Commentary

The Management Academy for Public Health: Transforming the Business of Healthcare

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The Management Academy for Public Health, a joint venture between the Kenan-Flagler Business School and the School of Public Health at the University of North Carolina at Chapel Hill, has provided more than 700 public and community health professionals and practitioners unique experiences and training through a customized executive education program and curriculum. The program affords the participants the advantage of understanding the business fundamentals needed to support, organize, and sustain clinical and public health initiatives. As public and private sector resources have become more difficult to procure, astute management and custodial skills have become more critical.

The 9-month curriculum, punctuated by onsite and distance learning that emphasizes personal development as well as team/group dynamics, mirrors education models that maximize learning from the cross-pollination of diverse opinions, experiences, and training. Assembling team members from different regions/states together on projects during the onsite sessions has further advanced learning by exposing participants to myriad effective approaches to problem solving.

While the Management Academy for Public Health has been well subscribed, it would be important to survey those targeted public health agencies that have not participated to date, as part of future recruitment and marketing. Multiple possible barriers to participation come to mind, including failure to understand the program's purpose/value, lack of financial resources needed to participate, and the fear of failure in an academic environment. Nonparticipants' insights and apprehensions could contribute to strengthening the recruitment of future program participants and fine-tuning the program's design.

The face of healthcare and healthcare delivery systems has dramatically changed over the last decade. What began as an evolution triggered by changes in the financing of healthcare from public- and employer-sponsored indemnity plans to managed care with its multiplex of ABCs has now blossomed into a revolution. The cost and reimbursement burden has shifted dramatically from the employer and government to the insured individual. Emblematic of this shift, the employee's share of family health insurance coverage increased 143 percent between 2000 and 2005.[1] For many workers, this burden is increasingly becoming more difficult to carry.

These changes have contributed to the growing numbers of uninsured and underinsured in this country. Compounding this problem is the growing number of aging Americans and the baby boomers' expected impact on the healthcare system. Scientific and technological breakthroughs have increased the length and quality of life of this geriatric population, but at a very high cost. Current annual healthcare spending ($1.9 trillion), according to the Kaiser Family Foundation, represents about 16 percent of America's gross domestic product.[2] The current payer system rewards providers for acute high tech, high-cost care and, to some extent, chronic care for certain diseases, leaving a chasm between those who can and cannot afford the best treatment.

These circumstances raise some important questions about the public health system:

- How can the public health system bridge the gap between the haves and the have-nots?

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- Is it time for the system to expand its preventative, screening, and primary care capacity?
- How can the system engage other community agencies, private foundations, churches, etc in a dialog about how to service the needs of the underserved, uninsured, undocumented, and the aged?
- How can public health system outreach programs better target nontraditional sites—schools, workplaces, malls, churches/synagogues/mosques, community centers, etc?

To answer these questions, the public health system should think about what it has done well traditionally and how it can expand its partnerships to build on its strengths. The public health system has competed well for state and federal funds in areas such as mental health, immunization, family planning, drug and substance abuse, and infectious disease prevention. With extensive experience and capacity in these areas, the system has a unique opportunity to forge mutually beneficial strategic alliances with private enterprises (hospital systems, managed care organizations) that frequently outsource services in these specialty areas. Such partnerships, if properly leveraged and managed, would open the door for new revenue streams and profit.

Entrepreneurs follow the money. As the popularity of long-term care insurance has risen, so have the number and cost of assisted living facilities. With Medicare Part D implementation this year, we are already seeing an influx of new specialty drug sponsors, organizations, and companies. Even AARP, the large nonpartisan group for American senior citizens, has partnered with a large national insurer to get in on the action. "Doc in the box" kiosks are springing up in malls and retail stores to capture the walk-through "Cash and Carry" health consumer. The public health system must become more entrepreneurial, market driven, and less dependent on public and grant funding, in order to get a bigger slice of this nearly $2 trillion industry.

The Management Academy for Public Health is an excellent vehicle through which to challenge old paradigms and introduce entrepreneurial concepts in the public health system. The revolution is here. Will the public health system spend its intellectual and financial capital just on bioterrorism and the avian flu, or will it become a more active participant in improving the health status and well-being of all Americans? The faculty and participants of the Management Academy for Public Health, coupled with forward thinkers at the UNC Schools of Public Health and Business, and including, I suggest, partners from the UNC School of Medicine, can make a major impact on the cost-effective distribution of health services. Now is the time.

REFERENCES

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