increasing their effectiveness. It seems that somebody always wants to take charge when even two people are in a room. A team is a group of people who come together to pursue a common purpose.[28] The results of the team's activities are often greater than the sum of the results that would have occurred had each team member been acting alone.

Each team member should be viewed as leader although one person will generally become the official leader. The team leader will share information in an equitable manner with other team members.[29] The leader will build trust in the team process and share authority and power with other members. The leader will also intervene when necessary to move the team forward. The expectation is that all members will be involved in the performance of the team tasks.

Team members who are also members of the public health agency may need to act as a link between the team and the agency and community constituents. These team members, in particular, will need to learn the skills of conflict resolution and negotiation. When a skilled leader guides the team process, creativity and innovation are the result.

Reasons for Creating Teams

The reasons for creating teams include the following: First, a team allows an organization to use the leadership skills and talents and the multidisciplinary and multicultural backgrounds of its staff. For example, a multidisciplinary team that includes nurses, social workers, and environmental health specialists, among others, might be assembled to address the low level of prenatal care in the community. If we add multicultural team members, potential conflicts may arise due to different cultural orientations related to prenatal care. Second, creating a team allows the members time to get to know one another and to develop a sense of togetherness in the context of shared leadership. In general, team members find they can communicate with each other better even after they have left the team or the team has been disbanded. In addition, they learn how to cooperate and collaborate, and cooperation and collaboration increase productivity.[30] Finally, team decision making produces decisions that are supported by the majority of the team's members.

Teams that are created to lighten a supervisor's workload are often doomed to failure.[31] Teams are not a replacement for training and not a way for leaders to observe the opinions

and working style of the staff. Teams do not necessarily increase the personal productivity of their members. They need leaders to clarify issues and set the parameters of their activities.[32] One of the strengths of teams is that they are flexible and can reorient themselves as roadblocks occur. Yet the freedom teams are given can be a weakness as well. Teams sometimes fail because they lack discipline and a sense of responsibility for achieving the desired outcomes. When team members realize they will be completely in charge of their activities and will have the power to make decisions, they sometimes abuse this power, with negative results for the agency. This risk can be reduced if the agency leaders make clear to each team how they expect it to proceed and what results they expect it to achieve.

Leadership teams work differently than management teams. Management teams carry out the instructions of a supervisor. Their tasks are circumscribed, and there is very little room for creativity or innovation. Leadership teams share leadership with the public health administrator, who openly delegates decision-making power to them. In some leadership teams, the health administrator becomes a team member. If given the trust of the agency administrator, leadership team members become committed to the agency and lose their fear of reprisal. They feel that recommendations will be seriously considered.

Facts About Teams

Katzenbach and Smith studied teams in 30 organizations, including businesses, schools, and social agencies.[33] They found that teams were critical for building high-quality organizations and improving customer service. The authors came up with 10 findings about teams in general. The first finding is that teams are created to address a performance challenge, and indeed a leadership team must have a purpose (mission) if it is to succeed. The second finding is that the team's composition and its purpose need to be thought through. Not every leadership team should be of the same size or professional composition. Third, leaders need to promote team performance opportunities. As the leaders view the organization, they will find these opportunities exist throughout. Fourth, many teams composed primarily of people at the top fail because of the other demands made on these individuals' time and energy. Fifth, organizations and their leaders find it easier to work with individuals than with teams. Everything, including the hiring of people, the determination of salary, the construction of career paths, and the monitoring of performance, is oriented toward the individual. Teamwork seems to go against the structure of individual responsibility.

The sixth finding is that organizations committed to high performance standards are more likely to use teams than organizations with lower performance standards. Seventh, very few high-performance teams exist. High-performance teams can be either leadership or management teams. However, leadership teams are generally clearer on the purpose for which they were created. They take control of their activities and promote the development of relationships between their members. They build team activities on good communication. The leaders maintain their flexibility, work productively together, and recognize the accomplishments of their leader colleagues. Leadership teams also seem to have high morale. (High-performance teams can be created using the PERFORM model, propounded by Blanchard and colleagues.[34] The acronym stands for Purpose, Empowerment, Relationships and communication, Flexibility, Optimal productivity, Recognition and appreciation, and Morale.)

The eighth finding is that teams do not replace organizational hierarchies. Instead, teams enhance these hierarchies, partly because they are able to cross over structural boundaries. Because of the strong community orientation of public health agencies, leadership teams can be used to address community concerns. These teams may include community partners among their membership.

The ninth finding is that teams are small learning organizations that integrate performance and learning. Typically, a team will do research on a subject related to its purpose. Team members also learn team-building and leadership skills. They often learn that each member is a leader or potential leader. The conjoining of performance and learning in teams is generally a plus, because their conjunction throughout an organization is often a prerequisite for the organization to increase its effectiveness. This applies to public health agencies as well.

The final finding is that teams are effective in addressing new issues as well as old issues. In the case of old issues or problems, they often discover new solutions. One reason teams are good at discovering solutions to problems is that they view the problems from a systems perspective rather than using the traditional cause-and-effect approach.[35] They are also experts at sharing information and coordinating actions, and members of one team frequently tie their activities to the activities of other teams working on different though related issues.

The important question is why so many teams fail when their importance to the work of public health is so important. Lencioni pointed to five major dysfunctions that affect the success of team-based activities.[36] First, teams fail when there is a lack of trust either in their organization or in their

leadership. This includes the implicit leadership of the team as well. Second, team members fear conflict and contesting the decisions of other team members. Conflict is not necessarily a personal issue but rather is often an issue related to the challenge that the group must address. The third dysfunction relates to the level or lack of commitment of team members to the process. If there is a lack of commitment, then the fourth dysfunction occurs. The lack of accountability will often affect the effectiveness of team activities. The fifth dysfunction relates to the problem of ignoring the results of the teamwork regardless of the reasons. If the boss had the team do busywork or did not allow the team any involvement in the decision-making process, all the dysfunctions come into play. There will be no trust, no conflict on the surface, no commitment to the process, no accountability, and obviously no attention to the results.

Teams build social capital, which brings people together in a way that individuals alone cannot do. Building social capital helps to develop trust, allows for shared leadership and creativity, expands social networks for the team members, develops shared purpose in team activities, levels the playing field for the members in terms of equity, increases collaboration and commitment, enhances knowledge sharing, and fits different talents of individuals into a comprehensive whole.[37] Teamwork provides many benefits to the individual as well and creates satisfaction and sometimes personal rewards in the accomplishments of the team.

Team Classification

Many writers have attempted to classify teams. One helpful classification is as follows:[38] Natural work teams are made up primarily of individuals who work together as part of their regular activities. These teams, which can be either management or leadership teams, are usually given a set of designated activities to perform. Cross-functional teams, the second type, include members who have different functions within the organization. They are primarily leadership teams. Corrective action teams are management teams assigned to work on the solutions to problems that are already determined. Finally, hybrid teams address issues not addressed elsewhere in the organization. They may be either management or leadership teams, and they use the techniques associated with all the other types. Local public health departments use all four types of teams.

The Importance of Empowerment

Teams and their members need to be empowered by administrators to take active decision-making roles.[39] Empowerment, which gives team members the freedom to use their knowledge, experience, and skills to address important issues,[40] tends to increase their commitment to the agency and the level of their performance as well. Empowerment must come from the agency leader, and there appears to be a direct relationship between the amount of responsibility staff are given and the degree of their empowerment.[41]

The transfer of power to a team must be real and not merely nominal. A public health leadership team from a state public health leadership institute worked with a local health department to develop a lead-screening program for children. The administrator allowed the team to work on the creation of this new program because she had been told by the state to develop the program. However, the administrator viewed the team members as outsiders, and though she told them that she had respect for them and would seriously review any recommendations they made, she used the team merely to show the state that she was complying with its request and in reality had no intention of implementing the team's recommendations. This is an example of team activity subverted by a hidden agenda. The power to have an effect on the development of a program through recommendations was implied but was in fact an illusion.

Empowerment is related to organizational values, leadership activities, human resource systems, and the structure and activities of the organization.[42] Empowerment is often used as a tool for the improvement of programs and services. With empowerment, teams can improve their performance and customer service.

Teams and Leadership Style

The situational leadership model identifies four leadership styles: directing, coaching, supporting, and delegating. This same classification can be applied to team-based activities.[43] When a team is first created, the leader is involved in formulating the team's purpose and determining the activities to be performed. The leader, in other words, is using a directive style. During the next phase, the leader, acting as a coach, clarifies the team's activities. The leader then begins to involve team members in decision making, a process that falls into the category of providing support. In the final phase, the leader empowers the team members, and empowerment, as pointed out, is closely related to the delegation of responsibility.

It is also important to concentrate on the leadership activities associated with working on teams. LaFasto and Larson discussed the six tasks of team leadership.[44] First, leaders clearly need to pay attention to the goals of the project that will occur during the teamwork. Second, the critical nature of collaboration within the team to get the work done

is an important leadership activity. Third, team members like to think and feel that the team process builds their confidence in the way the work is progressing. Team members want to see short-term and long-term results in the work. Team leaders need to help build this confidence and be willing to keep team members knowledgeable about external events that affect the work of the team. Secrets defeat teamwork. The fourth leadership activity involves leaders demonstrating technical knowledge and abilities. This activity also means the leader will ask for help or technical assistance when necessary. The fifth leadership activity involves keeping the team on track by setting priorities. It is important to keep the team on task and prevent distractions if possible. When priorities change, leaders must inform the team. The sixth and final task relates to the necessity of managing performance, giving feedback through the group process, and rewarding results.

Of course, teams are at different places in their involvement in and commitment to the tasks they have been assigned, and leaders need to monitor team readiness, which ranges from unable and unwilling to carry out the team assignment to able, willing, and confident. In some cases, leaders may have to use planning strategies for key team members as well as for the team as a whole.

One useful team technique, based on the so-called skunkworks model, is to send a team to a neutral place away from the organization to work on issues related to the team's activities.[45] The "skunkworks" is a subteam composed of experts on the topic that is the focus of the team activities. These team members tend to be transformational leaders who will move the organization forward.

Team Members

Mallory studied the characteristics of various types of team members.[46] Some members tried to take control of the activities of the team, and these he labeled dominant members. These individuals do well in structured situations with a well-defined purpose. The influencers tend to be creative and extremely talented in interpersonal relationships. They also tend to be optimistic and try to keep the team together. The balancers look at the big picture in an objective manner and try to reconcile the differences among the team members. The loyalists are committed to the status quo. Each actual team member, although mainly of one type, has at least a little of every personality characteristic associated with any of the four types.

Team members benefit in several ways from working on a team. First, they gain experience in working together with colleagues on a project.[47] They also learn problem-solving skills, interpersonal relationship skills, and new technological information. In addition, they learn about accountability from a personal perspective as well as a team perspective and become more committed to the team's goals and objectives.

The Life Cycle of Teams

Teams have a life cycle that is similar to the life cycle of human beings.[48] A team starts out as an infant and disbands as it ages and finishes its tasks. Organizational leaders must develop the ability to function as team leaders at each stage of the team life cycle. This is especially true in the public health field, where so many leadership activities occur in a team setting.

Following are guidelines that organizational leaders should use when creating and working with teams:

- Develop teams to address agency or community public health problems.
- Choose multidisciplinary team members for their expertise and leadership qualities.
- Allow teams to make decisions and recommendations for change. Share power and control.
- Share information.
- Intervene in the team process when necessary.
- Do not create teams to alleviate your workload.
- Use the skunkworks technique for dealing with team issues.
- Tie team development to performance standards.
- Put a time limit on the activities of the team.

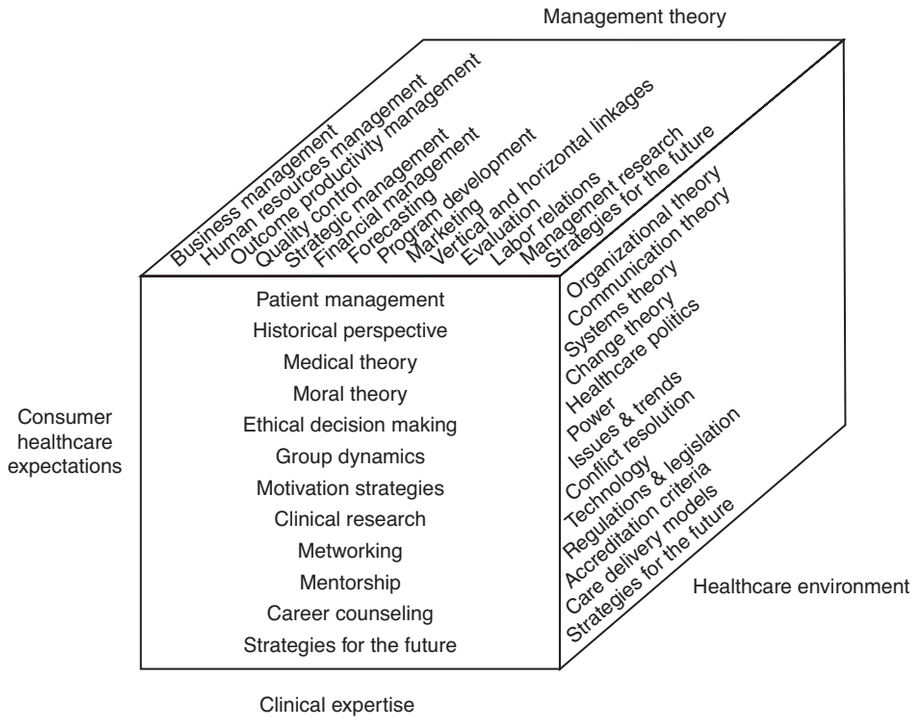
LEADERSHIP AT THE ORGANIZATION LEVEL

In a 2011 book on management in the health field, the authors claimed that managers nowadays have to integrate clinical practice skills and management skills.[49] The view propounded here is that public health leaders have to integrate public health practitioner skills, management, and leadership skills.

Currently, public health agencies typically have a management orientation. In the 21st century, they will need to become consumer and community driven. [50] The leadership expertise of agency staff must be increased if the agencies are to keep up with the speed of change. **Figure 3-1** shows the relationships among management theories, the healthcare environment, clinical expertise, and consumer healthcare expectations. Most of the items listed are relevant to public health as well as medical care. Two missing items that pertain particularly to public health are building community coalitions and health promotion and disease prevention.

Public health agencies, along with other types of organizations, are undergoing many reforms but need to change

FIGURE 3-1 Characteristics of the Healthcare Management Role



Reproduced from J.G. Liebler and C.R. McConnell, Management Principles for Health Professionals, 4th ed. Sudbury, MA: Jones & Bartlett, 2004.

further. For one thing, they have not fully incorporated the lessons of business. They are still run as traditional bureaucracies, although community groups are trying to take a role in the making of decisions about public health issues.

In a bureaucracy, the managers and leaders are often far removed from the daily activities of the staff,[51] yet they feel the need to control these activities. Perhaps this is one reason that Peters and Austin urged the importance of "managing by wandering around."[52] Of course, it is true that leaders need to monitor operations, but they also need to delegate authority to managers and staff members.[53] By doing this, they can help make the professionals in their organization excited about coming to work in the morning. Leaders need to remember that associates are customers too.

In the late 1950s, Drucker noted that traditional bureaucratic organizations were gradually becoming knowledge-based organizations.[54] Public health agencies have always been knowledge based, and in fact business communities can learn much from public health leaders about knowledge-based organizations and how they work. However, the models for knowledge management are more developed on the business side. For example, Tiwana has examined the four phases of knowledge management strategies for knowledge-based organizations.[55] First, it is necessary to evaluate the current structure for dealing with knowledge in an agency (an infrastructure issue). Second, it is important to develop the system related to knowledge in terms of the analysis dimension, the design of the system, and how it is developed. Third is the issue of deployment and how to use the results of the performance evaluation of the system and to make refinements as necessary. Public health leaders have an important role in knowledge management. It will be important for leaders to apply these phases to public health and to modify the models to better reflect the knowledge management aspects of public health practice.

Public health leaders, in order to thrive in the ever-changing environment, need to make a commitment to change and to focus on increasing customer satisfaction, fostering innovation, empowering staff, and instituting appropriate structural reforms.[56] Leadership is not just a matter of charisma; it is hard work.[57]

Nanus identified four main leadership roles.[58] First, public health leaders (to keep to the focus of this discussion) are spokespeople who present the contemporary public health issues to the community. Second, they are "direction setters" and involve community leaders in prevention activities and in the search for ways to increase the level of health in the community. Third, they act as coaches or mentors for agency associates as a means of improving the agency's effectiveness. Finally, they act as organizational change agents.

Public Health Functions

From the 1840s to the 1940s, six basic local health agency functions evolved: the collection and interpretation of vital statistics, sanitation, communicable disease control, the provision of maternal and child health programs, health education, and the provision of laboratory services.[59] Between 1940 and 1980, other functions were added, including the provision of environmental health services, the development and provision of personal health services, the coordination of community health services, the operation of medical care and public health facilities, areawide planning, and the assessment of the adequacy of health services. The year 1988 saw the release of the Institute of Medicine report on public health. This report promoted the use of core functions to organize the activities of public health at the community level.[60]

Public health leaders have changed as public health has changed. They have adapted to new developments and devised innovative approaches to performing the standard public health functions. Since 1995, local health departments have continued to change. Many direct service activities have been outsourced. Local health departments have reoriented some of their activities to emergency preparedness and response activities.[61] Different organizations, performance management committees, and public health professional writers will often come up with different lists of required services and performance measures. Thus, it is important to determine the credibility of the source.

Not all states have local public health agencies. In states that do not, the state health department operates like a local agency. In states with local agencies, the activities of the state health department leaders are separate from the activities of the agency leaders. For example, state health departments have tended to stay away from the provision of direct services, especially in the case of services being provided by local public health agencies.[62] A state health department may provide special services that the local agencies do not offer. It is also likely to be engaged in overseeing and coordinating public health activities in the state.

State health department functions include communicable disease control, tuberculosis control, venereal disease control, acquired immune deficiency syndrome monitoring, sanitation, industrial hygiene, dental health, laboratory services provision, public health nursing, case management, maternal and child health program provision, public health education, technical assistance, public health workforce training, development of new local health departments, epidemiologic surveillance, regulation of healthcare facilities, licensure, inspection, cancer screening, and many more. The state health department also serves as the repository for state health data. Since 2001, the activities related to emergency preparedness and response have been added to the list. There clearly is still a need for inclusion of emergency mitigation and recovery dimensions for public health work as well.

State health department leaders are responsible for organizing the state public health system to reflect its mission, vision, and goals and objectives. They need courage to carry out their action plans in the face of community opposition and must know how to reform the state public health system without overstepping the boundaries of the state political system because, among other reasons, the state is the conduit of funding for local public health agency programs.

In order to see where our performance measurement thinking is today, a recent list of measures was determined by the U.S. Department of Health and Human Services (HHS) in 2011.[63] There are five major goals for public health and a number of objectives tied to each goal. The five major goals are:

1. Strengthen Health Care.
2. Advance Scientific Knowledge and Innovation.
3. Advance the Health, Safety, and Well-Being of the American People
4. Increase Efficiency, Transparency, and Accountability of HHS Programs
5. Strengthen the National HHS Infrastructure and Workforce.

The goals provide a framework for state and local agencies and their leaders to guide public health programs going forward.

Responsibilities of Public Health Leaders

Leaders of local public health agencies have the responsibility to promote their agencies. They make sure the agencies are viewed as repositories of public health information as well as providers of high-quality programs and services. They develop relationships with the leaders of public health agencies throughout their state and also develop partnerships with community health providers.

Funding, of course, is critical for strengthening the public health system, and there is currently intense competition in the entire health industry for additional money.[64] Public health leaders must be involved both in the allocation of public health funds and in the funding for related health service programs. They will need to make strong arguments for public revenues. Public health leaders have become more entrepreneurial since the 1990s. They received grants from and developed contracts with public and private funding organizations to supplement their base budgets. Fund-raising should be tied to the mission and vision of the public health agency.

Public health leaders are concerned with excellence in public health. They act as role models for emerging public health leaders. They develop benchmarks for best practices. In their oversight role, they motivate community providers to improve their performance. They work with the leaders of other organizations to develop a comprehensive, integrative approach to improving public health in the community. Public health agencies do not want to duplicate programs or services adequately provided by others, although they might offer competing services if the quality of a community provider's services is open to question.

Public health agency leaders have important responsibilities toward agency staff. They must honestly monitor and evaluate job performance and job satisfaction.[65] If job evaluations are done fairly and regularly, staff will be able to learn their full job responsibilities and meet them more effectively. In addition, public health leaders must be enthusiastic about the task of protecting public health and be able to motivate their colleagues to be enthusiastic as well, by fostering collaboration and sharing power with them, for example.[66] They also should cheer colleagues and their progress. Einstein's formula $e = mc^2$ has been reinterpreted as enthusiasm equals mission times cash and congratulations. People have to be cheered, and they also have to be paid for their efforts.

As noted already, leaders need to empower agency staff. Empowerment must occur at the team level, the agency level, and the community level.[67] Leaders empower their employees by delegating work to them and trusting that they have the skills to carry out the work activities. If the employee needs special training, the leader must provide it.

In summation at the organization level, public health leaders have the responsibility to:

- understand how the agency functions
- delegate authority whenever possible
- monitor client satisfaction
- develop performance measurement metrics
- make structural changes in the agency to accommodate new or emerging public health issues
- encourage knowledge management systems development
- explore alternate futures for the agency
- apply the core functions model to agency activities
- empower the agency staff and the community residents

LEADERSHIP AT THE COMMUNITY LEVEL

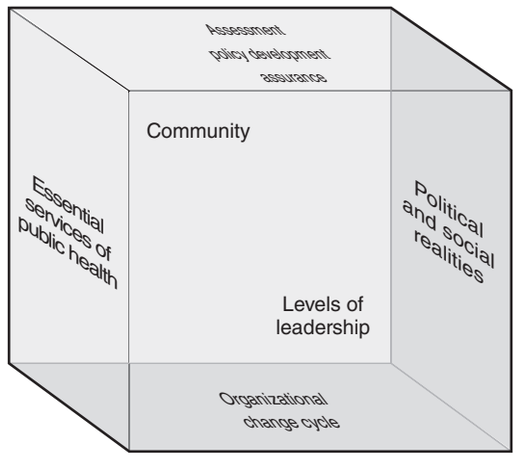
Leadership at the community level requires more systems-based skills than are used at the team and agency levels. At this level, public health leaders work to increase the visibility of the public health agency. In interviews with 100 American public health leaders, the author found consistent agreement that the public lacked in-depth knowledge about public health. Thus, public health leaders have a duty to provide public health information to the business community, the medical and health industry community, social agencies, and the general public. Public health leaders need to develop skills in community building in order to work with community groups to create an environment for positive social change.

Figure 3-2 shows the dimensions of public health leadership. Public health leaders build on the core functions model, regardless of the level of leadership, while taking into account the political and social realities that affect the agency and the community. Public health agencies must take into consideration social and political issues if they are to survive. For one thing, they are mandated by funding sources to provide certain basic services and programs. (This raises the issue of the proper balance between mandated services and community-based services and programs not included in the mandated services protocol.)

The Nature of Community

Over the past couple of decades, business discovered community.[68] Business leaders now see that community involvement needs to be part of the practice of business. Public

FIGURE 3-2 Dimensions of Public Health



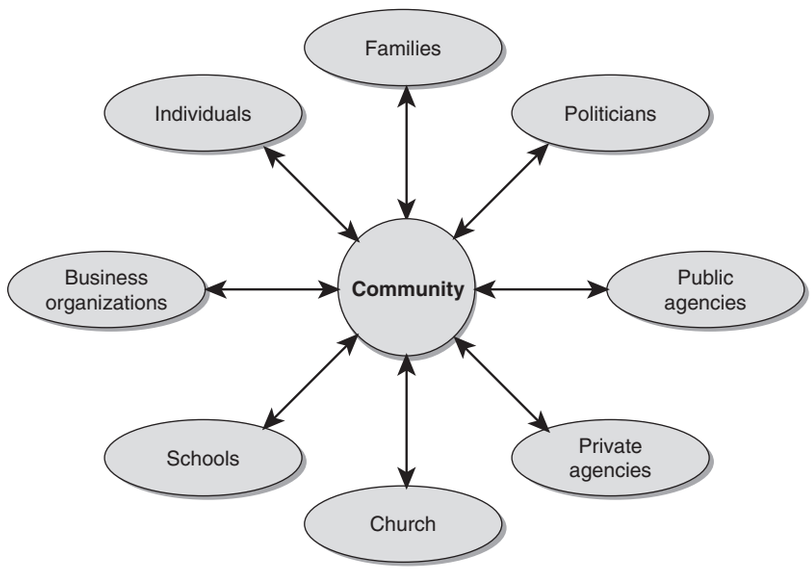
health agencies, by their nature, serve communities, but serving a group of citizens who live in a specified geographic area does not mean community issues are being addressed.

My study of public health leaders found that their efforts at developing community coalitions have been uneven at best. Almost all of the respondents stated that public health agencies have not been successful in getting the public to understand public health.

Community is more than bricks and mortar. It is more than a place to live. It is the place in which our dreams and aspirations are or are not fulfilled. When we talk about improvement in our quality of life, community is part of the improvement process. Community is the place where values are put into action. Community is a complex system made up of individuals, families, politicians, health organizations, human services agencies, churches, schools, businesses, business organizations, and so on (**Figure 3-3**). It is a system that accepts challenges, and to develop the resources to deal with them it needs to be built on the strengths of its constituent parts, not on their weaknesses.[69]

One view currently prevalent is that we need to rediscover civility.[70] Civility requires that community leaders be open to the opinions of other people and other organizations. It also means that it is important not to degrade others. If civility training is needed, it should include a discussion of civility and its components, the relationship of civility to leadership, problem solving and decision making, conflict

FIGURE 3-3 Community Constituents



resolution and negotiation, levels of collaboration at the vertical and horizontal levels, systems thinking, values and ethics, and the relationship of civility to trusteeship. Furthermore, public health leaders must transfer the leadership skills they use at the team and organizational levels to the community level. Leaders build communities in all their leadership activities.

Advocacy Through the Media

Media advocacy is an important way to promote public health programs and services.[71] The use of social media like Facebook and Twitter is another approach. Public health leaders should learn how to use the media to create support for agency goals. For example, they should consider sending letters on a regular basis to newspapers and other sources to increase the visibility of public health.

Think of the importance of using the media in the following situation: a public health leader in a conservative, middle-class community discovers that five cases of human immunodeficiency virus infection have recently been discovered. A statistic like this can hit the nerve center of a community. It is the public health leader who will have the skills to defuse the crisis and get community constituents to become partners in dealing with the problem.

One of the most important responsibilities of public health leaders is to promote prevention at the community level.[72] Our knowledge of health and disease is constantly growing, and new technologies and community-based prevention strategies are continually being developed to address public health concerns. The public needs to be convinced of the importance of using these technologies and strategies. It is the job of public health leaders to make the case.

Linking Programs

There is a good argument that public health programs should be linked together where possible.[73] The Centers for Disease Control and Prevention created prevention research centers in a number of universities. Many, if not all, of these centers rely on community support to carry out their activities. Public health leaders, who see the future of their agencies as tied to primary prevention rather than direct services, know that linkage to academic programs will strengthen the infrastructure of public health in their communities.

Community Building

Community building is a complex process that does not occur overnight. Peck's analysis revealed four stages.[74] In the first stage, various community representatives who have formed a coalition pretend to have the community's interests at heart in order to gain acceptance for their own agendas. Peck called this the pseudocommunity stage. The second stage, which begins when the coalition realizes that community concerns are not being addressed, is one of chaos. Next comes the stage of emptiness, in which the leaders have to empty themselves of all their preconceived notions about the community and its concerns. It is extremely difficult for the leaders to leave their agendas at the door. The fourth stage is when true community comes into being.

Organizations involved in building a community need leaders.[75] These leaders must be students of the community and its culture and be able to involve individuals with different power bases in community change. Because each community resident has an agenda to which he or she is committed, leaders have to find ways to reconcile the differing agendas.

Community coalitions ideally should be learning organizations.[76] The members of a coalition need to examine their predispositions and how these predispositions affect the community-building process. In addition, the scientific perspective should be incorporated into the group's deliberations.

Community building is best achieved through the use of collaborative leadership.[77] Following are 10 factors that can contribute to the success of collaboration and community building:

1. Good timing and a clear need
2. Strong stakeholder groups
3. Broad-based involvement
4. Credibility and openness of process
5. Commitment and/or involvement of high-level leaders
6. Support or acquiescence of "established" authorities or powers
7. Overcoming mistrust and skepticism
8. Strong leadership of the process
9. Interim successes
10. A shift to broader concerns[78]

Coalition Building

Coalition building is an important part of empowering communities. Public health agencies can no longer work in isolation. Community leaders need to be involved in addressing public health issues. The major advantage of a coalition is that all voices are heard and programs can be developed that better reflect the health needs of the community. The major disadvantage is that being part of a coalition is time consuming.

Cohen and colleagues developed an eight-step model for developing community coalitions (**Table 3-1**).[79] The model

TABLE 3-1 Eight Steps to Building an Effective Coalition

Step 1: Analyze the program's objectives and determine whether to form a coalition.
Step 2: Recruit the right people.
Step 3: Devise a set of preliminary objectives and activities.
Step 4: Convene the coalition.
Step 5: Anticipate the necessary resources.
Step 6: Define elements of a successful coalition structure.
Step 7: Maintain coalition vitality.
Step 8: Make improvements through evaluation.

Reprinted with permission of Contra Costa Health Services, *Developing Effective Coalitions: An Eight Step Guide*. © 1994, Contra Costa County Health Services Department Prevention Programs.

is based on the experience of the Contra Costa County (California) Health Services Department Prevention Programs. The authors define a coalition as a group of interested parties (individuals and organizations) that want to influence the attempt to solve a critical problem. The coalition members need to develop strategies for each of the eight steps and know when to move to the next step.

A coalition can have many advantages. It can help to save resources. It can influence a large number of people in a community through its diversified membership. It can create an agenda that is more comprehensive than the agenda of any single community organization. It can create a network for the sharing of information, a network that could be used beneficially by the local public health agency for purposes of marketing and fostering change in the community. In addition, coalition members gain satisfaction when they see positive things happen, and a coalition can influence emerging grassroots organizations as they explore their roles in the

Building community through coalitions that are responsible and credible is an important goal of public health leaders. A report from the Centers for Disease Control and Prevention stated that public health should use a process called community engagement.[80] Community engagement involves collaboration between people who are in the same geographic area, share special interests, or are in similar situations. A mixture of social science and art, community engagement integrates the ideas of culture, community, coalition building, and collaboration. The report reviewed the literature for examples of successful engagement and presented a list of the principles of community engagement (**Table 3-2**).

Partnerships are collaborative relationships that involve more than minimal cooperation. They tend to evolve through the same steps outlined in the systems model of organizational change. Partnerships have a vision and a mission, they

TABLE 3-2 Characteristics of Successful Community Engagement

- Community engagement efforts should address multiple levels of the social environment, rather than only individual behaviors, to bring about desired changes.
- Health behaviors are influenced by culture. To ensure that engagement efforts are culturally and linguistically appropriate, they must be developed from a knowledge of and respect for the targeted community's culture.
- People participate when they feel a sense of community, see their involvement and the issues as relevant and worth their time, and view the process and organizational climate of participation as open and supportive of their right to have a voice in the process.
- Although it cannot be externally imposed on a community, a sense of empowerment—the ability to take action, influence, and make decisions on critical issues—is crucial to successful engagement efforts.
- Community mobilization and self-determination frequently need nurturing. Before individuals and organizations can gain control and influence and become players and partners in community health decision making and action, they may need additional knowledge, skills, and resources.
- Coalitions, when adequately supported, can be useful vehicles for mobilizing and using community assets for health decision making and action.
- Participation is influenced by whether community members believe that the benefits of participation outweigh the costs. Community leaders can use their understanding of perceived costs to develop appropriate incentives for participation.

Reproduced from Centers for Disease Control and Prevention (1997). Public Health Practice Program Office, *Principles of Community Engagement*, Agency for Toxic Substances and Disease Registry.

have goals and objectives, and they develop and implement action plans and evaluate their degree of success.

Each community coalition needs to be revitalized on a regular basis. A community coalition often seems to work better when a community crisis is occurring.[81] When the crisis is over, people tend to move away from the coalition back to their own personal agendas. Thus, public health leaders need to be aware of this fact and make an extra effort to keep community coalitions alive after crises are resolved.

LEADERSHIP AT THE GLOBAL LEVEL

The fifth level of leadership includes two major activities and set of tools. Today's public health leader can decide to work in a country other than the United States. The other aspect of this leadership level is the important concern of watching disease outbreaks in other parts of the world and observing whether these outbreaks will spread elsewhere. Public health issues are global in nature. Many public health professionals have pointed out that leaders need to think globally but act locally. Health and disease do not honor government or country boundaries. Epidemiologic surveillance needs to be a global as well as a local concern. Communication is critical at this level. In recent years, the Internet has helped speed up the flow of information.

National and International Communities

Thus far the discussion has been on leadership in local communities, but there are also national and international communities that offer an arena for action by public health leaders. National leaders, like local leaders, act as advocates for public health. They keep the public informed about health issues. They work on the construction of a national mission and vision as well as public health goals for the future. They collaborate with leaders at the state level on the creation of a coordinated nationwide approach to public health. They collaborate with national elected officials to address key public health concerns, including the training of the public health workforce.

On the international level, public health leaders implement public health programs in countries where public health is not a priority. These leaders need to develop skills to enhance their ability to improve the quality of life of people in these countries. Rather than reinvent public health, these leaders develop networks with public health leaders throughout the world to share model program methods for addressing specific public health problems. As already stated, public health leaders need to think globally about public health concerns while acting locally (to protect community residents from potential health crises). Building healthy communities is partially a matter of applying knowledge gained from all parts of the world to local conditions. The importance of the 2005 International Health Regulations (IHR) cannot be overestimated. These rules and regulations were agreed upon by 193 countries. These countries believe that these international rules and procedures will help to make the world safe from potential threats to global health. The IHR were approved by the World Health Organization in the summer of 2005.[82] These rules will affect every community in the world.

Most of the strategies and techniques discussed in this chapter have universal application. Following is a list of guidelines of special pertinence for public health leaders working at the community level:

- Build trust.
- Form coalitions.
- Develop partnerships.
- Teach community groups about the core public health functions.
- Do community building with partners.
- See the community as a system.
- Encourage coalitions or partnerships to continue after a public health crisis has been resolved.
- Use the media to promote best practices in public health.
- Push a prevention agenda.
- Understand the connections between public health at a global level and public health at a local community level and their connections.

LEADERSHIP AT THE PROFESSIONAL LEVEL

Despite the multidisciplinary nature of public health, its leaders need to speak with a unified voice. Public health as a profession takes precedence over the particular educational backgrounds of the public health workforce. The following situation occurs much too often. A physician with almost no background in public health was appointed the administrator of a large county health department. He made decisions from a medical viewpoint and felt that physicians were the only ones who were qualified to do the department's work. He ran the department using a direct medical service approach and totally ignored the population-based approach to public health.

Public health practitioners tend not to travel to professional meetings or for professional development. Many

local health departments have a small staff and are reluctant to let employees go to meetings. Funds for professional development are generally minimal, and paying for professional development is typically considered by taxpayers to be a waste of money. Yet public health leaders know that it is important to communicate with other public health professionals. Some of these leaders go to the annual meetings held by the various public health associations and even take a leadership role in these associations. They help to create public health policy that will trickle down to the local public health programs. Leadership development training seems to be a factor here. For example, most of the presidents over the past 22 years of the Illinois Public Health Association were either faculty members or fellows of the Mid-America Regional Public Health Leadership Institute (Illinois, Indiana, Wisconsin, and Michigan) which existed from 1992 to 2015.

Public health leaders need to become active participants of the American Public Health Association (APHA). This association represents all segments of the professional public health workforce. It is at the annual meetings of the APHA that national public health policy tends to be made. The National Association of County and City Health Officials (NACCHO) is a key national organization for local health leaders. Leaders should also consider taking key roles in the various associations for state and county public health directors. Board of health leaders can also become involved in the National Association of Local Boards of Health (NALBOH). Following is a list of guidelines for leaders who wish to make a mark in the profession of public health:

- Promote public health as a profession.
- Encourage staff to become involved in state and national public health associations.
- Be active in state and national public health associations by serving on committees or agreeing to run for an association office.

Exercise 3-2 gives you the opportunity to work with the six levels model.

SUMMARY

Leaders need to operate on six different levels. On the most basic level, they need to know how to exert their influence as leaders on other individuals at a person-to-person level. To do this, they need a whole range of skills and abilities, from communication skills to the ability to balance work and private life. Regardless of the level at which the leader works, commitment and passion for the work are critical. Leaders strongly believe in what they do. Bolman and Deal believe that there is a spiritual quality to leadership that is difficult to explain or study.[83] However, it can be seen in the work and the dedication of leaders. Thus, leadership is not only about money; it is also about all the things that make us wake up in the morning with anticipation for the job we have to do today. Leadership at the personal level is about our passion in action.

Leaders also must be capable of functioning in teams, either as team leaders or as ordinary team members. Some of the leadership skills needed for teamwork are also needed on the personal level, but some are different. It is on teams that we see the mission of our work in action.[84] It is at the team level that we also see the emotional aspects of working together and creating networks of collaboration and friendship.

Public health leaders are often the heads of public health departments or agencies and thus need agency-level leadership skills as well. Their duties as agency heads include such things as mission and vision statement development, fundraising, job performance evaluation, and role modeling. At the agency level, leaders also see systems thinking in action. It is the big picture that guides our work.

Public health is obviously community oriented, and so public health leaders need to be able to play a major role in

EXERCISE 3-2 The Six Levels of Leadership

Purpose: to explore the six levels of leadership and view a public health outbreak from each of the six levels

Key Concepts: six levels of leadership, disease outbreak

Scenario: In August 2015, 15 cases of bubonic plague are reported in country X.

Procedure: Put six sheets of newsprint in front of the room. Divide the class or workshop participants into six groups. Each group will take one level. The group will explore the scenario and how the group would address the problem from its leadership level (15–30 minutes). Present your findings to the whole class or workshop.

the community by acting as advocates on public health issues and building coalitions to deal with such issues. They thus need advocacy skills and coalition-building skills, among others. At the community level, we can see the passion and commitment of our partners.

At the fifth level, leaders need to address global health issues. With the ability of people to move around the world quickly, diseases can also spread quickly. It is critical that public health leaders learn to collaborate and if possible coordinate their public health initiatives.

At the sixth level, public health leaders, like other public health practitioners, have an obligation to try to improve the field of public health by becoming involved, for instance, in professional organizations such as the APHA, NACCHO, and NALBOH. Many leaders have told me that the networking that occurs at the national level is important and helps leaders to sustain their strong belief that public health can make a difference. Fighting our battles legislatively becomes easier when we work with our public health colleagues. Professional friends often become lifelong learners.

Discussion Questions

1. What is the difference between politics and governance?
2. What is the relationship between communication and empowerment?
3. What are several of the main barriers preventing public health leaders from being as effective as they could be?
4. What is one way public health leaders can deal with the increasing cultural diversity in the public health workforce?
5. What are some of the main reasons for creating and using teams?
6. What are the main agency-related responsibilities of public health leaders?
7. What are the main community-related responsibilities of public health leaders?
8. How do partnerships differ from other types of collaborative relationships?
9. How can public health leaders further the interests of the public health profession?

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