
PRIVATIZATION AND PUBLIC HEALTH

A Report of Initiatives and
Early Lessons Learned

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EXECUTIVE SUMMARY

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Market forces have significantly changed the financial base and functional role of public health departments. Health departments are becoming leaner and more effective delivery systems as they confront managed care, downsized governmental agencies, and reductions in revenues from Medicaid and other third-party payers. One consequence is that health departments have begun examining “privatization,” the outsourcing of services to private, for-profit agencies, as a potential strategy for assuring delivery of necessary public health services.

In 1996, The Annie E. Casey Foundation commissioned the Public Health Foundation to explore the move to privatization by collecting information through a three-tiered study of local health departments.¹ Study sites included Los Angeles County, CA; San Diego County, CA; Middletown, CT; Broward County, FL; Lake County, IL; Fayette-Lexington County, KY; Minneapolis, MN; Atlantic City, NJ; Onondaga County, NY; Union County, OR; Nashville/Davidson County, TN; Austin/Travis County, TX; Southwest Washington Health District, WA; and the following Maryland counties: Anne Arundel, Baltimore City, Baltimore County, Calvert, Cecil, Charles, Frederick, Harford, Montgomery, St. Mary’s, Washington, and Wicomico.

Study findings indicate that a broad range of public health services have been privatized. However, the decision to privatize generally depends more on a community’s unique characteristics and service delivery system than on a specific type of needed services.

¹ These three tiers consisted of: a survey of 11 local health departments that had privatized one or two public health services; site visits to two local health departments that had extensively privatized public health services; and a comprehensive, statewide analysis of local health department privatization in one state.

This study found that the **catalysts** for privatization of health department services vary, but fall into four general areas:

Medicaid Managed Care: Implementation of Medicaid waivers has prompted many local public health departments to move toward privatization.

Cost savings and other fiscal concerns: Many health departments hoped to reduce costs by outsourcing services to private sector entities who may provide services more efficiently.

Improving quality and efficiency of services: A few health departments discovered that outsourcing to private providers, who often had more comprehensive clinical capacity, could improve quality as well as efficiency.

Reorganizing state and/or local health departments: Downsizing and governmental reorganization, often prompted by budgetary cuts, were also cited as catalysts for privatization.

Individuals interviewed cited some common challenges in the privatization process. These **difficulties** included:

- personnel issues;
- philosophical differences between health department administrations;
- staffs;
- private partners; and
- difficulty in finding able or willing partners in the private sector.

Conversely, study participants pointed to several factors that were **facilitators** of the privatization process, including:

- an involved community;
- a history of partnership with the private sector; and
- a local health official with a strong vision of community health.

Other important findings derived from the study sites include:

Accountability: Most health departments have maintained assurance functions—such as case management, outreach, or monitoring for the service privatized. Some have formalized the role through contracts with providers.

Quality: Several survey participants reported that the quality of care has improved or remained the same. Others were unable to assess changes in quality.

Access: Several health departments indicated that privatization improved access to clinical services, but for some, it diminished access to psychosocial services and health education.

Fiscal issues: Most health departments were forced to implement cost shifting or other redirection of expenditures to compensate for lost income. This happened regardless of the service privatized or the funding mechanisms involved in the process.

Essential Public Health Services: Almost all respondents indicated that privatization initiatives freed scarce resources to provide Essential Public Health Services.²

Community relationships: Typically, privatization strengthened, but in a few cases weakened, relationships between health departments and their private and public partners.

This study identified several **lessons learned** relevant for public health departments contemplating privatization. These include:

Provide strong leadership: A successful privatization effort needs to be championed by a local leader who possesses the vision and forethought to guide the process from conception through implementation.

Maintain public health department identity: The health department must continue to fulfill its assessment, policy development, and assurance roles. This can happen through close cooperation with the private sector. Once services are privatized, health departments must continue to maintain a strong community presence. Public health departments must monitor private sector parties for compliance with legal and programmatic requirements.

Ensure quality of care: Public health departments must ensure that quality is not sacrificed for cost containment. They must be available as the provider of last resort. They must aggressively step forward whenever necessary.

Prepare Internally: It is critical for the health department to understand the time, effort, and information needed to successfully privatize. Staff concerns are important and need to be addressed early and throughout this process.

Increase knowledge of business practices: Successful navigation of the privatization process requires adoption of special skills; such as an understanding of contracting and other business-related activities.

Build Collaboration: Successful privatization requires educating and involving the community. This must be done not only in implementation, but in goal setting and planning stages of the process.

Acknowledge and reconcile divergent philosophies: Acknowledging and reconciling divergent philosophies into the process of privatization can foster the long-term success of an initiative.

While this study provides useful background information on privatization activities in selected localities, more research is needed to adequately understand this trend and its impact on the public's health and the public health system. An important first step is to develop a universal definition of privatization to assist in the development of more comprehensive and possibly

² For the list of Essential Public Health Services, see Appendix A.

service-specific studies. Subsequent research should seek more detailed information related to costs, health outcomes, and the long-term impacts of privatization. Such information could guide the public health system in making informed choices about the proper role of government in managing and providing population-based services.

STUDY AND FINDINGS

I. INTRODUCTION

Traditionally, the public health system has been a vital resource for disadvantaged communities and families. Its unique ability to provide population-based solutions to health problems has been essential to promoting and protecting the health of the underserved. However, market forces are significantly changing the financial base and functional role of public health departments.

Three fundamental trends in health care finance and organization are affecting children and families in the 1990s:

- expanding managed care models;
- public hospital conversion and hospital mergers; and
- the rapidly increasing practice of "outsourcing" or "privatizing" public health department services and programs.

In the past, health departments have provided population-based public health services to assure the health and safety of the entire community, while the private sector provided medical care services. However, with the inception of the Medicaid program in 1965, public health departments began to shift more of their attention to providing care to vulnerable populations, such as the chronically ill, disabled and the poor. Health Departments had to do this as a way of competing with private providers for Medicaid dollars.³

However, in the 1990s, the Medicaid program witnessed a dramatic shift in the way its populations are served. Managed care arrangements have become the predominant service delivery mechanism, with these organizations assuming much of the Medicaid case load typically held by health departments.

³ Suzanne Dandoy, "Filling the Gaps: The Role of Public Health Departments Under Health Care Reform," *Journal of American Health Policy* (May/June 1994).

While the cost containment and preventive care emphasis of managed care has definite advantages, certain aspects of programs or services may be overlooked in the process. Private provider networks may lack the capacity, infrastructure, or quality assurance mechanisms that protect clients from slipping through programmatic "cracks." This risk is particularly relevant for localities with large numbers of individuals lacking health insurance or with undocumented immigrant populations.

For example, research about Medicaid managed care reveals that many population-based services traditionally provided through public health departments (such as communicable disease control, health promotion, and prenatal outreach) have been omitted from some Medicaid managed care contracts.⁴ Plan providers frequently are not required to deliver these services. Since Medicaid dollars diverted to managed care would no longer support the health departments in providing these services, a glaring gap in the health of the community remains.

In addition to the market forces shaping health systems delivery over the past decade, the 1990s have been characterized by governmental downsizing and budget cuts at all levels. These cuts have compromised the ability of local agencies to provide basic services.⁵ As a result, policy makers at all levels of government are calling for leaner, more efficient service delivery.

⁴ Sara Rosenbaum et al., "Negotiating the New Health Care System: A Nationwide Study of Medicaid Managed Care Contracts" (Washington, D.C.: The George Washington University Center for Health Policy Research, February 1997).

⁵ Arden S. Handler and Bernard J. Turnock, "Local Health Department Effectiveness in Addressing the Core Functions of Public Health: Essential Ingredients," *Journal of Public Health Policy*, vol. 17, no. 4, and Brian Morris, 1996: 460-483 "The Big Shift," *The Council of State Governments* (April 1997).

Given the trends in health care finance and organization, new strategies for addressing service delivery gaps must be developed. One such strategy, “privatizing” public health services, is being explored as a potential community-based approach for assuring delivery of these services.

Today, as more and more services for publicly-insured populations are provided by managed care or other private sector organizations, many believe that public health departments must return to population-based services. This view suggests that public and private provider collaborations have become more important than ever.

Collaborative efforts between government and the private sector must ensure that Essential Public Health Services⁶ are delivered within the community as efficiently and effectively as possible. A 1996 study by the Joint Council of Governmental Public Health Agencies⁷ contends that both the public and private sectors have much to gain from collaboration. The study concluded that private providers are able to assume “responsibility for providing services traditionally associated with health departments, leaving the health department to concentrate on assessment, policy development, and assurance.”⁸

⁶ For the list of Essential Public Health Services, see Appendix A.

⁷ The Joint Council of Governmental Public Health Agencies is comprised of representatives of two national organizations that represent the directors of local and state public health departments—the National Association of County and City Health Officials and the Association of State and Territorial Health Officials.

⁸ “Improving the Public’s Health: Collaborations Between Public Health Departments and Managed Care Organizations,” Joint Council of Governmental Public Health Agencies, Work Group on Access, Assurance, and Reimbursement for Primary Care, Public Health Foundation, Washington, DC (July 1996) pg. 27.

Rationale for Conducting Study

To better understand how market forces and trends in health care finance and organization are affecting services to disadvantaged children and families in this country, the Public Health Foundation (PHF) undertook a study of selected local health departments that have outsourced some public health programs and services.

This study provides information on early lessons learned about privatization efforts by local health departments. While this study focused purely on *public health* services, other studies have focused on the extensive trend toward privatization throughout government in general.⁹

What Is Privatization?

In its purest form, privatization is the process of complete divestiture of a public good or service to a private interest. This may include all aspects of the service, such as delivery/provision, personnel, program oversight, and administrative functions. It also implies that one of the intentions of privatization is to decrease the size of government.

In preliminary discussions with public health professionals, it became clear that there is no one accepted definition of privatization. Therefore, PHF, with help from other public health professionals, developed a broad, working definition of privatization as applied specifically to public health.

Privatization encompasses those activities/services for which the state or local health department has reached a formal decision to withdraw from or contract out for provision of a public health service, in whole or in part, and a non-governmental entity has taken over responsibility for provision of that

⁹ Diane Kittower, “Guide to Privatization: Serving the Public with Private Partners,” *Governing* (May 1997).

service. This may include development of formal partnerships with the private sector to offer public health activities/services not previously provided by the health department.

This definition excludes those cases where a health department joins with another type of governmental entity, either by absorption or through contractual arrangements.

The privatization initiatives described in this study most frequently are based on some type of contractual arrangement, either formalized by a contract between the health department and the private provider, or through a Memorandum of Understanding (MOU). Although many local health departments used "contracting out" to describe privatization efforts, the term "outsourcing" is used throughout this study. According to reactions from study respondents, outsourcing has a more positive connotation, suggesting that assurance functions such as case management, oversight, and policy development are maintained by the health department, with service delivery handed over to the private partner.

II. METHODOLOGY

The methodology for collecting data from local health departments employed by PHF was a structured, three-tiered survey of public health privatization. These surveys were conducted and compiled in 1996 and 1997. These three tiers consisted of:

- a survey of 11 local health departments that had privatized one or two public health services;
- site visits to two local health departments that had extensively privatized public health services; and
- a comprehensive, statewide analysis of privatization in one state.

This section describes these three survey approaches and discusses the limitations of the study.

Survey

The first research tier surveyed local health departments that privatized one or more public health services. The purpose of this survey was to identify:

- catalysts for privatization;
- types of services being privatized;
- contractual relationships;
- effects on other services not privatized;
- service delivery problems and solutions; and
- early successes and challenges.

The survey instrument, which was also used in the statewide analysis described later in this section, was developed by the project team. It was then reviewed, field tested, and critiqued by several public health professionals. The instrument was designed to collect baseline information regarding the privatization process and its impact on other health department services or functions. Follow-up interviews provided an opportunity to clarify written

information and gain some narrative perspective.¹⁰

The local health departments selected for this survey had three characteristics: First, they had turned over at least one previously delivered public health service to a non-government agency, preferably direct care to children and/or families. Second, they had privatized this service for at least six months. Finally, they were willing to participate in the study by completing a written survey and a subsequent telephone or personal interview.

The health departments initially recruited for participation were selected through recommendations from staff at the National Association of County and City Health Officials (NACCHO), the Centers for Disease Control and Prevention (CDC), and experts within the public health community who had researched similar issues. A literature review was also helpful in selecting candidates. In addition, sites were recruited through a notice posted on PHF's electronic public health forum, the Public Health Network (PHN).

Following the identification of potential sites, health officers or members of their staff were contacted by telephone. The project team briefly queried potential respondents about their privatization efforts and willingness to participate in the study. Participants were sent copies of the project description, encouraged to complete the survey, and asked to be available for follow-up interviews.

Ultimately, eleven sites completed the survey and follow-up interviews. Seven of these sites had representatives attending the 1996 American Public Health Association annual meeting in New York City who were able to meet directly with the project team. The remaining follow-up interviews were conducted via telephone. After the interview, all interviewees were

¹⁰ The survey instrument is included as Appendix B.

provided drafts of the interview summaries for comment and review. The chart below sets forth the participant counties and the service(s) privatized that were the focus of this study.

Health Department	Service(s) Privatized
Los Angeles County, California	<ul style="list-style-type: none"> • Primary care
San Diego County, California	<ul style="list-style-type: none"> • Family planning • TB/chest x-rays • Perinatal outreach and referrals • Immunization
City of Middletown, Connecticut*	<ul style="list-style-type: none"> • Communicable disease • Well-child clinics • Home health services • Immunization outreach • Emergency medical services • Primary care services • Elderly health services
Broward County, Florida	<ul style="list-style-type: none"> • Pediatric primary care • Prenatal care
Lake County, Illinois*	<ul style="list-style-type: none"> • Outpatient X-ray
Fayette-Lexington County, Kentucky*	<ul style="list-style-type: none"> • Obstetrics
Atlantic City, New Jersey*	<ul style="list-style-type: none"> • Communicable disease
Onondaga County, New York	<ul style="list-style-type: none"> • Early intervention/pre-school billing • Correctional health clinics billing • Lead and clinical labs • Family health clinic • Physician services
Nashville/Davidson County, Tennessee*	<ul style="list-style-type: none"> • Home health
Austin/Travis County, Texas	<ul style="list-style-type: none"> • Health care for MAP enrollees
Southwest Washington Health District, Washington (SWWHD)*	<ul style="list-style-type: none"> • Well-baby clinics

* Follow-up interviews conducted in person in New York City, November 1996.

Site Visits

The second tier of research entailed site visits to two local health departments that had extensively privatized public health services. These visits provided the project team with the opportunity to collect comprehensive information on privatization through in-depth interviews and focus groups with individuals in both the public and private sectors.

Minneapolis, Minnesota, and Union County, Oregon, were chosen because of their widespread privatization of public health services and willingness to commit time and personnel to the study. The site visits specifically focused on issues related to accountability, public-private partnerships, community-level service delivery, community participation, and changes in expenditures and other revenue sources related to privatization.

Minneapolis

The selection of Minneapolis was based on the city's extensive structural reorganization and privatization efforts along with Minnesota's general focus on health care reform. Preliminary research showed that throughout 1994 and 1995, the Minneapolis Department of Health, Family Services, and Support had privatized nearly all direct care services through contracts with private providers and redistribution of duties and responsibilities. Other services, such as environmental health, were transferred to relevant governmental divisions. As a result of all these changes, the public health department was reduced from approximately 224 to 44 full-time employees (FTEs) within a one-year period.

The study team spent three days (December 18-20, 1996) in Minneapolis interviewing practitioners in both the public and private sectors, as well as policy makers from the city government. The visit culminated in a group discussion with individuals representing the health department, the finance department, and private partners. Public health professionals from nearby local health departments were also contacted to participate in phone interviews after completion of the site visit.

Union County

Union County was chosen based on Oregon's comprehensive efforts in health care reform as well as the county's innovative and extensive privatization of public health services. In July 1995, the public health department of Union County, the Center for Human Development (CHD), became incorporated as a private, non-profit organization rather than a governmental agency, and assumed responsibility for providing all county-related public health services. The County's only remaining involvement in public health entails monitoring the contract with CHD and assuring that CHD responsibilities were met.

Three days (January 28-30, 1997) were spent in La Grande, Oregon, interviewing the individuals instrumental in the transformation of CHD from a governmental entity to its current private, non-profit status. Many of the interviewees, who served some of the same clients before and after the conversion, provided useful insights about the effect of privatization and described the CHD's team approach to management and public health services. The project team also met with representatives from CHD, county government, and community stakeholders during the visit.

On-location interviews in both Minneapolis and Union County provided the study team with a greater understanding of the facilities utilized by both private and public partners. These site visits shed light on valuable information, such as the need to address unique public transportation or demographic barriers to public health services. In addition, engaging key players in discussion provided details about group dynamics and decision-making processes that may have been missed without the face-to-face contact.

The survey used in the first tier was adapted for these two sites. Copies were forwarded to interviewees prior to the site visit and used as the basis for the information gathering process. During the group discussions, the basic survey information was supplemented by a discussion guide to generate more in-depth information from the respondents. The discussion guide focused specifically on:

- community involvement in the privatization effort;
- relationships between various levels of government;
- assessment, policy development, and assurance roles; and
- challenges in privatizing.¹¹

¹¹ A sample discussion guide is included as Appendix C.

Statewide Analysis

A comprehensive statewide analysis of privatization activities in Maryland comprised the third tier of data collection and research. The statewide survey examined the impact of privatization upon state and local health department relationships and public accountability. The State survey also sought information on public and private expenditures, program oversight, challenges that had emerged at multiple levels of government, and the extent of privatization across a state.

Maryland was chosen for the statewide survey for various reasons. Maryland's "all-payer" system has maintained lower hospital rates than the national average while maintaining a privatized hospital delivery system. During the interview period, the state and local health departments also were preparing for implementation of Maryland's 1115 waiver¹² plan on June 2, 1997. In addition, because of its close proximity to PHF, Maryland was easily accessible for site visits to several local health departments.

After an initial focus group session at the monthly meeting of the Maryland Association of County Health Officers,¹³ the study team sent the basic survey instrument plus a supplemental questionnaire¹⁴ to all of Maryland's 23 counties as well as Baltimore City.¹⁵ Fourteen counties responded. While one county indicated that no privatization efforts had taken place (Queen Anne's), 13 counties indicated that one or more public health services had been privatized. Five counties were selected for site visits based on the variety of services privatized, regional variance, and focus on services for

children and families. These counties were Anne Arundel, Montgomery, St. Mary's, Washington, and Wicomico.

All interviewees were provided drafts of the interview summaries for review. The chart on page 8 details the local health departments participating in the Maryland survey.

As with the Union County and Minneapolis site visits, the Maryland site visits were examined to gather more in-depth information from specific areas of the survey, to further explore issues such as expenditures and intergovernmental relations, and to meet with private sector providers. In-depth telephone interviews were conducted with the other seven counties that completed the survey.

In addition, the project team interviewed key Maryland State health officials including Dr. Martin Wasserman, Secretary of the Maryland Department of Health and Mental Hygiene (DHMH); Dr. Georges Benjamin, Deputy Secretary of Public Health Services, DHMH; Dr. Russell Moy, Director of Community and Public Health Administration, DHMH; and Mr. Stu Silver, Director of Mental Hygiene Administration, DHMH. These individuals provided background information regarding HealthChoice, other statewide health initiatives, and decision-making processes related to privatization issues.

Limitations

The study was an analysis of survey, interview, and site visit data. It was based on qualitative information and did not seek to establish statistical significance in any particular area of privatization. The focus of the study was information collection rather than causal analysis. As the study progressed and better perspectives were gained, information was added and subtracted from the standard interviews to better capture the relevant issues.

The timing and voluntary nature of the study also limited the range of its comprehensiveness. For example, several

¹² 1115 and 1915(b) waivers granted by the Health Care Financing Administration allowed states to implement Medicaid research and demonstration programs (such as managed care) for up to 5 years

¹³ Annapolis, Maryland, January 9, 1997.

¹⁴ See Appendix D.

¹⁵ Maryland and its local health departments are divided into 23 county jurisdictions and the City of Baltimore.

sites were unable to participate due to the timing of the request and their need to complete other reports or funding proposals. Other sites were too involved in the actual reorganization and privatization process to participate.

This study does not seek to make sweeping generalizations or inferences on outcomes of privatization efforts across the United States. Furthermore, due to the limited sample size, it is difficult to make conclusions as to the prevalence of privatization practices nationwide. Statements made throughout the report are only reflective of the sample surveyed.

Local Health Department	Service(s) Privatized (focus of interview in bold)
Anne Arundel*	STD clinical treatment Child health clinic
Baltimore County	Outpatient mental health
Baltimore City	Children and youth clinics Substance abuse Mental health School-based health
Calvert	Maternity Well child
Cecil	Well child Mental health
Charles	Breast and cervical cancer screening
Frederick	Maternity
Harford	Maternity Child health Seizure Orthopedics Chest Adult health
Montgomery*	Family planning Child health Maternity
Prince George's**	Child health Pediatric subspecialty Speech pathology and audiology Occupational and physical therapy School-based health center Adult health Home health Senior dental
Queen Anne's	None
St. Mary's*	Well child Mental health Substance abuse Home health
Washington*	Maternity Child health Prenatal care Mental health
Wicomico*	Maternity

* Site visits

**Prince George's completed the interview but withdrew from the study.

III. FINDINGS

Privatization varies greatly among study sites. Some localities are outsourcing one service; others are developing more comprehensive schemes involving several services and programs. Although public health includes much more than health care delivery, our study found that health departments are most frequently privatizing clinical services. The catalysts, barriers, and facilitators behind these efforts are driven by the unique characteristics of the community and its current mode of service delivery, and are usually not specific to a given type of service. However, the results of outsourcing various public health responsibilities remain fairly consistent across the sites.

Catalysts for Privatization

Some of the catalysts for privatization cited by local health departments were external, such as comprehensive government reorganization or implementation of Medicaid managed care through an 1115 waiver. Other factors were internal and unique to that particular health department and community. Each local health department considering privatization faced many issues and concerns before moving forward. Some study sites, such as **Anne Arundel County**, **San Diego County**, **Southwest Washington Health District (SWWHD)**, **Onondaga County**, and **Lake County**, developed specific criteria, which focused on client care goals and public health needs that programs must meet as a prerequisite for privatization.

In general, the catalysts or driving forces cited for privatization can be grouped as follows:

- Medicaid managed care;
- cost savings or other fiscal issues;
- quality improvement and efficiency; and
- organizational streamlining.

Medicaid Managed Care

Medicaid managed care is significantly affecting the way local health departments operate and provide services. Although many of the counties had already begun thinking about the idea of privatization, in Maryland, the June 2, 1997, deadline to implement the 1115 waiver plan prompted more thorough and decisive action. Several Maryland local health departments noted that they were unprepared to implement HealthChoice. Rather, they moved toward privatization of specific public health services in advance of the waiver. Once the waiver implementation preparations began, these health departments were better equipped to assume their new roles under the waiver. Other Maryland health departments noted that waiver required promptly moving some provisions for personal care service delivery out of the health department and increased their role in monitoring and case management.

Several sites reported that increased Medicaid reimbursement motivated a search for participants by previously uninterested private providers. For example, some private providers in **St. Mary's** were partnered with the health department to offset the costs of providing uncompensated care. Through this arrangement, the health department reimbursed private physicians for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided to the uninsured.

Cost Savings or Other Fiscal Issues

Respondents often cited cost savings and fiscal concerns as a primary catalyst for privatization. However, many were uncertain whether privatization would successfully release dollars for additional services or other health department functions. They felt that private providers had the capacity to deliver certain types of services in a more cost-effective manner.

In Maryland, state health professionals, in their view, saw HealthChoice (their Medicaid Managed Care Program) as a way of providing health care in a more organized fashion. This could potentially lead to cost reduction. Baltimore City hoped outsourcing to community clinics would limit debt in providing child health services.

Other fiscal justifications for privatization cited by respondents included decreased demand for clinical services issues surrounding Federally Qualified Health Center (FQHC) status; and greater fiscal flexibility within the private sector. The decreased demand for pediatric orthopedic services in **Harford** led to its eventual decision to privatize. For **Frederick**, countywide budget cuts of 50% forced privatization of maternity services. Another challenge for privatization concerned FQHC status.¹⁶ To obtain FQHC status, **Lake County** needed to provide outpatient radiology services or enter into a formal contract with a private provider for such services. By outsourcing x-ray services, Lake County obtained FQHC status thereby receiving a higher cost-based rate for providing personal care services. **Austin/Travis** contracted with three HMOs for primary care specifically to expand its capabilities, enabling it to meet FQHC requirements. Conversely, **Atlantic City** had been turned down for FQHC status, which motivated the administration to look more closely at alternative delivery systems. In addition, study respondents reported that outsourcing to private providers can create greater spending flexibility. Private organizations often have more financial flexibility than government agencies, which are bound by debt limits and spending regulations. In some states, local governments must obtain legislative approval for certain expenditures and have limited authority to carry unspent funds

¹⁶ Health departments and other qualified providers that are major providers of primary care services to large, underserved populations may petition the federal government to become certified as a FQHC. As a FQHC, they can receive cost-based Medicaid reimbursement versus fee-for-service for provision of primary care services.

into the next fiscal year. On the other hand, private organizations can freely reinvest savings in capital improvements or programs to increase the quality and/or capacity for services.

In deciding whether to provide radiology services in-house or contract out, **Lake County** recognized that its x-ray equipment was outdated. Outsourcing the service to a private provider who had better equipment and greater knowledge of radiology was in the client's best interest. Respondents also pointed out, however, that private sector profits may also be distributed to shareholders and not reinvested in client care.

Quality Improvement and Efficiency

Only a few sites indicated that improving quality of care primarily motivated privatization initiatives. Some sites reported that increased technology and sophisticated services available in the private sector discouraged them from continuing to offer services that could be performed more efficiently, if not better, by private providers. In **Broward**, health department officials realized that the hospital district had more resources available, including specialized pediatric services. Similarly, **Onondaga** realized that privatization offered the opportunity for more comprehensive laboratory services. According to the **SWWHD**, privatization of most immunization services offered the potential to significantly increase community immunization rates and improve quality of practices in private medical offices.

One example, seemingly unique among study sites, was **San Diego's** privatization of family planning, which involved complete voluntary withdrawal from a single service. In California, family planning services are contracted out by the state health department, and prior to 1993, the San Diego County health department was one of several contracted providers. After careful analysis, San Diego health officials determined that there was an abundance of proficient private providers in the county already under contract with the

state to provide family planning services. The County, therefore, determined it need not provide the service.

Los Angeles privatized its primary care services to more efficiently serve an increasing uninsured population. (The project goal was met by increased numbers of primary care visits.) In addition, a centralized monitoring program has enabled the county to develop and track performance measures with its private partners.

Some counties outsourced services in order to increase the continuity of care for clients, especially for maternity care and well-child care. Prior to privatization in several Maryland counties, such as **Harford, Frederick, and Washington County**, women would see a nurse practitioner or medical resident at the health department for prenatal care, but would then be sent to the county hospital for labor and delivery services. Under this system, clients saw many different individuals for treatment, which often led to confusion and to disruption in the continuity of care. For example, the on-call obstetrician delivering the baby typically had never seen the patient before and was unfamiliar with her medical history, potentially threatening the care she and her child received. Now, however, clients in **Washington County** establish relationships with one health center and provider in order to improve the continuity of care throughout the prenatal period. Similarly, in privatizing breast and cervical cancer screenings, **Charles County** sought to combine mammograms, breast exams, and pap smears in one clinic visit.

Structural Streamlining

The 1988 Institute of Medicine report, *The Future of Public Health*,¹⁷ has stimulated many health departments to increase their focus on population-based services and to phase out clinical care. Maryland for

¹⁷ The Institute of Medicine, *The Future of Public Health*, National Academy Press: Washington, DC 1988.

example has encouraged local health departments to provide less personal, and more population-based, care. Those Maryland local health departments surveyed seemed acutely aware of this “charge” to refocus their efforts and programs. Most Maryland health departments surveyed were undertaking partial, if not complete, reorganization to better provide essential public health services.

The statewide trend in California toward reducing bureaucracy and streamlining operations prompted **San Diego** to privatize several services.¹⁸ In **Baltimore City**, the mayor mandated annual reductions in the city workforce, prompting a close examination of all services and programs provided by the health department. In **Los Angeles**, major budget crises forced substantial personnel layoffs. The health department saw privatizing as a way to better serve city residents and still meet the state mandate to downsize local government.

Reorganization in **Minneapolis** was comprehensive. In the early 1990s, Minneapolis looked at ways of better providing services, reducing costs, and meeting the demands of citizens despite decreasing dollars. Focus teams determined which city government functions and services were essential to its mission, and which ones might be outsourced. Once budgets were cut and departmental restructuring and funding redirection took effect, privatization needed to be implemented quickly to maintain continuity of care.

¹⁸ Currently, immunization, family planning, tuberculosis (TB) chest x-rays in certain geographic areas, prenatal outreach and referral, direct provision of primary care, and alcohol and drug services are privatized. The county is also considering moving mental health services to private providers. Health officials decided to retain certain services such as AIDS testing, TB, sexually transmitted diseases (STD), and Hansen’s disease services, mainly due to a steady patient load and seemingly few, if any, willing providers in the area.

Aside from the four sites just mentioned, most health departments indicated that the resulting reorganization was more a positive result than a motivating cause. Privatization usually involved redirecting revenue sources and personnel, and provided an ideal time to rework organizational structures that support population-based services.

Preparations for Privatization

Health departments need adequate information before moving to privatization. The survey instrument¹⁹ asked whether or not the following preparations for privatization were made at the state and/or local levels:

- needs assessment;
- business/market analysis;
- Medicaid waiver;
- other legislative/regulatory changes;
- executive decision/negotiations;
- technical assistance;
- and staff retraining.

Most sites did not conduct a formal needs assessment or business/market analysis prior to outsourcing. In fact, planning prior to privatization was often minimal. The move to privatization was often made as a reaction to external events such as an 1115 waiver.

Some exceptions were noted. A countywide needs assessment in **Broward** assisted the health department in privatizing its programs and services. **Lake County** conducted a thorough needs assessment and business analysis as part of its extensive preparations for privatizing outpatient radiology services. **SWWHD**, working with its Healthy Communities partners (the Chamber of Commerce, businesses, social services, health care providers, churches, and schools), also

completed a community assessment prior to moving to Medicaid managed care. The results of the assessment led to the implementation plan for privatizing public health services.

Legislative and regulatory changes were not necessarily made in preparation for privatization, but served more as motivation to move away from direct service provision. None of the sites indicated that their state specifically sought an 1115 or 1915(b) waiver as a means to privatization. In **Washington County**, increases in Maternal and Child Health Services Block Grant (Title V) allotments facilitated decisions already made to privatize maternal and child health services. In **San Diego**, implementation of the Vaccines for Children Program,²⁰ changes in school entrance regulations, and organization of the state family planning office influenced preparations toward privatization.

Through the survey instrument, executive decision was repeatedly listed as a preparation for the privatization effort. But, upon clarification and as detailed later in this section, the effect of strong leadership may be more precisely described as a facilitator to privatization.

A few sites reported that they had enough lead-time to provide some staff retraining or technical assistance prior to outsourcing. In outsourcing laboratory services, **Onondaga** needed to prepare its staff to better coordinate tests and results from external sites. **Frederick** health department staff actually provided technical assistance related to Medical Assistance (MA) billing for private physicians and hospital staff prior to outsourcing maternity care services. In most cases, retraining staff in new procedures and processes occurred during or after services were privatized.

¹⁹ See Appendix B.

²⁰ The Vaccines for Children Program is a federally funded program implemented in 1994 to give vaccines for inoculation by qualified providers.

Although many sites did not have the opportunity for extensive planning, they indicated that planning is important, and that, in hindsight, having more time for planning would have alleviated some of the problems they encountered.

Minneapolis representatives noted how valuable a needs assessment would have been to its efforts. Short time frames did not necessarily create problems with provision of care for some localities, but staff noted that more lead-time would have allowed for the formulation of a cohesive vision and workplan as well as for adjustment to the idea of such major changes in structure and philosophy.

Barriers to Privatization

External and internal barriers often hampered the privatization process. Issues relating to personnel, philosophy, and the availability and willingness of providers presented the greatest obstacles.

Personnel-Related Difficulties

Personnel issues were the most common barriers to privatization. Many local health departments encountered difficulties in negotiating with unions during the privatization process. However, individual employee resistance was also a barrier. Changes affecting individual job descriptions and responsibilities were often more challenging to resolve than the system-wide shifts.

Unions

Organized labor's effect on executive decisions and personnel changes can significantly influence privatization negotiations and planning. In private business, contracting out services can often reduce costs and increase flexibility. As health departments have begun to privatize services, government personnel, often union employees, are transferred to private organizations. This affects the salary and benefits of the individuals as well as the

regulations under which employees are governed.

Some localities encountered union resistance as they sought to create greater flexibility and efficiency in hiring, firing, and case load requirements. Prior union/government contracts made changing such provisions difficult, if not impossible. Additionally, several sites mentioned that union resistance significantly impeded the general outsourcing process.

This seemed particularly true for **Minneapolis**. The strong union presence and the collective bargaining power slowed the restructuring process. It was important to collaborate and communicate with union representatives in order to ease negotiations on benefits and tenure. Although faced with a similar situation, the **SWWHD** was able to find opportunities in the community for nurse practitioners who had been laid-off because of improved collaborative bargaining and several years of relationship building with its union.

In **Union County**, because CHD employed a combination of union and non-union employees, comparable compensation and benefits needed to be closely examined. The union issue was resolved by allowing individuals to leave the union and transfer to CHD personnel regulations. In the end, **Union County** subcontracted with 10 individuals, who chose to remain union members. The goal is to eliminate this arrangement through attrition and new hires until all personnel are employees of CHD.

Employee Fears

Rumors of privatization nearly always prompted fears about job security. In many of the sites, health department staff were very concerned about losing their jobs. This fear was one of the most commonly cited barriers to the privatization effort.

Some sites did experience job losses. For example, in **Atlantic City**, the contract stipulated that the new provider had to

employ the 34 former health department employees. However, after just one year, three-fourths of the employees left because of reduced benefits or philosophical differences. Although **Baltimore City** had not implemented its privatization plan, the health department expected to lay off up to 22 full-time equivalents (FTEs). Because of privatization efforts, **Montgomery's** workforce of public health nurses has dropped by more than 50% over the last three years.

Many formal agreements required private partners to take on former health department employees and provide comparable salaries and benefits. As a prerequisite to outsourcing, **St. Mary's** required that any private provider assuming provision of mental health services employ all the former mental health services health department staff. Some private providers offered to grandfather long-term employees into existing retirement plans as in **Baltimore County**. However, some workers reported losing their sense of *public service* after they became *private* employees. Their desire to "serve the people" was often cited as the reason that many had chosen employment with the government.

Minneapolis was particularly exemplary in easing the difficult transition to privatization of certain services. Citywide, hundreds of government employees were required to change jobs, but very few actually lost their tenure or benefits from their years of service. Since most of the city employees had worked for the government for more than 30 years, strong mutual loyalty existed.

Although the employee roster of the health department was reduced from 224 to 44 FTEs, several steps were taken to ease this transition. A job bank was established to help re-employ individuals, while a hiring freeze and retirement incentives also mitigated the loss. In addition, the reorganization opened up a few new positions. All of the public health nurses were moved to the school-based health clinics and employed by a non-profit community organization, while the rest of

the staff was appropriately placed in different positions.

Although personnel were generally adverse to change, most sites discovered that the fear of imminent change decreased significantly once changes were implemented. One way to reduce the stress inherent with change was through effective communication. One nurse in **Cecil County** commented that upper management must be considerate of staff fears and recognize that it takes time to overcome them. The private sector personnel can also be uneasy with change. In some instances, private providers felt that their practices would be overwhelmed by the influx of new and often needier patients.

Defining the Role of Public Health

Resistance to privatization often extends beyond personnel issues. Public health officials and their staff strongly believe in maintaining certain services within the auspices of the public health department. For example, they believe that the safety net traditionally provided by the health department for the poor may be damaged by a shift away from personal care services toward population-based services.

Some respondents interviewed feared that transferring whole groups of patients into the private sector could result in "dumping," whereby patients do not get the individualized attention needed for positive outcomes. One public health nurse in **Union County** expressed the following concern: "Public health clinics are for the poor and tend to be unappealing and not utilized by people with money. When public health services are marketed to those with money, the poor are shut out." One Maryland respondent expressed concern that by splitting Medicaid and non-Medicaid patients for receipt of mental health care through HealthChoice, neither system will have enough resources.

Philosophical barriers may also arise between public health departments and private partners. **St. Mary's** acknowledged that the lack of a shared philosophy prior to

signing the contract for home health services with the private provider significantly contributed to limited success. Similarly, **Minneapolis** reported that such differences made contract negotiations more difficult and lengthy.

No Willing or Available Provider

In several instances, first attempts to privatize by the health department may have been unsuccessful because no providers were willing or available to assume provision of the service. **Lake County** experienced this problem when they sought to privatize x-ray services. When the county issued its first Request for Proposals (RFP), there were no bidders. As a result, the health department sought out a desirable partner and negotiated successfully with Victory Hospital.

Broward found that at first few providers were willing to see Medicaid maternity patients, but as more private providers accepted Medicaid, the two tax-assisted hospital districts established clinics and were capable of increasing their patient load. Several counties in Maryland also were unable to interest a private provider in partnering until Medicaid reimbursement increased enough to become financially appealing. Furthermore, in **San Diego**, some providers were not interested in providing services considered “less flashy,” such as treatment for sexually transmitted diseases.

Making Privatization Easier

While these barriers often hindered privatization efforts, several factors seemed to help the process: community characteristics, prior collaboration, and strong leadership. All of these factors contributed to implementation of these initiatives.

Community Involvement

The majority of sites utilized community meetings and information sessions to raise public awareness and to garner public support for privatization efforts. Working

with the community also facilitated the privatization process, particularly in smaller communities where public health departments better understand the populations served and more easily gather informal feedback from clients and community partners to guide decisions.

Some of the smaller Maryland counties, as well as **Union County**, are examples of where a smaller community has enabled increased communication. Existing relationships with private providers also greatly facilitated the privatization process. Health officials often noted that it takes significant effort and extra time to make privatization work, but the support of non-health related community leaders is important.

Having prior success in building community relationships was an important factor in enabling community interest and participation in the privatization process. In two Maryland counties, for example, forums were already in place that allowed for extensive community input into assessment and planning activities.

Harford had established a consortium of community leaders who frequently meet to address health-related issues. Through a small grant from the Centers for Disease Control and Prevention (CDC), **Charles County** had formed the Partnership for a Healthier Charles County. The group of public health leaders, community leaders, and private providers met regularly to research, prioritize, and solve community public health problems. In both sites, these forums had already established cross-sector relationships built on trust and understanding, and, therefore, offered an ideal venue through which community partners could participate in the privatization dialogue.

Prior Collaboration

Prior collaboration between the health department and local private providers was one of the most frequently cited reasons for the ease of privatization. Among the many unique characteristics of **Minneapolis** that eased the transition to privatization was their long-term relationship with the

Metropolitan Visiting Nurses Association (MVNA). The City of Minneapolis and MVNA had been involved in partnership activities since 1952, when the city wanted to expand services and needed the staff of MVNA to achieve this goal. MVNA also had strong relationships with nearby counties. MVNA gained credibility by working with families and building community relationships. A second private partner was the Neighborhood Health Care Network, comprised of community health clinics already established in the neighborhoods served by the public health department.

Other sites also reported that prior, well-established relationships with private sector providers facilitated the privatization process. As one respondent from **St. Mary's County** noted, "We see the private sector providers every day—in the grocery store, at school, everywhere." In **Harford** and **Broward**, organizations such as the health department, managed care organizations, community health organizations (hospitals, health clubs, etc.), and other government agencies joined together to form an official collaboration to improve the health of the community and perform community needs assessments. These groups have helped decision-making and program planning for many public health-related activities, including privatization.

Strong Leadership

The role of the health officer or other public health leader in pursuing change was commonly cited as essential to the success of a privatization endeavor. The role of a strong leader with a clear vision of public health is critical to overcoming the barriers discussed above, especially those related to personnel issues.

Many interviewees credited success in outsourcing to the vision and community respect of the local health official. Staff in **Frederick** commended its health officer for making privatization of maternity care a reality. According to the interviewee, "without the respect of the health officer in the community, the change would not have been possible." Aside from the health

officer's vision for privatization, he had 40 years of public health experience and was an obstetrician. In **St. Mary's**, the health officer personally visited with individual physicians to remedy problems that arose in the early stages of privatization.

In the initial stages of privatization for **Minneapolis**, lack of decisiveness and intractability created confusion and hampered the health department from adapting and being better prepared for change. After a solid commitment to privatization, the department was better equipped to implement plans with vision and strength. The new leadership shared all information with employees and included them in relevant decisions. Overall, without the strong commitment of the management team to make the plans work and revitalize the department, privatization would have probably failed, according to interviewees.

Similarly, **Union County** staff loyalty to its Administrative Services Team was attributed to strong health department leadership. Staff strongly believed in their community mission, which enabled them to effectively motivate others and foster greater creativity and innovation to solve many of the obstacles in their transition.

Impacts of Privatization

Privatization may effect many aspects of a health department's operations. According to the survey, those most frequently effected are staff retraining, accountability, quality, access to care, revenues, essential public health services, and governmental relationships.

Staff Retraining

Although job security and fear of layoffs hindered some privatization efforts, retraining was necessary in most sites to move employees into other public health jobs or to secure jobs with the new private provider. Even in locations where staff was redeployed to private organizations, new skills needed to be learned. Almost all respondents acknowledged that

outsourcing required some staff retraining, particularly for public health nurses. Traditionally, nurses are trained and experienced in clinical skills and often lack the skills needed after privatization, e.g., case management, outreach, and monitoring. Staff in **Cecil** expressed concern about assuming case management responsibilities involving home visits. Nurses had to be trained in making home visits for the Healthy Start program once their well-child clinics were privatized. Several other public health nurses in **Minneapolis** and **Anne Arundel County** noted that it was difficult to adapt to conducting records review and data monitoring activities instead of providing face-to-face patient care.

Many counties successfully retrained and redeployed employees to other functions within the health department or county government. As a result of reorganization, new jobs were created that utilized different but similar skills. For example, after outsourcing prenatal services in **Wicomico**, displaced staff began providing family planning services. A versatile and well-trained nursing staff facilitated this transition. Similarly, in **Baltimore County**, counselors have been redeployed to the mobile crisis system to proactively contact the community. In **Harford**, most public health nurses who had formerly provided clinical care were shifted to home care. At **SWWHD**, several staff have been retrained and deployed for community assessment, access, assurance, and health promotion roles.

Privatization has prompted other initiatives to ensure continued employment for staff. In Maryland, some state employees have considered forming their own private organization to address community needs while avoiding county overhead costs and the merit-based system. In particular, **Prince George's**, which had withdrawn completely from several direct care services due to budget cuts, at one point considered helping former employees establish a private corporation to provide those services discontinued by the county. The elimination of clinical programs will free up resources for outcome evaluation and

monitoring. Prince George's is exploring options with local providers to serve mental health patients by hiring as many former health department staff as possible. A similar endeavor with mental health services is under consideration in **Baltimore City** as well.

Accountability

Regardless of its direct service role, the health department bears the ultimate responsibility for assuring that key services are being properly delivered to the people who need them. When a health department relinquishes control over delivery of services, there is a risk of diminished accountability. In general, study sites acknowledged that health departments should remain accountable and, accordingly, nearly all sites have retained outreach, case management, and monitoring roles.

Many of the local health departments surveyed use their contracts with private providers to maintain better control over their assurance role. For example, several of these health department contracts include many service delivery details and outcome and process objectives that must be met by the private providers. These provisions minimize the risk that health departments could be "held hostage" or bound by the different goals of their private partners.

In **Middletown**, for example, case management, outreach, monitoring, and assurance responsibilities for communicable disease services were turned over to the private provider. The health department only maintained reporting responsibilities, a duty mandated for local health departments by the State. Should any outbreaks or other problems occur, the health department would intervene to help solve the problem.

With the exception of **Nashville/Davidson**, and some small, rural counties in Maryland, privatized services in the study sites were outsourced through formal contracts. Some sites, such as **Baltimore City, Baltimore County**, and

Austin/Travis, formalized these contracts more than others with a competitive bidding process. Some counties, such as **Cecil** and **Washington County**, had already established informal relationships with private providers, and the contract process simply entailed working out details. Representatives of **Washington County** noted that, in hindsight, a formal contract or other type of written agreement would have been helpful in maintaining health department involvement and a higher level of success. **Harford** combined these two approaches: after completion of a three-year formal contract and review of future objectives, services were maintained with the private provider without a contract due to long-term relationships with a strong history of collaboration.

It is also helpful when states, such as Maryland, solicit the input of local health departments in developing Medicaid managed care waivers or statewide contracting processes. Without input into planning and implementation, the ability of local health departments to effectively monitor the provision of services provided by managed care organizations would be diminished. It would also be more difficult to continue assuring that quality care is being delivered to their former clients.

Maryland has given local health departments responsibility for five specific tasks to assure accountability under Medicaid managed care. These tasks were to provide:

- eligibility and income determinations for assistance programs;
- client and provider education and outreach services;
- non-compliant case management, enhanced case management, and home visits to assist Healthy Start clients who are eligible but not enrolled;
- ombudsman function to resolve disputes between providers and clients; and

- patient education about the grievance process.

In **Union County**, the county commissioners retained the accountability role through maintaining and monitoring the contract with CHD. The agreement covers all the services, funds, and obligations for which the county is responsible to the state and federal government. This agreement gives CHD the authority and responsibility to operate all the services previously delegated to the county, including state-mandated mental health and public health authorities and veteran services program. In addition, CHD assumed responsibility for liability, risk management, and state performance requirements. In order to maintain its assurance functions, the county commissioners included several outcome objectives in the contract. In addition, a Union County Health and Human Services Advisory Committee serves as a liaison between Union County and CHD. With less than two years experience under the current arrangement, it is too soon to determine whether or not the county government can effectively fulfill its assurance role.

Quality

Very few health departments surveyed believed that private providers would provide better quality of service. On the contrary, health department practitioners often feared that the quality of care provided by the private sector would be worse. Despite these pre-implementation fears, few of the respondents actually identified a decrease in the quality of the service following implementation.

Concerns regarding quality have been remarkably few and easily resolved. Several safeguards have been taken to ensure quality. Quality considerations were included in contracts, MOUs, and informal negotiations depending on the site or the service being provided. For example, in **Anne Arundel**, private providers were monitored to ensure that clients received complete and accurate educational information regarding STDs. Contracts

with private providers in **St. Mary's** included provisions for on-site evaluations and review of all patient records to assure quality care. Through the review process, health department personnel discovered that the provider had neglected to perform all the required EPSDT functions during well-child visits. This problem was easily rectified after the health officer visited with the individual physicians.

SWWHD staff discovered that the private providers operating immunization clinics were not handling the vaccine biologicals properly. Health department staff remedied the problem by training the private providers' staff on how to properly store and administer the biologicals. Through continued technical assistance to the private provider, vaccination rates have increased. On the other hand, **Anne Arundel** health officials investigating an increase in county gonorrhea rates, found that the increase was unrelated to privatization.

Unfortunately, some problems are more ambiguous and less easily resolved. **Atlantic City** reported a lack of quality management and less aggressive treatment of sexually transmitted diseases by its private providers. Additionally, an Atlantic City health department official stated that clients have complained about staff "discounting" their problems and a general lack of responsiveness from the private provider.

Many of the sites interviewed had not implemented privatized services long enough to perform a formal evaluation or were still in the process of developing evaluation tools. **Baltimore County** did deploy staff to sit in the private providers' waiting rooms and randomly question patients about their satisfaction with the quality of care. Private providers invested their own time and resources to conduct a survey in **Washington County**. **Austin/Travis** formed a committee to develop a patient satisfaction survey to assess whether the Medical Assistance Program (MAP) patients were satisfied with services from private providers. Preliminary results showed that there were

no significant differences in client satisfaction between the public and private providers.

Accurate and timely data are critical to assuring quality public health services. Unfortunately, the health officer from **Middletown**, where monitoring was outsourced along with communicable disease services, reported that assuring quality service is difficult because the information systems of the health department and the private sector are incompatible. In addition, there is a lag time in reporting, making it difficult for the health department to keep abreast of outbreaks.

Several localities also stated that private providers lacked translators to assist certain sub-populations in receiving services. Some health departments have sent their translators to private providers' offices to assist foreign language speaking individuals. However, this often compromised the health department's ability to provide services. Conversely, in privatizing primary care services, **Los Angeles** added language capacity by increasing the number and cultural diversity of providers and community clinics.

In general, quality has not been a contentious issue. This may be attributed in part to the fact that most local health departments surveyed have maintained case management, outreach, and monitoring components of service delivery. Also, in most instances, the role for private providers is generally limited and usually well defined. Finally, many health departments and their private partners have developed a close working relationship where quality can easily be monitored.

Access to Care

Access to care is often cited as an important issue in privatization. Overall, private providers' ability to offer increased office hours, more convenient locations, and more comprehensive care created

greater access to clinical components of public health services in the study sites.

For example, health departments often hold clinics only once a week on a walk-in basis, while private practitioners offer services five or six days a week. In **St. Mary's**, the rate of kept appointments at the pediatrician's office increased by 80% compared to the health department. **Baltimore County** found that utilization and follow-up rates for mental health services increased 20% following privatization. Access to care for Medicaid patients in **Cecil** also increased following privatization of well-child clinics. **Anne Arundel** reported that some private clinicians providing STD treatment were willing at times to provide more comprehensive exams for no extra cost.

Privatization in some cases has helped achieve a continuum of care. In **San Diego**, private providers no longer need to refer children outside their practice for immunization and patients no longer need to make separate trips to receive well-child care and vaccinations. After privatizing prenatal care, the health department in **Frederick** has been able to concentrate more on outreach and case management. Also, the health department has been more successful in enrolling Medicaid-eligible women and helping them make appointments with private physicians. By increasing access to care, **Anne Arundel** has successfully achieved its main goal for privatizing sexually transmitted diseases clinical services.

On the other hand, several sites noted that clients had less access to services such as psychosocial services and health education, which remained within the health departments. Clients receiving clinical care at private providers' offices were no longer returning to the health department for ancillary services, such as WIC certification and nutrition counseling.

Some sites, such as **Wicomico**, fault the private providers, in part, for failing to refer clients back to the health department for psychosocial services. Private obstetricians, who recently contracted with

the county for maternity care, demonstrated a lack of knowledge regarding the ancillary services still being provided by the health department. **SWWHD** acknowledged a similar problem, which was partially attributed to the physicians' interest in the "medical" aspects of treatment rather than the psychosocial components important to public health.

In one case, the respondent reported that clients were not able to find an adequate provider at all. In **San Diego County**, which completely withdrew from state family planning services, 45% of the active clients utilized other state-funded clinics and an additional 27% shifted to private providers. However, some clients did "disappear" or were not able to find a satisfactory clinical provider.

Cost Savings, Revenues, and Other Fiscal Impacts

Six sites reported savings in direct service delivery as a result of privatization. **Atlantic City** and **Onondaga** reduced the costs for communicable disease and lab services. **Lake County** and **Montgomery** also demonstrated that private provider costs for outpatient x-rays and maternity services were approximately 50% less than health department costs. **Anne Arundel** reported cost savings through its voucher-based privatization of STD clinical services. After privatizing services in **Austin/Travis**, there was a 14% decrease in cost per client for primary care services under the new managed care partners. It should be emphasized again that these savings are related only to the clinical component of care since most health departments retained the assurance-related aspects for outsourced programs.

Despite extensive reorganization and privatization, **Minneapolis** achieved only minimal savings—\$80,000 from an \$18 million budget. Through outsourcing direct care and transferring many functions to other city departments, the Minneapolis Health Department hoped to better serve its citizens. Cost savings however, were not the chief goal of privatization.

Similarly, in **Union County**, public health service funding was redirected from the county to CHD. The small savings realized through more efficient management were only indirectly related to privatization.

Several respondents cautioned that focusing exclusively on cost savings by either the public health department or private providers will lead to failure. **Calvert** noted that the main reason its privatization of well-child services has not been particularly successful is that the private providers originally viewed the effort as a moneymaking endeavor. Similarly, **St. Mary's** health department officials strongly cautioned that a successful privatization effort must focus on the needs of clients rather than fiscal issues.

Regardless of the program or the funding mechanisms, privatization always had some effect on health department revenues and expenditures. Many health departments have struggled with how to recover funds after losing clinic dollars from Medicaid, third-party reimbursement, and/or client co-payments. Under the fee-for-service structure specific to clinical services, the health departments lost the fees associated with providing the service but also reduced their needs for personnel and supplies. However, in many instances the Medicaid dollars cross-subsidized non-direct services such as surveillance, monitoring, and outreach. The loss of Medicaid reimbursement reduced funds for these critical health department functions.

However, several health departments reported that lost revenues from maternity care or child health clinics were partially recouped through case management associated with the Healthy Start program. But these reimbursements alone were not sufficient to sustain the case management, outreach, and monitoring components of maternity care still maintained by the health department. In **Calvert**, these lost revenues from the prenatal clinics have been replaced in part with revenues from Healthy Start and reallocation of funds, as well as staff reduction.

Following privatization of clinical well-child services, **St. Mary's** needed additional public funding to maintain the assurance components associated with the outsourcing. To accomplish this, the county reallocated state formula monies that were saved in the privatization process and obtained a 5% increase in the local budget. Similarly, **SWWHD** was forced to increase fees and general tax revenues to offset the loss of federal revenue from privatizing EPSDT services. For **Atlantic City**, the lost Medicaid revenues for the communicable disease clinics forced closing of its pediatric HIV program.

Privatization also can effect the clients financially. A common criticism cited by many health department officials was that the private providers instituted or possibly increased the sliding fee scale to cover some of their costs of providing care to the underinsured or uninsured populations.

Re-evaluation of Department Focus

One effect of privatization cited by virtually all respondents was that outsourcing created an opportunity for the health department to re-focus resources on the Essential Public Health Services.²¹ Most sites reported that they were better able to increase or initiate one or more of the essential services by reducing personnel and costs associated with privatizing clinical services.

For example, **Baltimore County** and **Anne Arundel** respondents reported that they could devote more resources to monitoring their contracts, and thus were better able to evaluate the effectiveness, accessibility, and quality of health services. **Anne Arundel** also found that it was better able to link clients to needed personal health services and assure provision of health care. Through privatizing MAP health care, **Austin/Travis** residents had additional primary care provider locations and felt more able to utilize services offered through managed care. Health department staff could better focus on the eligibility

²¹ See Appendix A.

and enrollment functions and provide managed care education to enrollees. **Los Angeles** was successful in further mobilizing community partnerships to identify and better solve health problems.

By privatizing communicable disease services, **Atlantic City** engaged in more community health education and instituted Public Health Week and Minority Health Month. Likewise, as **SWWHD** phased out its primary care services, the health department has increased its ability to conduct community assessment and strategic planning.

Governmental Relationships

The **Minneapolis** site visit revealed how comprehensive privatization can impact community relationships. For example, nearby public health districts, which also were reorganizing, expressed strong feelings about Minneapolis' privatization and its effect on future city/county relationships. Because Minneapolis is within Hennepin County but across the river from St. Paul and Ramsey County, clients often do not distinguish between the four public health departments and private community-based clinics within the same area. Differences in goals, objectives, and structure between Minneapolis and Hennepin makes coordinating Essential Public Health Services more difficult. Interviewees reported that since its comprehensive privatization effort Minneapolis has minimized its leadership role in the Center for Population Health, a consortium of 28 health groups in the surrounding area. This has led many Minnesota health professionals to express concern about how Minneapolis fits with other nearby health departments that have not privatized.

In addition, Ramsey County and St. Paul health departments planned to merge together and provide public health services jointly. This community-based partnership would build a stronger, more positive relationship and enhance their ability to secure state grants jointly. Because of the unique geographic circumstances, many individuals disagree with Minneapolis'

decision to withdraw from services instead of combining with Hennepin County, as was first considered. If the two health departments had merged, many issues such as duplication of services, improving public health "presence" and strength in the community, and data reliability would have been resolved. Interviewees reported that data analysis is effected by clients who utilize services provided by both Hennepin and Minneapolis, thus making it difficult to distinguish effects unique to each separate health department. From St. Paul's viewpoint, a local health department must provide direct services and interact with clients so the community can identify with the purpose and utility of public health.

In Maryland, the State health department holds the local health departments accountable for all state-funded local public health services performed in the counties. When local health departments contract out activities, the State health department may provide assistance in determining the most appropriate ways to monitor these activities, but does not alter its county reporting requirements. Local health departments must demonstrate that state funds are spent appropriately, regardless of who performs the service. The relative level of comfort and comprehension of the Maryland waiver plan partly results from strong leaders at the state level who have helped facilitate the transition. Local health officers from throughout the State also meet monthly to discuss pertinent issues and to learn from each other's experiences.

IV. LESSONS LEARNED

The study sites provide rich experiences in privatizing public health services. The following “lessons learned” were gleaned by the project team from an analysis of these sites’ experiences. While some of the lessons may be site specific, the following are relevant to any public health department considering privatization.

Provide Strong Leadership

Motivation to change must originate at the local level. A successful privatization effort needs to be championed by a local public health leader who possesses the vision and forethought to guide the process from conception through implementation. Without the direction, motivation, and acumen of a strong local health officer, it is more difficult to solve the inherent financial and service issues related to privatizing programs or entire agencies.

First, it is essential that leaders recognize the unique environment in which the community operates. Strong leaders must amass support from their staff and the community, who initially may have negative reactions to outsourcing. Developing broad commitment to the concept of privatization will help achieve desired goals and objectives. A skillful leader will also resolve the inevitable philosophical and ideological differences which may arise between the private and public sectors.

While individual leadership at the local level is vital, direction from the state government is also important to a successful endeavor. For example, state guidance and communication can be particularly helpful in preparing for new local health department roles under Medicaid managed care.

Maintain Public Health Identity

As states continue to move Medicaid populations into managed care

arrangements, private managed care organizations will increasingly provide clinical services to vulnerable populations. However, as public agencies, health departments need to remain committed to the citizenry and work with these new partners to assure that high quality services are readily available. Moreover, the health department must continue to fulfill its assessment, policy development, and assurance roles through close communication with providers by monitoring contracts and health status indicators, and by maintaining case management and outreach services.

Once services are privatized, it is necessary to maintain a strong community presence and avoid the pitfall of seeming to “disappear.” One way to accomplish this is to participate on relevant community advisory committees to provide information, insight, and guidance about local health problems, and to provide a public voice and maintain a high profile for the health department.

Ensure Quality of Care

Ultimately, health departments must ensure that quality is not sacrificed for cost containment. They must also ensure that vulnerable populations have access to Essential Public Health Services. Ideally, Medicaid managed care plans may be able to address all the needs of the population served. It is important for public health departments, however, to maintain their role in assuring that its citizens receive high quality care and to be available as the provider of last resort.

As health departments begin to outsource a variety of services, they need to construct mechanisms to hold their private partners accountable for quality. Incorporating various public health components into contracts can increase the likelihood that information necessary for making determinations related to quality is communicated back to the health

department. These components should include process and outcome objectives, performance evaluations, and problem resolution responsibility. The health department must then fulfill its ultimate accountability role and adequately train its staff to monitor these components. Components of services not specifically included in the partnership agreements should be referred to the health department. This would provide good quality, comprehensive public health services.

Prepare Internally

Any plan to privatize should take into account the requisite time, effort, and information needs of this undertaking. The health department should consider undertaking a needs assessment and business analysis to help prepare for the process. Proactively building skills and tools for change prepares the department, enables a more facile process, and promotes a forum for open communication between staff and department leaders.

Whenever possible, health departments need to involve personnel in the decision-making process to address their concerns up front. Retraining and/or repositioning existing staff eases the transition and equips employees to better fulfill the newly defined role(s) of the health department. Involvement at all levels builds an internal infrastructure capable of supporting the new health department. Setting clear and realistic goals will ease the demand on personnel and resources, and allow privatization to be accomplished in a reasonable amount of time.

After allowing time for the “wounds to heal,” local health departments must continue to determine how to better serve the community through continual adaptation and readjustment. It is much easier to move forward with a department that is already in motion than attempting to “jump-start” one that has become idle.

Increase Knowledge of Business Practices

Public health departments should have staff or access to persons knowledgeable in contracting and other business-related skills. This is important to successful negotiations and contracting. Although on-the-job training is possible, albeit difficult and time-consuming, advance training is preferable.

For example, basic business skills are essential when partnering with private agencies, which are often large managed care organizations with sophisticated finance departments. Greater proficiency in problem resolution and fiduciary issues is essential to negotiating and executing contracts with private providers and unions. By bringing these skills to the table, health officials gain credibility and are able to make sure that community needs are not sacrificed because of administrative inefficiencies.

In addition, partnering with other professionals, particularly lawyers, may result in stronger and more comprehensive contracts. State health departments may also be able to provide these types of resources to local health departments.

Technologically knowledgeable staff also can ensure better data uniformity and compatibility with new and different private information systems.

Build Collaboration

This study has shown that educating and involving the community, not only for implementation, but also for goal setting and planning, contributes greatly to the success of the privatization effort. Although time-consuming, building trust and a strong track record in the community and establishing common goals and objectives with the community contributes greatly to securing private partners and community support. Study sites demonstrated that success is often

proportional to the level of community and partner involvement.

The privatization process frequently fostered a more intense relationship between the communities, private providers, and health departments. The formal RFP process can bring together stakeholders for discussions and increase community education. As the relationships evolved, clarity about goals and challenges faced by each partner enhanced their ability to address community and individual problems in a collaborative manner. Under ideal circumstances, highly productive relationships can evolve to create momentum to reach additional health care goals.

In attempting to address their health needs in a comprehensive manner, all community stakeholders must understand their roles and responsibilities and be held accountable for them. Partners need a common language and an understanding of the multi-dimensional nature of public health to work together effectively. Prior, well-established relationships with private sector providers, as seen in community health consortia, ease the process of privatization and may also generate more responsive public health services.

Acknowledge and Reconcile Divergent Philosophies

By encouraging and accommodating diversity in values, health departments and their partners can “get out of the box” to achieve higher goals. However, without mutual understanding, internal and external differences *can* significantly hinder the privatization process.

The reasons for wanting to privatize services may vary considerably among public and private partners. The private sector partners’ aim may be to increase their client base and generate additional revenues, while the public sector is seeking greater efficiency while maintaining quality and access. Regardless of these differences, it is important for health departments to recognize and understand divergent philosophies and work together with partners to ensure that, through privatization, the needs of the population continue to be met.

V. CONCLUSION AND FUTURE DIRECTIONS

While privatization can be achieved through many different mechanisms, certainly not all attempts have been successful. The distinction between providing public health services and ensuring the public's health is an important one. Future work must clarify common goals and steps that produce the most effective form of public health privatization.

Outcomes

The information gathered through this study demonstrates that most successful privatization efforts are actually partnerships, based upon mutual recognition and acceptance of goals, processes, and outcomes. Any changes in public health practices must be driven by client needs, such as continuity, increased access, and removal of fiscal and social barriers. The public agency involved must make sure clients receive care, while also recognizing that the private partner must perceive a benefit for itself. State and local collaboratives further engender success.

Some health departments have debated whether they are truly serving their populations by simply acting as brokers or purchasers of service. If outsourcing means creating a stronger and better public health system, then this may outweigh any disadvantages. Local health departments must remain committed to carrying out Essential Public Health Services.

When looking at the issue of privatization, one further question arises: are there certain services that should not be privatized?

When looking strictly at service components, the study demonstrates that virtually any clinical service could be outsourced. An overwhelming majority of respondents reported that roles relating to non-direct care mainly assurance and accountability should remain in the health department.

Research Needs and Strategies

Privatization is a burgeoning activity and the public health community can benefit tremendously from further examination of this complex issue. Appropriate collaboration and partnerships could support a range of possible research strategies to explore this phenomenon. For example, consensus on a working definition of public health privatization would be helpful. To this end, it may be important to develop standardized tools for collecting information regarding privatization efforts.

It would also be beneficial to further explore the issue through more focused studies on particular services or types of arrangement. A series of such studies could serve as a comprehensive database of privatization strategies and decision-making processes throughout state and local government. Only after fully developing the range, extent, and evaluation of privatization efforts can public health privatization be fully understood.

This study has confirmed that privatization efforts are widespread and will continue for the foreseeable future. It provides useful background information on privatization activities in selected localities, but more research is needed to adequately understand this trend and its impact on public health. Specifically, the field could benefit from answers to the following questions:

- What are the costs and quality of public health department services relative to their non-government peers?
- What segment of the market has been "captured" by competing private providers?
- Where public services have been privatized, what is the effect on access to care for the Medicaid and uninsured populations? What is the impact on

providers? What is the impact on services?

- What lessons can be learned from major cities and counties that lack publicly owned health care systems? How is privatization changing outcomes and health status indicators in these communities?

Answers to these questions can guide the public health system in making informed choices about the proper role of government in managing the safety net.

Conclusion

Privatization offers both opportunities and risks for public health.

Shrinking public budgets and increased competition in the health care marketplace have led some to call for dramatic changes in public health infrastructure. Several alternatives have emerged: re-configure current systems; change program ownership, in part or in whole; or consider their complete closure. An increasingly popular view is that government can best use its resources by diverting them to purchase services in private settings. This view has both its supporters and detractors.

For instance, proponents of privatization believe that building accountability into contracts and outsourcing services will produce better outcomes than a fee-for-service, government entitlement-oriented public system. They argue, in part, that large public health departments are inefficient, hindered by heavy unionization or bureaucratic inflation, and lack the performance incentives that successfully drive many private institutions. Privatization advocates have differing opinions, though, as to the extent public services should be privatized and whether the public systems should retain or transform their current structures.

On the other hand, critics of privatization argue that changes in direct services underscore the need for a public safety-net

system. There is general agreement that the private sector has not established its willingness or ability to absorb the public sector's entire caseload. A safety net must exist for the medically indigent. Public institutions are also needed to diagnose and limit a communicable disease outbreak. In addition, private institutions often do not have the expertise or incentives to provide indirect public health services.

As in any major transition, collaboration and partnerships must exist in order to develop common goals and successful programs. Privatization should not entail government agencies merely contracting out services. The public sector must maintain oversight and monitor private contractors to ensure that the affected populations receive the necessary level and quality of service.

Comprehensive local plans are needed to define the relationship between public health programs and health care market changes. As the health departments' role in clinical services declines, public health officials must give increasing attention to the Essential Public Health Services and to public health leadership in their communities. This means that local health departments should retain a role in quality assurance, case management, disease surveillance, education, and outreach services to vulnerable populations.

Preserving, protecting, and promoting the health of communities must remain the most important considerations when practicing public health. This study can assist the public health community by describing the characteristics of effective privatization efforts. Improving local public health practice and concentrating on the Essential Public Health Services cannot be addressed by one strategy alone. This report offers possible strategies to confront these complicated issues and can assist the tough decision-making required to redesign public health systems in complex political environments.

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APPENDICES

APPENDIX A

Public Health in America

PUBLIC HEALTH IN AMERICA

VISION:

Healthy People in Healthy Communities

MISSION:

*Promote Physical and Mental Health and
Prevent Disease, Injury, and Disability*

Public Health

- Prevents epidemics and the spread of disease
- Protects against environmental hazards
- Prevents injuries
- Promotes and encourages healthy behaviors
- Responds to disasters and assists communities in recovery
- Assures the quality and accessibility of health services

Essential Public Health Services

- Monitor health status to identify community health problems
- Diagnose and investigate health problems and health hazards in the community
- Enforce laws and regulations that protect health and ensure safety
- Inform, educate, and empower people about health issues
- Mobilize community partnerships to identify and solve health problems
- Link people to needed personal health services and assure the provision of health care when otherwise unavailable
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services
- Assure a competent public health and personal health care workforce
- Develop policies and plans that support individual and community health efforts
- Research for new insights and innovative solutions to health problems

Source: Essential Public Health Services Work Group of the Public Health Functions Steering Committee

Membership: American Public Health Association, Association of State and Territorial Health Officials, National Association of County and City Health Officials, Institute of Medicine, National Academy of Sciences, Association of Schools of Public Health, Public Health Foundation, National Association of State Alcohol and Drug Abuse Directors, National Association of State Mental Health Program Directors, U.S. Public Health Service, Centers for Disease Control and Prevention, Health Resources and Services Administration, Office of the Assistant Secretary for Health, Substance Abuse and Mental Health Services Administration, Agency for Health Care Policy and Research, Indian Health Service, Food and Drug Administration, National Institutes of Health

APPENDIX B

Survey Instrument for Local Health Departments

CASEY PRIVATIZATION STUDY

LOCAL HEALTH DEPARTMENT SURVEY INSTRUMENT

“Privatization” encompasses those activities/services for which the state or local health department has reached a formal decision to withdraw from or contract out for provision of a public health service, in whole or in part, AND a non-governmental entity has taken over responsibility for provision of that service. This may also include development of formal partnerships with the private sector to offer public health activities/services not previously provided by the health department.

Name and Title of Respondent : _____ Time in Job: _____

_____ Time in Health Dept./:
Organization: _____

Name of organization: _____

Address: _____ Division/Service
Privatized: _____

NOTE: Questions 1- 16 refer to the privatized service listed above.

1. For the privatized service formerly provided by the health department, please provide the following information:

Service	Private Provider (Specify)	Year Privatized	Numbers Served/Year (If known)		Cost (If known)	
			Before Privati. \$ per	Post- Privati. \$ per	Before Privati. \$ per	Post- Privati. \$ per

2. What preparations were made before deciding to privatize this service at the state, local and other levels? Check as appropriate.

Preparation	State	Local	Other (Specify)
Needs assessment			
Business/market analysis			
1115/1915 Medicaid waiver			
Other regulatory changes (specify)			
Executive decision/negotiations			
Technical assistance			
Staff (re)training			
None			

3. Where a formal contract exists, please check all government agencies involved in developing and negotiating the contract.

Skip to Question 6 if no contract exists.

- State health department _____
- Local health department _____
- State welfare agency _____
- State Medicaid agency _____
- Other (specify) _____

4. Please describe any fiscal relationships set out in the contract. Check all that apply.

- Governmental agency pays non-governmental agency _____
- Non-governmental agency pays governmental agency _____
- Other (specify) _____

5. Please check all obligations below which are set out in the contract.

- Process objectives _____
- Outcome objectives _____
- Provision of service data _____
- Other (specify) _____

6. What was the main reason(s) for this privatization? Check all which are appropriate.

- Increased demand for service _____
- To free scarce resources to concentrate on other public health services _____
- Cost savings _____
- Inadequate technical knowledge in health department _____
- Expand access to health care services _____
- More flexibility in personnel regulations _____
- Legislative mandate/political factors _____
- Other (specify) _____

7. What other options were considered instead of privatization? Check all which are appropriate.

- No longer providing service _____
- Reducing service provision _____
- Charging fees _____
- Other (specify) _____

8. What barriers had to be overcome in the privatization process for this service? Check as appropriate and explain.

- Health department resistance _____
- Community resistance _____
- No private provider available _____
- No private provider willing to take over service provision _____
- Other (specify) _____

Explain

9. What unique characteristics of your health department or community contributed to the privatization process for the service? Check as appropriate.

- Leadership: Community _____
- Health department _____
- Private sector _____
- Collaborating mechanism in place between public/private/community _____
- Regulatory/legal environment _____
- Other (specify) _____

10. What role, if any, has the health department retained in provision of the service? Please check all as appropriate, and check where this is a contractual obligation.

- | | | |
|-----------------------|-------|--------------------|
| | | <u>Contractual</u> |
| | | <u>Obligation</u> |
| Outreach | _____ | _____ |
| Case management | _____ | _____ |
| Monitoring | _____ | _____ |
| Regulatory | _____ | _____ |
| Other (specify) _____ | _____ | _____ |

10b. If outreach services are performed outside the health department, please describe what outreach services are provided and by whom. _____

11. Where multiple providers are involved in providing this service, what mechanism is used to coordinate the service? Check all where appropriate.

- Standing committee _____
- Community business group on health _____
- Contract provision _____
- Informal contacts _____
- Other (specify) _____

12. As a result of privatization, the role of other providers in the community may also have increased or decreased. If applicable, please describe briefly the changing role of other community providers such as hospitals, laboratories,

community health centers, physicians, etc. Consider areas such as needs assessment and planning, outbreak investigation, case management, diagnosis and treatment, outreach, and patient education. Please note if the increase/decrease resulted in a positive or negative change.

13. Have any specific population subgroups been more adversely affected than others by privatizing this service? Please check where appropriate and explain.

- Foreign-speaking populations (specify language) _____
- African-American _____
- Women _____
- Children _____
- Native Americans _____
- Other (specify) _____

Explain

14. In your opinion, has privatizing this service had an effect on the following areas of service delivery. For a positive effect, use a “+“ for a negative effect, use a “-“ for no change, use a “0” and a “?” for unknown.”

Area	Change	Describe change
Access to care for insured patients		
Access to care for un insured patients		
Technical competence in service provision		
Appropriateness of care - place - time - culture/language		
Health Status - general		
Service-specific rates (Mark only rates relevant to the privatized service)		
Immunization rate		
Vaccine preventable disease rate		
% women getting adequate prenatal care		
% low birth weight		
% eligible children receiving EPSDT required screens		
% eligible women receiving pap smear		
Teenage pregnancy rate		
STD rate		
Other (specify)		
Service utilization		
Cost of services - to providers		
Cost of services - to users		
Compensation to health department for services provided		
Use of emergency room services		
Patient satisfaction		
Availability of information for decision making		

15. Please note any additional problems encountered after this service was privatized. _____

16. Please note any other benefits experienced due to privatizing this service. _____

NOTE: Questions 17 - 19 refer to the effects of the privatization **on the health department.**

17. At times, privatizing personal health care services causes loss of revenues for other health department services. Please make note of any services still being provided by the health department which have had an increase or decrease in funding as a result of privatization. If changes are noted, please indicate whether funding increases/decreases were made at the federal, state, or local level.

If other services have not been affected, skip to Question 19.

18. Where funding sources for other services were affected as indicated in Question 17, how were lost revenues recovered? Please check, as appropriate.

- Received grants _____
- Entered into partnerships/collaborative agreements _____
- Instituted or increased service charges _____
- Special state/local tax set aside for health department _____
- Other (specify) _____

Explain

19. If privatization of this service allowed the local health department to initiate or increase participation in other essential public health services, please indicate below by placing a check, as appropriate.

If no change has occurred, skip to Question 21.

Essential Public Health Service	Initiate	Increase	Describe Specific Service
1. Monitor health status to identify community health problems			
2. Diagnose and investigate health problems and health hazards in the community			
3. Enforce laws and regulations that protect health and ensure safety			
4. Inform, educate and empower people about health issues			
5. Mobilize community partnerships to identify and solve health problems			
6. Link people to needed personal health services and Assure the provision of health care when otherwise unavailable			
7. Evaluate effectiveness, accessibility, and quality of personal- and population-based health services			
8. Assure a competent public health and personal health care workforce			
9. Develop policies and plans that support individual and community health efforts			
10. Research for new insights and innovative solutions to health problems			
11. Other (Specify)			

20. Often restructuring and expansion for new services requires retraining and/or reassessment of skills and knowledge bases. What, if any, type of staff and/or community retraining or education was necessary to introduce privatization of services?

21. Has there been any evaluation of this health service since privatization?

Yes If yes, please provide a copy of the report.

No If no, are there plans to conduct a formal evaluation of the affected service and/or structural change? Please explain the nature and format of this evaluation:

When will this be completed? _____

22. What plans does the health department have for privatizing other services in the future?

<u>Service</u>	<u>Potential Future Service Provider</u>
_____	_____
_____	_____
_____	_____

None

Don't Know

23. Please describe any lessons learned from your privatization experiences which could assist others interested in privatization efforts.

APPENDIX C

Sample Discussion Guide for Focus Groups

Sample Discussion Guide for Focus Groups

Through a series of general and open-ended questions, our discussion will cover a variety of topics including the following:

- accountability;
- public/private partnerships;
- community-level service delivery;
- community participation; and
- changes in expenditures and other revenue sources.

Listed below are some specific questions to consider during this time period:

- How were health department priorities established?
- How does the health department view privatization? The community? Private providers?
- How were community organizations involved in the planning process?
- How have relationships within and among the relevant organizations evolved since inception of privatization?
- How does the health department fulfill its assessment, assurance, and policy development roles? What services do the private partners provide to accomplish these tasks?
- What has made the XXX privatization process unique? What lessons learned can be useful in other localities?

Other topics to address:

- training
 - expenditures and budget
 - service delivery
 - internal preparations before introduction of new service
 - needs assessment
 - department restructuring
 - staff retraining
 - replace staff with more appropriate skills
 - technical assistance
-

APPENDIX D

Supplemental Maryland Questionnaire

Supplemental Maryland Questionnaire

1. Do you agree with the definition of privatization as described on page 1 of the *Local Health Department Survey*? If no, how does your definition differ?
2. How does the health department view privatization? The community? Private providers?
3. What is the range of privatization in your county or jurisdiction?
4. How are/were health department priorities established in relationship to privatization of services and public/private partnerships?
5. How were community organizations involved in the planning process to change the delivery of public health services?
6. How have relationships within and among the relevant organizations evolved since inception of privatization?
7. How has the privatization affected the relationship between local health departments and the state health department?
8. How does the health department fulfill its assessment, policy development, and assurance roles? What services do the private partners provide to accomplish these tasks?
9. What have been the most successful efforts? The most challenging?
10. What has made the Maryland privatization process unique? What are some common issues that every health department faces in privatizing services?