VIEWPOINT

ON COMMUNITY PARTNERSHIPS

MICHAEL A. STOTO, PHD

Sharing Responsibility for the Public's Health

Dr. Stoto is Professor and Chair, Department of Epidemiology and Biostatistics, School of Public Health and Health Services, George Washington University, Washington DC. He was formerly the Director of the Division of Health Promotion and Disease Prevention of the Institute of Medicine (IOM) and was involved in the preparation of the IOM reports summarized in this paper. The ideas presented here are derived from the work of the Committee on Public Health, the Committee on Using Performance Monitoring to Improve Community Health, and the Board on Health Promotion and Disease Prevention.

Address correspondence to Dr. Stoto, Dept. of Epidemiology and Biostatistics, Ross 120, 2300 I St. NW, Washington DC 20037; tel. 202-994-0236; fax 202-994-7893; e-mail <sphmas@mail.gwumc.edu>.

MANY OF THE HEALTH-RELATED CHALLENGES FACING THE UNITED States today—such as providing vaccinations to all children, controlling infectious disease outbreaks and epidemics, and dealing with environmental health risks—require public health solutions. Medical care alone is not sufficient to address these challenges. Although good medical care is a necessity, individuals and families can address the majority of health problems most effectively in collaboration with government, business, and community groups as well as with health care systems. Because so many entities can influence health, the public's health must be seen as a shared responsibility. Finding solutions to health problems calls for a new leadership role for government public health agencies: to convene the interested stakeholders and ensure that they work together to improve the public's health.

The Future of Public Health, issued by the Institute of Medicine (IOM) in 1988, identified the mission of public health as "fulfilling society's interest in assuring conditions in which people can be healthy."[1] Its aim was to generate organized community efforts to apply scientific and technical knowledge to prevent disease and promote health. During the last few years, several IOM committees have addressed a variety of public health issues and reexamined the infrastructure needed to deal with them. While the principles in *The Future of Public Health* remain vital, the critical importance of partnerships between government public health agencies and both communities and managed care organizations has emerged. Two new IOM reports, *Healthy Communities: New Partnerships for the Future of Public Health*[2] and *Improving Health in the Community: A Role for Performance Monitoring*,[3] provide the basis for this reassessment of the public health paradigm. The complete text of these and related reports, illustrated with examples from a variety of local and national settings, can be found on the Web at **www2.nas.edu/hpdp**.

Finding solutions to health problems calls for a new leadership role for government public health agencies: to convene the interested stakeholders and ensure that they work together to improve the public's health.

CHANGING VIEWS OF HEALTH AND PUBLIC HEALTH

New understandings on the part of scientists and practitioners are affecting the practice of public health. These new ways of thinking include a broader understanding of health, a community perspective on its determinants, and a heightened interest in accountability and performance monitoring.

A broader understanding of health. Health is increasingly being seen as a dynamic state that embraces well-being as well as the absence of illness. This definition underscores the important contributions to health that are made outside the formal medical care and public health systems. The multiple determinants of health are best understood in a dynamic interdependent relationship with the social environment, the physical environment, genetic endowment, individual behavioral and biological responses, disease, health care, health status and social functioning, well-being, and prosperity.[4]

A community perspective. One implication of today's broader understanding of health is that many public and private entities have a stake in or can affect the community's health. These stakeholders can include health care providers (clinicians, health plans, and hospitals), public health agencies, and community organizations explicitly concerned with health. They can also include various other government agencies and community organizations along with private industry and other entities that may not see themselves as having an explicit health role—such as sports clubs, employers, faith communities, the criminal justice system, the educational system, and agencies providing social services and housing and transportation services.

Communities are often defined in geopolitical terms, but can also be any group of individuals who identify themselves as a community because of common interests.

Interest in accountability and performance monitoring. Accountability in public health and medicine has traditionally been viewed as a top-down process in which government agencies and health care providers must report to legislators, funders, and regulatory bodies on expenditures of funds, services provided, and so on. More recently, practitioners and agencies are becoming accountable to the communities they serve. With this change, performance monitoring has gained attention as a tool for evaluating the delivery of personal health care services and for examining population-based activities addressing the health of the public.[5]

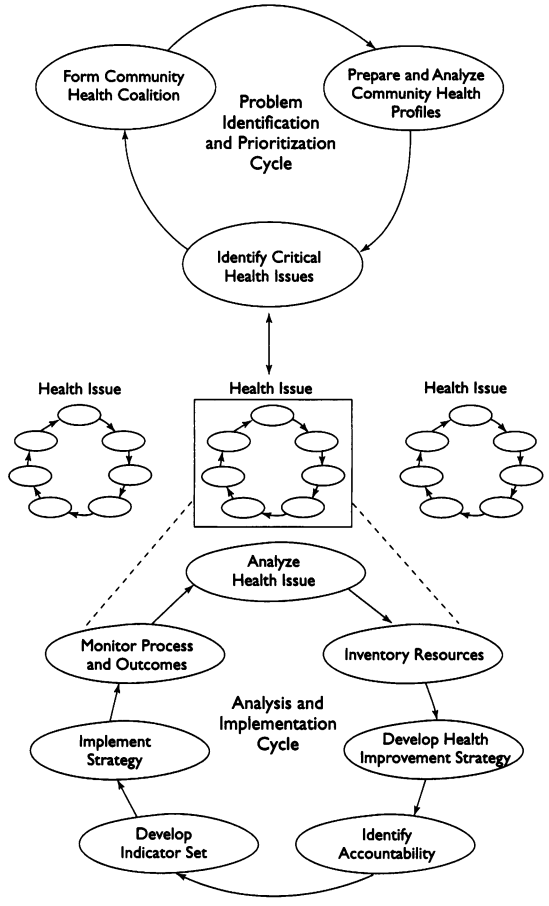
A COMMUNITY HEALTH IMPROVEMENT PROCESS

Because a wide array of factors influence a community's health, many entities in the community share the responsibility for maintaining and improving the health of community members. Responsibility shared, however, can easily become responsibility ignored or abandoned.

A community health improvement process (CHIP) (see Figure) that includes performance monitoring can be an effective tool for developing a shared vision and supporting a planned and integrated approach to improving community health.

Each community should base its CHIP on a broad definition of health and a comprehensive conceptual model of how good health is produced in the community. The model should enable the community to specify (*a*) what individual entities can contribute and thus be held accountable for contributing and (*b*) where collaborative action and shared responsibility are essential. In this

Figure. The Community Health Improvement Process (CHIP)



Reprinted from Reference 3

model, official public health agencies, like all other public and private health-promoting institutions, become accountable to the communities they serve.

To operationalize the concepts of shared responsibility and individual accountability, stakeholders need to know how the actions of each potentially accountable entity can contribute to the community's health. Thus, a CHIP should include the identification of a set of specific, quantitative performance measures linking accountable entities to the performance of specific activities expected to lead to the production of desired outcomes. Activities for which there is clear evidence of efficacy should, of course, receive priority. A set of indicators should balance population-based measures of risk factors and health outcomes and health systems–based measures of services performed. Process measures (such as the availability of insurance coverage for vaccinations) might be included, but only to the extent that there is evidence linking them to health outcomes. To encourage full participation, the selected performance measures should also be balanced across the interests and contributions of the various accountable entities in the community. Experience suggests that performance monitoring used as a tool for organizational learning is more effective in achieving needed improvements than monitoring used as a basis for inspection and discipline.[5,6]

To institutionalize the health improvement process as a multi-party effort, a CHIP should be centered in a community health coalition or similar entity. Some communities will have appropriate coalitions in place, but others will have to expand existing groups or establish workable forums for collective action for the first time. Government public health agencies can take a leadership role by organizing a coalition if none exists.

A CHIP should include two principal interacting cycles. The health assessment activities that are part of a CHIP's *problem identification and prioritization cycle* should include preparation of a health profile that can provide basic information to a community about its demographic and socioeconomic characteristics and its health status and health risks. The set of indicators for a community health profile might include:

- Sociodemographic characteristics; for example, the high school graduation rate and median household income;
- Health risk factors; for example, child vaccination rates, the adult smoking rate, and the prevalence of obesity;
- Consumption of health care resources; for example, per capita health care spending;
- Health status; for example, the infant mortality rate, deaths due to preventable causes, and confirmed child abuse and neglect cases;
- Functional status; for example, the proportion of adults in good to excellent health;
- Quality of life; for example, proportion of adults satisfied with the health care system in the community.

Within the CHIP framework, performance monitoring takes place in the *analysis and implementation cycle*. A community may have a portfolio of health improvement activities, each of which will progress through this cycle at its own pace.

The functions of local public health agencies should include assuring that high quality services, including personal health services, are available and accessible to all.

Examples of performance indicators, in this case for vaccine-preventable diseases, include:

- Vaccination rate for all children and specifically those enrolled in managed care programs and Medicaid;
- Availability of full insurance coverage for childhood vaccinations;
- Influenza and pneumococcal pneumonia vaccination rates and death rates for people ages 65 and older;
- Existence of a computerized vaccination registry and an active childhood vaccination coalition.

Measures like these can be further articulated to clarify the accountability of individuals and families, the medical care and public health systems, and community organizations.

Public Health and Managed Care

Drawing on their extensive knowledge of the community and the depth and breadth of their experience in fields such as epidemiology and injury prevention, government public health agencies should work with managed care organizations, in the public interest, as part of their overall mandate. In particular, state and local public health agencies can: (*a*) develop information about health status, health risks, and health determinants in communities, including the populations served by managed care organizations; (*b*) participate with managed care organizations in planning and policy development; (*c*) provide case management and other services to managed care clients; and (d) take on assurance and oversight functions, working with state agencies that have regulatory responsibilities. *(See related article on pages 225–230.)*

Managed care organizations can strengthen their capacity to improve the health of populations by integrating public programs and services with their primary health care services and by collaborating with public health agencies in community-based activities.[7] In cooperation with public health agencies, managed care organizations can advocate for measures to improve the public's health in the communities they serve. Managed care organizations can also develop their data systems to support surveillance and epidemiologic research.

Because plans are responsible for delivering care to a defined group of enrollees, managed care makes possible, for the first time, accountability in terms of quality of care for populations, including access to care and health outcomes. A managed care organization's responsibility for a defined population also gives it an interest in promoting health and preventing disease in that population, which, of course, is the same as the mission of public health.[8] Some managed care organizations may collaborate with public health agencies more out of enlightened self-interest than moral obligation, viewing everyone in the community as a potential future member.

Implications for Public Health Agencies

To ensure that partnerships between government public health agencies and managed care organizations work effectively toward improving the health of the public, the functions of local public health agencies should include assuring that high quality services, including personal health services, are available and accessible to all. Public health agencies can carry out this assurance

function by (*a*) encouraging other entities in the public and private sectors to provide services through example, persuasion, or technical assistance; (*b*) requiring (with appropriate legal authority) that services be provided; (*c*) assessing the quality of services provided by others; or (*d*) providing services directly. To exercise this responsibility, public health agencies require adequate staff and resources as well as appropriate relationships with health service providers.

Most public health agencies do not currently have the full statutory and regulatory authority necessary to ensure the public accountability of organized health care delivery systems. In the current regulatory structure, insurance commissions that focus on fiscal integrity rather than health often regulate such systems. State Medicaid agencies, usually separate from public health agencies, also typically focus on fiscal rather than medical dimensions of accountability. To ensure that the public's health is addressed in the regulation of public and private health care delivery systems, most state public health agencies need additional legislative authority to oversee providers. The goal should be to become coequal partners with insurance regulators and state Medicaid agencies.

Traditionally, the delivery of public health services has been seen as the exclusive province of official public health agencies. Increasingly, however, these agencies are contracting with private community-based providers for specific direct care services. Given their changing role, public health agencies must transform themselves from service providers to leaders in organizing a community's resources to enhance its health.

State and local public health agencies have a responsibility to monitor the health status of the populations that they serve, including those in managed care organizations. Public health agencies must also ensure that the public has access to quality health care; community health profiles provide some of the information needed to carry out this function. If a community chooses to implement a community health improvement process like the one proposed above, data needs become a priority. Because all parties share the goal of improving community health, it is reasonable to combine public and private resources to support the data collection and analysis needed to obtain health profile information, to conduct health status assessments and communicate results, and to sustain performance monitoring programs. Managed care organizations, which serve defined populations, can and should participate in data collection and analysis, and their data systems can facilitate these activities. If there are to be independent checks on managed care plans' performance, public health or other government agencies must be involved.

Because data on a wide variety of topics and groups are essential for effective performance monitoring, states and the Federal government can assist communities by helping them gain access to relevant data held by the private sector. In particular, states and the Federal government should require that health plans, indemnity insurers, and other private entities report standard data on the characteristics and health status of their enrolled populations, on services provided, and on outcomes of those services, for performance monitoring purposes.

Ultimately, society must reinvest in government public health agencies, with contributions from government, the private and nonprofit sectors, and substantial legal (including regulatory) authority, if the public's health is to improve. Partnerships between government public health agencies and managed care organizations and between public health agencies and communities can provide both political support and a vehicle for this reinvestment.

References

1. Institute of Medicine. The future of public health. Washington: National Academy Press; 1988.
2. Institute of Medicine. Healthy communities: new partnerships for the future of public health. Washington: National Academy Press; 1996.
3. Institute of Medicine. Improving health in the community: a role for performance monitoring. Washington: National Academy Press; 1997.
4. Evans RG, Stoddart GL. Producing health, consuming health care. In: Evans RG, Barer ML, Marmor TR, editors. Why are some people healthy and others not? the determinants of health of populations. New York: Aldine De Gruyter; 1994.
5. Berwick DM. Continuous improvement as an ideal in health care. N Engl J Med 1989;320:53–6.
6. Osborne D, Gaebler T. Reinventing government: how the entrepreneurial spirit is transforming the public sector. Reading (MA): Harper Collins; 1992.
7. Robbins A, Freeman P. How organized medical care can advance public health. Public Health Rep 1998;114:120-5.
8. Showstack J, Lurie N, Leatherman S, Fisher E, Inui T. Health of the public: the private sector challenge. JAMA 1996;276:1071-4. ■