Schools of Public Health and Their Future Role

A review

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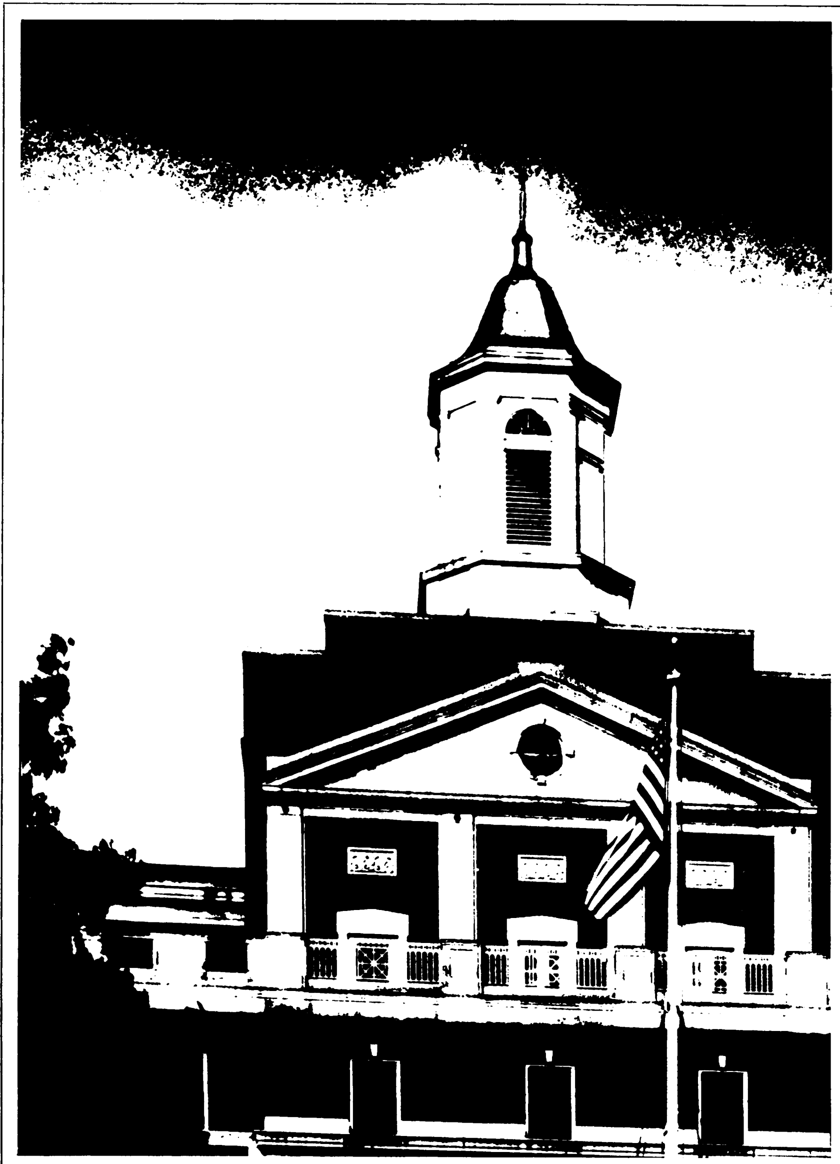

ONE OF THE FEW FIELDS of higher education in which the United States was the world pioneer is public health. Schools of medicine in Europe and elsewhere had long had departments of hygiene or offered instruction in "social medicine," but the separate graduate school of public health, for physicians and others, was an American innovation in 1916. Since then, many other nations have followed suit, and in the United States such schools have grown to 20 in number. Highly relevant also has been the growth of numerous other university graduate or undergraduate programs that prepare men and women in special public health disciplines such as environmental control, hospital administration, or health education. It is altogether fitting that, after some 60 years of such educational programs, the Milbank Memorial Fund should have sponsored an evaluation of these activities along with the recommendations for future development published

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in "Higher Education for Public Health" (*1*).

Selection of Dr. Cecil Sheps as chairman of the Milbank Commission for the Study of Higher Education in Public Health was an admirable choice. In his professional career Sheps has made major contributions in both governmental and private (as an administrator of voluntary hospitals) sectors of public health and as a teacher in both public health and medical schools. The Commission likewise included persons from the principal components of public health work as well as higher education generally.

The structure of the Commission's report is clear, logical, and comprehensive. In part I, the public health field is defined, and the needs of the population as well as the social activities and organizations through which those needs are met are examined. In part II, current characteristics of the schools of public health and other academic settings are examined—the professional personnel to be trained, the knowledge base, and the variety of university programs imparting that knowledge to students.

Finally, and most important, in part III of the report, recommendations are offered for rationalizing the structure of higher education for public health in the future. The heart of the recommendations is that schools of public health should concentrate their efforts on the preparation of administrative leaders of public health, epidemiologists, biostatisticians, research scientists, and educators. Persons at the operating level in various public health specialties should be prepared in other schools of the universities. Other recommendations about prerequisites for admission, field studies, research, and so on follow from this basic dichotomization in the preparation of public health workers, but the part III proposal, concerning the "redirection and reorganization of higher education for public health," is the central thrust of the report.

Dr. L. E. Burney, president of the Milbank Memorial Fund, stated in his "Foreword" that the report "will have a positive impact . . . if it exposes the major issues and if it promotes discussion, debate, and controversy." Accordingly, in the spirit of this invitation, I respectfully offer two comments—one on the historical review of the public health field and the other on the report's primary recommendation, noted previously.

The information assembled in the first and second parts is sound and relevant as a basis for formulating the recommendations in the third part. Unfortunately, one major feature of the historical development of both the field of public health, and higher education to prepare for it, is all but ignored. For approximately their first 20 years (that is, 1916 to 1936) the schools of public health of the United States—which clearly served as the vanguard of higher education in the field—limited their scope almost entirely to study of the theory and practice of preventive health services. It took the Great Depression of the 1930s to dramatize the need for analysis, teaching, and preparation of health personnel in the manifold problems of organization and administration of the treatment services, or what was initially called *medical care*.

The importance of this crucial change in orientation in the education of public health workers is strangely overlooked in the report. One may identify, of course, many other components of public health that elicited new academic programs over the years—health education, nutrition, international health programs, geriatrics, or the greatly broadened perspective of epidemiology are some examples. Recognition of the vast field of medical care organization as an aspect of public health, however, exerted a wholly different type of impact. This recognition broadened the concern of public health education from a tiny fraction of the health services—albeit the important preventive fraction—to the entire range of health services. It also widened the scope of the public health field from the relatively restricted bailiwick of governmental health authority (and only the preventive sector within this) to the entire panorama of health needs and activities in a community or nation.

This turning point, which occurred around 1934 to 1936, led to a realization that a university curriculum to train hospital administrators was needed. Indeed, so narrow were the horizons of the schools of public health in the early 1930s that none of them was willing to offer training in hospital administration, and the first two university programs in this field were established in schools of business administration. The turbulent issues surrounding medical care organization, which continued into the 1940s, led to instruction in the schools of public health on other aspects of this field—on the "macro" or community aspects of health economics, health insurance, public medical care programs, health manpower, health politics and policy, medical sociology and, more recently, on comprehensive health planning. The same issues gave rise to a large array of university programs in health services adminis-

tration (largely hospital-linked) outside the schools of public health—an array which graduates each year as many or more health care administrators than all the schools of public health combined.

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More important than this failure to appreciate the far-reaching significance of medical care becoming a public health concern, in the report's review of historical developments is a central theme of the recommendations that is somewhat related. For arising from the initially narrow definition of the scope of higher education in public health was not only the separate implantation of hospital administration curriculums in schools of business administration, but also the seeding and growth elsewhere of other diverse training programs; community health education took root in schools of education, in environmental sanitation programs in schools of engineering, in community nutrition programs in schools of home economics, and there were several other such offshoots. While the report does not give exact figures (due evidently to the very number and diversity of these academic programs), it seems likely that the aggregate output of all these specialized university curriculums exceeds that of the 20 U.S. schools of public health.

This pluralism leads the Commission to make its central and most important recommendation. The exact language of the report on this pivotal issue is quoted in full (*1a*):

> There should be a major redirection and reorganization of higher education, based on the recognition that different groups of personnel with different functions will require different kinds of education programs.
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> A. The schools of public health should concentrate their efforts primarily on: (1) The preparation of people who will function as executives, planners, and policy makers. (2) The preparation of epidemiologists and biostatisticians. (3) The preparation of research scientists and educators.
>
> B. Individual graduate programs in *other* schools in universities should continue concentrating on the preparation of people who will function at the operating level in respective specialty fields in public health.

In a word, as it is stated explicitly at several points in the report, schools of public health should train the leaders, thinkers, and teachers of the field. (All those entering the schools, moreover, should already possess qualifications in another health profession or have another graduate degree or "3 years of experience.") Other sectors of the universities should train the rank-and-file operators, the foot soldiers of the field. While the report anticipates the charge of "elitism" and disavows it, the full implications of this central recommendation must be appreciated.

The recommendation accepts, in effect, the unplanned reality of American higher education for public health—a circumstance in which teachers from almost any discipline, regardless of its orientation, have been free to venture into the community aspects of health. It accepts the policy of having hospital administrators trained by faculties whose central goals and inspiration have been the efficient management of profit-oriented corporations. It accepts the policy of having community health educators trained by faculties whose central motivation is schoolroom pedagogy or sometimes physical education. And so on. Only the "leaders" of the public health field, it is assumed, need to be educated by faculties that have as their central purpose and inspiration the protection, through both prevention and treatment, of the health of populations.

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In my judgment, this central recommendation constitutes an abdication of responsibility for the effective education of health manpower devoted to protecting the health of communities. It would relegate the education of all but the top personnel to teachers who inevitably look on the public's health as a matter of secondary importance—secondary to consideration of balancing the fiscal budget, secondary to the education of school children, to the training of athletes, to bedside nursing, to civil engineering, to household economics, or secondary to the various other fields in which public health students destined for the operating level are inevitably marginal occupants. Not only does training in such settings deprive these students of the essential content and philosophy of public health education necessary to high quality work, but it lays the basis for divergent sets of values that account so often for conflicts in community health programs.

Given the facts as presented in the first two parts of the Milbank report, why could the recommendations not have reached out boldly to face the enormous needs of the public health field? Why not end the chaotic, pluralistic mushrooming of all sorts of higher education for public health in all types of academic soils and mobilize all efforts toward the creation of unified and comprehensive institutions? Why should not the schools of public health be expanded from their current modest position into broad academic centers for the public health sciences and disciplines, encompassing all the fields—theoretical and applied, for leaders

and operators—relevant to the protection and promotion of the health of populations?

Such centers, would of course, require different departments or divisions for preparing the various members of the multi-faceted public health team. Some candidates might be oriented initially to becoming community health educators or hospital administrators or environmentalists, but they should learn from teachers of the same quality as those who prepare the leaders and the policy makers. The stronger student would naturally be offered more advanced courses, seminars probing contentious issues in depth, and probably a longer sequence in training. But the health focus of the education should be clear and not demarcated by a double standard.

The public health function arose originally as an offshoot of clinical medicine (later, of clinical nursing, clinical dentistry, and so forth). But, as understanding of the health of populations—its determinants and the strategies for its protection—has matured, we have come to learn that public health is not merely an offshoot of the biological knowledge that is oriented to the individual patient. Public health also rests on several other pillars—the social sciences, engineering, statistics, epidemiology, the behavioral sciences, and the administrative sciences. To meet the health needs of populations, academic centers of the public health sciences and disciplines should educate bright new university graduates for a public health role, just as law schools educate such new graduates for a legal role or medical schools educate them for a role in clinical medicine. In fact, the average age of students in the U.S. schools of public health has become steadily younger over the past 30 years—a trend we should view with pride, not disappointment. Many of them will doubtless become the health leaders of tomorrow.

Medical schools do not demand a prior advanced degree or 3 years of experience for entry. The student learns about practice within his graduate studies and later. Public health education should likewise integrate theory and practice. In the place of the microscope, there is the computer; in place of the hospital ward, the public health center or the health insurance plan's office; in place of the sick patient, the turbulent community. The method remains scientific, but the focus is social.

This would seem to be a positive direction toward which higher education for public health should be moving. This field of education should not be resigned to the chaotic fragmentation reflecting its past. Higher education for public health should acquire the strength that could come from unification of its disparate parts, to better meet the enormous health challenges of the future. In its recommendations or the other aspects of the future of schools of public health, the Milbank-Sheps report calls for broadened activities in research, continuing education, community service, and other functions that would enhance the effectiveness of the schools in tackling community health needs. One may hope that the primary recommendation, given most attention in this critique, will not nullify these constructive ideas.

Reference

1. Milbank Memorial Fund. Commission for the Study of Higher Education for Public Health. Cecil G. Sheps, Chairman: Higher education for public health. Prodist, New York, 1976 (*a*) p. 99.