

The Road from Overconfident to Excellent

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“Public Health” Services are not “Public” Health Services

Health care is a marketable commodity, but

Public Health is

“What we as a society do collectively to assure the conditions in which people can be healthy” IOM 1988

Classic Collective Goods Problem ala Elinor Ostrom

PH is a 200 year old profession devoted to this.

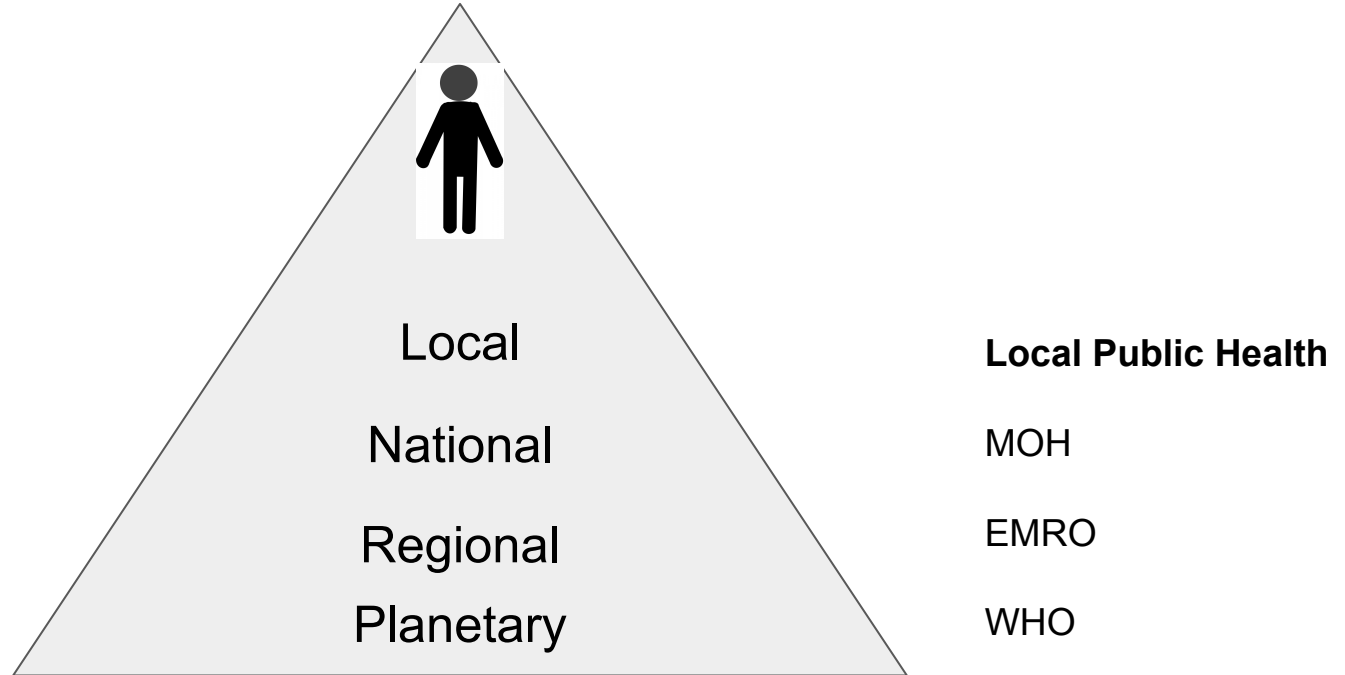
Starvation, Atrophy, and Overconfidence

- Public health is invisible yet essential for people and their economies
- As a public good it will suffer chronic underfunding

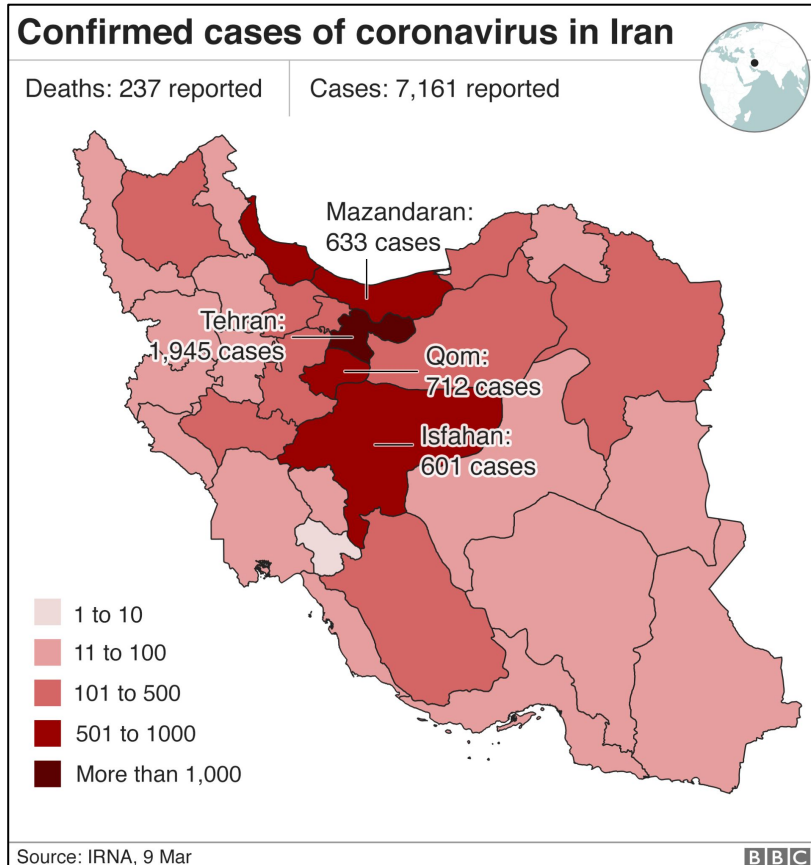
The need for an open and data-driven rapport between the state and its citizens about creating healthy places has never been more apparent

The workforce to do this has never been more tenuous and unready

How does public health get done?



Place Matters so Local Public Health Matters



What can local public health do? The ESSENTIALS

- Assess local health threats with local data
- Form partnerships with local problem solvers
 - Schools, private medical, faith community, transport, commerce
 - Solve the Elinor Ostrom obstacles to collective choice problems
- Scaled to build face to face trust between science and community values
- Coordinate a community participatory coordinated approach to emerging threats



“Overconfident” Report Comments on Chapter 5

- Main message of Report is sound. Overconfidence is unjustified
- “Overconfident” also applies to measuring public health in MENA
- Almost all objective metrics are metrics of “public” health services
 - Doctors per capita
 - Flows of funds
- National Health Accounts Inadequate
 - Code for Public Health Spending (H.C. 6) Left Blank
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Global Health Security Index (GHSI) Problems

Outcome Validity of GHSI is Unconvincing

Based on US and UK score high GHSI, but performed poorly on COVID

Table 5.1 runs a cross sectional regression of tests per capita vs. GHSI

Correlations driven by “capacity” component (Health Workers are not Public Health Capacity)

Construct Validity

GHSI Domains: Surveillance, Health Info, Doctors, Planning simulations

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Essential Public Health Functions

GHSI = latest disappointment in a cavalcade of checklists

Other failures included National “State of Public Health” white papers

Primary Health Care Checklists

Public health’s underperformance is a problem of:

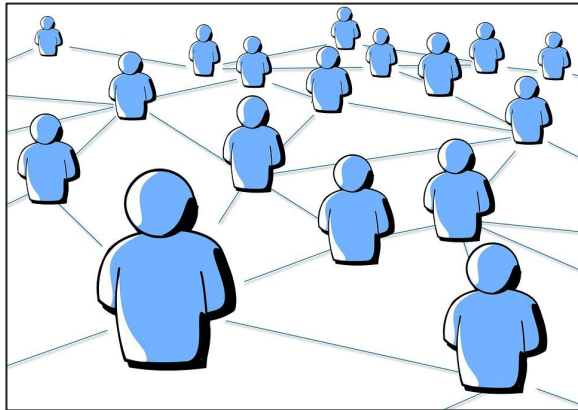
- Fragmentation
- Underfunding
- Poor governance
- Starved workforce
- **No constituency**

Checklists are OK--but they seem to always fall into the wrong hands

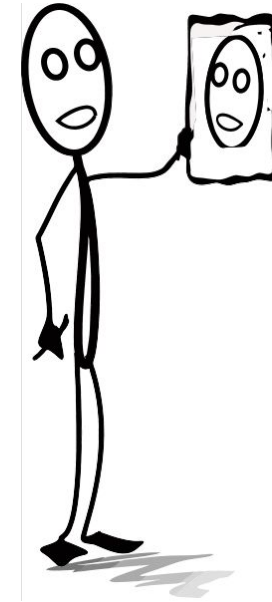
“Checklist” theory makes change a management issue



System Inspector as
Problem Solver



Better to give everyone a
checklist to use as a mirror,
but...



vs.

Pre-conditions for public health improvement are not present

- Starvation has led to atrophy
- Lack of schools of public health teaching essentials of the practice
- Lack of career pathways or agency in local health departments
- Top-Down dictation of all solutions
- Lack of local constituency

No Silver Bullets

- Do Not Just
 - Increase funding for same cadre of public health workers
 - Build a fancy information system without changing the modus operandi
 - Host “planning exercises”
- Do
 - Invest in workers trained in modern participatory bottom-up public health cycle
 - Focus on Local Public Health
 - Make checklists into mirrors
 - Nourish and normalize the expectation that local public health will work for livable communities

A Long Commitment But Worth It

- Invest in Public Health
 - Horizontal learning opportunities within the region
 - Professionalize **schools of public health** to train and professionalize workers
 - Adequate Funding for careers for a public health workforce

EXAMPLES

International Institute for Primary Health Care (IIPHC) Addis Ababa

Institute for Primary Care Libya

THANK YOU