Organization Development in Public Health:

The Root Causes of Dysfunction

By Ron Chapman © 2012

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How can so many educated, dedicated and impassioned people fall so short?

It is a classic public health dilemma. Deeply committed professionals with the highest of values come together in a desire to effect positive health outcomes, but for some reason are unable to deliver results. Whether public, non-profit, educational or private, the common theme for many of these organizations is dysfunction.

Dysfunction?

Leaders who do not or cannot lead. Strategic plans that accomplish little. Staff misbehavior or misconduct that goes unattended. Failure to develop and guide staff. Interminable meetings that are unproductive. Desperately needed decisions that

languish for years. Unresolved academic or philosophical debates that impede action. Teams that operate in isolation. Groups and individuals unable or unwilling to work with others who are essential to their success.

Is this every public health organization? Of course not. There are many fine organizations, but far too many face these and countless other dysfunctions. Their inability to be successful at their most fundamental purpose has negative consequences for the public's health. That's problematic enough, but it also discourages and demotivates many public health professionals who otherwise possess exceptional values and great desires for results.

A long-time state public health leader who was exposed in a workshop to a number of leadership and organization development approaches exclaimed, "I had no idea! If I knew about these approaches we could have been so much more successful. But they're not in any of the classes I took for my Masters in Public Health, and nowhere in continuing professional education."

In an echo of that leader's remarks, a federal health scientist with twenty-five years in public health said with some regret, "I could have accomplished so much more." This comment came when she saw the implementation of some of those approaches.

In my lengthy career in consulting, facilitating, and coaching in public health settings, most of my work has focused on developing leadership and organizational capacity. It is intriguing that most of the challenges public health leaders face are really very similar. The details vary widely, but most of these difficulties can be traced back to the same root causes. While that may sound simple, the causes and conditions that give rise to these challenges are usually complex and sometimes quite difficult to

overcome.

Although the education and skills of many public health leaders are exceptional, there are three significant deficiencies. The first is a gap in information about and access to the body of knowledge and practice associated with leadership and organization development. Unfortunately that lack causes an undervaluing of the importance of leadership and organizational roles, roles that are essential to creating a capacity for results and success. It is simply not sufficient to be an exceptional medical doctor, scientist, or public health practitioner when it is organization building that is lacking.

The second challenge is an educational bias. Because of extraordinarily strong educational backgrounds, all too frequently it is assumed by too many that a single training, class or course will provide for leadership skills development. In fact, leaders often need quite a lot of assistance in applying practices that build organizations. Consulting and coaching can fill some of that gap, but in the presence of real-world, real-time demands, there is a crucial need for hands-on involvement. Public health leaders often need someone who can and will work side-by-side with them in engaging the challenges they face.

The third concern, leader inertia, is actually a direct result of the first. There are a surprising number of public health leaders who are not really interested in tackling the issues associated with leadership. In part, this stems from the lack of promotional opportunities for content experts (i.e. scientists, medical experts, programmatic practitioners, etc.) other than those that also require significant management and leadership duties. Thus, many content experts are drawn to leadership and

management positions even though it is not what they really desire, nor what they have been trained to do.

A more important factor is that a number of these leaders want first and foremost to work with and in their areas of expertise, so leading and organization building become a distant second consideration. One client described this as "abdication of leadership." A review of any leadership or management book will quickly reveal that the resulting absence of direction and failure to develop culture and people is highly problematic to any organization.

A talented operational leader in public health summarized the larger issue this way. "Instead of focusing on achieving the most healthy public, focus on developing the best public health institutions and workforce." When we create the capacity to perform, success becomes the inevitable outcome. To get health impact, build organizations designed to produce health impact. This requires dealing with the problem of leadership and focusing greater attention to organization development.

Why haven't these matters been tackled? For an answer we must look to the means of funding public health activities.

Funds are provided to deliver goods and services. Hopefully those deliverables will produce outputs that lead to health impact and outcomes. Rarely is funding provided for leadership and organization development in a rigorous, systemic method that demands performance accountability. And quite often funds are not available for anything not directly related to the desired outputs or outcomes though an entity cannot possibly succeed without them, for example few foundations fund organizational capacity building and even those that allow some "overhead" expenses to be recouped cap it at very low levels.

A few years ago a major, national public health foundation launched major funding for infrastructure and capacity. Implicit in the model was an expectation for sustainability though there was no monitoring of that element. When the foundation redirected its attentions several years later, almost all the coalitions that had been created as part of that effort collapsed in very short order. Clearly the capacity building failed at its long-term outcome.

As a result of these means of funding many if not most public health organizations are launched without viable business plans. Key questions are not asked. How do you intend to produce the desired products and services. Is there demand for those services, and more importantly, is there a source of revenues and resources sufficient to ensure delivery and continuity? Since future resource generation depends on outcomes being realized, is there sufficient evidence to show the connection between deliverables and health impact? How will you build an organization with the leadership, structure, skills and capacity to deliver? Most importantly, does the business model ensure that funders will perceive a return on their investment?

So the organizational solution is to return to the organizational drawing board as many times as necessary to produce a viable organizational approach. Until that approach is sufficient, funding should not be provided for development and delivery

In theory, the standard approach of funding development and delivery in intended to ensure the effective use of scarce resources. In truth, it backfires and produces several very big problems.

The worst outcome is the lack of a viable and sustainable organizational design, which includes the high likelihood of hiring a content expert as a senior leader. The challenges this presents are exacerbated by an inordinately high focus on deliverables

at the expense of organizational functionality and capacity. Not surprisingly this is a self-reinforcing phenomenon since the people involved are passionate about the deliverables, which attracts similarly interested parties, but all at the expense of leaders and managers focused predominantly on directing and overseeing an effective organization.

Let's be clear ... there's no one to blame. It's a cultural reality that continues over time. It is self-reinforcing. It is a paradigm in need of transformation.

Now let's look at the organizational symptoms that result. The most common analogy is to compare a public health organization to an aircraft that has to be built while in flight. When the focus and funding are on deliverables, organizations are launched without sufficient time for laying the necessary foundation and without sufficient funds for capacity and activities not directly related to deliverables. The result is lack of core organizational capacity to perform though the deliverables must be provided to meet the obligation to funding entities.

The second most common symptom was captured by a client when he asked, "Why are we always taking really good public health people and turning them into really bad leaders?" The focus on deliverables tends to produce leaders and managers who are extremely content competent but either uninterested or insufficiently competent in leading and managing. So developing organizational capacity, already jeopardized by the means of creation, is further compromised by lack of attention to it by leaders.

Remember, in this model funding tends to continue regardless of demonstrated results because there are desired social goals. So complexity rises and problems compound because of the two previous challenges. Call this the legacy load. Leaders

and managers are increasingly drawn to solve breakdowns for which their core skills and aptitudes may not be well suited.

In a recent set of informal interviews with public health leaders, I asked them to compare their focus to that of an idealized leader who would spend at least eighty percent of their time on the three most critical roles: creating and communicating vision and direction, developing managers and key staff who can deliver that vision and direction, and cultivating an organizational culture to ensure success. Typically the public health leaders are devoting less than twenty percent of their time to these areas of focus. Instead they are drawn into an extraordinarily high number of meetings and troubleshooting as well as the very alluring content dialogue that stirs their passions.

Now we see a classic symptom of dysfunctionality arise. Without sufficient organizational capacity and effectiveness, the need for dialogue grows and grows. The result is an increasing need for meetings that are misfocused or ineffective.

Sometimes a high level leader will intervene in an attempt to get real, measurable outcomes. If their authority is especially high, staff will put forth a great deal of effort to satisfy their demands. Yet even more resource is committed to deliverables without addressing root causes, and long-term viability is further compromised.

In addition to great challenges in organizational performance, a great price is paid in terms of morale. People who come to public health desire more than anything for their efforts to produce beneficial results with the public. Organizational ineffectiveness thwarts the most important value they hold.

Not long ago, I was asked by an agency to investigate staff morale issues. In a key informant interview I asked a young professional how she felt about her work. She said, “I sure hope my work is having an impact. God knows I work really hard. We all

work really hard. And we care." I remember she paused a really long time before she offered the punchline. "But I really don't know if my work is making a difference."

One other unfortunate outcome is the depreciated value of leaders in the eyes of staff. Staff know something is not right, but in the absence of a sufficient understanding their only recourse is to blame leaders. Regrettably, many leaders just retreat further from attempts to lead.

The worst outcome is the inattention to developing staff. That's bad enough in any setting given that the secret to success lies in great people who perform, but in public health it's devastating given their passions and values.

In summation, organizational dilemmas in public health can be remarkably challenging to address. They are often quite complex and involve a range of approaches and strategies not commonly known in the field. Plus it involves leading cultural change, which is in itself sometimes quite challenging. And to be clear, the typical organizational change intervention is a long-term proposition, typically three to five years, and maybe more.

Despite these realities, there is a deep well of competency and dedication that public health professionals possess. With that and some expert and enduring focus on the causes and conditions that produce the organization's situation, it can be overcome. Over and over again experience confirms this possibility as long as leaders are willing to commit and persist.