Relationships Between Public and Private Providers of Health Care

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MOST PEOPLE IN THE UNITED STATES have a regular source of medical care, usually a privately practicing physician or group of practitioners (*1*). However, the source of care might be a local health department, since many health departments provide personal health services. The extent of such publicly provided care has increased over the past 30 years (*2–4*); currently about half of all health departments in the nation report major involvement in providing such services. Nevertheless, there are significant regional differences; health departments in the Sun Belt, Mountain, and Pacific Coast States are the most extensively involved (*4*). Health departments also vary in the kind and extent of the personal health care they provide; it ranges from complete and comprehensive services to contacts for such limited purposes as screening or immunization. During fiscal year 1979, an estimated 72 million people were served directly by personal health care programs under public health departments (*5*). The growth in such programs in recent years has been due in part to expansion of nutrition programs, to screening for hypertension, and to immunizations. Despite the large numbers of people served, the extent to which publicly provided personal health services have facilitated or disrupted more complete care among either public or private providers has largely gone unmeasured. Few studies have been done on the quality of these personal health services, although some studies have indicated that those supplied by health departments compare favorably with those of other provider systems (*6*).

Many people use a number of different providers of health care. A well-known example is the use of public clinics for well-child services and of private physicians or emergency rooms for medical care. Among poor children who receive medical care, about half make some use of public clinics, hospital outpatient departments, or emergency rooms (*1*). Another example is family planning. Among rural teenagers who receive services from an organized program of contraception, 67 percent obtain these services from the clinics of local health departments (*7*). Many of these same teenagers report the use of family physicians for other health services.

The frequent sharing of patients among a variety of providers has created a need for clarification of the working relationships among them. In the course of a study that we were conducting of selected local health departments, an opportunity was presented to analyze functional relationships between public and private providers in the same communities.

Method

We collected the data for our analysis from a panel of public health experts comprised of representatives from the United States Conference of City Health Officers, National Association of County Health Officers, Association of State and Territorial Health Officials, and the American Public Health Association. The panel members were asked to nominate local health departments that they considered to be extensively involved in programs

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of personal health care. Fifty-seven local health departments were nominated. The list of the departments was then circulated to the panel members, who were asked to make any additions they desired and then to indicate the 12 departments from the expanded list that they considered to be "most outstanding in the scope and quality of their personal health services."

Thirty-eight health departments were included in the second round of nominations. Departments from all parts of the country were nominated, but nominations were most plentiful for departments in the Sun Belt and Pacific Coast States. City health departments predominated, but no metropolitan giants were included.

From these nominations we selected 15 health departments for intensive case study: Appalachia II District (Greenville), S.C.; Cincinnati, Ohio; Contra Costa, Calif.; Cortland County, N.Y.; Craven County, N.C.; Denver City/County, Colo.; Detroit, Mich.; Lane County, Oreg.; Maricopa County, Ariz.; Multnomah County, Oreg.; Newark, N.J.; Seattle-King County, Wash.; Memphis-Shelby County, Tenn.; Thurston-Mason Health District, Wash.; and Yolo County, Calif. Three departments were selected from among the initial nominees to field-test our case study methods; six were selected because they received the largest number of final nominations; three were selected from the final list to balance geographic distribution and health department size; and three were selected from the list of initial nominees both because they fitted easily into our travel schedules and were reported to feature innovative programs that could not be observed in other departments.

Background data and reports on all 15 departments were reviewed, and teams of fieldworkers visited each of them at least once. In time, we will publish detailed case studies for each department, drawing on data from materials provided by the health department directors and from data collected on site visits by the study teams.

The information reported here is derived from interviews conducted during the site visits. These interviews were held with the director of the health department, and usually also with the administrative head of each of its divisions. At clinical sites, interviews were conducted with the administrator, providers, and patients or their families. Interviews were also arranged with directors of local hospitals, officers of local medical societies, local practicing physicians, appropriate officers of government such as the mayor or county commissioners, members of the health department board, and consumers who held positions on advisory or governing boards.

All interviews were semistructured; they followed protocols that had been written with specific regard to the interviewee's position in the community. The protocols were designed in part to elicit factual data, but the major emphasis was to gather attitudinal or judgmental responses about the health departments as providers of personal health care. Following each site visit, the study team members discussed their individual impressions and arrived at a consensus. When the directors subsequently reviewed the findings, all 15 agreed with the classifications that had been assigned to their departments. The issues revealed and the impressions gained from the interviews about the interaction of public and private sectors of care constitute the results reported here.

Results

Of the 15 health departments studied, 8 had a metropolitan population in excess of 300,000; 4 had combined town and rural populations in excess of 100,000 but were without a major metropolitan center; and 3 had town and rural populations of less than 100,000.

In one group of eight departments, the pattern of care offered derived from concepts established under a model that had been used initially by the Comprehensive Neighborhood Health Centers under the auspices of the Office of Economic Opportunity. Seven of these eight were city departments. All operated neighborhood health centers, many of which had satellite clinics. The centers offered comprehensive ambulatory services, including specialized secondary level care and assured access to tertiary care. Estimates on the number of people served in these communities approximated the size of the local poverty-level populations, although no claims were made that the programs reached all poor people or that services were confined exclusively to the poor.

In a second group of four departments, often with a rural constituency, the pattern of care combined primary health care programs with referral systems in order to assure secondary and tertiary care as needed. Frequently, these four departments relied heavily on collaboration with private providers. Use of mobile clinics was extensive: special projects such as those supported by Health for Underserved Rural Areas (a component of the Public Health Service) or the Appalachian Regional Commission were an important aspect of these departments.

In a third group of three departments, categorical programs were emphasized, such as dental care, well-child services, maternity care, screening clinics, and family planning. These services were coupled with efforts to provide entry into other established systems of

care. Outreach, mobile vans, and satellite clinics that provided limited services but excellent pathways to other provider systems were significant aspects of the care provided.

A feature of the 15 health departments studied was that with rare exceptions they had emerged in areas where other provider systems abounded. Yet, deficiencies in the use of health services by some sectors of the population could be documented in all the study areas. Establishment of programs of personal health care in the health departments was responsive to these deficiencies.

We readily identified three models of functional relationships between the 15 health departments and private providers: parallel, interactive, and accommodative. In the parallel model, the two systems of care—public and private—do not interact in any organized fashion around the delivery of patient care services (4 of the 15 communities studied). In the interactive model, the two systems intentionally rely on each other for one or more services, using well-defined referral linkages (seven study communities). In the accommodative model, the public and private sectors influence each other's services in a planned way, but they maintain a functional separation of services (four study communities).

Parallel model. The public and private sectors function independently from one another in the parallel model. The health department provides services to its population without any established reliance on the private sector either for resources (such as personnel and physical facilities) or for missing components in its direct care activities (such as specialized diagnosis and treatment). The private sector, likewise, functions independently and does not call upon the health department for programs such as laboratory service, screening, or consultation. There is no formal or intentional coordination between the two systems of care, although they sometimes come together for use of the same emergency room or hospital, which may be administered within either system.

The personal health care provided by a health department that does not interact with the private sector around service delivery may take one of several forms. One possibility is that the personal health services offered by the department may not be adequae to meet all of a patient's needs, so that clients have to arrange their own transfer into the private sector to supplement the health department's program. A second possibility is that the public sector may be called upon to supplement the care received by patients who usually see private providers. In such cases, patients may seek additional care from the health department because the services they desire are perceived to be otherwise unavailable or too costly. Examples are family planning and well-child care. A third possibility, observed in four of our study communities, is that the range of services available through the health department may be so extensive that comprehensive care can be assured to clients without any need for other providers. This situation necessitates that the health department have adequate personnel, physical facilities, and specialty resources to insure a comprehensive, self-contained program of care. A dual system is thereby established, and clear boundaries (often defined by income levels and geography) separate the public care program from that offered by the private sector. Nearly half of the clients interviewed in health department waiting rooms reported that they never found occasion to use services outside the health department.

In the four study communities where a dual or paralled system was operative, the private practitioners often were not knowledgeable about the health department programs. In several instances, the physicians who were interviewed openly supported the expansion of services as a device that would keep unwelcome poverty-level patients out of the offices of private physicians. In no instance did a private practitioner express hostility toward the activities of the four health departments.

Interactive model. In the interactive model, the public and private sectors intentionally rely on each other for one or more of the components of care necessary for a full complement of services. An administrative or functional linkage is maintained to facilitate referral of patients back and forth between the systems. The interaction of the two sectors is intentional, acceptable, and recognized by both systems, but it is not necessarily formalized through contracts or monetary exchange. This interactive model prevailed in seven of the study communities. In one of those communities, many of the physicians staffing the health department's clinics were principally engaged in private practice. In another, the local private hospital was a key referral agency for the health department clinics. The private practitioners, in turn, regularly referred patients to programs offered by the health department, such as home health care, laboratory services, screening activities, and emergency transport.

In some settings, the health department and the private sector collaborated on specific programs that concurrently met the interests of both systems. For example, the

health department and private practitioners at one rural site worked together to establish a medical care program for indigent children. The private practitioners endorsed the activity by caring for children referred to them by the program's staff and by serving as preceptors for the health department's nurse practitioners. This collaboration enabled the health department to undertake a comprehensive program of primary care. At the same time, the desires of the local pediatricians were met, since they were relieved from having to serve indigent children in their private offices.

In one city where the health department followed the interactive model, the medically indigent who were brought into contact with the department by a program of outreach were encouraged to obtain continuing care from private practitioners or from local health maintenance organizations. The outreach program was administered by the health department, which broadened its services with the help of the private medical community. Thus, the desires and needs of both systems in this setting were met. The staff of this health department reported that few people in the community were unserved.

Accommodative model. In the accommodative model, one sector influences or supports the other in setting up programs to respond to unmet health needs in the community, but both sectors maintain a functional separateness. A boundary separates public and private health care, but that boundary is moved from time to time by mutual consent. The health department may promote the establishment of programs in the private sector, or it may administer programs for a short time until provision can be made for their continued operation on a private or voluntary basis. The accommodative model was identified in four predominately rural study communities.

The relationship between the private and public sectors in one study community provides a good example of the accommodative model. In this community, the health department increased its capabilities for well-child care in response to the loss of a local pediatrician. Concurrently, the health department cooperated with the local medical society in recruiting a new practitioner for the area while the private practitioners accepted health department referrals for sick-child care.

In situations in which a health department has initially sponsored a program to address a personal health care need, the private sector may make substantial contributions to the undertaking. For instance, private obstetricians in one county encouraged the health department in establishing a maternity care program. In another county, a private practitioner assumed responsibility for supervision of the physician assistants who staffed the health department's rural health centers. The rural health centers, with health department support, eventually formed an independent corporation.

Although we have described as separate entities the three patterns of relationships that may exist between the private and public sectors, these relationships could also be considered as points on a continuum. Features of one system sometimes co-existed with another, but one of the three patterns predominated in each of the 15 study communities. Neither the pattern of care offered by the 15 health departments, nor the population characteristics of the communities, correlated consistently with the three models used to describe the relationships between public and private providers.

Comments

Identifiably different patterns characterized the functional relationships between the private sector of medical care and the personal health services rendered by the 15 public health departments. Any of the relationships can be associated with a health department's reputation for high-quality service. None of the health departments selected as outstanding appeared to be engaged in conflict with the private medical community. This observation is consistent with results of an earlier survey of health department directors (*4*). When asked to designate constraints on expanding or improving personal health services, the directors in that survey emphasized lack of facilities, staff, or money, but not constraints imposed by the attitudes of physicians, medical societies, or consumers. In many of the communities in the present study, observers reported that although relationships with individual providers sometimes became tense, a general climate of good will prevailed.

Of special interest is our observation that dual or parallel systems of care, public and private, need not characterize the provision of personal health services by local health departments. However, when such a pattern has developed in a community, it is defended by both its public and private sectors. This pattern is not identifiably less advantageous than other patterns so long as both sectors maintain a full spectrum of services. However, if one sector's services are incomplete and without linkages to the other, then increased burdens are placed on clients to seek out the indicated services. Dual or parallel systems in communities that can afford them may be defended on the grounds that consumers deserve a choice as to where they will obtain medical care and that the available choices

should include both public and private providers. In actuality, the study communities that adopted a dual system did so because some segments of the population did not use the existing private providers for a variety of reasons, including not only economic considerations but also geographic separation and the obstructive attitudes of some members of both professional and consumer groups.

We found no support in any of the case studies for certain widely held views. No interviewee suggested, for example, that public and private providers were competing for the same patients or offering competing services. Most of the patients cared for in health departments were reported to be those who would not otherwise be served. No one interviewed complained that the work of health departments diminished the role of private practitioners. On the contrary, health departments in some communities reportedly had helped to increased and improve the work of private practitioners by helping to identify unmet needs and by providing supplementary or enabling services such as outreach, home care, transportation, and casefinding.

Communities that seek to improve health services may logically look to both public and private systems of care. The communities that we studied demonstrate that both systems fulfill important needs and that a variety of ways can be worked out for the different provider systems to relate to each other. No one model of relationship is appropriate for all communities. The resources available to each system of care, the needs and desires of the populations to be served, and the history of previous public-private interactions are important considerations in shaping functional relationships between the two sectors of care. Expansion of public programs may well enable previously unserved persons to participate in programs of health care in either or both sectors. Expansion of public systems of health service may also relieve private providers of endeavors they are unprepared to assume. This study provides no evidence that initiatives which define a functional role for local health departments in the delivery of personal health care alter the prevailing circumstance in which most people and most services are covered by private providers or groups of providers. The study does suggest that two well-developed sectors of care, public and private, can successfully co-exist under a variety of models to benefit the populations they serve.

References

1. Kovar, M. D.: Children and youth: health status and use of services. *In* Health, United States, 1978. DHEW Publication No. (PHS) 78–1232. Hyattsville, Md., 1978, ch. 3.
2. Terris, M., and Kramer, N. A.: Medical care activities of full-time health departments. Am J Public Health 39: 1129–1135, September 1949.
3. Myers, B. A., Steinhardt, B. J., Mosley, M. L., and Cashman, J. W.: The medical care activities of local health units. Public Health Rep 83: 757–769, September 1968.
4. Miller, C. A., et al.: A survey of local health departments and their directors. Am J Public Health 67: 931–939, October 1977.
5. Association of State and Territorial Health Officers: Comprehensive NPHPRS report: services, expenditures and programs of State and Territorial health agencies, FY 1979. Washington, D.C., 1980.
6. Morehead, M., Donaldson, R. S., and Seravalli, M. R.: Comparison between OEO neighborhood health centers and other health care providers of the quality of health care. Am J Public Health 61: 1294–1306, July 1971.
7. Dryfoos, J., and Heisler T.: Contraceptive services for adolescents: an overview. Fam Plann Perspect 10: 223–233, July–August 1978.

SYNOPSIS

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Fifteen local health departments that were identified as notable for their involvement in rendering personal health care were intensively studied along with their communities. Interviews with local medical care leaders and practitioners provided much of the study data.

Three patterns characterized the relationships between the health departments and private providers in the communities. In one pattern, there were dual or parallel systems of care, both public and private, which were self-contained, with little planned linkage between them. In another pattern, the public and private sectors were interactive, relying on each other in deliberate ways for the exchange of services. In a third pattern, termed accommodative, the private and public sectors, although maintaining service separation, planned with each other for the establishment of complementary programs that would be responsive to community needs.

Provision of health services of high repute was associated with all three of these patterns. Although tensions were not absent between public and private providers in the study communities, a climate of mutual support and good will appeared to characterize their relationships. In none of the health departments selected as outstanding, was an atmosphere of conflict with the private medical community reported.