CHAPTER 2

Governance and Leadership

CHAPTER OBJECTIVES

After reading this chapter, readers will:

- Understand the importance of an effective governance structure for a local health department and its associated board.
- Appreciate the need for sound leadership, from both board and management, in an organization.
- Know the similarities and differences between board members and staff.

CHAPTER SUMMARY

This chapter briefly reviews the evolution of health boards in the United States. It outlines the need for governance structures and their development. Elements of leadership are introduced. The chapter concludes with a discussion of the importance of sound governance structures and a well-trained leadership team, including board members and staff.

CASE STUDY

Ray and Florence were discussing an assignment given by Dr. Louis, one of their instructors in public health administration and management.

"How do we begin?" asked Florence. "I don't really understand the topic that Dr. Louis assigned."

Ray replied, "That is the easy part. We have to discuss governance and leadership as they apply to boards of health. I agree with you, though. Where to begin? I have a feeling that once we have an outline, the rest of the assignment will flow logically. At least, I hope it will."

What suggestions would you offer to Florence and Ray?

INTRODUCTION

Governance and leadership are key components in effective and efficient enterprises. They are relevant in for-profit and nonprofit organizations. They are essential in industry, banking, education, health care, and public health, to mention a few. Governance can be defined as the marriage of policy development and implementation through leadership and systems improvement. Governance involves the administration of programs as well as adapting them so they align with existing policies that have been defined through political processes (Rowitz 2009).

Leadership is defined as the skills necessary to integrate local rules, regulations, and policies to enable an organization not only to exist but also to thrive and flourish in a given milieu. Leadership responsibilities are shared by a paid professional (CEO, President, Executive Director, Administrator, or Health Director) and an associated governing body (Board of Directors, Board of Education, Board of Supervisors, or Board of Health).

Many of the programs in public health governance or leadership have been developed or supported by the Centers for Disease Control and Prevention (CDC), the National Association of City and County Health Officials (NACCHO), or the National Association of Local Boards of Health (NALBOH). Some program support has been provided by the Department of Health and Human Services (DHHS).

In public health, a local health department is an administrative or service unit of the local or state government unit that is concerned with health and carrying some responsibility for the health of a jurisdiction

smaller than a state (CDC 2002). A jurisdiction-oriented approach provides a framework or set of boundaries under which public health activities take place. Local public health governance includes every community that must be served by a governmental entity, typically a local health department, board of health, or office of a state health department. The designated organization works in partnership with one or more communities to assure the development and maintenance of a flexible and dynamic community system that delivers services essential to the protection and promotion of the public's health (CDC 2002). The essential public health services include monitoring health status; diagnosing and investigating health problems; informing, educating, and empowering people; mobilizing community partnerships; developing policies and plans; enforcing laws and regulations; linking people to needed resources; assuring a competent workforce; conducting evaluations; and conducting research (DHHS 2010).

A governing body is an individual, board, council, commission, or other entity having legal authority over the public health activities offered by a local government, region, district, or reservation. The basis for such authority is provided by a state, territorial, or tribal constitution or statute. Other sources of authority include local charters, bylaws, or ordinances that may be authorized by state, territorial, or tribal constitutions or statutes (CDC 2002). In a majority of states, boards of health are legally designated governing bodies whose members are appointed or elected to provide advisory functions and/or governing oversight of public health activities, including assessment, assurance, and policy development, for the protection and promotion of health in their communities (CDC 2002).

Governance is a critical component in all aspects of public endeavor. It is oriented to both process and outcome. For public health, Rowitz (2009) has argued that governance activities must be tied to the core functions of assessment, policy development, and assurance, as well as the essential services of public health. An important aspect of public health leadership is monitoring the activities of practitioners. These activities are guided by the three core functions and are intended to ensure that the efforts of practitioners improve the health of the public that they serve. Governance is the oversight function in the public health system. Management implements the activities to make the system effective. (See Figure 2-1.)

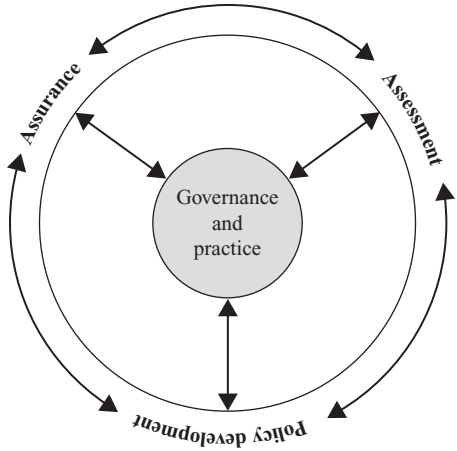

FIGURE 2-1 Core Functions System Paradigm

HISTORY

Boards of health have been a component of public health democracy for more than 200 years. Board members are citizen trustees that are expected to provide leadership, guidance, and oversight for the delivery of public health services in the United States. There are state, local, tribal, and territorial boards of health. Local departments of health exist in many jurisdictions and configurations. Examples include townships, municipalities, cities, single counties, multiple counties, and combined city–county jurisdictions.

Health departments have existed in New England since the late 1700s. Early health departments had been established in the American colonies before the United States was formed. In Boston, Paul Revere assembled several interested and influential citizens and formed the first board of health. This new board advised the Boston Health Department. Infectious disease epidemics prompted the formation of many additional health departments and boards of health in the 1800s. Isolating sick individuals and developing new methods for disease reporting and analysis were instrumental in promoting public health. Cholera outbreaks in the early 1800s were the impetus for creating boards of health in the eastern United States and port cities. In 1848 the first national board of health

was established through the Public Health Act. A seminal report on environmental health in 1850 recommended the founding of local boards of health in each town (Shattuck et al. 1850).

In 1865, boards of health were the perceived political answer to preventing a cholera epidemic in New York City. The New York Metropolitan Health Act of 1866 resulted in the culmination of a citizens' council, later named the New York Metropolitan Health Board. This board became a model for public health governance for over a century and is evident in many of the measures taken by active health boards today. All of these early efforts were initiated to identify and correct public health challenges by assigning the responsibility back to the locals who were affected (Novick et al. 2007).

The overarching elements of the New York Metropolitan Health Board are consistent with those of many current boards, including the use of scientific data to shape practices, centralized administration of public health enforcement activities, a leadership team that includes both professionals and citizens, and a structure that depoliticizes the delivery of public health services. This model has been replicated in some form in almost all jurisdictions throughout the United States, resulting in over 3200 active boards of health by the end of the 1900s (Leahy and Fallon 2005).

THE 21ST CENTURY

Public health encompasses a broad spectrum of practices and disciplines. A concise definition of public health was provided by the Institute of Medicine (1988):

> The committee defines the substance of public health as: organized community efforts aimed at the prevention of disease and promotion of health. It links many disciplines and rests upon the scientific core of epidemiology (41).

Health departments in the United States are the governmental providers of public health services. The majority (74%) of health departments have a local board of health (NACCHO 2005). Boards of health are bodies of elected or appointed individuals who provide guidance or oversight to health departments (Novick et al. 2007). Most local boards of health have governing and policy making responsibilities, with only a small percentage (13%) being purely advisory (NACCHO 2005).

Currently, there are over 3200 boards of health across the United States with more than 20,000 individual trustees charged with the governance of public health in their communities. Over 70% of these trustees are appointed to their boards of health (NALBOH 2008; NACCHO 2005). The appointment process has long-term implications with approximately 84% of board of health members having unlimited terms of office (NALBOH 1997). Trustees, whether elected or appointed, come with a wide range of skill sets, many with little or no education or training in governance, public health, or health in general.

The *National Profile of Local Boards of Health* (NALBOH 1997) is the only published national survey ever conducted to collect data on boards of health. The objectives of the study were to understand board of health roles, responsibilities, and authorities; to evaluate their communication capabilities and needs; and to identify gaps in training, education, and technical assistance. A literature review completed in conjunction with the *Profile* yielded no other research on the composition, activities, authorities, or capabilities of boards of health to carry out their roles and responsibilities. The *Profile* did report that 71% of health boards in the United States are made up of members that are appointed, 20% of boards have members that are elected, and 9% of boards have a combination of appointed and elected members. The majority of elected members were voted into other offices. The most common office was a county commissioner. A minority (31%) of health board members have received formal orientation training. A majority (over 70%) identified a need for education, training, or technical assistance (NALBOH 1997).

A more recent study of local public health agencies confirmed these earlier findings (NACCHO 2005). A majority of American health districts are governed by a board of health having policy-making authority. These boards were populated with a combination of community representatives, elected officials, and health professionals. Another recent study of health departments serving communities with populations of at least 100,000 reported that even though public health capacity varies widely at the local level, when boards also had policy making power, approximately 10% more public health programs or activities were offered, and the perceived effectiveness of these activities increased significantly (Mays et al. 2004).

Boards of health are not unique or limited to the United States. A study of local health boards in the Philippines confirmed that active health boards added value by including more fund-raising activities.

The additional funds facilitated a greater number of health initiatives, permitted higher per capita health expenditures, and led to higher customer satisfaction ratings with government-provided health services (Ramiro et al. 2001). One expert summarized the roles and benefits of boards of health by noting that as stewards of what is arguably a community's most important asset, boards of health have both a moral and legal obligation to carry out their duties in a responsible manner and to ensure that their organizations (health departments) are good citizens in the delivery of public health care (Curtis 2001).

GOVERNANCE ROLES AND RESPONSIBILITIES

The organization of public health in the United States varies from state to state. The most common structure is a local public health department. Local health departments have the day-to-day responsibility for public health matters in their jurisdiction (Schneider 2006). These day-to-day responsibilities are summarized within six basic service areas: collecting and analyzing vital statistics, sanitation, communicable disease control, maternal and child health, health education, and laboratory services (Turnock 2009). The leadership for the majority of health departments is provided by a board of health.

Members of boards of health are individuals who are appointed or elected to oversee, guide, and establish policy for local health departments. Responsibilities can include hiring, evaluating, and if necessary, firing the health commissioner; overseeing fiscal and performance accountability; representing the health department to the community and representing the community to the health department; and establishing health policy. The board of health provides governance leadership and is ultimately responsible for ensuring that needed public health services and programs are provided to communities within the jurisdiction of the health department.

The roles of boards of health vary by state as does the authority to carry out their responsibilities. Some boards can enact rules and regulations, while others may only advise or make recommendations to the governing body for public health, such as the county commissioners (NALBOH 2008). All boards of health, regardless of the extent of their legal authority, are obligated to either enact or recommend policies that meet the needs of community members and serve the interests of the public's health.

State statutes define the legal powers and duties of local boards of health. Forty-four state codes (statutes) address local boards of health. They include language defining jurisdiction, appointing authority, terms of office, composition, roles, powers, and duties (NALBOH 2008). State statutes also define the composition and assignments of board of health members.

Governing boards are responsible for guiding organizations and addressing the needs of constituents from very diverse communities. In some manner, the work of governing boards directly or indirectly touches the lives of everyone. Most board of health members serve without compensation. Most people are employed by organizations that are governed by a board of directors. Virtually all individuals are affected by the decisions of some type of board, whether the organization being governed is for profit or is not for profit. For example, boards of education determine the policies and future direction for schools; boards of trustees provide oversight and direction for colleges, universities, and places of religious worship; boards of directors guide the strategic directions of the companies and organizations in which people have investments; and boards of health have responsibility for protecting and promoting the public's health in the communities they serve (CDC 2002).

Boards of nonprofit organizations, such as boards of health, vary in their roles and responsibilities. They commonly include the following (Ingram 1988):

- Determining an organization's mission and purpose.
- Selecting, supporting, and conducting an annual performance review of the chief executive.
- Facilitating effective organizational planning.
- Ensuring that resources are adequate and effectively managed.
- Approving and monitoring an organization's programs and services.
- Enhancing an organization's public image.
- Assessing its own performance.

The work of governing and advisory boards, including boards of health, usually goes unnoticed until a problem arises. Some public health problems are caused by uncontrollable events, such as the massive destruction of a hurricane, tornado, or other natural disaster. Other public health problems may be within the governing body's control, such as establishing a policy for fluoridating water to prevent tooth decay. These problems may not be completely eliminated, but they can be minimized through

proactive measures. Proactive measures by boards begin with fundamental good governance practices, including evidence-based decision making (Zaza et al. 2005). A private organization defines governance as a creative and collaborative process that supports chief executives (health commissioners or health officers), engages board of health members, and furthers the goals that they have established (BoardSource 2005).

Effective governance in public health requires that individual members of governing entities within a local jurisdiction understand and exercise personal, board, agency, and other appropriate legal authority. Further, members charged with governing must appreciate all of their obligations and responsibilities, including ensuring that resources (including legal, financial, personnel, capital, equipment, and supplies) are sufficient to perform all of the essential public health services. Board members should help to develop policies that support public health activities and goals and assure that all relevant stakeholders participate in achieving public health objectives. Finally, they should regularly evaluate, monitor, and establish new goals for improving community health status (CDC 2002). Other experts add to this definition, stating that such a broad range of complex responsibilities cannot be upheld in the absence of a governing body charged with protecting public health (Leahy and Fallon 2005).

Even though all boards of health have slightly different roles, responsibilities, and composition, a general definition specifies that they provide advisory or governing oversight for public health activities. These activities include assessment, assurance, policy development, and enforcement (CDC 2002).

LEADERSHIP ROLES AND RESPONSIBILITIES

In the case of boards of health, a truly effective board has fiduciary responsibilities, serves as a strategic partner with a health commissioner, and is a major component of the leadership team of a health department. When a board's responsibilities are redefined into these essential categories, the implications for recruitment and selection are profound (Chait et al. 2004a). For individual board members, it is important they understand their board roles as trustees rather than as volunteers. Trustees make policies; their role is being a voice for their community constituents and not only for themselves. Volunteers do not make policies.

EFFECTIVE AND EFFICIENT GOVERNANCE AND LEADERSHIP

To a significant degree, the quality, continuity, and assurance of public health in the United States depends on the effectiveness of boards of health and the officials who oversee and manage local public health agencies. Public health consists of organized efforts at the community level with the goal of reducing disease and improving the health of the populations being served (Novick et al. 2007).

High-performing effective governing boards are knowledgeable, coordinated, collegial leadership teams that are focused on an unambiguous goal. The challenge of defining and building effective boards can be overwhelming (Nadler 2004). Numerous studies have characterized board effectiveness in a variety of ways using different words, but the underlying meanings and characteristics are consistent. The importance of effectiveness for nonprofit organizations is a concern for policy makers, stakeholders, and the community involved. A large number of studies have been conducted to help define effective governance in various industries, including education, health care, corporations, and nonprofit organizations, both domestically and internationally.

Effectiveness is the goal desired by all boards. Effective organizations tend to have boards that are active and attuned to the interests, concerns, and expectations of those that they serve. An inefficient and ineffective board of health is indeed not going to improve health, but boards of health can be very powerful when members understand their roles and take participation seriously (Nicola 2005). Organizational effectiveness includes the ability to develop and act on prioritized goals and to use all available resources. Human resources, including board composition and constituency representation, are important parts of the available resource mix.

Publications and research, both past and present, provide compelling evidence for the roles and responsibilities of effective boards. After extensively studying boards of education, Holland et al. (1989) developed a conceptual framework for board competency and effectiveness. There appears to be substantial evidence that more effective boards are differentiated from less effective ones in six areas of competence:

1. Understanding and valuing the institutional history and context.
2. Building the capacity for board learning.

3. Nurturing the development of the board as a cohesive group.
4. Recognizing the complexities and nuances of issues before them.
5. Respecting and guarding the integrity of the governance process.
6. Envisioning the shaping of future institutional directions (Holland et al. 1989).

These six frames (contextual, educational, interpersonal, intellectual, political, and strategic) can be used to analyze the effectiveness of boards of health.

Important contributors to local public health include appointers, board of health members, the health commissioner, and community members. Board of health members and the health commissioner compose a health district's leadership team. Together they have the potential to achieve a health district's goals and objectives. This success translates into improved public health for the communities they serve. When all concerned parties understand these leadership roles and responsibilities, the health district and public health will be the ultimate beneficiaries (Howe 2005).

As the leadership team, the board of health members and the health officer have the direct responsibility for ensuring that guidelines and protocols are in place to improve the effectiveness of the board (Roberts and Connors 1998). These responsibilities include building an environment of collaboration where trust, communication, and ongoing learning can occur. To start such a collaborative process, stakeholders (board of health members and the health officer or commissioner) must acknowledge and agree on the challenges that exist, and they must agree to work together to solve them. Careful attention must be given to the elements and responsibilities of leadership—understanding the framework for collaboration and creating an environment that embraces change. This means setting directions, committing to the tasks, and accomplishing desired results. Collaborative leaders are sustained by their deeply democratic belief that people have the capacity to create their own visions and solve their own problems. If the appropriate people can be together (being broadly inclusive) to work in constructive ways (creating a credible, open process) using good information (bringing about a shared understanding of problems and concerns), they will create authentic visions and strategies for addressing the shared concerns of an organization or community. The role of leadership is to convene, facilitate, and sustain this process (Chrislip and Larson 1994).

Collaborative leadership aligns well with the very reason that local boards of health were founded in the 1800s, namely to identify and correct public health challenges by assigning the responsibility back to the locals who are affected (Novick et al. 2007). Boards of health and health commissioners should return to the roots of their existence to reinforce collaborative team practices. An adversarial, or "us versus them," attitude will not accomplish the mutually desired goals and objectives of improving public health outcomes.

A different expert has supported the need to redefine the importance of leadership in board governance. In the last 15 or 20 years, boards have developed compartmentalized, if not marginalized roles, focused around a fairly narrow set of purposes. "We have asked very little from boards, and in some cases we have received even less. It's time, long overdue, to think of boards as sources of leadership" (Chait et al. 2004b, 7).

In many cases, the activities of boards of health are based on statutes that have not kept pace with the rapidly changing public health environment. Unfunded mandates, budget cuts, and workforce shortages keep health commissioners in an exhausting mode of crisis management. In most cases, boards of health are underutilized and underdeveloped. They are a much needed but largely untapped resource. It is time to build on the limited but sound knowledge that has been developed on governance, collaborative leadership, and board effectiveness. It is time to assemble boards of health who, together with their health commissioner, become exemplary partners of practice and learning, creating numerous opportunities for everyone to use their combined knowledge to fulfill the mission and vision of a health district (Chait 2004).

CONCLUSION

This chapter has reviewed governance and leadership as they pertain to boards. Guidelines for governance are contained in statutes. Changing laws require action by political bodies at the state and national levels. Public health professionals and board members can seek changes but ultimately cannot control either the process or the outcome.

Leadership is different. Applying and implementing relevant knowledge is entirely within the control of public health professionals and board members. The main restriction is personal inertia. Overcoming that

barrier requires a decision to do so followed by effort. Learning and a commitment to change are important prerequisites.

The time is right to harness untapped leadership potential. Leaders reside in every city and every county, in every position and every place. They are employees and volunteers and trustees, young and old, men and women. Leadership knows no racial or religious bounds, no ethnic or cultural borders. Exemplary leadership can be found almost everywhere. Appointers must seek out such individuals; existing board members and organization executives must demand that exemplary governance leaders be identified (Kouzes and Posner 2008).

CASE STUDY RESOLUTION

Returning to the students who were discussing their assignment, Ray's feeling turned out to be accurate. After outlining the history and need for governance, they turned to leadership. They decided that modifying governance structures required legislative intervention and was beyond their abilities. They could learn leadership and good governance. Those skills would greatly expand the potential of their careers in public health. That insight helped them to complete their assignment. The high grade on their assignment increased their self-confidence. Florence and Ray would look back on the assignment and come to regard it as a turning point in their careers.

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Web Sites

- **Free Management Library: Leadership Development Planning**: http://managementhelp.org/ldr_dev/ldr_dev.htm
- **Leadership**: http://www.nwlink.com/~donclark/leader/leader.html
- **National Association of Local Boards of Health**: http:/www.nalboh.org
- **National Public Health Leadership Institute**: http://www.phli.org
- **Team building**: http://www.funteambuilding.com/articles.php