Building a Culture of Health
Challenges for the Public Health Workforce

Alonzo L. Plough, PhD, MPH

Health and health care have reached a pivotal point in the U.S. For generations, Americans' health has been unequally influenced by income, education, ethnicity, and where people live. Healthcare systems have operated largely apart from each other and from community life. The definition of health has been "not needing to seek health care," rather than the broader public health view that all aspects of our lives—in our work, families, and communities—should support active and healthy living.

Today, however, the world is changing and the education, training, and practice strategies of the public health workforce must adapt to these changes. This requires new skills and perspectives, some of which are presented in papers in this special issue. A growing number of communities, regions, and states are working to redefine what it means to get and stay healthy by addressing social and physical spaces and conditions in which people live, learn, work, and play—the social, environmental, and economic determinants of health.

Demographics are shifting, especially in terms of the U.S. population's age, ethnic diversity, and education levels. Workforce constraints and financial pressures, along with the requirements of federal healthcare reform, are changing who has access to care, how care is paid for and delivered, and how patients and providers interact. Coordinated efforts to promote wellness and prevent disease are proliferating among a diverse set of stakeholders, including organizations that are traditionally "non-health" focused.

Providers of personal health services are connecting with their public health colleagues and multiple levels, and "big data"—large, varied data sets that are available in real or almost-real time—make it possible to analyze health patterns in unprecedented ways to gain a clearer picture of the actionable determinants, trends, and outcomes of societal health and well-being.

These developments in health and society present a window of opportunity for real societal transformation and an imperative for public health professionals to match their skill sets and programmatic strategies to assist this transformation—a chance to disrupt the status quo, eliminate health disparities based on the social, environmental, and economic determinants of health and well-being, and catalyze a national movement that demands and supports a widely shared, multifaceted vision for a Culture of Health to replace the siloed approach to health and health care.

The public health workforce is being challenged by the changes in the partnerships and expectations. The overall movement to a new community understanding of health in its broadest construction will demand continuous learning and expanded views of just who is a part of the public health workforce. A clear statement of principles on which the change can be based has been presented in the annual report of the Robert Wood Johnson Foundation (RWJF), "Toward a Culture of Health."

In its annual message, "Building a Culture of Health" (2014), RWJF proposes a new vision that addresses what all Americans can do to improve collective well-being. RWJF intends to help build a national movement to create a Culture of Health that enables all members of our diverse society to lead healthy lives, now and for generations to come.

The ten principles underlying RWJF's vision for a Culture of Health suggest a model for population-level health that can achieve the long-term desired outcomes for health and health systems (Table 1). The goal of clustering the ten principles into dimensions that can be measured and showing how they relate to each other provides an integrated perspective on what it takes to achieve population-level health and well-being. This action model also suggests important areas to further develop in the training of the workforce and how core competencies are further refined in Master of Public Health (MPH) curricula and through public health accreditation standards.

Four of the Foundation's ten Culture of Health principles describe long-term outcomes for the nation's health and healthcare systems:

- Optimal health and well-being flourishes across geographic, demographic, and social sectors.
- Everyone has access to affordable, high-quality health care.

Vice President and Chief Science Officer, Robert Wood Johnson Foundation, Princeton, New Jersey.

0749-3797/$36.00
http://dx.doi.org/10.1016/j.amepre.2014.07.037

 © 2014 Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/3.0/).

Table 1. Principles of action dimensions

Action dimension	Reflects these principles
Action dimension 1	Americans understand that we are all in this together; and Opportunities to be healthy and stay healthy are valued and accessible to everyone across the entire society.
Action dimension 2	Business, government, individuals, and organizations work together to foster healthy communities and lifestyles; and The health of the population guides public and private decision making.
Action dimension 3	Individuals and families have the means and opportunities to make choices that lead to healthy lifestyles and optimal well-being and functioning.
Action dimension 4	Health care is efficient and equitable.

- No one is excluded.
- The economy is less burdened by healthcare spending.

These outcomes encompass the improvements in health that the nation has long sought to attain. They also explicitly state a desire to attain better health as the WHO defines it: a state of complete emotional, social, and physical well-being.[1] The outcomes give special attention to equity and social justice—not to merely describe the health disparities that exist in society but to eliminate them.

The remaining six principles fall into four dimensions of action that are farther upstream in the sequence of change (Figure 1).

Action Dimension 1: Social Cohesion and Shared Value of Health

This area of work focuses on actions that set the context for widespread dialogue and understanding about a Culture of Health. The shared value of health is prioritized because individuals must view health as a priority. Social cohesion is prioritized because, in addition to valuing health, individuals must also feel a sense of community and believe they can be engaged members of the community to improve population health. Without a shared sense that we are all in this together, it is hard to convince people that good health for all is as important as health care for those who are ill.

The conceptual base for this action dimension rests on research and practice evidence in social network theory, community resilience, well-being science, and asset-based community development. In this dimension, the intention is to highlight the degree to which health is a shared value among individuals and the extent to which individuals feel a sense of interdependence with each other.

Action Dimension 2: Multi-Sector Collaboration to Build Health Partnerships

This area of work seeks to change approaches and processes so that traditional health delivery settings are connected with the community settings that influence residents' health (e.g., neighborhoods, schools, businesses) and so all organizations' assets, policies, and practices: (1) promote the health and health care of entire populations; (2) promote health and health care equally; (3) are aligned across sectors; and (4) operate together rather than in isolation. The nation's health problems are so pervasive, the solutions are so complex and costly, and the resources for addressing them are so fragmented that no single sector can achieve large-scale, sustainable results on its own.

The conceptual and research base for this dimension are studies of effective cross-sector partnerships among hospitals and other healthcare institutions; public health agencies and providers; healthcare payers and consumers; and education, government, business, and community-based organizations that improve local well-being. RWJF intends to highlight the increasing prevalence of innovative partnerships and their impact on improving the social, cultural, and environmental determinants of health and reducing health disparities.

Action Dimension 3: Improving Equity and Opportunity for Health Choices and Environments

This area of work focuses specifically on improving well-being and, correspondingly, eliminating disparities in health so that the Zip Code in which one lives does not increase one's likelihood of experiencing poor health outcomes. In a strong market economy like that of the U.S., poverty and economic marginality often lead to inequity in health and health care.

This work addresses policies and practices that advance healthy environments within and across populations. At the individual and family level, this action dimension aims to ensure that all people have equal opportunities to live in homes that are safe from social threats, such as violence; free from environmental threats, such as lead paint, poor air quality, blight, and general disrepair; and in neighborhoods that offer access to nutritious and affordable food, recreational facilities, elements that

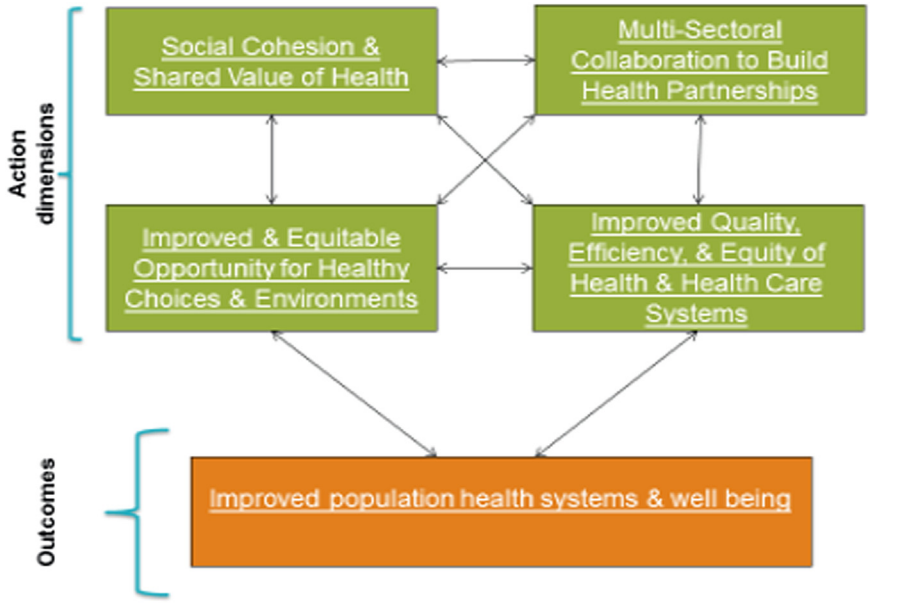

Figure 1. Four dimensions action model.

encourage active transport (e.g., sidewalks, bike trails, pedestrian crosswalks), and healthy school environments.

Decades of epidemiologic and population health science research have documented growing health disparities based on the social determinants of health. RWJF intends to measure and promote the increased prevalence of opportunities for physical activity, healthy food and diet, and healthy environments to eliminate these types of disparities.

Action Dimension 4: Improved Quality, Efficiency, and Equity of Health and Healthcare Systems

This area of work focuses on integrating healthcare and public health services and systems in (1) improving equitable access to health care that is high-quality, efficient, and affordable and (2) reducing systemic, avoidable barriers to equitable health care. Just as research has documented the growing disparities in health, an equally broad base of research documents the continuing challenge of access and coverage.

By linking preventive services more systematically with medical care, for example, at least some chronic illness can be avoided or postponed. By linking healthcare and health improvement services to community resources such as community-based organizations and consumer groups, transitions in care can be improved so that individuals avoid hospital readmissions and can better manage chronic illness. By considering patient wishes more systematically and with cultural competence, healthcare systems can better activate patients to participate in their own care.

The action model for advancing a Culture of Health will guide RWJF grant making and strategic collaborations. Implementing the model will take time and involve many sectors beyond what has been thought of as the public health workforce. Although much of the language in the action model is familiar to students and practitioners of public health, it will require deeper commitments among many partners in the workforce to spread and sustain innovative approaches to training and implement practice standards aligned with the Culture of Health principles. It will require those in leadership positions to recognize and seize opportunities for change. It will call for new norms and expectations, knowledge and capacities, and practices and behaviors. It will require a commitment to diversity and multi-cultural perspectives in building the composition of the workforce. It will force hard choices about how to allocate limited resources in new ways. And it will require careful selection of meaningful and action-oriented measures for tracking progress toward this goal.

Publication of this article was supported by the U.S. Centers for Disease Control and Prevention (CDC), an Agency of the Department of Health and Human Services, under the Cooperative Agreement with the Public Health Foundation and University of Michigan Center of Excellence in Public Health Workforce Studies (CDC RFA-OT13-1302). The ideas expressed in the articles are those of the authors and do not necessarily reflect the official position of CDC.

No other financial disclosures were reported by the author of this paper.

Reference

1. WHO. Declaration of Alma-Ata. Geneva: WHO, 1978. www.who.int/publications/almaata_declaration_en.pdf.