

From Theory to Practice: What Drives the Core Business of Public Health?

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In 1994, the Public Health Functions Steering Committee proffered a description of the Essential Public Health Services (Essential Services). Questions remain, however, about the relationship between the roles defined therein and current public health practice at state and local levels. This case study describes the core business of public health in Georgia relative to the theoretical ideal and elucidates the primary drivers of the core business, thus providing data to inform future efforts to strengthen practice in the state. The principal finding was that public health in Georgia is not aligned with the Essential Services. Further analysis revealed that the primary drivers or determinants of public health practice are finance-related rather than based in need or strategy, precluding an integrated and intentional focus on health improvement. This case study provides a systems context for public health financing discussions, suggests leverage points for public health system change, and furthers the examination of applications for systems thinking relative to public health finance, practice, and policy.

KEY WORDS: core business of public health, public health finance, public health systems, systems thinking

In 2004, faced with complex systemic and economic challenges and questions from policy makers regarding cost efficiency and duplication of services, Georgia's Division of Public Health (DPH, or "the Division") commissioned an assessment of public health practice within the state. The purpose of the study was to describe the Division's core business, or scope of practice, evaluate its alignment with the Essential Services, and ascertain the drivers of public health practice in the state. Framed within a larger systems context, the findings were intended to inform policy discussions and

strategic planning efforts to strengthen public health practice and improve the health of Georgians within the limits of available resources.

● Study Context

Georgia has a growing population of more than 8 million that is relatively young, diverse, poor, unhealthy, and less educated compared to other states.¹ Using the typology developed by Gostin and Hodge, Georgia has an "embedded" public health system,² with the DPH being one of four Divisions of the Georgia Department of Human Resources. Like many other southern states,³ Georgia has an intermediary district structure between state- and local-level public health. There are approximately 6,000 DPH staff, 18 district offices, and local health departments in each of Georgia's 159 counties.

● Design and Methods

This study was framed on the basis of an extensive review of the literature on public health practice

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assessments and approaches to system change. Multiple data sources and qualitative methods were used to construct a case study of the core business of public health in Georgia. While the basic research questions were practice-based and specific to Georgia's DPH, the study design was based on a holistic orientation—one that considered the Division itself as a complex system embedded within and influenced by even more complex, less well-defined systems related to health and healthcare. This systems perspective significantly impacted the emergent study design, data sources, and analytic methods.

The primary unit of analysis was the state's formal public health agency, while embedded units included state, district, and local infrastructure and activity; the flow of resources through the system; the extent of collaboration; organizational structure; and staff mindset and perceptions. Contextual factors included the political, economic, and regulatory environments, and public financing issues. Perceptions of external stakeholders were also considered in keeping with suggestions that public health systems and practice should value the input of the public to whom the system is accountable.⁴

Data sources included individual interviews, focus groups, and archival documents (ie, financial data, Georgia legal code, prior planning documentation). Using standardized protocols, researchers conducted individual interviews ($n = 69$) and six focus groups ($n = 86$) between June and September 2004 with internal and external stakeholders at the state, district, and local levels. Interview instruments were developed specific for each respondent group. Internal interviewees included district health directors, public health nurses, nurse managers, and state-level staff. A broad range of external stakeholders were chosen on the basis of influence in decision making and representation of the broader system of health: Governor's policy staff, legislators, Department of Human Resources Board, other state agency commissioners, and trade associations. County Boards of Health, healthcare providers, local government, social service providers, educators, and lay citizens participated in the focus groups held in six cities selected on the basis of diversity of geography, rurality, and health system infrastructure. The purpose of the conversations was to understand the perceptions of public health practice, current versus "ideal," including its relationship to the broader system of health.

The qualitative analysis was data-based and inductive, allowing patterns to emerge from the data rather than testing formal hypotheses. Archival documents and transcripts from interviews and focus groups were systematically mined and cross-referenced to define themes. Diverse perspectives and sources made it possible to triangulate the data and test interpretations.

Emergent findings were further tested in discussions with a 12-member Advisory Panel consisting of Division leaders and District Health Directors, a research-practice partnership constructed for the purpose of the study. This combination of methods and data sources helped maintain analytic sensitivity to the relationships, influences, and interdependencies within the Division and the larger public health system.

● Results

Core business

Interview and focus group participants generally perceived the core business to be dominated by the provision of direct personal medical services, eclipsing critical population-based activities. This theme was substantiated by written descriptions of services provided at the district and local levels, local health department Master Agreements, and documentation of trends in public health funding relative to various programmatic areas. Exceptions to this perspective were related to the fact that many external stakeholders at the state level were unable to describe what they believed to be the scope of public health services in the state beyond "services to the poor." Furthermore, state-level staff felt that their activities were relatively more aligned with the Essential Services than was expressed by district and local health department staff.

Compared with current practice, internal stakeholders generally agreed that a more balanced approach to the Essential Services would constitute the "ideal" core business of public health in Georgia. While district health directors preferred a more balanced allocation of financial and human resources across the Essential Services, they described their present practice as directing more resources toward the provision of personal health services at the expense of population-based services. External stakeholders, while limited in their understanding of the field, agreed with the value of prevention and saw a unique leadership responsibility for the Division in improving health in the state.

Business drivers

In spite of the fact that not all participants could clearly define the "ideal" core business of public health in practical terms, all agreed that the definition should be driven by three criteria: population need, evidence of effectiveness, and a statewide strategy that is informed by local input. These "ideal" drivers are in stark contrast to the primary drivers of the current core business that the data suggested were predominantly finance-related: the inherent complexity and categorical nature

of public health funding, declining state investments in population-based services, and broader health system financing challenges related to the uninsured and an increasingly fragile safety net.

Considered in combination, results from the interviews and data from financial and legal documents revealed that the nature and extent of funding for state, district, and local health department activities appeared to most significantly influence the scope and level of strategic intent and integration of public health practice in Georgia. A lack of discretionary resources, the predominance of categorical funding, and the acquisition of money from multiple public and private sources at local, state, and district levels appeared to preclude the desired level of planning and integration desired by stakeholders. This flow of resources into and through the system is highly complex. Because no statewide accounting framework exists, the use of resources was difficult to track, and we were unable to cross reference participants' perceptions of resource allocation relative to the Essential Services with actual financial records.

A review of the Division's financial statements revealed the priority-distorting impact of declining public health funding on the practice of public health in Georgia. State appropriations to the Division decreased by 15 percent from FY2003 to FY2005. Internal and external interviewees explained that performance-based budgeting is being used to determine public funding priorities, resulting in relatively less money appropriated for prevention and health promotion activities for which quantifying outcomes, especially in the short term, is difficult. Based on a ranked list of FY2003 DHR funding priorities, public health infrastructure and public safety receive higher priority rankings than most preventive health initiatives, the obvious exception being that of immunizations (the highest ranked public health preventive service). Furthermore, internal respondents explained that county and district health departments utilize local user fees, including Medicaid reimbursement, to subsidize the cost of population-based services.

Internal and external stakeholders also indicated two broader finance-related factors that act as determinants of the core business: the fragility of the safety net and the rising numbers of uninsured in Georgia. Historical documents and interviewee comments reflected that county health departments have served in a safety net role by providing medical services to uninsured and underserved populations throughout the state. Especially during tight economic times, study participants explained that many people look to their local county health departments as the primary safety net provider, especially in rural communities where the demand for medical care outstrips the supply of providers. Further-

more, local and district public health staff described a situation in which the burden of illness borne by much of the state's indigent, uninsured, and immigrant populations continues to be the responsibility of an already overburdened and underresourced public health system.

Although state and local public health officials differed in their opinions as to what the strategic and programmatic focus of the Division should be, all commented on the need for integrated action by public health leaders at local, state, and national levels. Internal and external stakeholders in Georgia identified a need for greater alignment between those who set policy and those responsible for local implementation. Furthermore, they stated that the Division needs to assume a leadership role in convening other parts of the healthcare sector in a collaborative effort to improve the health status of Georgians.

● Discussion

In summary, the case study revealed that the Division's current core business is not aligned with the Essential Services or internal stakeholder preferences. The results of the interviews, focus groups, and evaluation of archival and documentary evidence suggested that the misalignment between the perceived and desired core businesses is not the result of intentional design, but has evolved *de facto*.

Viewed individually, these findings may not be particularly startling. In fact, it is well documented that barriers exist in translating public health theory into practice,^{4,5} imbalances occur between the provision of direct patient services and population-based activities,⁶⁻⁹ and public health financing is complex and may impact performance.¹⁰⁻¹² Our study attempted to move from describing the state of public health practice to understanding the drivers creating these problems so that high-leverage strategies could be devised to improve the effectiveness of the public health system in a sustainable manner.

Our research revealed that there are underlying business drivers, some originating in the larger health-related system beyond the formal purview of the Division, that contribute to the Division's largely unintentional core business. In Georgia, inherent systemic challenges were found to mediate the translation of the theory into practice. This finding is consistent with a major systems principle, "structure influences behavior," in which structure refers to key interrelationships among resources, feedback, rules, goals, and mindsets within the system as opposed to the construction of an agency as shown by an organizational chart.¹³ Thus, achieving sustained realignment of public health practice with

the Essential Services in Georgia will likely require addressing broader system drivers. System change strategies consistent with this logic might include leading an inclusive process to create a statewide vision and strategy for health improvement; working to “build the safety net rather than be it”; and engaging in local, state, and national efforts to increase access to care and coverage for the un-/underinsured. Such a systemic approach would complement more internally focused, commonly found quality and process improvement strategies internal to the Division.

● Conclusion

Finance-related factors are significant drivers of public health practice. Efforts to further conceptualize public health finance^{14,15} should involve understanding its role from a broader systems perspective, creating an opportunity to examine the application of systems thinking and principles to public health policy and practice.^{16,17} It is important to note, however, that many barriers to accurate financial analysis of state and local public health systems exist. Specifically, our experience supports others’ call for more accurately tracking public health expenditures, both in general and with reference to the Essential Services.^{18–20}

Consideration of our findings within the context of a broader complex system that contributes to public health and provides personal healthcare leads to insights that may be relevant in other states. To use language familiar to public health practitioners, an analogy can be drawn between “upstream” interventions²¹ to affect population health and interventions intended to affect drivers of a complex system. Upstream interventions to address drivers of practice may provide higher “leverage points” as a counterpart to more proximal strategies—changes in organizational structure, internal processes, and staff behavior—to improve public health performance.²² Specifically, efforts to balance the Essential Services, better define the role of public health, and standardize the performance of public agencies through National Public Health Performance Standards²³ and accreditation processes may prove difficult in the absence of broader policy interventions to address drivers specific to each environment.

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