Public Health Medicine, Public Health Practice, and Public Health Systems

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This issue's commentary by Loh and Harvey¹ on the specialty of public health and preventive medicine (PHPM) prompts two key points.

The first is to make explicit that the PHPM specialist is a key contributor to the multi-disciplinary work of public health. With a deep understanding of human health and illness, combined with advanced public health knowledge, skills and problem-solving abilities, the PHPM specialist contributes "skills in leadership; development of public policy; design, implementation and evaluation of health programs and applies them to a broad range of community health issues."² Therefore, the state of PHPM is of relevance not only to its current and future specialists, but to the broader field of public health.

The second point is that many of the challenges faced by the specialty of PHPM are linked to broader public health system infrastructure issues. For example, seeking insight into the commentary's description of the apparent paradox of a finite number of PHPM specialists, chronic Medical Officer of Health (MOH) vacancies, and perceived underemployment by recent graduates requires consideration of the design of public health systems.

Public health is, by definition, focussed on the health of populations. However, the structural designs of public health systems frequently do not achieve the establishment of public health organizations with sufficient population bases to support a critical mass of expertise and capacity. For example, in Ontario, smaller public health units serving populations of less than 125,000 people have been found to be 37 times more likely to have a longstanding MOH vacancy compared with larger public health units.³ This recruitment challenge in smaller organizations is not limited to MOHs and may also apply to epidemiologists and other graduate-prepared public health staff. Since public health is very much a team-based practice, the absence of key team members limits the potential impact of a PHPM specialist. This coupled with the absence of other public health physician colleagues, as well as immediate expectations for administrative or executive responsibilities, represent challenges for recruiting new PHPM graduates to such settings.

In the past decade, several reports have described the key design elements for public health systems that have yet to be achieved in most jurisdictions.⁴⁻⁶ For example, most provinces and territories do not explicitly identify public health system functions or define a comprehensive set of core public health programs. Many public health acts are silent regarding MOH roles beyond traditional health protection responsibilities. This includes a lack of formal expectations in many provinces for public health to present to boards of health and to issue reports to the public. The net result is that the roles of MOHs within and among provinces can be highly variable.⁷ In the absence of legislative description, such roles can

literally change overnight depending upon the perspective of health care system executives. The point is that the role and relative attractiveness of MOH-type positions are intrinsically related to how public health is organized and operates.

Loh and Harvey give particular emphasis to the primary care-public health interface. This interface is important since primary care practitioners are a key intermediary for public health interventions to reach the public, as well as an essential source of information for public health analysis and action.⁸ However, PHPM's focus on the health of populations necessitates analysis and action on the broader determinants of health that are outside the scope of health care service delivery. This includes working with relevant partners to establish social and physical environments that support health. While there are opportunities created by embedding public health organizations within regional health authorities, an inherent challenge is a potential overemphasis of public health linkages to clinical care to the detriment of the linkages and actions that are needed more broadly to promote and protect the health of the public.⁹ This risk is augmented if core expectations for public health are not explicit.

The foregoing has focussed predominantly on the demand side for graduates. The commentary also raises questions regarding the supply side and the extent to which it is aligned with the realities of the practice context. For example, the vast majority of PHPM residency programs in this country are based in large urban centres. However, unless residents pursue placements elsewhere, the practice experience in such centres may not be representative of the practice context that exists in other areas of the province or country. Finding employment in formal public health organizations in these centres after PHPM training is often challenging due to the competition for existing positions. To avoid relocating, graduates may be faced with employment scenarios that do not fully utilize their newly acquired PHPM competencies. Furthermore, the nature of entrants to PHPM programs appears to have shifted over time, which may have implications for career paths. Today, many residents are completing their PHPM training immediately following their family medicine training, whereas in the past, many entrants to PHPM programs were physicians with years of clinical experience.

A striking observation regarding the commentary is the continuing lack of data to comprehensively understand the nature of the workforce issues facing the PHPM specialty. One could easily extend this statement to other public health disciplines, as well as public health systems overall. Almost a decade ago, the Naylor Report stated

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that its “assessment of the state of public health human resources is limited by sparse data.”⁵ Has the situation improved much since then? For a field that prides itself on surveillance and situational assessments for evidence-based planning and decision-making, it is a glaring system deficiency that we continue to try and peek through the fog to seek understanding and attempt to make work-force planning decisions in the absence of good data.

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