# The Quiet Dismantling of Public Health

## The impact of Pennsylvania state health center privatization and staff cutbacks

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The Keystone Research Center (KRC), a non-partisan think tank with offices in Harrisburg and the Philadelphia area, conducts research on the Pennsylvania economy and labor market. This research documents current conditions and seeks to develop innovative policy proposals to improve state economic, labor market, and social performance.

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# EXECUTIVE SUMMARY

Until 1996, public health staff at a statewide network of 60 Pennsylvania state health centers provided tests for HIV, sexually transmitted diseases (STD) and tuberculosis (TB); treated people with communicable diseases; conducted community outreach to inform, test, and treat others at risk; immunized infants; and investigated and responded to food-borne and other disease outbreaks. These staff, primarily public health nurses, also provided maternal and child health care, injury and lead-poisoning prevention services, and public health advice to child care centers, schools, and physicians. State spending on the state health centers, part of the annual appropriation of the Department of Health, was $15 million in 1996-97.[1]

In February 1996, Governor Ridge proposed the privatization of all Pennsylvania state health centers and the state public health laboratory. Without a feasibility study or cost-benefit analysis, the Governor's office projected that privatization would yield a $1 million savings in the first year and $8 million annually thereafter. The Legislature responded by passing Act 87, which prevented the full-scale privatization of the state health centers and prohibited the Governor from privatizing the state laboratory.

Act 87 allowed the Department of Health to privatize, on a pilot basis, three state health centers for a period of one year. The Department privatized state health centers in Butler, Berks, and Dauphin counties and contracted four clinical services to private bidders:

- HIV counseling and testing;
- immunizations;
- screening, testing, and treatment for sexually transmitted diseases; and
- screening, testing, and treatment for tuberculosis.

Act 87 also prohibited the Department of Health from reducing the "scope of services" at the remaining 57 health centers.

The state Legislature reserved the right in Act 87 to expand or end the privatization projects at the end of their legislated, one-year trial. To assist the Legislature in its deliberation about the future of the state health system, this report evaluates the pilot projects and the status of Pennsylvania's remaining state health centers. This evaluation relies on publicly available documentary evidence and on interviews with 29 front-line public health professionals. This report also compares the number of STD and TB cases in the affected counties before and after health center privatization, and before and after state health center staff cutbacks.

This report finds that the Pennsylvania Department of Health is gambling with the public's health in the following ways:

- The privatization pilots eliminate one-stop screening and treatment of tuberculosis patients. Under the pilot privatization projects, contractors screen patients but hand them off to district office staff for follow-up (and, in high-risk cases, for treatment). Some of these patients fall through the cracks, never receiving treatment, placing the public at risk for outbreaks and the development of tuberculosis strains that will resist current antibiotics.
- Access to sexually transmitted disease services has been reduced in two of the three counties where the health center was privatized. STD visits plummeted 40-50 percent in these counties as services became less accessible. In one of these sites (Dauphin County), reported syphilis cases fell from 35 the year before privatization to zero the year after. Undetected STDs create the potential for future epidemics.
- Standardized and well-established record-keeping and communication channels within the Department of Health has been disrupted. In the pilot privatization projects, contractors' and subcontractors' record-keeping and communication with the

Department of Health have been poor, making early detection and containment of communicable disease outbreaks more difficult.

- Throughout the state, deep-rooted links between public health nurses and local communities that enable the early detection of and rapid response to communicable disease outbreaks have been weakened. These links have been fostered by years of public health service, community outreach, coalition-building, education and home health visits. Increasingly, public health nurses throughout the state health center system are being transferred to multi-county district offices remote from the communities they serve.

- The number of adequately staffed state health centers has declined. Despite Act 87's prohibition on reducing the scope of services, half of the 57 remaining state health centers, many in rural areas, have experienced staff cutbacks since 1995. Some of these centers have lost 50 percent or more of their nurses.

- Quick response to potentially dangerous public health situations and to more routine inquiries are now less likely. In health centers with fewer staff, it may take nurses several days to attend to even high priority problems such as food-borne outbreaks.

- Years of public health practice and experience are not being passed down to new generations of nurses. More new recruits are now placed in one-nurse clinics without adequate training and mentoring.

The privatization pilots have weakened the public health system, but there is no evidence that they have saved money. The Department of Health has not measured the cost of monitoring and administering private contracts or of providing contractors with technical assistance. Nor does documentation exist on what costs the Department of Health has avoided as a result of contracting out the delivery of clinical services.

In the privatization pilots, moreover, the government is vulnerable to double billing since the names of individuals who receive confidential services are not reported to the Department of Health. A contractor could bill both the Department of Health and the Department of Public Welfare (under the Medicaid program) for the same service. A perverse financial incentive also exists for private contractors to ask patients to make separate office visits for HIV and other sexually transmitted disease services. (With separate visits, the provider receives higher reimbursement for HIV counseling.)

While a primary goal of the 1996 Department of Health proposal to privatize the public health system was to cut costs, eliminating the entire state health center system would save roughly $1.25 per Pennsylvania resident. Moreover, the research literature suggests that focusing on cost-cutting leads to the failure of public health privatization.[2] (See Box 3, page 26.) Privatizing the public health system solely to reduce costs is short-sighted, uneconomic, and potentially hazardous to our collective health.

Pennsylvania's public health system should not be dismantled quietly. The future of the state's public health system should be decided only after open, thoughtful debate among public health professionals, advocates, the Legislature and policymakers, all of them informed by rigorous evaluation of the alternative approaches the state could adopt. The following recommendations outline how Pennsylvania might adopt a new and more considered approach to protecting the public health.

## 1. Phase out the privatization pilots.

The privatization pilots in Berks, Butler, and Dauphin counties should be ended and the state health centers in these counties reopened. These actions should be taken because of operational problems with the pilots and the lack of demonstrable cost savings. The pilot projects also appear to have been extended without proper legal authority. While Act 87 specified that they were to last one year, they were extended simply by an executive order from the Secretary of Health.

**2. Conduct an assessment of the capacity of the Pennsylvania public health system to monitor health problems and respond to outbreaks.**

At the request of any state, a national council of state epidemiologists will help a state assess its public health capacity in three areas: surveillance and monitoring of health problems, crisis response, and use of epidemiological data to evaluate and guide policy. To date, at least 10 states, but not Pennsylvania, have requested that a public health capacity assessment be conducted by an outside team of experts. The Department of Health should request an external assessment of the entire Pennsylvania public health system. The assessors should be asked to comment specifically on:

- the adequacy of staffing levels, including at health centers where cutbacks have occurred;
- the importance of retaining a network of health centers distributed throughout the state; and
- whether additional inferences can be drawn from epidemiological data about the impact of the health center staff reductions or pilot privatizations.

Outside experts from the national council require only one week in a state to conduct a capacity assessment. It should, therefore, be possible to have an assessment completed by the end of January 1999; that would allow the Legislature to draw on the findings of the assessment during the appropriations hearing process.

**3. Require the Department of Health to raise staffing in state health centers.**

Declining staffing in state health centers undermines the effectiveness of the public health system. Once the capacity assessment outlined in recommendation two is completed, the Department of Health should raise staffing at health centers back to the levels necessary to restore service to 1995 levels (consistent with the intent of Act 87). Most of the necessary staff can be supplied by reassigning public health nurses from newly created district-level positions, where they are isolated from the communities they serve.

**4. Conduct an independent study of best practice in public health service delivery in other states and cities.**

The Legislature should commission an independent study of best practice public health systems, within which managers have aimed to make public health agencies more effective not to eliminate them. The study should include public health systems that have implemented "reinventing government" approaches. The goal should be to find ways of working *with*, not against, the Department of Health public health professionals, tapping into their professional commitment to protect the public health. The recommendations of this study should be delivered before any additional public health privatization is undertaken.

**5. The Office of the Auditor General should conduct an audit to provide an objective analysis of the true costs of the privatization pilots.**

The Department of Health has not collected the information necessary to conduct a meaningful audit of the costs of the privatization pilots, even though saving money was the justification for privatization. An audit by a third party, unconnected with the Department of Health, would help answer questions about the true costs of privatization. It would also be helpful for the Attorney General's office to render a legal opinion as to whether the extension of the privatization contracts can stand on executive authorization by the Secretary of Health without specific legislative authorization amending Act 87.

**6. Conduct hearings to define a Pennsylvania public health strategy for the 21st century.**

After implementing recommendations three through five, the Pennsylvania Legislature should conduct joint bipartisan hearings to define a Pennsylvania public health strategy for the future. These hearings should address basic questions about the goals of the public health system and how best to achieve those goals, including what should be the balance between public and private service delivery and what core public health functions government does best.

# I. INTRODUCTION

**What state health centers and the state laboratory do.** Prior to 1996, public health staff at a statewide network of 60 Pennsylvania state health centers provided tests for HIV, sexually transmitted diseases (STD) and tuberculosis (TB); treated people with communicable diseases; did community outreach to inform, test, and treat others at risk; immunized infants; and investigated and responded to food-borne and other disease outbreaks. These employees, primarily public health nurses, also provided injury and lead-poisoning prevention services; maternal and child health care; and public health advice to child care centers, schools, and physicians. The state public health laboratory conducts highly specialized, low-volume tests for diseases that pose a threat to the public health (such as tuberculosis, rabies, food-borne illnesses, and legionella).

State health centers operate throughout Pennsylvania, although 10 municipalities and counties have their own health departments (Allegheny, Allentown, Bethlehem, Bucks, Chester, Erie, Montgomery, Philadelphia, Wilkes-Barre, and York). Operational since 1952, state health centers' investigative work in preventing outbreaks is based upon long-standing relationships, formal and informal, in their communities.

**Privatization.** In February 1996, Governor Tom Ridge proposed contracting out all public health services, including the state laboratory, to private entities. The Governor's office and the Department of Health claimed that taxpayers would save $1 million during the first year and more than $8 million annually thereafter.[3] The six Department of Health district offices, they maintained, could provide non-clinical services without any loss of quality.[4] The Ridge Administration also argued that the job of the Department of Health is to "implement, oversee, and coordinate" services rather than to deliver them directly in competition with the private sector.[5] "Hands-on, direct patient care is not a core function of the Pennsylvania Department of Health," said a departmental spokesperson.[6]

No study had preceded the Governor's proposal. No analysis was presented to document the necessity of shrinking the Pennsylvania Department of Health, which already ranked 49th out of 50 states in employees per million population (Figure 1).

**The opposition to privatization.** The Governor's plan encountered an outpouring of opposition throughout the state from public health professionals, advocates, legislators, and newspaper editorial writers. An ad-hoc coalition of nearly 100 organizations and individuals (including the American Lung Association of Pennsylvania, the American Association of Retired Persons, the National Association for Professionals in Infection Control and Epidemiology, the Pennsylvania Nurses' Association, and over 30 County Commissioners) voiced opposition. (See Appendix A for a list.) The first public airing of these concerns took place on March 11, 1996, at a hearing convened by the House Health and Welfare Committee at the State Capitol.

**Act 87.** Following the hearing, bipartisan legislation aimed at stopping the privatization proposal was introduced in the Pennsylvania House of Representatives. The measure passed the House unanimously with a vote of 198-0. The House bill was then sent to the Senate Health and Welfare Committee, where it was amended to authorize a pilot privatization project. In this pilot, the Department of Health would be permitted to privatize three public health centers for one year. The House of Representatives concurred and the Governor signed Act 87 in April 1996. Under Act 87, the Department of Health was required to keep the other 57 health centers open and to "provide at a minimum those public health services in effect as of July 1, 1995." The state laboratory was not to be privatized. The law also required that an evaluation study of the pilot privatization projects be conducted and submitted to the Legislature by December 31, 1997, so that the Legislature could decide whether the pilot projects should continue and whether other health centers should be privatized.

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**Figure 1: Pennsylvania's Department of Health Already Has Very Few Employees**

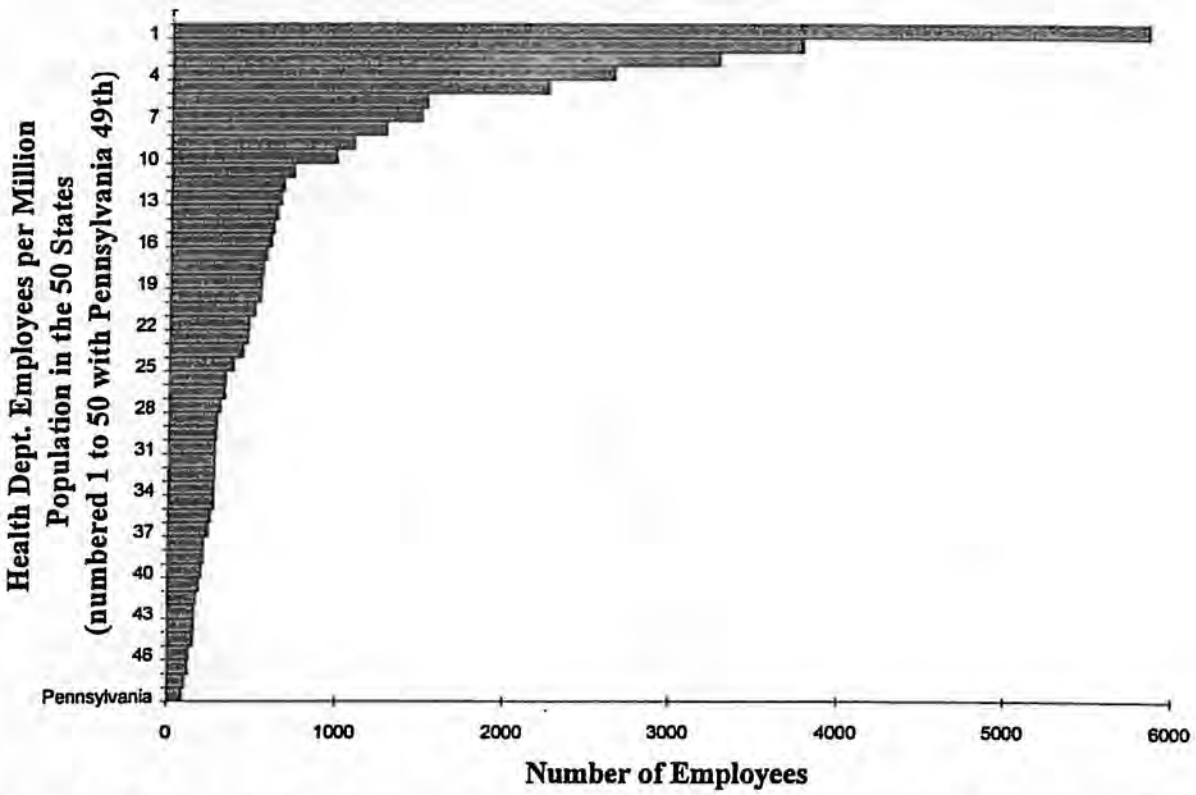



Figure 1 shows that Pennsylvania has 91 employees per million state residents in its state Department of Health. Hawaii, the top bar in the figure, has 5,804 employees per million state residents in its state Department of Health.
Source: Centers for Disease Control and Prevention web page.

**The pilot privatization projects.** The Department of Health chose the counties of Berks, Butler and Dauphin for the privatization projects. In these three counties, the existing health centers were closed and private organizations were contracted to provide clinical services in four areas: immunization, tuberculosis testing and treatment, STD testing and treatment, and HIV testing and counseling. The contracts were awarded to the Berks Visiting Nurses' Association, Butler Memorial Hospital, and the Dauphin Visiting Nurses' Association. The University of Pittsburgh's Center for Public Health Practice was awarded a non-competitive contract to evaluate the privatization pilots.

Evaluating the impact of changes in public health policy is inherently difficult (Box 1). To facilitate evaluation of the pilot projects, the University of Pittsburgh matched the three pilot counties with "similar" counties in which privatization did not take place. Butler was matched with neighboring Armstrong, also a rural county. Carbon was matched with nearby Berks, partly on the grounds that both are largely suburban. Dauphin and Luzerne, which contain the cities of Harrisburg and Wilkes-Barre, respectively, were also matched. The hope with a quasi-experimental design of this type is that the "other" factors (social, economic, epidemiological) that influence public health are the same in the pilot and matched counties. If that is so, differences observed in public health trends might be attributed to the impact of privatization.

**Box 1: The Challenges of Public Health Policy Evaluation**

Evaluating the impact of privatization experiments (or other policy changes) on the public's health is inherently difficult. Many factors influence public health: social values, the extent of poverty and malnutrition, the accessibility of health care, the evolution of new strains of infectious diseases, as well as public health policy and the strength of the public health infrastructure. A central challenge is separating the impact of any single factor from that of other variables.

Increasing the complexity, outbreaks of communicable diseases have a long fuse. Declining accessibility of public health services or failure to complete treatment cycles for TB patients may not lead to worsening health problems for several years.

Finally, evaluations of the health of the community are only as good as the data collected by public health authorities. If the incidence of certain problems declines when staffing falls or services become less accessible, has health improved or reporting on problems simply deteriorated? Often, no one knows.

The challenge of interpreting the "hard" numbers increases the value of interviews with public health professionals. These interviews permit grounded analysis of whether privatizing service delivery or shifting staff from state health centers to district offices has improved or weakened the public health system. Using a combination of quantitative, interview-based, and documentary evidence, as this report does, permits each source to be used as a check on the accuracy and plausibility of the others.

One problem with this quasi-experimental design is that the combined population of the three matched counties is only 60 percent of the combined population of the pilot counties.[7] While Berks County had a population of 359,000 in 1995, for example, Carbon County had a population of 59,000. Second, even before privatization, three major STDs (chlamydia, gonorrhea, and syphilis) were only 4-18 percent as prevalent in the matched counties, as a group, as in the pilot counties. (See Section V below.)

In light of these limitations of using the individual matched counties as controls, the University of Pittsburgh created a multi-county control group for each of the pilot counties. An "urban cluster" control group for Dauphin County included Beaver, Delaware, Berks, and Dauphin Counties. A "suburban cluster" control group for Berks County included Carbon, Cumberland, Lebanon, Montour, and Washington Counties. A "rural cluster" control group for Butler County included Armstrong, Indiana, Mifflin, Monroe, Perry, Snyder, Union, and Wyoming Counties.

Even the cluster county approach cannot overcome two other obstacles to evaluation posed by the design of the pilot privatization projects. (1) Two of the three pilot counties (Dauphin and Berks) contain district offices and the third pilot county (Butler) is adjacent to Allegheny County, where the southwest district office is located. The closing of state health center offices may have more consequences for health service quality and accessibility in counties that neither contain nor are adjacent to counties with district offices. The technical assistance provided to pilot project contractors by district offices could be more difficult to deliver to outlying counties.

(2) The pilot projects took place in the context of reductions in state health center staff. Staff reductions took place in all three of the matched counties and 10 of 17 "cluster counties" (including eight of nine in the urban and suburban cluster groups). This means that the pilot projects are not being compared with the state health center system as it existed prior to 1996 but with one that may have been weakened by reorganization and staff cutbacks.

In light of problem (2), when this report analyzes data on communicable disease trends, it constructs two new comparison groups in addition to reporting data on the pilot, matched, and cluster counties. The first new comparison group includes all counties in which

staff reductions took place. We call this group the "cutback counties." The second new comparison group includes a residual collection of "other counties" that did *not* experience staff cutbacks. This "other counties" group, which also excludes the pilot counties, matched counties, and Allegheny and Philadelphia Counties, is arguably the best control for the three pilot counties taken together. It should be noted, however, that the "other counties" group is still not an ideal control for the pilot counties because fully-staffed counties now often loan staff to neighboring short-handed counties. Finally, trends in Philadelphia and Allegheny Counties, which contain Pennsylvania's two largest cities, are worth comparing to those in Dauphin County, which contains the city of Harrisburg.

**The University of Pittsburgh's initial evaluation,** submitted on December 19, 1997, shed little light on the result of the privatization pilots. The University evaluation team argued that a second year of data collection and experience was necessary before a definitive opinion could be rendered. The December 31, 1997 deadline passed without the Legislature extending the privatization pilots. In the spring of 1998, the Secretary of Health extended funding for the pilot projects by executive authority.

**Overview of this report.** To aid the Legislature in its deliberation about the future of the state public health system, this study evaluates the pilot projects and the status of Pennsylvania's 57 remaining state health centers.

This report relies primarily on three kinds of evidence: (1) interviews with public health professionals within the Department of Health and from state health centers around the Commonwealth; (2) evidence from Department of Health internal documents, including audits of the privatization pilots; (3) data on reported cases of TB and STDs before and after the pilot privatizations and the state health center staff cutbacks.

Lopez interviewed 19 Department of Health employees (representing a range of views on public health privatization) responsible for supporting, assisting, or monitoring the privatization pilots at either the district or central office level. He also interviewed a physician and a nurse from one of the pilot project clinics. Finally, he conducted 10 interviews with public health nurses who worked at a random sample of 10 of the state health centers that have experienced staff reductions since 1995.

All interviews were conducted by telephone. No interviews were conducted during respondents' work time; several respondents chose to participate in interviews during a lunch break, while most preferred to be contacted at home during non-work hours. Every Department of Health employee interviewed agreed to participate in the research on the condition that his or her identity would remain confidential in the final report.

# II. EVALUATING THE PRIVATIZATION PILOTS

### A. The University of Pittsburgh's initial report

Act 87 required the Department of Health to submit an evaluation of the first year of the privatization pilot projects to the Pennsylvania Legislature by December 31, 1997.[8] To fulfill this obligation, the Department of Health contracted with an "Evaluation Team" of six researchers from the University of Pittsburgh's Center for Public Health Practice. The evaluation team submitted its "Report on Year One of the Community Health Project" on December 19, 1997.

The University of Pittsburgh's first report does not actually evaluate the privatization pilots. It argues that "Year One of the Community Health Project was not enough time to produce an adequate level of data and experience to make an evaluation as detailed and thorough as the one mandated by Act 87."[9] According to the report, data collection did not progress satisfactorily until near the end of the first year. The University of Pittsburgh study concludes that the official evaluation of the privatization pilots "should be completed based on a full year's experience – beginning after the start-up period – so that definitive conclusions about feasibility, effectiveness, and costs can be drawn."[10]

While not rendering any definitive conclusions, the University of Pittsburgh evaluation does note that a number of "barriers, issues, and problems" arose in Year One, in areas such as

> recruitment and training of contract site personnel, establishing methods of publicity and public information, creating essential service interfaces between the Department of Health and the local providers, identifying clients eligible for the Community Health Project, [and] equipping TB facilities.[11]

The University of Pittsburgh report also refers to "serious gaps in the provision of . . . diagnostic, epidemiological follow-up, counseling, and case management services."[12] The report observes that the Department of Health found it necessary in Year One to provide local providers with a great deal of technical assistance and instruction in areas including "record-keeping; chart reviews; reimbursement, billing, and client eligibility considerations; publicity and/or public information requirements; and special public health considerations for dealing with communicable diseases."[13]

The University of Pittsburgh report speculates that many of the problems observed in Year One may be transitional ones. It also maintains that "changes as significant as the [privatization pilots] cannot be realized without a certain amount of confusion."[14] In interviews, however, public health professionals maintained that the damage done to the public health during such periods of confusion may not be easily reparable. According to one Department of Health expert on the epidemiology of sexually-transmitted diseases, "communicable diseases do not wait until you have gotten things straightened out. If you get behind you may never get caught up."

### B. Research findings from the front lines

In spring 1998, Lopez interviewed 19 Department of Health employees who worked in pilot county district offices or other Department of Health positions. These employees provided data on the numbers of clients served in pilot counties before and after privatization and on the costs of contractual services. Lopez also reviewed Department of Health audits of the privatization pilot project clinic sites conducted in fall 1997. These audits were completed before the University of Pittsburgh report was released but were not discussed in that report.[15] Interviews conducted and documents reviewed revealed problems in six areas.

1. <u>Public-private communication and coordination problems</u>

Successful early detection and containment of communicable disease outbreaks depend upon the collection of up-to-date information about the health of the community. Under Pennsylvania's traditional system, public health nurses at state health centers combine information-gathering and clinical functions. In the privatization pilot projects, these responsibilities are divided between private contractors and the Department of Health. Dividing public health monitoring and clinical responsibilities makes accurate data collection and record-keeping by contractors, and effective and reliable

communication between contractors and the Department of Health, critical to the Department's ability to detect and respond to emerging public health problems. Contractors, however, are rewarded for seeing and treating individual clients; they have neither the incentive nor the training to use clients as sources of information for profiling the public's health.

In the privatization pilots thus far, problems have been experienced with both contractor record-keeping and contractor communication with the Department of Health. The Department of Health's internal audit of the privatization pilots found that client records were in very poor condition. At St. Joseph's Hospital in Berks County, for example, the audit gave poor ratings to 67 percent of STD client records for review of medications (including allergies to medications), as well as to 65 percent of client records for review of sexual activity.[16] In its review of client records at Polyclinic sites in Dauphin County, Department of Health evaluators likewise commented on a "significant lack of documentation at all three clinic sites."[17]

The internal audits also revealed communication problems between contractors and the Department of Health. A contractor in Dauphin County, for example, failed to notify the Department of Health district office about several TB patients who were "lost to follow-up."[18] These TB patients disappeared off the radar screen of the public health system. The evaluators went on to say that in Dauphin County,

> communication between the clinic and the [TB] registry has been minimal.[19] The . . . [Department of Health] district office has not been kept informed when patients are started on therapy or when medications are stopped. The [Department] is also not informed when patients are discharged from treatment. This information is critical for updating the registry. Reports required by the Tuberculosis Control Program cannot be completed without accurate information from the clinic.[20]

A Department of Health employee identified another communication problem. Under the old system, physicians reported cases of TB or suspected TB to the Department of Health via state health centers. While still required by law to do this, many private physicians now report TB to the privatization pilot contractor instead. "Now we have to wait for the contractor to report it to us," this respondent said. "For the Department of Health to be in a position to monitor TB in the community, we need to know sooner rather than later."

2. More TB patients may be lost to treatment

In the non-privatized state health center system, public health nurses are responsible for all interaction with patients suspected of having TB, including:

- Initial examination and skin tests (if tests are positive, treatment may be needed even though it may take weeks to ascertain that the patient has TB);
- Contact investigations (to find out who has come into contact with the person who may have TB, so that those people can also be tested);
- Treatment (preventive therapy for patients who can be counted on to take their treatment unsupervised and Directly Observed Therapy (DOT) for "non-compliant" patients (Box 2)); and
- Follow-up required to find patients who have stopped receiving treatment.

Continuity of service delivery through all these stages of treating TB builds rapport with patients. The same public health nurse who initially sees and tests the suspected tuberculosis patient usually conducts Directly Observed Therapy if it is necessary. If, for some reason, a DOT patient does not turn up at a pre-arranged meeting place, the nurse is responsible for locating the patient. The patient's relationship with the nurse increases the probability that patients will cooperate with contact investigations and complete their extended treatment, critical to containing the spread of TB (Box 2).

In the privatization pilots, Department of Health staff in district offices retain responsibility for contact investigations and follow-up when patients stop receiving treatment. Contractors were originally supposed to conduct initial examinations and skin tests, preventive treatment for compliant patients, and DOT. Early in the privatization process, however, Department of Health officials estimated that delivering Directly Observed Therapy through private vendors would be more expensive and decided to have Department of Health personnel in district offices perform most DOT.[21]

**BOX 2: WHY IT IS SO IMPORTANT – BUT DIFFICULT – TO ENSURE THAT ALL TB PATIENTS COMPLETE THEIR TREATMENT**

Since TB is spread through the air, a single patient can infect many other people. Contracting the disease ordinarily takes sustained, continuous contact, but children and those with compromised immune systems are more susceptible. In addition, failure to complete the treatment regimen can lead to the development of drug-resistant strains of TB. (These strains, which are costly and difficult to treat, are a worsening problem according to the U.S. Government's Centers for Disease Control and Prevention.[22]) For these reasons, the public health of the community as a whole depends on making sure that all those who may have TB complete the entire course of treatment.

Directly Observed Therapy, under which an outreach worker or a nurse delivers TB medication daily or biweekly and watches to make absolutely sure the patient takes it, is a critical aspect of the fight against TB. DOT is often necessary because of the complicating circumstances that impede treatment of some TB patients. One Department of Health employee explained:

> A lot of our clients are not inclined to be treated for [a complete treatment regimen of] six months. These are typically people who are impacted by a range of problems which impede their seeking out help on their own. . . . You're likely dealing with a 55-year-old alcoholic with schizophrenia who may *also* have tuberculosis.

The fact that many patients who have active TB do not feel sick also makes it difficult to convince them of the necessity that they take their medicine so often, so faithfully, and for so long. Finally, it is difficult for suspected TB patients to accept that their close friends and associates must be contacted and evaluated for TB.

There have been several problems with the current public-private division of labor in the TB program. First, some contractors have delivered low-quality clinical services. According to the Department of Health's internal quality assurance audit, contractors gave treatment regimens not meeting American Thoracic Society standards to a number of TB patients in Dauphin County. In Butler County, patients receiving preventive therapy for TB were not evaluated for HIV, as was previously done by public health nurses. HIV patients are at increased risk for TB and require more extended treatment because of their compromised immune systems -- 12 months of preventive therapy instead of the usual six months. Because preventive therapy TB patients were not being evaluated for HIV in Butler, HIV-infected patients may have received improperly brief TB therapy.

Department of Health employees in the field also believe that the new arrangement, which requires contractors to hand TB patients off to the Department of Health for contact investigations, Directly Observed Therapy, and patient follow-up, is less efficient than the former one-stop public service delivery.

> When we get [TB] referrals from the project clinics, we then have to go out and interview them ourselves. We end up asking a lot of the same questions that the patient has already answered in the clinic, if only to confirm the information they've passed on to us. It duplicates effort and it annoys the patients.

A related issue is that rapport with the patient, critical to obtaining the patient's cooperation, has to be established all over again. One Department of Health employee commented:

> The patient builds up a rapport with the providers in the clinic. If he's then referred to the Department of Health for follow-up, the person who does the contact investigation [or DOT] does not have rapport with the patient. And the patient often feels that confidentiality was lost. Suddenly, a person that the patient does not know is interviewing the patient's friends. As a result, we lose more patients to follow-up.

3. Breaking Department of Health links with local communities

In the three pilot counties, non-clinical functions performed by public health nurses have been transferred to Department of Health district offices (each of which serves about 10 counties). To help meet increased workloads at district offices, according to our interviews, public health nurses from each of the defunct state health centers have been given new district office positions.

The Department of Health in March 1996 maintained that public health nurses can perform the non-clinical parts of public health better, or as well, from district offices.[23] Our interviewees responded that public health professionals rely on local knowledge of community resources and direct relationships with local actors. Both, they said, would be difficult to maintain under a system that centralizes all non-clinical public health functions in district offices.

Effective public health service requires an intimate knowledge of local resources, which cannot be easily maintained under the privatization pilot project model. People call state health centers with questions regarding a wide range of health problems, not all of which are the responsibility of the Department of Health. State health center nurses said that when health centers cover relatively small geographical areas, they can effectively direct callers to appropriate local services:

> People turn to the state health centers all the time on many different issues, not just for clinic services . . . . Anything to do with health -- even if we don't know it, we know where to direct them.

Public health nurses contend that Department of Health staff will not remain adequately informed about these local resources without a permanent local Department presence. According to one nurse:

> The state health center nurses know who the resources are. [Since] county resources change all of the time, it's really difficult to keep a resource list current for 10 counties without someone in that county. If you're not in that county, it doesn't take too long before you don't know what resources are out there.

Nurses also view a strong rapport with the community as an invaluable aid to the prevention of disease and the maintenance of public health:

> Usually in the counties you've built up a relationship with the infection control nurses in hospitals. You're not just an unfamiliar name, calling up. It's a two-way street of cooperation. They call you and you call them. You build a reputation for being reliable. Because of this, for example, in my own county, the infection control nurse at a local hospital has alerted us about food-borne outbreaks. Instead of waiting for lab samples to come back, they alerted us. They didn't know what it was but they knew they had people coming in that had attended the same function that had similar symptoms. And they called us because we had an ongoing relationship. Even building a relationship with the secretary at the lab at the local hospital can be important. There's a secretary there who usually calls our office about salmonella or giardia instead of just mailing to us, which enables us to get a jump on things. How could you build and maintain these kinds of relationships in a dozen counties from the district office?

Close relationships with local communities themselves can also be very important:

> The Amish and Mennonite communities don't trust strangers . . . If there is ever an outbreak of communicable disease, I have a history of working with them. There is a trust that I have built up, and there's no substitute for that.

Familiarity with the county can also be central to nurses' ability to perform the routine, everyday public health services the community expects:

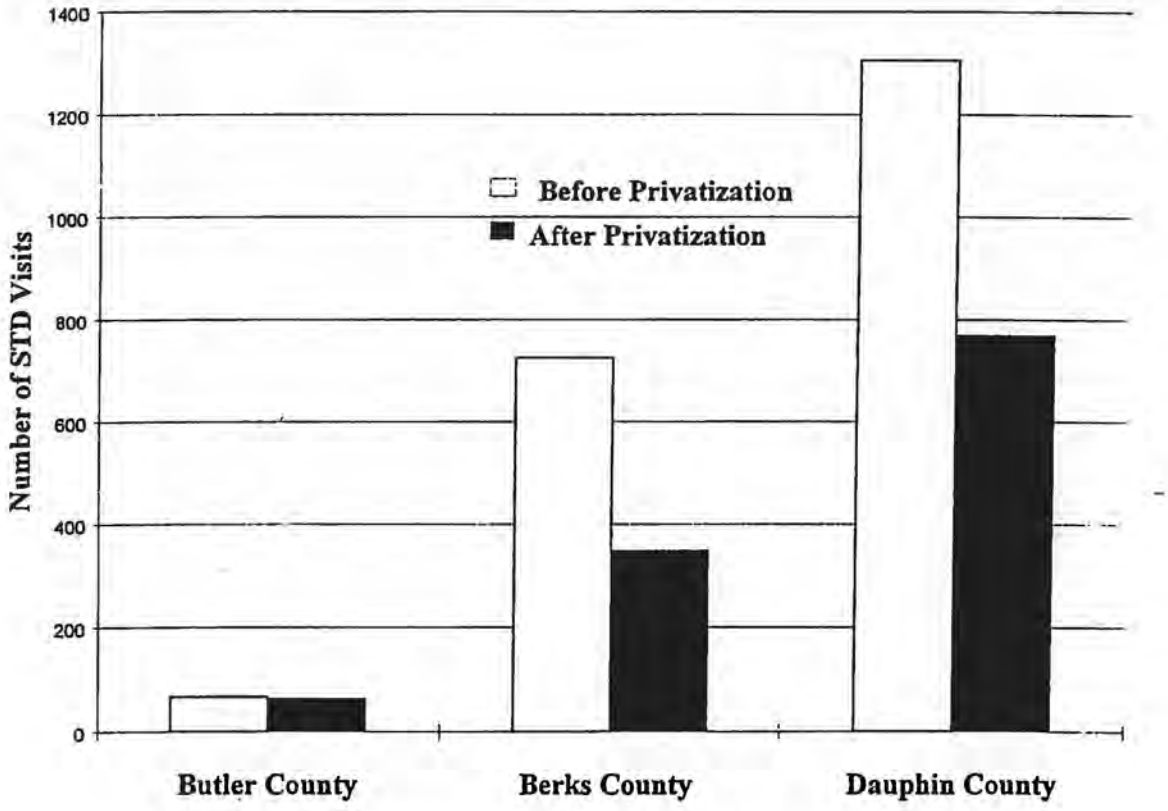
> Several years ago I had a day care in my county with a giardia outbreak. I knew that a number of kids in that day care were from other counties. So I knew right away that I had to alert people outside the county, and I knew exactly who to contact. Had I just been covering from another county, or working out of the district office, I wouldn't have known that.

4. Accessibility

Even prior to the privatization pilot projects, Department of Health contracted some clinical STD services to private sector providers. When private sector providers replace the entire state health center, however, the ability of the public health system to respond to problems with contractors diminishes. Developments in Dauphin and Berks counties during the first year of the privatization pilot projects illustrate that private contractors can experience unexpected problems (such as cash flow difficulties or ownership instability). They demonstrate that it can be hard for the Department of Health to respond quickly to these sorts of problems if public provision of public health services has been completely eliminated.

Figure 2 compares the numbers of STD visits in each of the three pilot counties in March-August 1996 with the corresponding numbers for the same months in 1997. In the three counties as a group, STD visits fell 44 percent, compared to 9 percent in the matched counties (Armstrong, Carbon, and Luzerne).

**Figure 2: Number of STD Visits in the Three Pilot Counties Before and After Privatization**




**Before privatization: March - August 1996**
**After privatization: March - August 1997**

Source: Department of Health request for proposals #95-07-26, 1996; Department of Health contractor billing statements, 1997.

The number of sexually transmitted disease visits in Butler County remained almost identical from one year to the next, even though STD services were shifted from the state health center to Butler Memorial Hospital. In the other two pilot counties, the numbers of STD visits plummeted. In Berks County (where a popular Spanish-speaking physician left and the hospital providing most of the STD services changed hands),[24] STD visits declined by 52 percent. In Dauphin County, the main STD service provider (Planned Parenthood) experienced financial problems unrelated to the privatization pilot projects, which forced drastic cuts in clinic staff and hours. STD visits in Dauphin County fell by 41 percent.[25]

Department of Health employees said that maintaining the provision of STD services at the state health center would have enabled a more effective response to the special circumstances in Berks and Dauphin counties:

> With the combination of an outside contractor and our state health center, we could have . . . expanded our state health center services. Whereas the VNA [the privatization pilot project contractor] was forced to look for another contractor.

In Berks County, the state health center had already discontinued STD services several years before. In this instance, a Department of Health employee noted:

> Again, we'd have had more options had there been a healthier mix [between public and private] to begin with. You'd have physicians under contract already, you'd have trained nurses, and so on. But now you're trying to start from scratch each time there's a problem.

Department of Health employees told us that in both Berks and Dauphin counties, privatization project contractors made good-faith efforts to find new subcontractors who could fill the void created by primary subcontractors who were experiencing difficulties. New subcontractors, however, were incapable of providing high-quality services quickly. As a result, in Dauphin County, Department of Health quality-assurance evaluators found that four of five clinics that were now supposed to provide STD services were not accepting STD visits in late 1997; instead, STD inquiries were being referred to Planned Parenthood. The fifth clinic, Hall Manor, was to have provided free STD services, but was instead offering an appointment for an STD exam for a fee of $20.00 (as well as giving clients referrals to the free STD services at Planned Parenthood).

At the Kline clinic, one of the three Dauphin County sites run by Pinnacle Health-Polyclinic, Department of Health evaluators were told that the clinic had not seen any STD patients under the contract and that it had received no inquiries for service. But Department of Health evaluators attempting to make appointments at each of the three Polyclinic sites reported that:

> On Tuesday afternoon, a Spanish-speaking male and an English-speaking female attempted to make arrangements to be seen in each of the appropriate clinics. In the first call to the Kline clinic, they were told to call the Adult clinic, where no one answered the phone. The call to the OB-GYN clinic at 3:41 pm resulted in being placed on hold for four minutes, at which time the caller terminated the call. Again we were told by the nurse manager of the Kline clinic that no inquiries for service had been received.[26]

Accessibility problems also arose when private providers reduced staffing in privatization pilot project clinics or changed scheduled clinic times. In one hospital-based STD clinic, for example, the privatization project began with one doctor, two nurses, and a clerk. This was later reduced to one nurse and one clerk. According to a Department of Health source, during clinic hours the physician who has responsibility for the clinic is usually elsewhere in the hospital.

Changing clinic hours at the hospital is also a problem:

> The time was [initially] set up for Friday afternoons, which was fine. But the time wasn't convenient for the doctor, so they changed it to Friday morning from 9 am to 11 am. [They changed it again and] now it's 11 am to 1 pm.

These changes were made even though after-school hours are a convenient time for teenagers. Furthermore, word of mouth is an important source of

information about these clinics, especially among teenagers who are at high risk for many sexually transmitted diseases. One Department of Health employee said, "You can't have people wondering when or where [an STD clinic] is, or they won't go. They're not going to seek information about it."

In the end, the combination of poor or no service delivery by new subcontractors and problems experienced with Planned Parenthood and St. Joseph's Hospital led to the drop in patients seen in Berks and Dauphin Counties. The failure to see these patients raises the risk of future STD epidemics in these communities.

5. Oversight

Under the pilot projects, the primary contractors to the Department of Health in Berks and Dauphin Counties subcontract portions of their responsibilities. This makes Department of Health oversight difficult. One Department of Health employee said:

> We're now forced to monitor somebody else's people, people over whom we no longer have direct authority . . . I can go to any state health center any time I want to see what's going on. But we can't just drop in on [subcontractors] when they're doing a clinic. The [primary contractor] doesn't want us to do it. They don't want us to see if something is wrong. We don't have the level of control that we should have.

Department of Health staff view this level of oversight and control as critical because of the need for contractors and subcontractors to follow appropriate procedures, particularly with respect to communicable diseases.

A second oversight issue raised by these contracting and subcontracting arrangements concerns billing. It is impossible to know whether the Department of Health is being billed correctly under the privatization pilot projects. Pilot project contracts require that private providers determine a client's insurance or Medical Assistance eligibility before providing "free" services. But because of the anonymous nature of the service, the Department has no way to verify that double billing is not occurring. One source explained:

> How do I know that they didn't bill the Department of Health *and* Medical Assistance? How can you check? Who's going to monitor that? What the [Department of Health] gets is a number of clients seen by that facility and that's what payment is based on. Now, I don't know if they double-bill or if they don't double-bill.

Another source confirmed that there is no way to track double billing.

The manner in which subcontractors structure office visits under the Sexually Transmitted Disease and HIV programs presents another billing issue. When clients request the complete battery of STD services, HIV testing and counseling are supposed to be included. The Department of Health then reimburses the provider in a lump sum under the STD program. If clients come in for HIV counseling and testing only, however, the provider can bill the Department of Health at a higher rate under the HIV program. One Department of Health source said:

> I was told by one clinic that they didn't do HIV on the same day as STD even when it's requested by the client. . . . How would you track that? The bills go to two separate programs and there is no way to cross-check.

Furthermore, requiring patients to make two separate visits for clinical care, especially for sensitive issues like HIV and STD counseling, means that some people will not return for the second visit.

A final oversight problem concerns physical conditions of clinic sites. One employee of the Health Department, commenting on the physical condition of a private provider's tuberculosis clinic, said:

> There has been a real problem with getting [the contractor] to come into compliance with . . . CDC [Centers for Disease Control] recommendations [for air filtration devices]. [They made some changes] but it still isn't adequate. The exhaust fan is in the bathroom and the bathroom door has to stay open. Also the air is being drawn from the waiting room to the examining room.

Department of Health auditors criticized another TB clinic site's physical location in Dauphin County's Pinnacle Polyclinic Medical Center.

> [To get to the clinic] we passed a waiting room with numerous people seated and walked through a hallway with many people congregating. An infectious patient could have the potential of passing germs on to numerous people prior to ever reaching the actual tuberculosis clinic.[27]

Employees commented that the Department has complete control over how state health center TB clinics are set up physically and how they are run. The Department of Health requires that state health center clinics meet Centers for Disease Control physical layout guidelines. It is difficult, officials told us, to ensure that private providers meet these guidelines.

6. Costs

Determining the actual costs of the privatization pilot projects is a complex issue. It would be misleading to compare the budget of a defunct state health center with the cost of a privatization pilot project contract because the pilot project contractors are responsible for only a small subset of the tasks originally performed by state health centers. The University of Pittsburgh evaluation study recognizes this problem in its five-step methodology for evaluating the costs of the privatization pilot projects.

> **Step 1:** Compute the fully associated costs of the state health centers' service delivery.
>
> **Step 2:** Identify which Department of Health costs are avoided as the result of contracting out the four clinical services.
>
> **Step 3:** Determine local health care providers' costs.
>
> **Step 4:** Estimate the Department of Health's contract monitoring and administration costs.
>
> **Step 5:** Estimate the total costs of contracting out by summing the costs of the local providers' invoices and the costs of the Department of Health's monitoring and administration. This total is then compared with the costs determined in Step 2 (those that the Department of Health avoids by contracting out the four clinical services).[28]

Computing these costs is difficult in principle and, in any event, is not being done. For example, no one in the Department of Health is attempting to complete step four by tracking the amount of time Department employees spend on contract monitoring and administration. A nurse who participated in one of the Department of Health audits in the fall of 1997 said:

> I wanted to know who was keeping track of the amount of time and personnel hours that were going into this audit. And I was told that it was not necessary to keep track of it because it is simply part of our jobs.

In Dauphin and Berks Counties, the two pilot counties with significant TB problems, the Department of Health has delivered a substantial amount of technical assistance over and above administration and contract monitoring. For example, Health Department nurses conduct weekly or fortnightly conferences with private clinic personnel to maintain quality assurance in handling TB cases. According to Department of Health personnel, the Department is not measuring the personnel costs of these activities.

With respect to measuring costs avoided as a result of contracting out clinical services (Step 2), one approach would have been to collect baseline data before the privatization pilots on the cost of delivering clinical services at the Berks, Butler, and Dauphin state health centers. Since this was not done, the Department of Health could instead attempt to measure the costs of delivering from district offices non-clinical public health activities that would previously have been performed in privatized health centers: epidemiology, Directly Observed Therapy, contact investigation, community education and outreach, and so on.[29] This, too, is not being done. (Department of Health employees believe that delivering non-clinical services from district offices is more costly than delivering them from county-based health centers. Public health nurses must travel from district offices to outlying counties on a permanent basis, incurring travel expenses and time lost while driving hundreds of miles.)

Finally, pilot project contractors receive more than private contractors previously did from the Department of Health for the same services. For example, the Berks Visiting Nurses' Association (VNA), the primary contractor under the privatization pilot project in that county, receives $45.00 for each STD visit performed by its subcontractors.[30] Before the privatization pilot project, the Department of Health contracted directly with Planned Parenthood and paid "no more than $25 or $26 per visit" according to a high-level Department of Health employee. The higher reimbursement covers the VNA's advertising and community outreach costs to make people aware of new service locations and hours. But departmental staff said that the Department of Health has made no attempt to ascertain the extent to which VNA (and the other primary privatization pilot project contractors) have actually incurred additional advertising and outreach costs. Several public health nurses claimed that in their pilot counties the primary contractor has made little or no effort to publicize the new clinic locations and clinic hours even though these contractors have received the revenue to do so.

To take another example, Butler Memorial Hospital, the primary contractor in Butler County, now receives $140 (after a recent retroactive increase) for each 15-minute increment of HIV counseling it performs.[31] For the same service, the Berks County VNA receives $19 and the VNA of Harrisburg is reimbursed $64.[32] By contrast, 15 minutes of a senior public health nurse's time costs less than $7.[33] Assuming an overhead of 40 percent, this implies a fully loaded cost of about $10.00, or between one-half and one-fourteenth of the rates being paid to private contractors. Why do reimbursement rates for the same service under the privatization pilot projects vary so widely among contractors? Whatever the rationale, Department of Health sources said that no accounting is being performed to ensure that contractors earning higher amounts are providing additional services.

As a result of the Department of Health's failure to document the costs of or savings from the privatization pilot projects, no detailed cost conclusions are possible. After two years of operation, there is no basis for policymakers to conclude that the privatization pilot projects have saved money.

# III. THE IMPACT OF STAFFING CUTBACKS IN STATE HEALTH CENTERS

Act 87 provides that:

> With the exception of the three State health centers selected for the review program established in [the Act], the department shall operate those public State health centers and provide at a minimum those public health services in effect as of July 1, 1995. Except as provided in paragraph (2) [which outlines the privatization pilots], the department shall not enter into contracts with any additional private providers that would result in the elimination of any State health center nor reduce the scope of services currently provided nor reduce the number of centers.[34]

The precise intent of this paragraph is a matter for the Legislature to determine. Its inclusion in Act 87, however, appears to have reflected legislators' concern that the Ridge Administration would pursue its privatization agenda by reducing services at the remaining 57 state health centers.

Evidence from interviews and data on employment in state health centers suggest that a reduction in services has in fact occurred. We obtained employment figures from two sources. Figures on employment of general public health nurses in 1995 and in October 1998 were reported to the Keystone Research Center by public health nurses. In addition, the Department of Health reported employment by job classification as of January 1998 at each state health center (and at district offices) in an attachment to a memo to the office of Representative Dwight Evans.[35]

According to public health nurses, 29 health centers have experienced reductions in non-supervisory nursing staffing. Total non-supervisory nursing employment at these 29 centers, nurses said, has been reduced from 92 nurses to 45. (According to the Department of Health, nursing employment at these 29 centers is now 49.) Table 2 shows staffing levels by health center at the 29 centers.

Much of the reduction in employment at health centers has resulted from a shift of employment to district offices. According to the Department of Health, the total number of nursing staff "assigned to" the state public health system (i.e., six district offices plus the state health centers) on June 23, 1995 was 187 and on January 30, 1998 was 188.[36] The shift in employment has been accomplished in part through nurses from state health centers bidding on new positions in district offices. In some cases, retiring employees at state health centers have not been replaced. Staff reductions have increased the number of one-nurse state health centers by 17 (Table 2).

According to public health nurses at a random sample of 10 state health centers that have experienced staff reductions, these reductions have had a negative impact upon both the quantity and quality of services delivered.

### A. Public health nurses are less able to act quickly when public health situations require rapid response.

Sometimes, nurses said, even high-priority items cannot be given a timely response, particularly in counties that have only one nurse. One nurse explained that delays can be especially problematic in cases involving food-borne illnesses:

> If a day care worker contracts an easily spread food-borne illness and we don't follow up really quickly, many more people could get sick than if it had been caught just a day or two earlier.

Nurses said they are often unable to respond quickly to requests for information.

> You prioritize. Animal bites, communicable diseases, and so on, these are the most pressing things. We are not able to . . . respond to the requests in a timely manner. For example, on Monday somebody called and wanted to know something fairly specific about training for lead abatement. And I have not had the time to research the information and respond.

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**Table 2: Non-supervisory General Public Health RN Staffing in 1995 and 1998**
(at Pennsylvania state health centers where public health nurses reported staff reductions)

| County | RNs 1995 | RNs 1998 | % Decrease |
|---|---|---|---|
| *Southwest* | | | |
| Armstrong | 2 | 1 | 50% |
| Beaver | 3 | 2 | 33% |
| Cambria | 5 | 1 | 80% |
| Fayette | 5 | 4 | 20% |
| Greene | 2 | 1 | 50% |
| Washington | 4 | 2 | 50% |
| Westmoreland | 6 | 2 | 67% |
| *Northwest* | | | |
| Crawford | 2 | 1 | 50% |
| Jefferson | 2 | 1 | 50% |
| Venango | 3 | 1 | 67% |
| Warren | 2 | 1 | 50% |
| *North Central* | | | |
| Centre | 3 | 2 | 33% |
| Columbia | 3 | 1 | 67% |
| Lycoming | 3 | 2 | 33% |
| Northumberland | 4 | 3 | 25% |
| Union | 2 | 1 | 50% |
| *South Central* | | | |
| Bedford | 2 | 1 | 50% |
| Huntington | 2 | 1 | 50% |
| Lebanon | 3 | 2 | 33% |
| *Southeast* | | | |
| Delaware | 7 | 4 | 43% |
| Schuylkill | 3 | 1 | 67% |
| Lancaster | 5 | 3 | 40% |
| *Northeast* | | | |
| Carbon | 2 | 1 | 50% |
| Lackawanna | 4 | 1 | 75% |
| Lehigh | 2 | 0 | 100% |
| Luzerne | 5 | 2 | 60% |
| Northampton | 2 | 1 | 50% |
| Susquehanna | 2 | 1 | 50% |
| Wayne | 2 | 1 | 50% |
| **TOTALS** | **92** | **45** | **51%** |

Note: Figures shown in the table were provided by state health center nurses. Employment figures for 1998 provided to the Pennsylvania Legislature by the Department of Health were the same as those shown in the table with the following exceptions:

- Schuylkill, Lackawanna, and Wayne, where the Department of Health reported one more nurse than shown in the table;
- Lehigh, where the Department of Health reported two more nurses than in the table;
- Lancaster, where the Department of Health reported one fewer nurse than in the table.

In two counties not shown, Cumberland and York, the Department of Health also reported one less non-supervisory nurse at a state health center than did public health nurses (and one less than in 1995).

Differences between employment reported by state public health nurses and the Department of Health may reflect changes between January 1998 (the month for which the Department reported numbers) and October 1998 (the month in which public health nurses made their estimates available to the Keystone Research Center).

Department of Health figures are contained in a memorandum from Clara Hartung, Director, Bureau of Financial Operations, Department of Health, to Stacey Thiemann, office of Representative Dwight Evans, February 27, 1998.

In addition to general public health nurses, some state health centers have nurses dedicated to specific programs (e.g., tobacco/oral health and immunization program nurses). For 1995 and 1998, such specialized nurses are not included in the employment counts in Table 2.

The number of employees at state health centers declines further when individuals from one county are assigned to other counties to cover for someone who is ill, or to help deal with problems. "People call in and often the secretary is also pulled to the same counties I'm pulled to," one nurse said. "So people call in and they get the answering machine. And a lot of times people want an immediate answer to something and you're not there."

**B. Public health nurses are unable to conduct as many home visits or maintain former levels of follow-up.**

Nurses in counties with fewer staff experience difficulty maintaining levels of non-emergency services such as home visits and patient follow-up. This affects the services that TB patients receive in some counties.

> The TB patients we start on preventive treatment, we are supposed to call them every week, but we don't do it now. We just don't have time.

Follow-up visits under the lead-poisoning program have also suffered.

> When kids are exposed to lead poisoning . . . we are supposed to follow up . . . but all we have time for is the initial visit. We never go back.

A nurse from another county went further:

> I don't want to admit that the work is not being done. . . . But in my situation I just can't get to the home visits for kids with elevated lead levels in their blood. Above a certain blood level they are supposed to get a home visit. I get the report in the office and I don't even have time to contact the doctor to find out whether it was a finger-prick test or a venous test, which is more accurate. Let alone get out to do the visits -- something always comes up.

Maternal and infant health programs have also been adversely affected in counties experiencing staffing reductions. Hospitals refer "high-risk"[37] infants to the state health centers' nurses, who are supposed to visit the mothers and infants before they are discharged from the hospital and then again afterwards, to provide education and well-baby counseling. One nurse said:

> When [these referrals] come in, they just get filed. We're supposed to do a pre- and post-discharge visit. Now granted, there are some other agencies picking up some of that, but other agencies don't do the pre-discharge visits, and these are important because a lot of mothers don't have adequate homes to bring a baby home to.

The phenylketonurea (PKU) program has also been jeopardized. Phenylketonuric infants are born unable to properly metabolize certain dietary elements. They require routine blood tests and a highly restricted diet. For low-income mothers in rural areas, dealing with a PKU child without assistance is extremely difficult. Therefore, public health nurses from the state health centers make home visits to provide blood tests and a special baby formula and to teach PKU mothers how to care for their child. One nurse explained:

> The PKU program is a state-mandated program. It entails home visiting and blood testing, a couple times a week at first and then decreasing, ultimately teaching mom to do it. It takes a while for them to get accustomed to it. You're advising with the formula and there's communication between the clinic and children's hospital. I used to get a call saying, there's a baby we think is PKU, would you go out and test, take formula, and so on. Now I'm unable to respond to those calls.

**C. Public health nurses are less able to build community coalitions and perform community outreach.**

Reduced staffing has also taken its toll on the ability of local public health nurses to participate in community coalitions, advisory boards, and educational outreach functions. Many of the nurses interviewed explained that community involvement enables local public health nurses to build relationships with community resources, allowing them to engage in proactive educational functions. In turn, they can help reduce future costs to society by preventing the spread of public health problems through their ongoing participation among in community networks.

In some cases, Department of Health staff from district offices have taken over these functions because of reduced staffing in the state health centers.

One nurse explained that she had always attended meetings of "Safe Kids" and other community organizations such as the Interagency Coordinating Council, but that now a district office employee was attending those meetings:

> Since I'm the only nurse working in this county, it would be better if I were the one representing the county, rather than my supervisor, who covers *four* counties. It's in these kinds of meetings that you network and find out problems in your county.

Outreach to child care facilities has also been negatively affected. Under this program, state health center nurses are expected to

> visit day care centers, canvass them to see if they have medical consultants, and if they don't, we are to be available for medical calls -- like for lice, to advise them. And we're to go in and teach them things like hand-washing. We're to visit three day care centers a month.

One nurse who works alone in a county with fewer staff has found it impossible to meet these goals herself. As a result,

> we're going to use student nurses plus the nurse from [neighboring county] who doesn't know the county that well. But these people are only temporary. They leave, and there's still no relationship developed between the state health center and the day care facility.

Despite the importance of fostering long-term relationships with the community, transferring nurses to district offices distances them from the people that they serve.

**D. More public health nurses conduct clinics alone.**

Traditionally public health nurses have conducted clinics in pairs. Staff reductions, however, have required more nurses to conduct clinics alone. For state health centers with only one nurse, operating a clinic with two nurses requires a nurse from a nearby county to travel to help.[38] This, in turn, creates service delivery problems in the neighboring county.

In an immunization clinic run by only one nurse:

> there is no time for health education. [Before] we would have talked about the development of the child, anticipatory guidance. We even used to perform a mini-physical assessment, check their ears, throat, listen to their chest. I don't do that anymore unless the mother brings up a particular problem she's worried about. For the most part now you just do the immunization and go on. It's down to the bare bones.

Nurses also felt that one-nurse clinics present safety risks:

> If there would be an [immunization] reaction, you need support. There's no way one person could adequately handle a child with a reaction and the mother and the rest of the clinic.

**E. New nurses receive less training and mentoring.**

In counties reduced to one nurse, problems arise when that nurse retires, resigns, or takes a new position in the district office. Months can go by in which the county has no nurse to cover its public health needs. Once someone is hired, that person has no access to the institutional memory possessed by the previous nurse. Nor is there any one to coach the new nurse in the practice of public health. The transition from other kinds of nursing to public health nursing is not an easy one to make. One new nurse noted,

> I had 15 years of nursing experience, but public health nursing is a different animal in so many different ways. It's a completely different way of thinking about problems.

This nurse went on to describe several problems that occurred during her training. Because her only source of training was a supervisor who had not practiced community health nursing for many years, this new nurse was incorrectly taught. She explained:

> We received this case of giardia, and the manual said you should conduct a site visit to the day care. And I asked my supervisor what sort of things I should look for, and she gave me very

basic information which wasn't anything more than I would know from my experience as a mother. I didn't find anything really bad and so my report said that I found no infection problems. Then by chance another nurse went to the day care and did a much more thorough evaluation. I was mortified that I had done such a poor job, but no one had taught me how to do it. There are a lot of things like that that I am only finding out about by accident, after the fact.

To maintain the quality of state health centers' services, new generations of public health nurses need to be properly trained and mentored. This nurse added,

> It's scary because having quality people in place. is the foundation for public health. And with all of these one-nurse counties, I wonder how new nurses are going to be able to benefit from the experiences of very knowledgeable nurses.

# IV. TB AND STD RATES IN PENNSYLVANIA AND THE NATION

Ideally, the impact of the privatization pilots and health center cutbacks on public health would be assessed by looking at "hard numbers." As explained in Box 1, the link between public policy and reported cases of communicable disease is complex. Reported cases may fluctuate because of actual changes in public health or because of improvements or deteriorations in reporting. Even if reporting is accurate (or the amount of underreporting stays the same over time), the time lag between changes in public health practice and changes in the prevalence of health problems makes interpreting the numbers difficult. Judiciously analyzed, nonetheless, reported cases of communicable disease *are* another source of information on the state of public health trends.

Data are readily available for two categories of communicable disease relevant to the debate about state health centers, Tuberculosis (TB) and Sexually Transmitted Diseases (STDs).

**Tuberculosis:** During the early 1990s, reported cases of TB increased by about 20 percent in the United States but by only about 5 percent in Pennsylvania. From the early 1990s to 1997, reported cases of TB declined by about a third in Pennsylvania, somewhat more than in the United States as a whole. Since 1994, Pennsylvania and U.S. trends have been similar. Table 3 shows that trends since 1994 have been similar in all groups of counties in Pennsylvania; an upward spike in reported cases of TB in the matched counties in 1997 has been followed by a sharp decline in the first three quarters of 1998. (Table A1 in Appendix C shows that no marked differences in trends exist between the pilot privatization counties and the urban, suburban, and rural cluster counties.)

**Sexually Transmitted Disease:** Since 1992, the number of reported cases (per 100,000 population) of syphilis, gonorrhea, and chlamydia have all declined substantially more in Pennsylvania than nationally (Table 4). For example, while the Pennsylvania syphilis rate was virtually the same as the United States rate in 1992 it was approximately 44 percent below the U.S. rate by 1997. For chlamydia, the Pennsylvania rate fell sharply below the United States rate in 1996 and 1997, the years in which the privatization pilot projects and staff cutbacks began. For gonorrhea, the Pennsylvania rate was 68 percent of the national rate in 1997 compared to 85 percent in 1992.

**Table 3: Reported Cases of Tuberculosis, 1994-1998**

| | 1994 | 1995 | 1996 | 1997 | 1998 (as of Oct. 9) | 1997 as Percent of average for 1994 and 1995 |
|---|---|---|---|---|---|---|
| Pilot Counties[1] | 27 | 25 | 25 | 22 | 17 | 85% |
| Matched Counties[2] | 16 | 18 | 10 | 24 | 4 | 141% |
| Cutback Counties[3] | 134 | 132 | 115 | 100 | 65 | 75% |
| Other Counties[4] | 163 | 129 | 118 | 92 | 55 | 77% |
| Philadelphia+Allegheny | 335 | 371 | 315 | 290 | 137 | 82% |
| All Pennsylvania | 621 | 675 | 583 | 528 | 278 | 81% |
| United States | 24361 | 22860 | 21337 | 19851 | | 84% |

[1]Butler, Berks, and Dauphin.
[2]Armstrong, Carbon, and Luzerne.
[3]See Table 2 for a list of counties in which state health centers reduced staff from 1995 to 1998.
[4]All other counties in the state except Philadelphia, Allegheny, and those counties listed in notes 1-3.
Source: Pennsylvania Department of Health and *Reported Tuberculosis in the United States, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

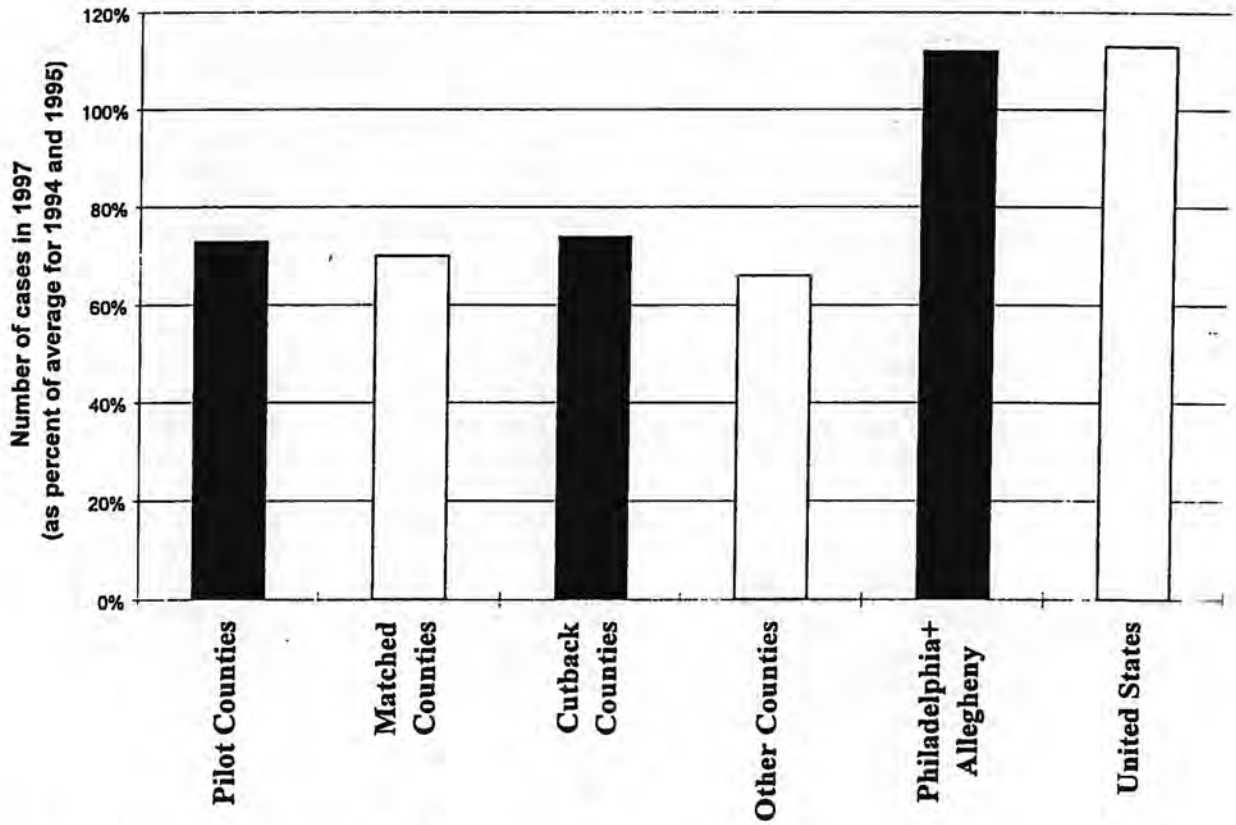
**Table 4: Sexually Transmitted Diseases in Pennsylvania and the United States, 1992-96 (rates per 100,00 population)**

| | 1992 | 1993 | 1994 | 1995 | 1996 | 1997 |
|---|---|---|---|---|---|---|
| Syphilis* | | | | | | |
| Pennsylvania | 45.1 | 35.4 | 22.7 | 16.1 | 11.9 | 9.8 |
| United States | 44.3 | 39.3 | 31.4 | 26.4 | 20.2 | 17.5 |
| | | | | | | |
| Gonorrhea | | | | | | |
| Pennsylvania | 167.9 | 151.5 | 109.4 | 108 | 89.5 | 82.7 |
| United States | 196.8 | 170.2 | 165.6 | 149.4 | 123.1 | 122.5 |
| | | | | | | |
| Chlamydia | | | | | | |
| Pennsylvania | 192.2 | 187.5 | 163.8 | 190.2 | 159.7 | 164.5 |
| United States | 181.7 | 179.5 | 194.5 | 190.4 | 192.6 | 207.0 |

*Includes all stages of syphilis.
Source: *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Figure 3: Chlamydia Cases After 1996 Compared to Before 1996**

(Infections due to *Chlamydia trachomatis* are among the most prevalent of all sexually transmitted diseases. In women these infections often result in pelvic inflammatory disease, which can cause infertility, ectopic pregnancy, and chronic pelvic pain.)




For definitions of county groups, see notes to Table 3.
Note: Chart shows the number of cases in 1997 as a percentage of the average for 1994 and 1995.
Source: Table A2.

What about STD rates in different parts of Pennsylvania? Figures 3 to 5 (and Tables A2 to A7 in Appendix C) compare changes since 1994 and 1995 in the number of reported cases of STDs in various parts of Pennsylvania: the three counties where health centers were privatized; the three matched counties; the 29 counties where staff cutbacks took place; the urban, suburban, and rural cluster counties; "other counties" served by state health centers but in which staff reductions did not take place; and Philadelphia and Allegheny Counties.

What do comparisons of STD trends within Pennsylvania reveal?

In Philadelphia and Allegheny Counties, the number of reported cases of STDs has fallen less rapidly than in the rest of Pennsylvania.

The number of reported cases of chlamydia has fallen at similar rates in the pilot privatization counties; the matched counties; the urban, suburban, and rural cluster counties; the counties where staffing has been reduced; and our "other counties" group (Figure 3 and Tables A-2 and A-3). With two exceptions, the same is true for gonorrhea (Figure 4 and Tables A-4 and A-5). The two exceptions are:

- counties with very small numbers of cases, within which year-to-year fluctuations can be very large in percentage terms;

- Luzerne County and the matched counties as a group, which reported few cases of gonorrhea in 1997 relative to 1994 and 1995 (and compared to Dauphin County and the pilot counties as a group). In the urban cluster as a whole, however, trends are very similar to Dauphin County.

For syphilis, reported cases have declined rapidly across the state (Figure 5 and Tables A-6 and A-7). The most dramatic example has been in Dauphin County. In 1995 in Dauphin County there were 35 cases of syphilis; in 1997 there were no cases. Figure 5 shows that the decline in reported cases of syphilis in Dauphin County has been more dramatic than that in other Pennsylvania urban areas, including both the urban cluster counties and Philadelphia (Allegheny County reported very few syphilis cases for the entire 1994-1997 period.)

The data do not permit us to definitively answer whether the falling rate of chlamydia and syphilis -- in Pennsylvania as a whole and in counties outside Philadelphia and Allegheny that depend on the state health system -- results from actual declines in the prevalence of communicable disease or a fraying of the public health reporting system. In the case of syphilis, one hypothesis is that the vanishing of the disease in Dauphin County reflects, in part, accessibility problems at private clinics described above.

Two differences between syphilis and gonorrhea could explain why syphilis cases disappeared as a result of STD service accessibility problems in Dauphin County, but gonorrhea cases did not. In men, the early symptoms of syphilis are often transient and painless compared to the urethral discharge and dysuria of gonorrhea. People with syphilis may, therefore, not as actively seek out health care as people with gonorrhea. In addition, syphilis patients are likely to come from populations that have more difficulty accessing the health care system.

While it can not be proved that declining Dauphin County syphilis rates stem from underreporting, a study of the effects of reduced STD clinic access in Washington, D.C., makes this interpretation more plausible. After an STD clinic in Northwest Washington was closed (leaving only one Southeast Washington clinic to cover the whole city), the number of reported syphilis cases among Northwest residents fell from 44 to 19, while gonorrhea cases went from 269 to 264. An analysis of the Washington experience concludes that "The decline in reported primary and secondary syphilis cases in the NW wards compared to the SE wards [where syphilis cases rose] likely reflects an increase in undetected cases in the NW wards."[39]

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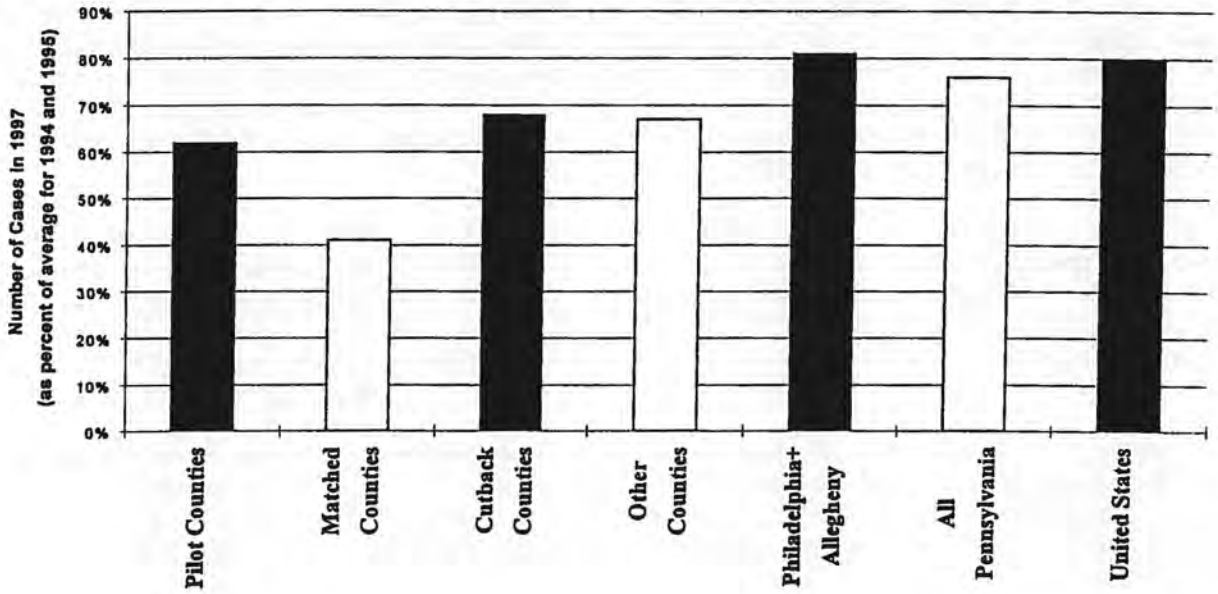
**Figure 4: Gonorrhea Cases After 1996 Compared to Before 1996**

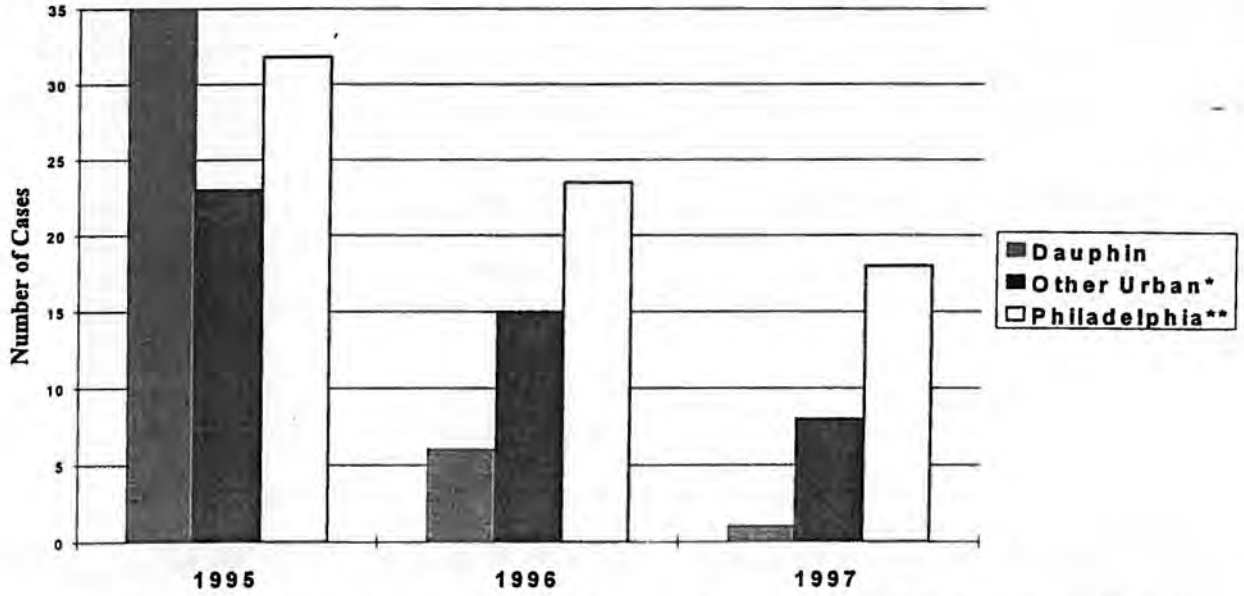
(Infections due to *Neisseria gonorrhoeae* remain a major cause of pelvic inflammatory disease, tubal infertility, ectopic pregnancy, and chronic pelvic pain in the United States. Epidemiologic studies provide strong evidence that gonococcal infections facilitate HIV transmission.)




For definitions of county groups, see notes to Table 3.
Note: Chart shows the number of cases in 1997 as a percentage of the average for 1994 and 1995.
Source: Table A4.

**Figure 5: Cases of Syphilis in Dauphin County, Cluster, and Urban Counties, 1995-97**

(Syphilis, a genital ulcerative disease, facilitates the transmission of HIV and may be particularly important in contributing to HIV transmission. Untreated early syphilis during pregnancy results in perinatal death in up to 40% of cases.)




*The University of Pittsburgh considers the urban cluster (Beaver, Delaware, Lackawanna, and Luzerne) a control group for the pilot privatization in Dauphin County.

**For Philadelphia, the figure reports the actual number of cases divided by 6.
Source: Table A7.

**Box 3: Public Health Privatization in Other States**

Privatization of public health services is proceeding in health departments across the United States. In 1993, a survey by the Council of State Governments found that about half of all state-level public health agencies in the United States had privatized some part of their operations. The services most commonly privatized across the country were "AIDS clinics, drug and alcohol treatment, infant mortality reduction, lead poisoning, and research and development."[40] In 1996, the Centers for Disease Control and Prevention surveyed 47 state health departments and found that new privatization initiatives had been taken in 23 states in the preceding year alone.[41]

Dr. Pomery Sinnock, chief of the Centers for Disease Control and Prevention's Health Systems Research Branch, groups public health privatization efforts into three categories. Some states and localities, he notes, have created quasi-governmental public health authorities to take over all public health functions in certain cities and communities. Some localities have contracted out all responsibility for public health to private service providers, such as hospitals. And in other still other cases, discrete portions of the responsibility for public health have been contracted out to private providers, creating public-private partnerships requiring close communication between public and private entities.[42]

Unfortunately, the existing research has not advanced far beyond surveying and categorizing privatization experiments. Dr. Sinnock's research group at CDC has begun creating short case studies of selected privatization experiments in addition to its health department survey.[43] Several other researchers, notably Dr. Keon Chi, Director of the Council of State Governments' Center for State Trends and Innovation, have also published recent work surveying privatization experiments and initiatives.[44]

In 1997, the Washington, D.C.-based Public Health Foundation conducted a three-tiered study of privatization. This study (which included a survey of 20 sites, site visits to two local health departments that had extensively privatized public health services, and a study of public health privatization across the state of Maryland) attempts to evaluate the results of privatization rather than simply to survey, categorize, and/or cheerlead privatization efforts. These features make the Public Health Foundation report a valuable addition to the small literature on public health privatization.[45] Unfortunately, however, the study suffers from several problems.

First, the study treats public health privatization generically. It does not distinguish carefully among different *kinds* of privatization and evaluate the results of each type separately. It does not always specify which services were privatized, or the precise division of labor in each case. Second, the study's criteria for privatization success are not clear. Data such as utilization rates are not presented, so it is impossible to evaluate claims about increased access. Likewise, the study does not evaluate the effectiveness of public monitoring and oversight.

Existing survey and case study work thus does not lead to definitive conclusions about the central issues discussed in this report: the health impacts of dividing up public health responsibilities between public and private entities, the impact of this type of privatization on the quality and accessibility of services, or the difficulties involved in effective oversight and accountability. According to the CDC's Dr. Sinnock, "These are questions of critical importance about which the jury is still out."[46]

Despite the limitations of existing research, the Public Health Foundation's study does indicate some conditions under which privatization seems *not* to work. Privatization is unlikely to succeed, the Public Health Foundation study concludes, when:

- it is not supported by a leader who has a genuine commitment to public health and to a vision of a well-functioning public-private partnership that can guide implementation,
- support is not amassed from those in the community and on staff who fear that it will undercut the public health, and
- it focuses primarily on cost savings.[47]

In Pennsylvania, these three predictors of unsuccessful privatization were all present.

# V. MARKETS VS. PROFESSIONAL COMMUNITIES: TWO VIEWS OF HOW TO ENSURE AN EFFECTIVE PENNSYLVANIA PUBLIC HEALTH SYSTEM

Interviews with public health professionals and statements by privatization advocates make clear that underlying the debate about Pennsylvania's state health centers are two different interpretations of what makes for high-quality, cost-effective public health service. Making explicit the two perspectives may make it easier for Pennsylvanians to think about which perspective they see as most consistent with the evidence.

Advocates of privatization, such as Secretary of Health Daniel Hoffmann, view the public health system through the lens of free-market economics. Speaking to reporters in 1996, Secretary Hoffmann expressed the view that there is nothing very special about public health center services. According to the Secretary, health centers deliver a "narrow clinical" service. He said that private sector nurses could learn what public health nurses know and labeled the claim that other nurses cannot do what public health nurses do "the most slanderous, arrogant thing I've ever heard."[48] From this point of view, competition between private contractors to provide public health services may be an effective way of obtaining value for money (just as it may be a good way to achieve value for money in the purchase of commodities by the public sector, such as paper clips or police cars).

Lack of competition, the Secretary of Health implied, leads to inflated prices for the services delivered by health centers. According to the Secretary the public health system is "grossly inefficient. . . . It's only through the state subsidies that these health centers have been able to exist." The Secretary further contended that Pennsylvania paid $185 per person served through the state health centers in 1995, when "a trip to the doctor would cost $35."[49] (This claim ignored the investigative and outreach work performed by health center nurses. For example, a nurse might investigate hundreds of contacts to serve four tuberculosis patients.) The Secretary also maintained that public health nurses are paid 20 percent more than private sector nurses with equivalent experience. Competition, we are led to believe, would lead to lower wages and benefits at private contractors, saving the state money: "I could save [$8 million annually] in the blink of an eye," the Secretary maintained.[50] (Note that this is half of state spending on state health centers in 1996.)

A different worldview exists among public health professionals across the state who are skeptical of the benefits of wholesale privatization. They see public health as a distinct specialty within health care. They believe that the specialized training that public health professionals receive, complemented by local knowledge and experience built up in the field, enable public health professionals to protect the public better than inexperienced staff without specialized training. They also believe that the orientation of public health professionals differs from that of medical practitioners who think in terms of diagnosing and treating individuals. As Perry County nurse Barbara Dougherty told the *Patriot News*, "I see health centers working for the entire community."[51]

Professionals in public health centers see themselves as embedded in two communities that are critical to their effectiveness. The first of these is the community within the geographical area for which they are responsible. Because of trust nurtured over years, public health nurses believe that they often learn about impending health dangers quickly. Members of local communities themselves (including the Amish) testify that they trust and cooperate with public health nurses in the prevention of health problems and response to outbreaks. Health professionals also see themselves as part of a professional community that spans the state. Through this professional community, public health nurses learn about problems in other areas for which they need to be on the alert. They also learn about new clinical, educational, outreach, and investigative approaches.

In sum, while Secretary Hoffmann sees the "market" and competition as the best guarantor of quality and service in the public health system, public health nurses point to their own expertise and commitment,

as individuals and as part of a larger occupational community.[52]

Secretary Hoffmann dismisses the perspective of public health professionals as pure rationalization to protect their jobs. The Secretary, the *Patriot News* said in 1996, believes that the "238 health center employees . . . are acting purely out of self-preservation." The Secretary added "I'm disappointed, frankly, that their self-interest exceeds [their interest in] the people of Pennsylvania."[53]

Another interpretation, however, is that reservations about wholesale privatization flow naturally out of public health professionals' view of how best to protect the public health. First, privatization may mean turning public health responsibilities over to individuals without specialized training and experience. Second, it may mean turning responsibilities over to individuals who are not members of either the local or professional community. If contractors change with some regularity (as the state seeks to keep costs down), and if contractors keep wages and benefits low (with turnover of staff resulting), loss of experience and of links to local and professional communities would be recurring problems. On the other hand, if contractors do not change regularly and wages and benefits of staff are not cut, there is little reason to expect lower costs through privatization.

Third, if privatization parcels out public health responsibilities among several contractors and subcontractors, these organizations and their staff are likely to have a "narrow, clinical" orientation to their work, and are less likely to spot or take action in response to early warnings of public health problems. Some public health professionals and community members also see a narrow orientation as likely to be reinforced by the profit motive and by cost pressures on not-for-profit clinical providers. For example, organizations reimbursed a fixed amount per client served have no incentive to be persistent in efforts to deliver Directly Observed Therapy (DOT) to non-compliant TB patients. By contrast, delivering DOT to the least compliant client, even if it means working longer hours, is part of the professional identity -- part of "getting the job done" -- to many public health professionals.

The public health perspective does not necessarily imply that all forms of privatization are a bad idea. Privatization that transfers authority for all of public health in a community to a not-for-profit entity led by public health professionals might avoid the dangers from privatization noted above. Distinct clinical services, to take a second example, might be privatized successfully if good communication and reporting exist or can be developed between private contractors and the public health infrastructure. This is the case with some long-established contracting by health centers to STD clinics (although, as in Berks and Dauphin counties, even longstanding clinical contractors may suffer organizational or personnel changes that disrupt clinical service delivery). A well-integrated combination of state health centers and private contractors for some clinical services might also increase the accessibility of services.

Secretary Hoffmann's assertions about the general superiority of markets -- for example, his claim that "the business case for privatization is irrefutable"[54] -- are not supported by either logic or case studies of public health privatization. The public health worldview -- grounded as it is in the actual experience of delivering health services -- is a more sensible starting point for making health policy.

Rather than start with the premise that private is necessarily better, state policymakers should challenge Pennsylvania public health professionals to live up to their own claims to be the guarantors of the public health. Managers and policymakers from outside the professional community are not in a position to manage the public health system better than these experts. Managers and policymakers, are, however, in a position to ensure that the professional community continually questions its customary practices, and is scientific in its evaluation of different approaches to cost-effectively achieving a healthy community.

# VI. CONCLUSION AND RECOMMENDATIONS

In early 1996, the Ridge Administration proposed the wholesale privatization of Pennsylvania's network of 60 public health centers and the state's public health laboratory, a step unprecedented in any of the 50 states. The Pennsylvania House of Representatives voted unanimously to prevent this proposal from being implemented. The Pennsylvania Legislature then approved a pilot privatization of three health centers, stipulating that remaining centers continue to provide those services in effect as of July 1, 1995. Despite that stipulation, the number of general public health nurses at nearly 40 percent of state health centers has been slashed in half (Table 2).

The original Ridge Administration proposal and the continued quiet dismantling of the Pennsylvania public health system are consistent with a market-oriented economic perspective and a correspondingly narrow interpretation of the services that should be delivered directly by state government. The evidence in this report indicates, however, that the virtues of the market bear little relationship to the means by which the Pennsylvania public health system contains the spread of communicable disease and other health problems. Surveillance of health problems and response to outbreaks depend upon the specialized knowledge and experience of public health professionals, and on maintenance of an integrated information and communication network that reaches into local communities and cuts across geographical areas.

There may be cases in which additional privatization would not jeopardize these communication networks or would bring valuable new specialized skills into the system that protects the public health. But because of the distinct skills needed in public health nursing, and because of the importance of links with the local community and of communication within the state-wide public health infrastructure, frequent changes in contractors, even for clinical services, would result in recurring losses of critical knowledge and experience. Since disruption of the human communication networks that protect the public health is dangerous, contracting out and privatization have to be handled with great care. This does not mean that there are no ways to save money or that current practices -- or even the current division of labor between the public and private sector -- are the best that Pennsylvania can do. It does mean that improving performance (defined as achieving a higher level of quality and accessibility for the same cost or the same level at a lower cost) depends on engaging the community of public health practitioners, whether those are wholly in the public sector or span the public and private sectors.

Problems experienced with the health center privatization pilots illustrate some specific ways that changes in service delivery can weaken the public health system.

- The attempt to privatize some TB services has been problematic, leading to more cases lost to treatment. Provision of TB services should probably be retained by the public sector because of the specialized knowledge required to treat TB *as a public health problem* (rather than as an individual illness), as well as the difficulty of structuring incentives to ensure that private providers make the extra effort necessary to track down and treat the most difficult cases.

- Inadequate contractor communication with the Department of Health and poor contractor record-keeping have risked delaying detection and impeding containment of outbreaks.

- The reassignment of non-clinical functions to district offices threatens to undermine informal communication channels and trust relationships that lead to rapid detection of and response to public health problems.

- Organizational changes and financial problems at private clinics have made STD services less accessible in Berks and Dauphin counties. Changes in clinic location and hours may also have weakened word of mouth mechanisms (e.g., peer networks) by which individuals know where to go and when to show up.

The privatization pilots have weakened the public health system, but there is no evidence that the privatization pilots have saved money. The Department of Health has not measured the cost of monitoring and administering private contracts or of providing contractors with technical assistance. Nor does documentation exist on what costs the Department of Health has avoided as a result of contracting out the delivery of clinical services. Therefore, it is not possible to know whether the privatization pilot projects are less expensive than the state health centers they have replaced.

At the same time, reductions in staff at remaining state health centers have strained the Pennsylvania public health infrastructure. Because of staff reductions, nurses at a sample of 10 centers reported:

- an inability to respond as quickly when public health situations require rapid response;
- an inability to conduct as many home visits or as much follow-up as was provided in 1995;
- significant loss of coalition-building, community outreach, and education;
- an increase in the number of one-nurse clinics;
- inadequate training of public health nurses.

Our analysis of the Pennsylvania public health system has produced no smoking gun. Public health problems that result from short-sighted cost-cutting or ideologically driven privatization, however, will not show up for some time, and then it may be too late to prevent epidemics. Rather than waiting for a health crisis, it makes more sense to implement the following recommendations.

### 1. Phase out the privatization pilots.

The privatization pilots in Berks, Butler, and Dauphin counties should be ended and the state health centers in these counties reopened. These actions should be taken because of the operational problems with the pilots described in the body of this report and the lack of demonstrable cost savings. The pilot projects also appear to have been extended without proper legal authority. While Act 87 specified that they were to last one year, they were extended simply by an executive order from the Secretary of Health.

### 2. Conduct an assessment of the capacity of the Pennsylvania public health system to monitor health problems and respond to outbreaks.

At the request of any state, the Council of State and Territorial Epidemiologists (CSTE) helps the state assess its public health capacity in three areas: surveillance and monitoring of health problems, crisis response, and use of epidemiological data to evaluate and guide policy.[55] To date, at least 10 states, but not Pennsylvania, have requested that CSTE and its consultants conduct a public health capacity assessment. The Department of Health should request such an independent external assessment. The assessors should be asked to comment specifically on:

- the adequacy of staffing levels, including at health centers where cutbacks have occurred;
- the importance of retaining a network of health centers distributed throughout the state; and
- whether additional inferences can be drawn from epidemiological data about the impact of the health center cutbacks or pilot privatizations.

Outside experts from CSTE require only one week in a state to conduct a capacity assessment. It should, therefore, be possible to have an assessment completed by the end of January 1999, so that the Legislature can draw on the assessment findings during the appropriations hearing process.

### 3. Require the Department of Health to raise staffing in state health centers.

Declining staffing in state health centers undermines the effectiveness of the public health system. Once CSTE has completed its capacity assessment, the Department of Health should raise staffing at health centers back to the levels necessary to restore service

to 1995 levels (consistent with the intent of Act 87). Most of the necessary staff can be supplied by reassigning public health nurses from newly created district-level positions, where they are isolated from the communities they serve.

**4. Conduct an independent study of best practice in public health service delivery in other states and cities**

The Legislature should commission an independent study of best practice public health systems, within which managers have aimed to make public health agencies more effective not to eliminate them. The study should include public health systems that have implemented "reinventing government" approaches. The goal should be to find ways of working *with*, not against, the Department of Health public health professionals, tapping into their commitment to protect the public health. The recommendations of this study should be delivered before any additional public health privatization is undertaken.

One practice that should be considered is establishing a few bargaining unit Quality Assurance positions. This practice has been introduced in some private health care organizations in which professional employees are concerned that cost pressures will undermine service quality. Through such positions, front-line staff members gain rights to information and a voice in strategic decisionmaking. Creating such positions could be particularly valuable in the public health system because it would increase continuity in system management between political transitions. In addition, Quality Assurance positions could reduce misunderstanding and mutual disrespect between professional staff and managers. Serving in QA roles might encourage nurses to think more broadly about system-wide and policy issues, making them potentially valuable supporters of strategic organizational shifts. Hearing from QA staff might increase the likelihood that top-level decisions are reached with greater appreciation for both perception and reality on the front lines.

**5. The Office of the Auditor General should conduct an audit to provide an objective analysis of the true costs of the privatization pilots.**

The Department of Health has not collected the information necessary to conduct a meaningful audit of the costs of the privatization pilots, even though saving money was the justification for privatization. An audit by a third party, unconnected with the Department of Health, would help answer questions about the true costs of privatization. The Attorney General's office should also render a legal opinion as to whether the extension of the privatization contracts can stand on executive authorization by the Secretary of Health without specific legislative authorization amending Act 87.

**6. Conduct hearings to define a Pennsylvania public health strategy for the 21st century.**

Using knowledge gained from implementing recommendations three through five, the Pennsylvania Legislature should conduct joint bipartisan hearings to define a Pennsylvania public health strategy for the future. These hearings should address basic questions about the goals of the public health system and how best to achieve those goals, including what should be the balance between public and private service delivery and what core public health functions government does best.

* * * * * * * * *

The Ridge Administration's first-term public health privatization initiative was a top-down initiative that faced strong community, legislative, and staff opposition. A primary motivation behind it was to cut costs. The research on public health privatization indicates that an initiative with these characteristics will fail. (See the end of Box 3.) In Pennsylvania even more than other states, the goal of cost savings is an illusory one. Of the 50 states, the Pennsylvania Department of Health has the second fewest employees relative to the size of the population. Eliminating the entire state health center system would save roughly $1.25 per Pennsylvania resident.

The beginning of its second term in office gives the Ridge Administration an opportunity to start afresh in its management of Pennsylvania's public health system. We offer the analysis and recommendations in this report in the hope that they will help the Department of Health and the Legislature to chart a new and successful course for the Pennsylvania public health system.

# APPENDIX A

**Individuals and Organizations Opposing the Privatization of the State Laboratory and Local Health Centers in 1996**

**Organizations**

American Lung Association of Pennsylvania
American Cancer Society, Dauphin County
Easter Seal Society of Lebanon County
Pennsylvania Mothers Against Drunk Driving
Pennsylvania Nurses' Association
Fulton County Chamber of Commerce
Perry County Commissioners
Snyder County Commissioners
Lancaster General Hospital, Department of Pathology
Pennsylvania Veterinary Medical Association
National Committee for Clinical Laboratory Standards
Lancaster AIDS Project
Northside Family Health Practice, Lebanon County
Lebanon County Housing Authority
Fredricksburg Health Center
Lebanon Valley Family Medicine
Pennsylvania DUI (Driving Under the Influence) Association
Union County Board of Assistance
Community Action Commission of Dauphin County
Black Ministry of Harrisburg
Inter-denominational Ministries Conference of Greater Harrisburg
Association for Professionals in Infection Control and Epidemiology
Chester County Health Department
Montour County Commissioners
Family Health Services of Chambersburg
Mountain Valley Center for Human Services
Franklin County Health Care Consortium
Women, Infants and Children Program of Chambersburg
South Central Community Action Program
Head Start of Franklin County
Maternity Clinic of Chambersburg Hospital
Migrant Head Start
March of Dimes of Cumberland Valley
United Cerebral Palsy of South Central Pennsylvania
Women In Need
Franklin County Area Agency on Aging
The Wellspring Group
Cameron County Family Center
Elk County Commissioners
Elk County Regional Medical Center
Children and Youth Services, Elk/Cameron County
Ridgeway Community Nurse Services
Commodore Perry Family Center, Mercer County
Mercer County Area Agency on Aging
Stoneboro Amish Sects

Mercer County School Nurse Association
Association of Practitioners in Infection Control
Healthy Communities of Western Pennsylvania
Mercer County Community Action Agency
American Red Cross of Mercer County
Farrell Senior Centers
Penn Slate Family Health Services
North Central Center City Office on Aging
SenClear Children's Services
AIDS Project of North Central Pennsylvania
AARP

**Individuals**

Dr. Jeffrey C. Lazar, Tuberculosis Clinician, Mercer County State Health Department
Dr. George F. Reeher, Well Baby Clinic, Greenville
Dr. William H. Fee, Jr., Primary Care Physician, Franklin County
Dr. Michael Fetterholf, Primary Care Physician, Franklin County
Dr. Leon G. DeMasi, board-certified in public health & preventive medicine, former physician with the state laboratories
Diane H. Green, Chief of Microbiology, Philadelphia Department of Public Health
Dr. Irving Nachamkin, Department of Pathology and Laboratory Medicine, University of Pennsylvania School of Medicine
Dr. Arthur H. McTighe, Evangelical Hospital
James E. Prier D. V.M., Ph.D., JD, Former Director of the Pennsylvania Bureau of Laboratories
Josephine Bartola, Former Director of the Clinical Laboratory Regulatory Program for the Commonwealth
Dr. Rodger Rothenberger, Member, Board of Directors, Chester County Medical Society; Family Physician
Janice Runyan, Geisinger Regional Support Technologist
Dr. Wilson Morris, Pulmonary Specialist & TB Clinician, Lebanon County
Tom McDowell, City Public Health & Safety Inspector
Carol Peters, R.N., Former District Executive Director of South Central State Health Centers
Dr. Robert Kantor, Harrisburg Hospital
Dr. Robert Sautter, Lab Manager, Department of Microbiology, Harrisburg Hospital
Dr. David R Trevino, Chairman Infection Control Committee, Memorial Hospital
Sandra Jackson, Infection Control Manager, Magee-Womens Hospital
Sharon Mahanna, Microbiology Laboratory Supervisor, Children's Hospital of Philadelphia
Dr. Richard Facklam, Centers for Disease Control (national expert on streptococcus)
Joel Mortenson, Ph.D., Director of Clinical Microbiology, St. Christopher's Hospital, Philadelphia
Dr. George Trajtenberg, President, Chester County Medical Society
Dr. Eugene Bentley, Clinical Laboratory Director, Chester County Hospital
Dr. Paul Bourbeau, Supervisor, Microbiology Lab, Geisinger Medical Center
Jim Davidson, Lab Manager, Allegheny County Health Department
Drs. Boyd Myers, Karen M. Squire and George Limpert, West Chester, Pennsylvania
Dr. Fred Martin, Arendtsville, Pennsylvania
Wanda Hutchings, R.N., Manager, Infection Control, Chambersburg Hospital
Dr. Tom Rocks, Director of Pupil Services, Waynesboro School District
Lori Dressler Lower, Administrator, Perry County Children and Youth Services
Dr. David E. Tanner, Family Practice Physician
Sally Tice, R. N., Sharon Regional Hospital
Dr. John Bravo, Director of Public Health Education, Slippery Rock University
Mayor Stephen Reed, City of Harrisburg

# APPENDIX B

**Department of Health Expenditures Under the Privatization Pilot Project Contracts, 1997**

| | Dauphin County | Butler County | Berks County | Total |
|---|---|---|---|---|
| January | $11,821.50 | $3,073.00 | $5,019.00 | $19,913.50 |
| February | $11,707.50 | $4,064.63 | $10,914.00 | $26,686.13 |
| March | $11,711.00 | $6,143.59 | $18,706.00 | $36,560.59 |
| April | $17,439.50 | $6,306.95 | $21,446.00 | $45,192.45 |
| May | $14,513.00 | $7,960.75 | $26,076.00 | $48,549.75 |
| June | $15,354.00 | $4,863.63 | $14,602.00 | $34,819.63 |
| July | $23,425.50 | $3,789.48 | $22,948.00 | $50,162.98 |
| August | $21,734.50 | $5,225.30 | $22,540.20 | $49,500.00 |
| September | $17,310.50 | $5,910.40 | $25,890.00 | $49,110.90 |
| October | $27,399.00 | $4,619.32 | $18,055.00 | $50,073.32 |
| Retroactive Increase, HIV Counseling, Jan-Oct 97 | | $28,801.00 | | $28,801.00 |
| Immunization Administrative Fee, Jan-Oct 97 (2/98) | | $584.78 | | $584.78 |
| November | $20,108.85 | $4,728.58 | $21,900.00 | $46,737.43 |
| December | $21,955.05 | $5,861.70 | $20,946.00 | $48,762.75 |
| **Totals** | **$214,479.90** | **$91,933.11** | **$229,042.20** | **$535,455.21** |

Source: Department of Health contractor billing statements.

# APPENDIX C

**Table A1: Reported Cases of Tuberculosis in Pilot, Matched, and Urban, Suburban, and Rural Cluster* Counties, 1993-97**

| | 1993 | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|---|
| Dauphin | 13 | 11 | 12 | 11 | 7 | 92% |
| Luzerne | 11 | 15 | 10 | 22 | 4 | 169% |
| Urban Cluster[1] | 40 | 58 | 28 | 45 | 21 | 92% |
| Berks | 11 | 12 | 11 | 10 | 8 | 87% |
| Carbon | 2 | 0 | 0 | 1 | 0 | 100% |
| Suburban Cluster[2] | 23 | 16 | 19 | 14 | 10 | 72% |
| Butler | 3 | 2 | 2 | 1 | 2 | 40% |
| Armstrong | 3 | 3 | 0 | 1 | 0 | 33% |
| Rural Cluster[3] | 19 | 10 | 16 | 10 | 1 | 69% |
| Other[4] | 177 | 195 | 180 | 147 | 92 | 79% |

*The University of Pittsburgh evaluation team considers the urban, suburban, and rural "cluster" counties to be control groups for the pilot privatization of the Dauphin, Berks, and Butler County state health centers, respectively.

[1]Beaver, Delaware, Lackawanna, and Luzerne.

[2]Carbon, Cumberland, Lebanon, Montour, and Washington

[3]Armstrong, Indiana, Mifflin, Monroe, Perry, Snyder, Union, and Wyoming.

[4]All other Pennsylvania counties except Philadelphia and Allegheny and those listed in notes 1-3. Note that this group differs from the other counties group that includes counties in which health center staff were not reduced (see text, p.7).

Source: Pennsylvania Department of Health and *Reported Tuberculosis in The United States, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Table A2: Reported Cases of Chlamydia in Several Groups of Pennsylvania Counties, 1993-97**

| | 1993 | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|---|
| Pilot Counties[1] | 1433 | 977 | 1746 | 1239 | 991 | 73% |
| Matched Counties[2] | 251 | 166 | 324 | 213 | 171 | 70% |
| Cutback Counties[3] | 3764 | 2536 | 4892 | 3578 | 2741 | 74% |
| Other Counties[4] | 3852 | 2777 | 5055 | 3633 | 2756 | 66% |
| Philadelphia+Allegheny | 13247 | 13074 | 10811 | 10612 | 13359 | 112% |
| All Pennsylvania | 22547 | 19530 | 22828 | 19275 | 19838 | 94% |
| United States | 405275 | 451705 | 478533 | 490047 | 526653 | 113% |

[1]Butler, Berks, and Dauphin.

[2]Armstrong, Carbon, and Luzerne.

[3]See Table 2 for a list of counties in which state health centers reduced staff from 1995 to 1998.

[4]All other counties in the state except Philadelphia, Allegheny, and those counties listed in notes 1-3.

Sources: Pennsylvania Department of Health data; *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Table A3. Reported Cases of Chlamydia in Pilot, Matched, and Urban, Suburban, and Rural Cluster* Counties, 1993-1997**

| | 1993 | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|---|
| Dauphin | 860 | 571 | 1000 | 704 | 595 | 76% |
| Luzerne | 195 | 121 | 257 | 158 | 134 | 71% |
| Urban Cluster** | 1215 | 825 | 1580 | 1197 | 997 | 83% |
| Berks | 480 | 347 | 631 | 469 | 359 | 73% |
| Carbon | 7 | 18 | 40 | 22 | 19 | 66% |
| Suburban Cluster | 597 | 361 | 666 | 493 | 316 | 62% |
| Butler | 93 | 59 | 115 | 66 | 37 | 43% |
| Armstrong | 49 | 27 | 27 | 33 | 18 | 67% |
| Rural Cluster | 303 | 213 | 406 | 306 | 195 | 63% |
| Other | 5752 | 4080 | 7619 | 5428 | 3980 | 68% |

*The University of Pittsburgh evaluation team considers the urban, suburban, and rural "cluster" counties to be control groups for the pilot privatization of the Dauphin, Berks, and Butler County state health centers, respectively.

**For definitions of the three cluster county groups, see notes to Table A-1.

Sources: Pennsylvania Department of Health data; *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Table A4: Reported Cases of Gonorrhea in Several Groups of Pennsylvania Counties, 1993-97**

| | 1993 | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|---|
| Pilot Counties* | 830 | 608 | 1212 | 741 | 560 | 62% |
| Matched Counties | 94 | 34 | 84 | 47 | 24 | 41% |
| Cutback Counties | 1389 | 953 | 1902 | 1316 | 959 | 67% |
| Other Counties | 1604 | 961 | 1677 | 1226 | 894 | 68% |
| Philadelphia+Allegheny | 14299 | 10600 | 8045 | 7473 | 7530 | 81% |
| All Pennsylvania | 18216 | 13156 | 12920 | 10803 | 9967 | 76% |
| United States | 444578 | 419470 | 392622 | 326522 | 324901 | 80% |

*For definitions of county groups, see notes to Table A-2.

Sources: Pennsylvania Department of Health data; *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Table A5: Reported Cases of Gonorrhea in Pilot, Matched, and Urban, Suburban, and Rural Cluster* Counties, 1993-1997**

| | 1993 | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|---|
| Dauphin | 619 | 448 | 930 | 541 | 385 | 56% |
| Luzerne | 84 | 31 | 81 | 41 | 13 | 23% |
| Urban Cluster** | 649 | 475 | 927 | 557 | 404 | 58% |
| Berks | 201 | 151 | 267 | 191 | 168 | 80% |
| Carbon | 1 | 0 | 3 | 2 | 5 | 333% |
| Suburban Cluster | 138 | 92 | 198 | 137 | 100 | 69% |
| Butler | 10 | 9 | 15 | 9 | 7 | 58% |
| Armstrong | 9 | 3 | 0 | 4 | 6 | 400% |
| Rural Cluster | 51 | 31 | 56 | 47 | 37 | 85% |
| Other | 2249 | 1350 | 2482 | 1848 | 1336 | 70% |

*The University of Pittsburgh evaluation team considers the urban, suburban, and rural "cluster" counties to be control groups for the pilot privatization of the Dauphin, Berks, and Butler County state health centers, respectively.

**For definitions of the three cluster county groups, see notes to Table A-1.

Sources: Pennsylvania Department of Health data; *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Table A6: Reported Cases of Syphilis* in Several Groups of Pennsylvania Counties, 1994-97**

| | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|
| Pilot Counties** | 95 | 37 | 7 | 0 | 0% |
| Matched Counties | 4 | 4 | 1 | 1 | 25% |
| Cutback Counties | 142 | 55 | 28 | 13 | 13% |
| Other Counties | 129 | 81 | 26 | 14 | 13% |
| Philadelphia+Allegheny | 304 | 206 | 147 | 117 | 46% |
| All Pennsylvania | 674 | 383 | 209 | 145 | 27% |
| United States | 52639 | 43197 | 31578 | 25167 | 53% |

*This table includes figures for primary and secondary plus early latent syphilis. From 1994-96, these stages of syphilis account for about 60 percent of reported syphilis cases in the United States.

**For definitions of county groupings, see notes to Table A-2.

Sources: Pennsylvania Department of Health data; *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

**Table A7: Reported Cases of Syphilis*, 1994-97**

| | 1994 | 1995 | 1996 | 1997 | Number of Cases in 1997 as a Percentage of the Average Number in 1994 and 1995 |
|---|---|---|---|---|---|
| Dauphin | 91 | 35 | 6 | 0 | 0% |
| Luzerne | 4 | 3 | 1 | 1 | 29% |
| Urban Cluster[1] | 75 | 23 | 15 | 8 | 16% |
| Berks | 4 | 2 | 1 | 0 | 0% |
| Carbon | 0 | 1 | 0 | 0 | 0% |
| Suburban Cluster[2] | 49 | 17 | 7 | 0 | 0% |
| Butler | 0 | 0 | 0 | 0 | |
| Armstrong | 0 | 1 | 0 | 0 | 0% |
| Rural Cluster[3] | 19 | 6 | 0 | 2 | 16% |
| Philadelphia plus Allegheny | 304 | 206 | 147 | 117 | 46% |
| Other[4] | 128 | 90 | 32 | 17 | 16% |
| All Pennsylvania | 674 | 383 | 209 | 145 | 38% |

*The University of Pittsburgh evaluation team considers the urban, suburban, and rural "cluster" counties to be control groups for the pilot privatization of the Dauphin, Berks, and Butler County state health centers, respectively.

[1]Beaver, Delaware, Lackawanna, and Luzerne.

[2]Carbon, Cumberland, Lebanon, Montour, and Washington

[3]Armstrong, Indiana, Mifflin, Monroe, Perry, Snyder, Union, and Wyoming.

[4]All other Pennsylvania counties except Philadelphia, Allegheny, Dauphin, Berks, Butler, and those counties listed in notes 1-3.

Sources: Pennsylvania Department of Health data; *Sexually Transmitted Disease Surveillance, 1997* (Atlanta: Centers for Disease Control and Prevention, 1998).

## REFERENCES

[1] Commonwealth of Pennsylvania, *Governor's Executive Budget Proposal 1998-1999* (Harrisburg: Commonwealth of Pennsylvania, 1998), p. E20.4.

[2] Lori Whitehead, Michon Bechamps, and Ron Bialek, *Privatization and Public Health: A Study of Initiatives and Early Lessons Learned* (Washington, DC: Public Health Foundation, 1997), pp. 11, 26.

[3] "Plan to Privatize State Health Centers Opposed," *Harrisburg Patriot-News*, February 11, 1996.

[4] "Health Proposal Brings Worry," *Scranton Times*, March 4, 1996, p. 1.

[5] "Officials Bemoan Closing of Public Health Center," *Harrisburg Patriot-News*, February 27, 1996.

[6] "Ridge Budget Would Cut State Health Center," *Pocono Record*, February 10, 1996, p. A-1.

[7] Calculated from figures for 1995 population by county contained in Pennsylvania State Data Center, *A Statistical Fact Book* (Harrisburg: Pennsylvania State Data Center, 1996).

[8] Act 87 specified that the Year One report should contain (but not be limited to) the following six elements: "(i) a review and analysis of the three health care centers or of the provision of equivalent services in the review program, including patient utilization and services provided; (ii) an analysis of the performance of each local health care provider, including patient satisfaction with the provision of services; (iii) a review of other delivery systems for health services in the community, both public and private; (iv) a comparison of the cost and effectiveness of the operation of each of the three health care centers by the Commonwealth with the cost of the provision of equivalent services by local health care providers; (v) recommendations regarding continuation of the provision of the services previously provided by the three health care centers included in the study program by local health care providers; and (vi) recommendations regarding the public and private operation of all remaining health care centers or the provision of equivalent services in this Commonwealth." P.L. 518, No. 87, Section 8 (c) (4).

[9] Gary Marsh et al., *Report on Year One of the Community Health Project*, Center For Public Health Practice, Graduate School of Public Health, University of Pittsburgh, December 19, 1997, p. iv .

[10] Ibid., p. 21.

[11] Ibid., p. v.

[12] Ibid., pp. 19-20.

[13] Ibid.

[14] Ibid., p. 20.

[15] The results of the Department of Health's internal audits of the privatization pilot project clinics should ideally be compared to previous audits of state health center clinics in the same counties. Unfortunately, it was not possible to obtain older audit reports.

[16] Pennsylvania Department of Health, "1997 Berks County STD Evaluation," performed October 1-2, 1997, no page numbers.

[17] Ibid.

[18] Ibid.

[19] The TB registry is a centralized state data base that tracks all Pennsylvania TB patients, the treatment they have received, and their test results.

[20] Ibid., p. 4.

[21] With the shift of DOT responsibility to district offices serving pilot counties, the South-Central District Office (in Dauphin County) funded an outreach worker who devotes "90 to 95 percent" of her time to performing DOT in Dauphin County. In Berks County, the Department's District office retains primary responsibility for DOT, but allows the Berks Visiting Nurses' Association to perform a small number of DOTs when the district office is unable to perform them for lack of staff.

[22] U.S. Department of Health and Human Services, Public Health Centers for Disease Control and Prevention, *Questions and Answers About TB, 1994*. See also American Thoracic Society, Medical Section of the American Lung Association, "Control of Tuberculosis in the United States," *American Review of Respiratory Disease* 145 (1992): 1623-1633. In Pennsylvania in 1997, 6.1 percent of those who tested positive for TB in 1997 were resistant to isoniazid, a drug taken by virtually all TB patients. This compares with 7.6 percent nationally. Only one Pennsylvania case (or 0.3 percent) was resistant to both isoniazid and rifampin, compared to 1.4 percent of cases nationally. Tom Ridge and Daniel F. Hoffmann, *Tuberculosis in the Commonwealth of Pennsylvania* (Harrisburg: Pennsylvania Department of Health, 1998).

[23] "Health Proposal Brings Worry," *Scranton Times*, March 4, 1996, p. 1.

[24] In Berks County, the departure of the Spanish-speaking physician from the clinic may have affected utilization by members of the area's Spanish-speaking community, which historically had been one of the most important communities served by the clinic. The hospital was also bought by a Catholic organization during this period and renamed St. Joseph's Hospital; these changes may have affected people's willingness to avail themselves of the facility's STD services, given the Catholic Church's official opposition to contraception and premarital sex.

[25] According to the Pennsylvania Department of Health Request for Proposals, over 85 percent of annual STD visits in Dauphin County had already been provided by Planned Parenthood of Harrisburg. As a result of cash-flow difficulties unrelated to the privatization pilot project, the Harrisburg Planned Parenthood office was closed in the summer of 1997. Although the STD clinic remained operational, services were reduced from two days a week, including after-work hours, to a half day once a week.

[26] Pennsylvania Department of Health, *Dauphin County STD Provider Evaluation*, September 17, 1997, no page numbers.

[27] *Audit of the Community Health Project of Dauphin County -- TB Program*, p. 4.

[28] *Report on Year One*, p. 16.

[29] Public health nurses from across the Commonwealth, interviewed for this project, estimated that the clinical portion of their duties amounts to between 20 and 30 percent of their activities. An accounting of public health services in the Northwest District in 1995, written by a Pennsylvania Department of Health supervisor, came to similar conclusions: in 1995, "16,959 clinic visits in the Northwest District account for only 27 percent of the public health nursing services rendered at the state health centers in the Northwest District."

[30] Pennsylvania Department of Health Contract # ME96251.

[31] Pennsylvania Department of Health Contract # ME96252.

[32] Pennsylvania Department of Health Contracts # ME96251, ME96253.

[33] The total annual cost of a public health nurse earning $37,000 per year with benefits is approximately $51,800, or about $26.50 per hour.

[34] P.L 518, No. 87, Section 8(c)(1).

[35] Memorandum from Clara Hartung, Director, Bureau of Financial Operations, Department of Health to Stacey Thiemann, office of Representative Dwight Evans, February 27, 1998.

[36] These figures are contained in an attachment to a March 10, 1998 letter from Secretary of Health Daniel F. Hoffmann to Representative John Barley. The letter does not indicate the distribution of nurses between state health centers and district offices at each point in time.

[37] Infants defined as "high-risk" include those who may bephenylketonurics or SIDS (sudden infant death syndrome) babies, or who have high levels of exposure to lead. Also classified as high-risk are infants born to mothers who have used drugs during pregnancy, to teen mothers with special problems, or to families where drug and/or alcohol abuse may be present.

[38] Excluding state health centers that have a supervisory nurse as well a non-supervisory one, the Department of Health placed the number of clinics with one nurse at 19 in January 1998. Memorandum from ClaraHartung, Director, Bureau of Financial Operations, Department of Health to Stacey Thiemann, office of Representative Dwight Evans, February 27, 1998.

[39] Information in this paragraph is based on Centers for Disease Control, "Impact of a Sexually Transmitted Disease Clinic Closure on Public Health Surveillance of Sexually Transmitted Diseases, Washington, D.C.," forthcoming in CDC *Morbidity and Mortality Weekly Report*. (Prepublication copy provided by Roxanne Barrow.) In another relevant case, a county in Washington state, anticipating national health care reform, closed its STD clinic in 1993. Major declines in STD visits (-43%), lab testing (-46%), and reported chlamydia (-23%) and gonorrhea (-49%) resulted in the next two years, while little change took place in two other counties that continued to provide STD services. While unable to prove, as in Dauphin County today, that the drop in cases of disease results from underreporting, an evaluation of the Washington state "natural experiment" sees this as a plausible explanation. The evaluation concludes that local health departments divesting themselves of STD clinics "are moving into uncharted and potentially dangerous territory without a map or a compass." Ann M. Kimball et al, "The Impact of Health Care Changes on Local Decision Making and STD Care: Experience in Three Counties," *The Research Linkages Between Academia and Public Health Practice 1997*: 75-84. The quote above is on p. 84.

[40] "The Direction of Public Health Privatization," *Council of State Governments Health Policy Monitor*, Fall 1997, p. 2.

[41] Ibid.

[42] Telephone interview, Dr. Pomery Sinnock, Centers for Disease Control and Prevention, Health Systems Research Branch, August 4, 1998.

[43] Centers for Disease Control and Prevention, Public Health Practice Program Office, *Privatization Update* (unpublished draft), August 1998.

[44] Keon S. Chi, "Privatization," *State Trends and Forecasts,* November 1993, pp. 1-39.

[45] Whitehead, Béchamps, Bialek, *Privatization and Public Health.*

[46] Telephone interview, August 4, 1998.

[47] Whitehead, Béchamps, Bialek, *Privatization and Public Health*, pp. 26 and 11.

[48] For Hoffmann's views, see "Plans For Privatization Go Too Far, Nurses Say," *Harrisburg Patriot-News*, March 24, 1996, p. B-1.

[49] Ibid.

[50] Ibid.

[51] Ibid.

[52] Readers may notice a parallel here with debates about health care and the benefits or problems associated with the spread of managed competition. Research on service industries and occupations suggests that knowledge embedded in occupational communities is pivotal to productivity and quality -- to economic performance -- in much of today's economy. See Stephen A. Herzenberg, John Alic, and Howard Wial, *New Rules for A New Economy: Employment and Opportunity in Postindustrial America*, a Twentieth Century Fund book (Ithaca: Cornell University Press, 1998), especially chapter 5.

[53] "Plans For Privatization Go Too Far," p. B-1.

[54] Ibid.

[55] Warren G. Brown, *Epidemiologic Capacity of State Health Agencies: A Guide for Assessment, Final Report to the Council of State and Territorial Epidemiologists*, January 23, 1998.