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Public Health, Primary Care, and Privatization

Arlesia Brock, M.A.

Abstract

Public health is an extremely vital but still little understood area of human endeavor. 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 the public health departments. As a result, policymakers at all levels of government are looking for ways to provide leaner and more efficient delivery of services. A popular strategy is the privatization of public health services. This paper examines the changes in the public health system and primary care services in Florida's county health departments. Florida Public Health Review, 2004; 1: 63-66

The Development of the Public Health System

Public health is a fundamental but still little understood area of human endeavor. The history of public health extends back at least 4000 years to the ancient Indian cities of Mohenjo-Daro and Harappa that first developed public sanitation. The major problems of health that humankind has faced throughout history have been concerned with community life: -- the control of transmissible disease, the control and improvement of the physical environment (sanitation), the provision of medical care and the relief of disability and destitution. The relative emphasis placed on each of these problems has varied from time to time, but outgrowths of these emphases have come to form the public health system as we know it today (Rosen, 1958). The public health system's unique ability to provide population based solutions to health problems has been essential in promoting and protecting the health of the community. More recently, the public health system has evolved to include personal health care and serves as a critical resource for disadvantaged communities and families.

After the establishment of the local health departments in the U.S. during the mid-1800s, these bodies provided population-based public health services to assure the health and safety of the entire community, while the private sector provided medical care services. Public health services generally are categorized into the areas of assessment, policy development, and assurance. Assessment includes diagnosing illnesses and disease. Policy development involves shaping positions on key health issues by the government. Assurance encompasses developing programs that attest to quality in the operations of programs. However, with the inception of the Medicaid program in 1965, public health departments began to

shift more of their attention to providing medical care and services to vulnerable populations, such as the chronically ill, the disabled, and the poor. This change redirected traditional public health services from population health to personal health care. Public health departments became the providers of last resort.

The Development of Primary Care

The integration of public health and primary care is a relatively recent phenomenon. As a result, most of the research in the area of primary care is from the perspective of family medicine, and occasionally, internal medicine or pediatrics. The Institute of Medicine (1996) released a report to provide guidance in the development of the appropriate roles and relationships of public health and primary care.

Since its introduction in 1961, the term *primary care* has been defined in various ways, often using one or more categories to describe what primary care is or who provides it. These categories include: the care provided by clinicians in certain areas such as family medicine, pediatrics, obstetrics and gynecology; a set of activities whose functions define the boundaries of primary care such as curing or alleviating common illnesses and disabilities; a level of care or a setting -- an entry point to a system that includes secondary and tertiary care; a set of attributes, as in the 1978 IOM definition—care that is accessible, comprehensive, coordinated, continuous, and accountable; and finally a strategy for organizing the health care system as a whole—such as community-oriented primary care, which gives priority to and allocates resources to community-based health care (IOM, 1996). The definition used by Barbara Starfield, a well known researcher in the area of primary care incorporates many of these categories. She defines primary care as that level of

the health service system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others (Starfield, 1998).

In the past two decades, public health and primary care has gone through important transitions. Prior to this time, primary care and public health developed as distinct, largely unrelated cultures. However in the last 20 years these cultures have increasingly been forced to work together because of market reforms. Market reforms emphasized the development of competitive managed care programs and strategies to organize and provide integrated health care and preventive services at controlled cost and quality to defined populations, including most of those cared for directly by local and state health departments. In the 1980s, Medicaid populations were transitioned into a broad range of managed care programs. Consequently, public health will again become population health and primary care will become clinical and preventive primary care and community based medicine of the future. The combination of these two is likely to evolve toward an integrated community health system.

Merging Public Health and Primary Care

In 1984, the State of Florida Legislature enacted the Health Care Access Act that stated that access to adequate health care is a right available to all Floridians. The legislation established state-funded local primary care programs administered by the Florida Department of Health. Primary care programs were implemented in three phases:

Phase 1: The legislature appropriated \$10 million to establish programs in 18 counties.

Phase 2: In 1987, primary care programs were added in 27 more counties.

Phase 3: In 1988, the remaining 22 counties were funded.

These programs provided basic health care for low-income individuals and others who were eligible for Medicaid. This basic health care allows for determination of the individual's health status through health and risk assessment. A person who is found to have a health problem or is at risk of developing a health problem receives ongoing counseling and treatment. When the necessary treatment was not available within the county health department, the person was referred to the appropriate agency for care.

However, in the 1990s the Medicaid program witnessed a dramatic shift in the way that its populations were served. Managed care arrangements became the predominant service delivery mechanism, with managed care organizations assuming most of the Medicaid case load usually held by the health department. In addition to these market forces, the 1990s were characterized by governmental downsizing and budget cuts at all levels. These cuts compromised the ability of public health departments to provide all necessary services. Emanating from this change, *privatization* was adopted by some of the larger counties as a means to control costs to the local health departments. Privatization was defined as the transfer of responsibility for services from governmental agencies to private providers. Privatization actually has many forms that fall along a continuum. These forms range from contracting out to franchise agreements. The Public Health Foundation (PHF) developed a broad working definition of privatization applied specifically to public health. According to this definition, "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" (PHF,1999).

The pressure to privatize public health services began in the early 1980s when initiatives favoring privatization brought a 25% reduction to the budget of the U.S. Department of Health and Human Services. In 1993, the Council of State Governments conducted a comprehensive landmark study on privatization activities. The findings stated that almost 50% of state health departments had privatized some aspect of their operations. In 1996, the U.S. Centers for Disease Control and Prevention carried out an environmental scan of state health departments, with the intention of building upon the 1993 study, looking specifically at public health. In 1998, the Florida Association of County Health Officials recommended a survey of Florida county health departments to determine which services were currently and previously privatized. This study was completed in 2000 by the Florida Department of Health. According to results more than 50% of the large counties (ones with 500,000 residents or more) had privatized primary care programs. Florida's large counties include Broward, Duval, Hillsborough, Miami-Dade, Orange, Palm Beach and Pinellas.

Changes in the Provision of Primary Care in Two Large Counties

The Broward County Health Department was established in 1936 and has six sites in the county. The county health department currently contracts with South Broward Hospital District, North Broward Hospital District and Sunshine Health Center, Inc. to provide primary care services. Payment is made to contractors on a per patient basis for individuals who are not eligible for Medicaid and have no insurance.

In 1990, county health department officials approached officials of the hospital taxing district relative to their assuming the role of provider of prenatal care for low income women in the county. This transition was made easier by the fact that low income pregnant women were eligible for Medicaid and no transfer of funds was necessary. In October 1992, the South Broward Hospital District assumed child health services. One year later, adult primary care that had been subcontracted through the county also was transferred to both districts. In November 1994, comprehensive child health was transferred to the North. The transfer of these two groups was accompanied by a transfer of funds that included dollars for the Community Health Center. The county provides substantial support for indigent primary care in addition to the support provided by the county health department. The public hospitals operated by the districts are obligated to provide hospitalization if necessary, even if the patient has no resources to pay for care. Some clinic sites are shared with the county health department. The county health department has retained the role of provider of care coordination services and is also a provider of enhanced services. The county health department, receiving primary care dollars from the State of Florida as well as dollars for categorical clinical services, traditionally provided extensive clinical care for the maternity and child health patients as well as adult primary care.

The most recent county health department to make changes to delivery of primary care services is the Duval County Health Department. The Duval County Health Department was established in 1938. However, the Jacksonville City Council established a city health department in 1889. When the Duval County Health Department was established it operated as a combination city and county health department until 1992, when it became a solely a part of the state system. In the 1970s, the city of Jacksonville began to provide health care to indigent residents. Night clinics were held in health department clinic space and the service was heavily used. However, because of insufficient funding, the service was discontinued. In 1973, in response to

growing needs, the health department established primary care teams to deliver services at five major sites with the city. There were no income requirements for this service.

In 1984, the county received \$1.4 million in primary care through the Health Care Access Act and the health department began a collaborative agreement with the University Medical Center to offer services in two sites. The health department spent \$5 million and the city provided \$18 million to the University Medical Center. During the early period of the program there was explosive growth. Individuals with incomes up to 200% of poverty level were served by the program and no cap was placed on the number of patients. In 1990, severe budget problems developed, but by 1993, with budget problems abated, the health department again expanded primary care services to family members of Medicaid children and adults up to 150% of poverty income. The services were expanded because only three HMOs accepted Medicaid patients and only 10% of the private physicians. However, in 1995, because of health care reforms, a large percentage of the private physicians began to accept Medicaid patients. In addition, the county health department entered into an agreement to establish a clinic network for pediatric services. However, the health department continued to provide primary care services because an inadequate number of providers were available for the community. Growth throughout the 1990s continued. Today, primary care services are provided through 16 community health centers.

Pros and Cons of Privatization

Privatization offers opportunities and risks for public health. Shrinking public budgets and increased competition in the health care marketplace have led to calls for dramatic changes in the public health infrastructure. Whereas privatization can be achieved through many different mechanisms, the one used most frequently by Florida's public health departments is contracting. Other alternatives emergent in national studies include reconfiguration of current systems, changes in program ownership, in part or in its entirety, and complete closure (Clarkson, 1980; McLaughlin, 1998). An increasingly popular view is that the government can make better use of scarce resources by diverting them to purchase services in private settings. This view has both supporters and detractors with two broad categories of debate (Keane, Marx, & Ricci, 2002). Whereas one involves the proper role and scope of government, the other involves the desirability of contracting employees.

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 (Shleifer, 1998). They argue, in part, that large public institutions, like public health departments, are inefficient, hindered by heavy unionization or bureaucratic inflation, and lack performance incentives that successfully drive many private institutions (Hart, Shleifer, & Vishny, 1997). Privatization advocates have differing opinions as to the extent to which public services should be privatized, and whether the public systems should retain or transform their current structures.

Critics of privatization argue that changes in direct services underscore the need for a public safety-net system (Citrin, 1998; Jacobsen, 2002). Authorities generally agree that the private sector has not established its willingness or ability to absorb the public sector's caseload. A safety net must exist for the medically indigent. Public institutions also are needed to diagnose and limit communicable disease outbreaks. In addition, private institutions have neither the expertise nor incentives to offer indirect health services (Halverson, 2002).

Conclusion

Public health systems continue to be in transition. However, the trend toward privatization should not merely entail health departments contracting out services. Most public health professionals believe that the public sector should maintain oversight and monitor private contractors to ensure that populations receive the necessary level and quality of care. They also believe (as the health department's role in clinical services declines) that public health officials should increase their attention on essential public health services. Preserving, protecting, and promoting the health of communities should remain an important consideration. County health departments should retain a role in quality assurance, case management, disease surveillance, education and outreach to vulnerable populations. By making the appropriate choices, the public health departments can effectively and efficiently manage the safety net.

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Arlesia Brock is a doctoral student in the Department of Health Policy and Management, University of South Florida College of Public Health, Tampa, FL (abrock@hsc.usf.edu). This paper was submitted to the *FPHR* on June 16, 2004, and accepted for publication on December 21, 2004. Copyright 2004 by the *Florida Public Health Review*.