Perceived Outcomes of Public Health Privatization: A National Survey of Local Health Department Directors

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SINCE THE 1970S, THE CONTRACTING OUT OF SERVICE work has become increasingly popular in practice as well as in managerial theory (Lash and Urry 1987; Kettner and Martin 1994; Ascher 1996; Gewirtz 1996). Indeed, the idea of using contractors has become so favored that the question almost becomes what *not* to “out-source.” Both the public and private sectors use outside contractors, but when public agencies contract with private organizations to perform public services, the term “privatization” is typically used.

Issues surrounding outsourcing and privatization raise questions about the essence of organizations: their purpose, focus, and even why they exist at all. Management theories have been concerned for many decades with identifying the nature of organizations. The fundamental questions are: why should firms or governmental agencies exist, and why are they a better vehicle for conducting business than using contracts or informal relationships between relatively autonomous individuals or small groups (Coase 1937; Demsetz 1993; Sclar 2000)? A related managerial issue concerns defining the organizational mission and focus in terms of core functions or core competencies. In the rhetoric of “reinventing government,” governmental organizations are urged to focus on “steering, not rowing,” meaning managing rather than directly performing services

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(Osborne and Gaebler 1993). According to this perspective, services and functions that do not relate to the core mission of government should be contracted out to the private sector. The claim is that this privatization will sharpen the focus of governmental departments and agencies.

The public health version of this model, defining the uniquely governmental roles in public health, is reflected in the Institute of Medicine's (1988) "core functions" of public health: assessment, assurance, and policy making. According to one interpretation, health departments should withdraw from, or contract out, the direct provision of services—particularly personal health care—in order to focus on these core functions (Wall 1998).

The most general arguments for outsourcing, including privatization, are grounded in managerial theory—as are, ironically, the arguments for performing services in-house. According to the theory of the firm (Demsetz 1993), a formal organization is preferable to individual contracts because the transaction costs are much higher when many persons or relatively small organizations do business with each other through contracting (Coase 1937; Sclar 2000). Indeed, many instances of privatization have revealed significant transaction costs (Sclar 2000). And although it is often touted as a way of avoiding governmental bureaucracy, contracting out a public service often produces its own organizational complications (Belluck 1999; Sclar 2000). Additional managerial time and resources in the form of oversight responsibility, paperwork, and other transaction costs are generally required (Ramanadham 1994). Partly for this reason, any costs savings attributable to privatization have generally been in single-digit percentages (Reh fuss 1989).

More sweeping generalizations about privatization have been made by those who advocate privatization as a means of allowing competition in the "free market" to improve the efficiency of public services (Poole 1980; Friedman and Friedman 1980; Savas 1987; Fitzgerald 1988; Osborne and Gaebler 1993). For most public services, the free-market competition argument for privatization is easily criticized for the existence of significant departures from market-model assumptions (Sclar 2000). Yet privatization is often carried out for reasons other than to stimulate competition (Sappington and Stiglitz 1987; Starr 1990).

Public services are often privatized with the expectation of general managerial benefits, such as reduced costs, increased organizational flexibility, and increased organizational focus (Donahue 1989). This means that privatization can be systematically evaluated in terms of these and

other organizational-level outcomes. However, specific public services should also be evaluated based on outcomes that are deemed appropriate by professionals in specialized arenas and agencies. Local health departments (LHDs), for example, operate largely on the foundation of the skills, expertise, and knowledge base of public health professionals. For this reason, the privatization of public health is best studied in the light of concerns particular to public health professionals and the field of public health.

Privatizing Public Health

The privatization of public health services is of special concern because the nation's LHDs perform essential public health services that private organizations may have neither the authority, the capacity, nor the incentive to provide. Yet, although the literature on privatization has reviewed many public functions (Stevens 1984; Savas 1987; Donahue 1989; Lieberman 1989; Gomez-Ibanez and Meyer 1993; Ryan 1997; Wallin 1997), it has given very little attention to public health. A recent monograph on privatization, covering a great many types of public services, does not mention public health (Sclar 2000).

Our own recent research uncovered that privatization has quickly and quietly become commonplace in public health. We report elsewhere (Keane, Marx, and Ricci 2001) that more than half of health departments (57 percent) have delegated to outside contractors the direct performance of least one service that was formerly performed in-house (table 1). A different kind of privatization occurs when an LHD becomes involved with a new service, but contracts out (or otherwise delegates) the performance of that service from its inception; about half (52 percent) have contracted out at least one public health service from its inception. In all, 73 percent of LHDs have privatized public health services of some type. The most commonly privatized services included personal health care services (70 percent of LHDs), including such services as maternal care (20 percent of LHDs), pediatric primary care (19 percent), and family planning (12 percent). Some communicable disease services were privatized in 27 percent of LHDs, including HIV services (13 percent), sexually transmitted disease services other than HIV (9 percent), and tuberculosis services (9 percent). Some environmental health services were privatized in 24 percent of LHDs (Keane, Marx, Ricci, et al. 2000).

TABLE 1
LHD Directors' View of Privatization and the Role of LHDs in Performing Core Functions (% of all LHDs
by size of jurisdiction)

	Size of jurisdiction of local health department					Total n = 347 ^a
	<25,000 n = 68	25–49 K n = 68	50–99 K n = 67	100–349 K n = 71	350,000 + n = 73	
Any service privatized						
≥1 service privatized	60.3%	73.5%	82.1%	90.1%	90.4%	72.6%**
≥1 service privatized in last 5 years	44.1%	45.6%	71.6%	74.6%	82.2%	55.2%**
Formerly in-house services privatized						
≥1 service privatized	47.1%	54.4%	65.7%	69.0%	80.8%	56.6%**
≥1 service privatized in last 5 years	36.8%	41.2%	50.7%	57.7%	71.2%	44.9%**
Services privatized from inception						
≥1 service privatized	41.2%	47.1%	59.7%	73.2%	71.2%	51.7%**
≥1 service privatized in last 5 years	19.1%	17.6%	44.8%	31.0%	41.1%	25.5%**
Types of services privatized ^b						
Any personal health services privatized	58.8%	70.6%	77.6%	87.3%	84.9%	69.9%**
Any environmental health services privatized	23.5%	13.2%	23.9%	35.2%	31.5%	23.5%*
Any data services/functions privatized	4.4%	5.9%	19.4%	22.5%	24.7%	10.8%**
Any health education/community outreach	22.1%	23.5%	40.3%	49.3%	49.3%	30.7%**

Ideal focus of local health departments						
Move entirely out of directly providing personal health care	11.9%	9.1%	9.0%	14.1%	17.8%	11.6%
Directly provide personal health services when no else to it	34.3%	25.8%	40.3%	39.4%	42.5%	34.6%
Perform core functions and provide personal health care	50.7%	62.1%	50.7%	45.1%	38.4%	51.6%
Privatization decision makers very/most influential in the decision making ^c						
State government/state health dept.	35.9%	18.0%	27.8%	23.0%	20.0%	26.9%
County/city officials	25.6%	28.0%	24.1%	23.0%	33.8%	26.1%
Health department top administration	38.5%	60.0%	51.9%	57.4%	63.1%	50.9%*

* $p \leq 0.05$ for differences by size of jurisdiction according to the Pearson chi-square statistic.

** $p \leq 0.005$ for differences by size of jurisdiction according to the Pearson chi-square statistic.

^aNs reported in this row are for unweighted sample size, all proportions reported elsewhere are weighted.

^bFor each, at least one service.

^cCategories are not mutually exclusive.

In this article, we examine the outcomes of this privatization, as LHD directors perceive them. We also report the expected outcomes of privatization as forecast by directors who have not privatized services. In addition, we describe directors' perspectives on what specific services should *not* be privatized. The nationally representative quantitative and qualitative information we present may be useful to public health officials and professionals as they confront decisions regarding privatization. Our data may also inform state and federal as well as local government officials as they help to shape the funding and policy context that drives privatization.

Data and Methods

We drew a random sample of 380 local health departments from a universe of 2,488 LHDs listed in the 1997 database of the National Association of County and City Health Officials (NACCHO). (NACCHO defines *local health department* as "an administrative or service unit of local or state government, concerned with health, and carrying some responsibility for the health of a jurisdiction smaller than the state.") We randomly selected 76 LHDs from each of five strata, based on the size of the jurisdiction served by the health department. All quantitative data presented were weighted to be representative of the entire universe of LHDs in the United States. We completed intensive telephone interviews, between July 1998 and March 1999, with 347 LHD directors or persons closest to that position. This represents a 91.3 percent response rate. We asked the directors to describe all local health department services that were contracted out or otherwise delegated to a private-sector organization. The directors were asked to include all specific services under the following general categories: (1) personal health services, (2) environmental health services, (3) data services, (4) health education, and (5) community outreach. The survey consisted of fixed-ended and open-ended questions. Open-ended questions were coded into appropriate response categories.

We utilized reports from the directors on outcomes of privatization as well as their perspectives on what services should not be contracted out. The views they expressed inform and influence organizational decision making. In a previous paper, we reported that directors' views on issues relating to privatization predicted their decision to contract services out

(Keane, Marx, and Ricci 2001). In addition, their narrative interpretations help contextualize and interpret the significance of privatization in their departments. This subjective perspective is simultaneously an advantage and a liability. Directors' beliefs tend to justify as well as influence the decision they made, either to privatize or not to privatize. Directors that have privatized a service tend to emphasize the benefits of that decision, while directors who have not privatized tend to emphasize what they view as the wisdom of that decision. Nevertheless, the perspectives of these experienced public health professionals are worth describing, as they have a significant influence on the dynamics of privatization as well as provide an invaluable source for understanding how privatization affects public health.

Study Results

Privatization's Effect on Performance of Core Functions

Of the directors whose departments privatized services, about half claimed that privatization had a positive effect on their department's performance of core functions (table 2). Another third either believed that privatization hindered performance of the core functions or were not sure how the core functions were affected. Twelve percent believed privatization made no difference in the performance of core functions. Among the directors of departments that did not privatize any services, only one of five believed that privatization would facilitate the performance of core functions. As shown in table 2, almost half of these directors who did not privatize believed that privatization would hinder the performance of the core functions.

After asking directors whether performance of core functions would be helped or hindered by privatization, we solicited explanations of their answers. Responses to these open-ended questions reveal that many directors who believed privatizing would (or could) impede core functions were concerned about the LHD's loss of control over various aspects of services. For instance, directors felt it was easier to keep track of in-house service performance, noting that privatization added another layer of administration through which information must flow. Directors linked this loss of control to poorer performance of core functions, especially

TABLE 2
Privatization's Effect on Performance of Core Functions, Time Spent on Administration, and Staffing
(% of all LHDs by size of jurisdiction)

	Size of jurisdiction					Total
	<25,000	25–49 K	50–99 K	100–349 K	350,000 +	
How privatization affected LHD's performance of the core functions						
<i>Of those who privatized any service</i>						
Helps	48.8%	44.0%	47.3%	58.1%	56.1%	49.7%
Hinders	17.1%	18.0%	20.0%	11.3%	9.1%	16.1%
Makes no difference	12.2%	14.0%	10.9%	9.7%	12.1%	11.9%
Not sure/helps and hinders	22.0%	24.0%	21.8%	21.0%	22.7%	22.3%
How privatization would affect LHD's performance of the core functions						
<i>Of those who did not privatize**</i>						
Would help	19.2%	6.2%	25.0%	14.3%	28.6%	17.1%
Would hinder	38.5%	56.2%	41.7%	57.1%	28.6%	43.1%
Makes no difference	7.7%	12.5%	0.0%	0.0%	0.0%	7.3%
Not sure/helps and hinders	34.6%	25.0%	33.3%	28.6%	42.9%	32.4%
Change in total time LHD spends on administration and program management						
<i>Of those who privatized any services</i>						
Increased	45.0%	40.0%	33.3%	37.1%	52.3%	41.1%
Stayed the same	32.5%	50.0%	50.0%	45.2%	29.2%	41.4%
Decreased	22.5%	8.0%	14.8%	16.1%	12.3%	16.0%

Effect of privatization on staffing of LHDs privatizing						
<i>Of those who privatized any services</i>						
Reduced staff	15.4%	18.7%	17.0%	29.5%	35.9%	20.6%
Added staff	15.4%	10.4%	13.2%	11.5%	12.5%	13.0%
No overall change in staff	69.2%	70.8%	69.8%	59.0%	51.6%	66.5%
How privatization affected costs						
<i>Of those who privatized any services</i>						
Costs are lower/more cost effective	50.0%	38.0%	46.3%	41.0%	39.1%	44.2%
Costs kept low/costs stabilized	7.5%	8.0%	11.1%	11.5%	7.8%	8.9%
Costs unchanged/very little change	25.0%	30.0%	20.4%	19.7%	25.0%	24.4%
Raised costs, less efficient or lost revenue	7.5%	12.0%	11.1%	11.5%	12.5%	10.2%
Not sure/some costs higher and some lower	10.0%	12.0%	11.1%	16.4%	15.6%	12.2%

**p ≤ 0.005 for differences between those privatizing and those not privatizing, according to the Pearson chi-square statistic.

assurance. Many directors saw LHD control over performance of services as absolutely necessary for the successful implementation of core functions. For example, one director said that with privatization “we wouldn’t have control over services or functions, therefore the performance of the core functions would be hindered.” Another director stated that privatization would hinder performance of core functions and “would erode the infrastructure of public health. If contracted, those who actually provide the services and do hands-on work would not be able to participate as well in the assessment and assurance functions.” Similarly, another director pointed out that “it’s easier to keep track of things when one entity is providing the services.”

Some directors asserted that accountability is more difficult to maintain following privatization: “We lose our identity and accountability in the process of contracting.” Similar concerns were voiced by directors who were “not sure” of the effect of privatization on the LHD’s performance of core functions, although some of these directors saw both positive and negative effects on performance of core functions. One such director observed that while the department had more time for core functions, the downside was that “we are accountable, but have no authority.”

Many directors believed that by contracting out certain services, their department could devote more time or monetary resources to the performance of core functions. For example, one director said that privatization “has freed us up to focus on these core functions rather than spending too much money and time on clinical care.” Said another director, privatization “allows us to distill our function. Direct delivery takes 99 percent of our focus.” Some qualified their views by indicating that the performance of core functions would be facilitated, but only if the LHD retained control over provision of those services that are contracted out: “It helps [the performance of core functions] so long as the health department maintains overall control.” And while some directors claimed that assurance of service access was facilitated by privatization because the involvement of more service providers expanded the number of clients served, others found privatization made “assurance of access difficult.”

Impact of Privatization on Staffing and Time Devoted to Management

The privatization of services is associated with an increased emphasis on management and administration in health departments (table 2). Of

LHDs privatizing at least one service, more than two-fifths reported an increase in total time spent on administration and program management. However, the same proportion reported no change, and 16 percent reported a decrease in the time devoted to management and administration.

Two-thirds of the directors reported no change in staffing in-house as a result of privatization. Overall, one in five experienced a decrease, and one in eight saw an increase in staffing due to privatization (table 2). The proportion reporting staff reductions rose with the size of LHD jurisdiction. Open-ended comments revealed that the relatively few LHDs that increased their staff did so because they needed the new employees to manage contracted programs. In some cases, those reporting no overall difference in numbers of employees had added program management staff while reducing staff engaged in direct provision of services. Among departments that reduced staff, directors frequently noted that workers were transferred to the private provider.

Impact of Privatization on Costs

When asked an open-ended question about how privatization affected costs, more than half of the directors reported that costs were lower or had stabilized, or that there were gains in cost effectiveness, efficiency, or revenue (table 2). One in 10 directors reported increased costs, decreased revenue, or a loss of efficiency due to privatization.

The narrative responses to the question about how privatization affected costs specified where funds were saved or lost (table 3). Many directors indicated that monitoring costs had increased. Similarly, the increased levels of administration associated with contracting out services resulted in increased costs. In fact, the increased costs associated with monitoring and administering privatized services often wiped out the savings realized through cheaper service provision. As one director reported: "There was a neutral effect on cost, overall. We privatized services which could be more cheaply performed by the private sector. However, the resulting extra administration is costly. Thus, privatization has shifted costs to administration." Another director stated that the "health department's costs are now more administrative than service-oriented."

In some cases, the costs of privately provided services were reported to be higher than their public counterparts. One director noted that his LHD was limited to 2 percent annual increases and, in his experience,

TABLE 3

Local Health Department Directors' View of How Privatization Affected Costs, of Those Who Privatized at Least One Service

Lowered costs, raised revenue, or stabilized costs (53%)

- "We reduced our financial risk by transferring it from the local health department to the private sector. The private providers pay lower salary and benefits and are not unionized, so it's cheaper to contract."
- "We privatized to organizations that make more use of volunteers; so costs are lower."
- "By contracting out for water testing, the health department has saved the costs of the required technology."
- "Privatizing has helped to lower costs, but I do not evaluate privatization that way. There are a lot of needs being unmet. There is higher teen pregnancy, a lower number of well-baby checkups, and a higher number of nonimmunized children since the county clinic was replaced by a private provider."
- "At first, costs were raised; currently they are lower."
- "Privatizing saves a little money, certainly equipment costs. Contracting with physicians costs less than hiring [them] full time."
- "[There has been increased efficiency because] our costs have not increased at all, yet the privatization has helped us to get more done. We manage the effort rather than do the functions."

Costs unchanged (24%)

- "No change overall. There are more monitoring costs but fewer operating costs."
- "There was a neutral effect on cost, overall. We privatized services which could be more cheaply performed by the private sector. However, the resulting extra administration is costly. Thus, privatization has shifted costs to administration."
- "Neutral, but the health department's costs are now more administrative than service-oriented. We do bring in more Medicaid dollars to [the] state. Overall, the same dollars are expended."
- "The idea that you can get more for less has not been found to be true. Our budgets have flattened. At the state level, delegation is being reversed through disinterest by private organizations when services are no longer found to be profitable."
- "Our costs are fixed. Our issue is how the privatization affects performance. We get more benefits with more bidders. The problem is that we do not have enough bidders in this small area."
- "Not much of a change. The notion of outsourcing as a cost saver is bogus. The process of competitive analysis enhances cost- and effectiveness-consciousness. It is the tension which produces the improvements."
- "Kept costs about the same. Kept the budget from growing. The health department is limited to 2% increases per year."

TABLE 3—continued

Raised costs or lost revenue (10%)

- “It’s made getting resources tougher. The department no longer receives home-care revenue and so is more grant-dependent.”
- “We’ve actually struggled more financially. The health department has lost Medicaid revenue, yet still provides services to nonpayers.”
- “Usually privatization produces immediate savings. However, in 3 to 5 years it starts to cost more.”
- “Initial costs were the same, but costs increased 30% in 7 to 8 years.”
- “Jail medical services have raised costs. They got the program by lowballing estimated costs, but then they increased their price 50% the next year. I guess privatization has saved money elsewhere.”
- “Our costs have gone up because of the extra time and effort involved. Also, contracting out is absolutely more expensive than having services done in-house in this area. It costs \$95 for a nonprofit hospital to do home health visits versus \$55 for us to do them.”
- “Overall, it has decreased our revenue by \$1 million, while saving much less on expenses. Turnover and hiring costs wipe out savings on fringe benefits. Delegation has led to a net loss in savings.”
- “It has caused costs to go up a little bit. The county limits the health department to 2% annual increases, but it is very hard to use contracts to keep the private sector to the same rules. They are allowed bigger increases in funding than we are.”

*Don’t know, some costs are higher and some are lower (7%)**Other (5%)*

private providers expect higher increases. Several directors reported initial savings, but then increases in cost several years after privatization. In one instance, this was attributed to the private organization “lowballing” estimated costs, then increasing costs by 50 percent the following year.

A common way of generating savings involved using private providers who paid lower salaries and benefits. One director noted: “We reduced our financial risk by transferring it from the LHD to the private sector. The private providers pay lower salaries and benefits and are not unionized, so it’s cheaper to contract.” Cost savings also were achieved by contracting for part-time work and saving on equipment costs, particularly when there was low demand for particular services. Many directors reported savings from privatizing particular services that lost money when provided in-house. For example, they often described home care as a “money loser” when kept within the department. At the same time,

a few directors reported losing revenue by privatizing home care; one stated that it “made getting resources tougher. The department no longer receives home-care revenue and so is more grant-dependent.”

Positive Outcomes of Privatization

We examined directors’ views about the positive outcomes of privatization using an open-ended question; responses were coded into nonexclusive categories. The most commonly reported positive outcome was increased access to services (38 percent of LHDs). This response encompassed diverse improvements in access, including expanded hours, more service locations, and improved access for vulnerable populations. Significantly, many directors claimed that without privatization, some services would not have been provided at all. And in many instances, contracting enabled the LHD to become involved in new services. For example, one director explained: “We have been able to continue to provide acute care to the indigent and underinsured or those not insured at all. Without this arrangement they may not receive it.”

After improved access, the most common responses were cost savings (31 percent) followed by quality (28 percent). The latter included responses indicating that quality was “good” or that satisfaction or continuity of services had been maintained. That is, the category “quality” was not limited to improvements, but also included maintenance of quality. In a very few instances, improved health outcomes, such as lowered infant mortality, were attributed to privatization. More often, directors described good or better continuity of care.

Almost one in five directors described gains in expertise or access to specialized equipment as a result of privatization (18 percent). On this issue, one director said, “We would not have had the needed expertise, being in a small rural community.” Directors also mentioned a number of organizational-level benefits, including the building of organizational collaboration and of closeness with the community (17 percent). One director found that privatization “strengthens [the LHD’s] partnerships with grassroot organizations [and] makes programs ‘richer’ and more accessible.”

Eleven percent of the directors described “flexibility” as a positive outcome of privatization. One director indicated that “flexibility is the most important outcome. Working with contracting agencies allows functions

to be performed outside of business hours without increasing costs.” Privatization is sometimes seen to increase flexibility, in that various rigid governmental or civil service regulations can be avoided by contracting with the private sector. One director noted that “civil service laws can be cumbersome, and private sector agencies aren’t bound by them.” And some directors (8 percent) described an increase in their department’s focus as a positive outcome, indicating, for example, that contracting out “enabled us to stay focused on other projects we’re working on—our core activities.”

Negative Outcomes of Privatization

Loss of control was the most commonly reported negative outcome of privatization. Just over a quarter of the directors (26 percent) claimed that privatization resulted in some loss of control over functions and services; another tenth (11 percent) found control more difficult than before. Among directors who had privatized services, almost a tenth (9 percent) reported problems in monitoring, assurance, or getting information from contractors: “Monitoring contracts can be cumbersome and there can be miscommunication issues.” On this point, another director explained, “It can be hard to monitor the activity of contractors. It’s very time-consuming to make sure the agencies are properly representing the health department.”

Because monitoring and information gathering are prerequisite to control over performance, we calculated an overall measure of loss of control that combined three categories: less control, harder to control, and lack of information required for control. Using this broad measure, more than a third of the directors reported some type of loss of control as a negative outcome of privatization. Among LHDs serving jurisdictions of 350,000 or more, half of the directors reported some type of loss of control in monitoring or information gathering.

Surprisingly, almost half of the directors who reported spending more time on administration and management as a result of privatization mentioned some type of loss or difficulty controlling the performance of services. By contrast, loss of control is mentioned only by a quarter of those reporting no change and a third of those reporting a decrease in time spent on management and administration. These differences in loss of control are significant at the $p < .005$ level.

Open-ended explanations emphasized loss of control over specific aspects of the service provision. Many directors felt it was easier to keep track of services provided in-house. Privatization added another administrative layer, which made it more difficult to obtain reliable, specific information quickly. As one director put it, privatization resulted in a “lack of control over employees of contracting agencies. Sometimes this has created conflict, as there isn’t much the health department can do in terms of monitoring employees of contracting organizations. There are many layers between us.” Some directors observed that although LHDs are held accountable for the performance of services, they have little control over contractors: “When you delegate you give up some control; although you have ultimate responsibility you don’t have day-to-day control.”

Other negative outcomes included the loss of quality (13 percent). A director noted the difficulty in specifying quality standards in contracts: “Sometimes underqualified people do the work. It is difficult to specify quality in contracts. Public health work takes a lot of skill.” One in 10 directors (10 percent) noted poorer access to services as a result of privatization. For instance, a director was “concerned that they’re getting the services they got previously. I think some EPSDT [Early and Periodic Screening, Diagnosis, and Treatment] are falling through the cracks.”

Director’s Views Regarding What Services Should Not Be Privatized

When asked “Which aspects of any local public health department services, including environmental, personal health services, data management, or outreach and education, do you think local health departments should not delegate out to a nongovernmental organization?,” respondents most commonly pointed to communicable-disease services. About 27 percent of all LHD directors reported that communicable-disease services should not be privatized; however, approximately 40 percent of the directors of LHDs serving jurisdictions of 100,000 or more were opposed to privatizing these services. It is evident from their open-ended comments that many directors considered communicable-disease control a specific responsibility of LHDs, sometimes noting the unique skills required as well as the fact that communicable disease is tied to surveillance functions.

Directors, especially among the largest health departments, commonly responded that regulatory or enforcement functions should not be privatized, often adding that control should not be given up. Twenty-two percent of all LHD directors claimed that regulatory and enforcement functions or overall control must be maintained by LHDs, but this proportion rose to 47 percent among directors serving jurisdictions of 350,000 or more. And although 12 percent of directors said that any service could be privatized, some qualified this by adding that the LHD must remain in control. Ironically, another 12 percent stated that no service should be privatized.

Directors provided explanations of their answers to the question about what services should not be privatized. These comments revealed general issues and concerns surrounding the privatization of particular services. The most pervasive concern was that privatizing certain services will result in a loss in the capacity of health departments to respond to disease outbreaks, environmental disasters, and other crises. For instance, one director stated: "Services that should not be privatized include environmental health, communicable-disease control, and services that have to do with our capability to respond to outbreaks." Another asserted: "Sometimes a private organization misses the point. There is a whole public health system in place to make sure there are no threats to the population like communicable-disease outbreaks."

Another common theme was that privatization reduces control and that communication is hindered. Said one director, "It's best to keep all services in-house so there is better control, and the ability to communicate is not interfered with by a second party." This rationale was typically given for the claim that no service should be privatized. However, one director used the same logic to conclude that any service could be privatized, but only if the service were completely privatized: "Any service can be privatized, but the whole service should be contracted out, rather than part of the service, so that one entity has the responsibility for control and accountability, rather than involving a middleman." These statements emphasize the strength with which some directors believed that authority and control are lost when services are contracted out. Most directors contended that health departments must maintain authority. For example: "Local health departments should not give away public health authority in any area. Local health departments must stay in the trenches and keep close contact with clients rather than merely doing oversight and assurance. Our credibility falters if we don't touch people."

A number of directors expressed two related points: that departments lose control when they privatize and that this loss of control results in a reduced capacity to respond to particular public health problems or crises. As one director put it: "No services should be privatized. It produces a fragmenting of services, and it reduces staffing, so if there is an emergency there is no staff." Problems with communication and reporting also impair the ability of LHDs to respond to epidemics in the eyes of some directors. One director said: "Environmental services, data services, health education, and community outreach should not be privatized. Among personal health services, communicable disease control should not be privatized because communicable diseases often aren't reported by private sector providers, and this shouldn't happen."

Some directors asserted that LHDs have developed special skills and capacity for delivering personal health services to the poor and underserved, and worry that privatizing will lead to the decay of these capabilities, thereby undermining the safety net: "We have to be careful not to lose our skill base so we can always be there as a safety net." Similarly, some directors said that LHDs have special skills in the delivery of traditional public health services, such as communicable-disease control—particularly with respect to sexually transmitted disease and tuberculosis. Thus, concerns about the loss of public health skills and the impairment of communication are linked with worries about an impaired capacity to respond to epidemics and, more generally, about the erosion of the public health infrastructure.

Discussion

In describing what they believe should not be privatized, directors are implicitly saying that the essential work of health departments involves activities such as communicable-disease control, surveillance, environmental health services, and regulation. All of these services qualify as "public goods," meaning that the benefits of the services cannot be limited to an individual user of that service (Sclar 2000). Environmental health services are a prime example of a public good; it is difficult to exclude anyone from the benefits of clean air and water. By contrast, a "private good" generally takes the form of many separate and individually consumable products or services. One person's or family's consumption of an individual private good is exclusive of another person's or family's

consumption of that same item, whereas a public good is generally available for simultaneous use by the whole community (Sclar 2000).

Many of the most purely public goods, such as environmental health activities involving clean air and clean water, benefit everyone; one does not have to seek out these services in order to benefit. Some analysts argue that such public goods constitute a “natural monopoly,” or lack the incentives necessary for private sector performance, and therefore must be provided by government, whereas private goods can be privatized (Donahue 1989; Starr 1990; Sclar 2000). Like the “core functions” used in public health and in other domains, public goods are often considered a unique purview of government. However, some services or functions have qualities of both public and private goods, an important example being communicable-disease control. Although communicable-disease treatment services do have individual clients or patients, these services benefit others who do not directly use them because the reduction of active cases of communicable disease reduces everyone’s risk of becoming infected. This is analogous to the way that firefighting services can benefit a whole row of townhouses, even if only one family calls the fire department because their house is burning. The infrastructure for providing such public goods needs to be in place regardless of the current incidence and prevalence of the phenomenon in question. By contrast, a personal health service (excluding communicable disease) is a private good, because it primarily benefits only the individual clients receiving treatment, and it is easier to exclude other individuals from these benefits by denying them services. While many directors expressed that public goods such as communicable-disease control, surveillance, environmental health services, and regulation should not be privatized, few indicated that personal health services should not be privatized.

In fact, a majority of LHDs have privatized some personal health services. Many directors maintained that personal health services are not integral to the essence of public health, and have contracted out these services for the purpose of focusing more narrowly on the basic mission of their departments. When directors do privatize specific personal health services, it is often as a means of expanding access. Yet, a large proportion of directors do not believe LHDs should get entirely out of the direct provision of personal health services because that would impair access to these services by the poor and vulnerable. The issue of access primarily relates to personal health services, which are private goods.

Problems of financial or even geographical barriers to access are less relevant to public goods like public water purification or fire prevention. It is easier to encounter barriers to receiving personal health services than it is to be excluded from the benefits of environmental protection and communicable-disease control.

As might be expected from this argument, expanded access to services was the most commonly reported benefit that directors described as positive outcomes of privatization. When expanded access was reported, it always referred to personal health services. In some cases, it might have been possible to expand access by enlarging the department's in-house services. However, many directors observed that the only way LHDs could ensure the provision of certain services would be to contract with private organizations to provide those services. And although some directors did report that privatization hindered the ability of certain groups to receive services, a more common outcome was increased overall access to services.

At the same time, privatization of personal health services sometimes had negative financial ramifications for LHDs and, thus, on their ability to carry out essential public health functions. Some directors reported that a significant proportion of their revenue previously had come from self-generated fee-for-service dollars for clinical services and that these revenues had been used to fund implementation of the core functions. This has been changing rapidly as the increasing penetration of managed care under Medicaid draws Medicaid beneficiaries away from LHDs (Wall 1998).

Many directors believed that delegating certain services to the private sector helped their departments focus on the core public health functions. Half of the directors reported that privatization had a positive impact on the performance of core functions, but it is highly significant that half of the directors found that it did not. Unanticipated consequences of privatization, such as loss of control or impaired information flow, often hindered implementing these functions.

The most commonly reported negative outcome of privatization was loss of control over the performance of services. Indeed, it is costly and difficult to maintain control over contracted services. The directors in our study reported increases in the time and resources devoted to management, administration, and monitoring as a result of contracting, which is consistent with other studies revealing that significant transaction costs often accompany privatization (Sclar 2000). Despite this increased

focus on management, however, approximately one-third of the directors reported some loss of control or greater difficulty maintaining control. In fact, directors who spent the most time on management and administration were the most likely to report problems of control.

Loss of control over public services, such as communicable-disease services, was seen as particularly undesirable, which was one argument directors offered against privatizing services involving communicable disease and environmental health. Control is a critical component of basic public health functions. These functions require an ongoing capacity for problem-solving, as well as for immediate response to sudden disease outbreaks and other unanticipated health crises. Some of the directors' experiences suggest that privatization disrupts the integration of these basic public health functions.

The loss of control over services that often accompanies privatization threatens the capacity of LHDs to carry out the assurance function. As noted in *The Future of Public Health* (Institute of Medicine 1988), "carrying out the assurance function requires the exercise of authority. This is not a responsibility that can be delegated to the private sector." Our findings raise questions about the capacity of LHDs to exercise authority over core public health functions if they are losing the ability to monitor and control services.

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