Public Health and Health Care: Integration, Disintegration, or Eclipse

Peter D. Jacobson and Wendy E. Parmet

I. Introduction

Public health has long been health care's poor stepcousin.[1] For decades, spending on clinical health care services has dwarfed spending on public health.[2] This imbalance continues; today, only 3 % of health expenditures go to federal, state and local public health agencies.[3]

The disparity has not bought positive health outcomes. Although Americans spend far more per capita on health care than residents of any other developed country,[4] the United States performs poorly compared to other nations on a wide range of health measures. For example, the U.S. ranks 43rd in life expectancy,[5] and 55th in infant mortality.[6] These figures mask continuing racial and ethnic disparities,[7] as well as troubling increases in deaths by opioids, suicide, and other so-called diseases of despair.[8]

The combination of high spending on health services and poor population outcomes has led many commentators to argue that a rebalance is needed.[9] For some health policy experts, the rebalance requires increased funding for public health agencies.[10] Others argue that the health care system needs to be reformed to become more efficient and attentive to the type of population health concerns that have traditionally been the focus of public health.[11] In 2008, Don Berwick and colleagues described the now ubiquitous "triple aim," which would redesign the health care system to not only care for individual patients, but also reduce costs and improve "the health of populations."[12] As they argued, by redesigning the health care system in this fashion, we could both improve population health and save money.[13] Other commentators have suggested that we go further and integrate our public health and health care systems. For example, Hardcastle and colleagues question the commonly-accepted dichotomy between public health and health care, stating that "A well-integrated system with interdependent parts fosters continuity and comprehensiveness of care and improves cost-effectiveness. Conversely, a lack of integration causes duplication, gaps, inconsistencies, and wasteful spending on treating preventable conditions."[14] In 2011, the Institute of Medicine concluded that we need to move toward a system in which professionals worked "across sectors" "tackling root causes that are outside of the traditional health sector."[15]

Peter D. Jacobson, J.D., M.P.H., *is Professor Emeritus of Health Law and Policy and Director, Center for Law, Ethics, and Health at the University of Michigan School of Public Health.* **Wendy E. Parmet, J.D.**, *is Matthews Distinguished Professor of Law and Professor of Public Policy & Urban Affairs and Director of the Center for Health Policy & Law at Northeastern University.*

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The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 seemed to herald the promise of such cross-sector partnerships, if not the full integration of the health care and public systems.[16] A report by the National Academy of Sciences in 2013 stated that the ACA "offers an unprecedented opportunity to shift the focus of health experts, policy makers, and the public beyond health care delivery to the broader array of factors that play a role in shaping health outcomes."[17]

Now, eight years after the ACA's enactment, and almost two years into the administration of a President who was determined to repeal and replace the ACA, it seems timely to reassess the quest for integration, a quest we call the "integration project." This paper takes the first step toward that assessment. We first discuss what integration means, and the forces that are driving it. Next, we review several ACA provisions, along with other similar public policies, that may have moved us toward integration. We then examine the potential impact of the changes proposed or implemented since President Trump's inauguration. (As of this writing in summer 2018, the Trump administration's ACA-related and general health policies remain in flux. Our discussion reflects the latest available information.) Finally, we consider some conceptual barriers to integration as well as some of the less-explored risks it might portend for the public health system.

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Before embarking, it's important to recognize that discussions about health reform and integration frequently rely on different definitions of "population." For example, health care providers usually use the term when referring to their patient panels.[18] The health services literature uses the term to reference patients who are enrolled in a particular plan, or in the case of Accountable Care Organizations (ACOs), are "attributed" to a particular ACO.[19] Conversely, public health agencies understand the term to refer to the residents of a geographically-defined community.[20] "Population health" can also refer to subpopulations that share a common trait or exposure, as in the "population of smokers."[21] These distinct meanings of "population" need to be kept in mind in any discussion of the integration project.

II. The Concept of Integration

Traditionally, we assume that health is the province of two distinct, albeit overlapping, systems. The health care system focuses on financing, organizing, and delivering personal clinical services. The public health system is primarily devoted to safeguarding and improving the health status of a population, including through community-wide interventions designed to address the social determinants of health (SDOH). Thus, health care is concerned with individual patient care and treatment, while public health focuses on the health and well-being of populations.

The separation between health care and public health is exaggerated. Both systems have contributed to expanded longevity and reduced morbidity. As Brandt and Gardner argue, "no single approach…adequately accounts for significant changes in many health-related behaviors."[22] Murray and Frenk add that the "distinctive methods, values, and approaches" of each system will be vital to reducing the burden of disease in the 21st century.[23] At least in theory, an integrated health system can more effectively allocate resources to address both the individual and population health aspects of health threats, such as the opioid epidemic.

Defining Integration. Hardcastle et al. are critical of the dichotomy between health care delivery and public health, arguing that they should be conceptualized as two interconnected parts of a single health system.[24] In their view, "a fully integrated health system requires that all government policies reflect the ultimate goal of improving the health of the population."[25] Hence, public health and personal clinical care are interdependent fields that can, and should be, merged into one health system. We call this "full integration."

At the moment, full integration remains elusive. However, as described below, many initiatives exhibiting some degree of integration already exist. This suggests that it makes sense to view integration as a continuum, from incidental to total.

What's lacking is an overall assessment of how existing initiatives differ, which strategies are most effective, and whether any of them are sustainable. As discussed below, recent evaluations of new health care delivery models that move toward integration, along

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with community-based programs and multi-sector partnerships, have shown limited improvements in population health.[26] These initiatives, however, do not exemplify full integration. Moreover, it remains unclear what full integration would entail and how it could be implemented. At a minimum, moves toward full integration would require close cooperation between health departments and provider organizations to identify and measure population health outcomes[27] as well as connections to community organizations.

Drivers of Integration. As noted above, there is a growing awareness that poor health status indicators, rates of disease and injury in the community, and the high cost of medical care cannot be addressed through clinical care changes alone. This is especially true regarding chronic diseases, such as cancer or diabetes. In particular, people with multiple chronic diseases incur very high medical costs that can best be reduced through community interventions and general prevention efforts that reduce disease rates over time.[28] As a result, federal and state governments, and private foundations are investing in programs to reduce the SDOH that substantially contribute to systematic health care deficiencies.

Another push for integration comes from the continuing decline in the public health system's ability to achieve sustained community health improvements due to declining public investment, persistent attacks from opponents (including affected industries and antigovernment political groups), limited political power, and competitors encroaching on its responsibilities. From 2008 to 2010, the local health department (LHD) workforce declined by approximately 19%.[29] In Washtenaw County (Michigan), a relatively wealthy community, the health department's budget is equivalent to 1992 dollars, despite a growing population and many new demands.[30] (The opioid crisis is not the only unfunded responsibility straining health department budgets.)

A third factor driving integration is pressure from payers and policymakers for health systems to take responsibility for population health improvements. The current health policy mantra of moving from volume to value requires caring for patients (especially chronic care patients) in the community rather than through long inpatient stays. Thus, reimbursement incentives and pressure to justify tax-exempt status are likely to support community-based care in the future.

III. Existing Integration Efforts

The ACA's Population Health Initiatives

The ACA included several provisions designed to move the health care system closer to public health. These can be roughly divided into three categories: 1) provisions that aimed to increase access to clinical services; 2) payment reforms that incentivized providers to focus more on population health; and 3) reforms that enhanced community-based initiatives and broader public health efforts. Although space precludes a thorough assessment of each, and important research continues, it is clear that some gains toward integration have occurred. Nevertheless, true integration remains far off.

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(1) CLINICAL ACCESS PROVISIONS

Prevention is a hallmark of public health.[31] Numerous ACA provisions sought to promote access and utilization of preventive services. Studies to date suggest that the ACA was at least somewhat successful in achieving these goals, primarily by increasing access to health insurance, especially through the Medicaid expansion. Reviewing the literature on the expansion's impact on preventive services, Sommers and colleagues note that: "Research specifically comparing

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populations in Medicaid expansion versus non-expansion states has shown important clinical changes for these populations, including increased primary care visits, improved blood pressure control and Pap testing rates, and improved self-reported health status."[32] They also report that adults in expansion states experienced significant increases in preventive health visits, glucose testing, and a 23-percentage point increase in reporting their own health as "excellent."[33]

The ACA also increased access to prevention in other ways. for one thing, the Act treats ambulatory care, preventive services, and mental health and substance use disorder services as essential benefits. For another, it eliminates cost-sharing for a wide range of mental health and substance use disorder services, and preventive services in non-grandfathered health plans.[34] Early studies indicate some success on this front, too. Han and colleagues report that two years after ACA implementation, individuals with insurance were more likely to have blood pressure and cholesterol checks, as well as a flu shot, but they detected no increase in cancer screenings.[35]

Increases in using preventive services are important, but their impact on population health remains uncertain.[36] Many preventive services, such as cancer screenings, have been shown to have little or no positive impact on health.[37] In any event, the ACA's preventive services remain rooted primarily within the health care system as another component of patient care. They do not address SDOH; nor do they require substantial or any collaboration with public health agencies.

(2) ACOs

Several ACA provisions incentivize providers to improve population health. Most notable are the provisions encouraging the establishment of Medicare ACOs.[38] Since the ACA's enactment, the number of ACOs has grown dramatically. As of 2016, there were 838 ACOs, covering 28.3 million lives.[39] ACOs attempt to reduce health care costs by improving the health of a patient population through better care coordination and management, potentially including the provision of social services designed to address non-medical factors that affect patient health.[40] When ACOs achieve their goals, they earn "shared savings" payments.[41] To achieve their goals, some ACOs have moved beyond clinical care to address a wider range of social factors, including transportation, housing, and food insecurity, that may affect their patients' health.[42] Shortell and colleagues, for example, report on an ACO that was able to reduce a patient's emergency department visits by building her a ramp, donating a refrigerator, and providing her with meals.[43]

Despite considerable optimism and some achievements, there is no research indicating that ACOs address SDOH broadly viewed.[44] Instead, ACOs focus almost entirely on their already insured patient population, not on the broader community,[45] devoting most of their population health efforts to "providing better medical care" rather than addressing upstream factors that affect health.[46] Patient care, after all, is where their knowledge and expertise lies.[47]

As such, ACOs and similar entities move us only marginally toward integration. This has led some commentators to call for the expansion of a different type of entity, in which hospitals and/or ACOs partner with community-based groups to address community health.[48] Casalino and colleagues refer to these as "population health organizations," which, they argue, "would focus on the underlying behavioral and social determinants of health."[49] Although such organizations move us further on the continuum toward integration, they still do not take us all the way there.[50]

(3) non-clinical population health initiatives

a) CHNAs. The ACA sections that support community-based and other public health initiatives promise more significant integration efforts than the modest steps promoted by expanded access to preventive services and payment reform. One such provision requires that non-profit hospitals conduct community health needs assessments (CHNAs) at least once every three years and work to address the needs identified.[51] The CHNA regulations encourage, but do not require, hospitals to incorporate social determinants and seek input from local public health departments and members of underserved communities.[52] As Mary Crossley explains, this nudges hospitals to collaborate more deeply with LHDs and think more broadly about how to allocate their community benefit obligations, which traditionally went primarily to paying for unreimbursed care.[53]

One promising development that CHNAs have helped support is the concept of anchor institutions. These are partnership arrangements in which large, place-based institutions such as hospitals and universities that cannot easily move to another location, provide resources to improve community health.[54] According to a study of hospital-public health partnerships, "The long-term survival and success of these partnerships is enhanced when one or more of the principal partners step forward to serve as a strong 'anchor institution.' Partnerships without one or more anchor institutions to provide a solid, dependable foundation of economic and non-economic support are inherently fragile and constantly dependent upon

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obtaining new sources of financial support to sustain core operations."[55]

Despite such promising developments, the results from CHNAs have been largely disappointing. In Michigan, for instance, even where LHDs have been equal partners in the process, there is little indication that CHNAs have led to broader integration.[56] Even so, CHNAs remain a potential mechanism for further integration.

b) Population-Based Grant Programs. Two of the most promising ACA provisions established population-based funding programs—the Community Transformation Grants program and the Public Health and Prevention Trust Fund.[57] Had they been fully funded, both would have provided substantial resources for community-based population health initiatives. For political reasons, however, funds were transferred to other efforts, including support of primary care.[58] Still, CDC reports that the Community Transformation Grants helped communities design and carry out programs that prevent chronic diseases such as obesity, diabetes, and heart disease.[59] At this point, unfortunately, both programs suffer from underinvestment and political attacks.

c) Accountable Health Communities. One of the more promising ACA provisions, from the perspective of the integration project, authorized the Centers for Medicare and Medicaid Services (CMS) to develop a model to promote clinical-community integration based on "emerging evidence that addressing health-related social needs through enhanced clinical-community linkages can improve health outcomes and reduce costs."[60] Its focus is on screening for health-related social needs, referrals to and navigation assistance for community services, and clinical-community services alignment.

Over a five-year period, 32 participating organizations established such "Accountable Health Communities" (AHCs). Health care organizations initiated most of them (e.g., Yale-New Haven Hospital), but some were formed by health departments (e.g., Baltimore City Health Department), coalitions (e.g., Camden Coalition of Healthcare Providers), or social service agencies (e.g., United Way of Greater Cleveland).[61]

As Casalino and colleagues explain, AHCs (some of which have been funded by Medicaid waivers or private foundations) "manage a population health budget, allocate resources, and [are] held accountable for performance on a range of population health metrics, including metrics of reducing socioeconomic disparities in health."[62] Because providers partner with social service agencies and community organizations, AHCs have a "community perspective."[63] Nevertheless, no systematic studies of outcomes or measures have yet been reported, and their long-term sustainability beyond the expiration of their grants remains uncertain. Indeed, an AHC experiment underway in Vermont demonstrates that results will take years to determine because of the time it takes to develop the infrastructure and measures, collect data, and ensure sustainable funding.[64]

IV. Non-ACA Population Health Programs

Not all of the movements along the integration continuum derive explicitly from the ACA. Beyond the ACA, a wide array of ongoing governmental and private sector activities have sought to address SDOH. At this point, no typology exists to distinguish the initiatives from one-another or from the ACA-related efforts already described. This results in both overlap and somewhat arbitrary distinctions in classifying the approaches.

a) Collaborations and Partnerships. Even apart from the ACA, many LHDs, hospitals, and other stakeholders have entered into collaborations to improve community health. These efforts include some initiatives similar to those discussed above as well as efforts that are narrower in scope and scale than the ACA-related programs.

In some cases, clinical care organizations have undertaken innovative activities to address SDOH. These may or may not currently involve the LHD, but serve as examples of potential strategies for greater integration. One example is a Henry Ford Health System initiative to fund a light rail project in Detroit).[65] Another is a Rutland Regional Medical Center (VT) project with NeighborWorks of Western Vermont, a community development financial institution (CDFI) that provides loans, financial education, and renovations to homebuyers and owners.[66] The hospital gave $75,000 toward grants and loans for home repairs, and sends nurses on home visits to determine how to prevent falls or asthma attacks with those repairs.[67]

Some of these initiatives focus on improving access to healthy food. For instance, Mount Carmel Health System (Trinity Health) funds the Healthy Food for Ohio program, which offers grants and loans to businesses providing healthy foods in designated food deserts across the state.[68] Other initiatives offer a broader range of services. For example, Hennepin Health-PMAP is a Medicaid plan in the Minneapolis area that covers health care and also dental services, transportation, housing, and employment services for high-risk, low-income patients.[69] Providers partnered with social service and public health leaders to create a "tightly integrated medical and social service system."[70] From 2012 to 2013, ED visits fell 55% among clients placed in supportive housing through the program.[71]

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So far, success for these collaborations has been mixed. For example, Mattessich and Rausch found that about 45% of community health collaborations have been successful.[72] In contrast, some have achieved impressive successes.[73] A 2014 report from the Commonwealth Center for Governance Studies concluded that such partnerships can be "important vehicles for identifying and addressing community health needs."[74] The report also emphasized the importance of hospitals working with public health departments as well as broad sections of the community.[75]

Since the onset of the Trump Administration, the integration project has faced an uncertain future. Although Republican efforts to "repeal and replace" the ACA failed several times in 2017, and litigation over the ACA's fate continues, a series of less dramatic legislative and regulatory actions have already taken place, which threaten the modest steps that have been taken to date.

Although new collaborations continue to develop, and research continues, the future of such efforts and their ability to promote integration remain questionable. The CHNA regulations do not require hospitals to fund community partnerships; and hospitals' incentives and capacity to do so may decline if insurance rates fall, leading to more uncompensated care.[76] In any event, long-term sustainable funding models for AHCs remain uncertain.

Equally important, collaborations often emphasize short-term clinically-based metrics that can be expected to reduce health care costs. In effect, they adopt what Tanenbaum calls an "instrumental" view of population health, seeing it in service to cost-savings in the health care sector.[77] Given current measurement techniques, population health gains cannot be easily translated into short-term savings. Moreover, AHCs and similar collaborations lack the capacity to engage in a wide-range of public health functions, including investigating disease outbreaks, abating nuisances, or promulgating regulations. In effect, these collaborations lack both legal authority and public accountability. These key points will be discussed further below.

b) Health in All Policies/Health Equity. One important development is the proliferation of Health in All Policies (HiAP) initiatives, which have been promoted in recent decades by major public health organizations, academic researchers, and nonprofit organizations. As Rudolph et al. explain, "Health in all policies is an approach to improving the health of all people by incorporating health considerations into collaborative decision-making across sectors and policy areas."[78] The term does not refer to a specific set of policies, rather an approach to developing and implementing governmental policies that address the SDOH.[79] HiAPs' defining feature is cross-sectoral collaboration, and its core insight is that health is largely determined outside of the health care sector. Nonetheless, these initiatives usually occur within the government, with only sporadic private sector involvement, primarily through foundation grants.

HiAP initiatives are closely related to health equity programs. Hall and Jacobson found that HiAP programs are gradually transitioning to focus on health equity.[80] They conclude that HiAP is useful as an organizing principle in providing a framework around which multiple stakeholders can operate, but data demonstrating how these initiatives have improved health equity or reduced health disparities are limited.[81]

c) The Triple Aim. Several new initiatives have also emerged from private foundations and not-for-profit organizations. For example, the Institute for Healthcare Improvement's has championed the triple aim strategy, which as discussed above, focuses on redesigning primary care and linking it to population health and disease management.[82] Specifically, the triple aim comprises three critical objectives: improving population health; enhancing the patient experience of care (including quality, access, and reliability); and reducing, or controlling the costs of care.[83] So far, there is no systematic empirical evidence that the approach has in fact integrated population health factors into clinical settings, probably because it relies on the payment mechanisms that have limited ability to offer providers incentives to address SDOH.[84]

IV. Challenges

Current Political Challenges

Since the onset of the Trump Administration, the integration project has faced an uncertain future. Although Republican efforts to "repeal and replace" the ACA failed several times in 2017,[85] and litigation over the ACA's fate continues,[86] a series of less dramatic legislative and regulatory actions have already

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The Prevention and Public Health Fund has faced particular threats. Each of the failed Congressional efforts to repeal and replace the ACA would have slashed support for that program. Since then, the Tax Cuts and Jobs Act cut $750 million from the Fund to pay for the Children's Health Insurance Program, and the Bipartisan Budget Act of 2018 cut the fund by another $1.35 billion over 10 years so that only $840,600 remains available, further reducing its potential effectiveness.[87] These cuts to the fund which helps support many local public health agencies, indicates the low priority the current leadership in Washington holds for prevention, never mind the integration project.

Access to preventive services may also decline if the numbers of the uninsured rise due to the repeal of the individual mandate,[88] and other less heralded, steps that the Administration has taken to reduce access to the ACA exchanges.[89] Equally significant, are new regulations designed to ease the way for association and short-term, limit-duration insurance plans.[90] Both types of plans may lead healthy people away from the exchanges and to less-comprehensive coverage. Likewise, the President has required federal agencies to encourage the expanded use of Health Reimbursement Accounts,[91] which may also move people into less comprehensive plans that do not cover essential benefits. In addition, women with ACA-compliant employer-sponsored plans may lose access to contraceptive coverage as the result of the Administration's decision to allow any employer to opt out on grounds of conscience.[92]

Moving somewhat in the other direction was the recent passage of the CHRONIC Care Act, which will allow Medicare Advantage Plans to provide more flexible supplemental benefits for individuals with chronic care, including environmental modifications and transportation services.[93] The Act also attempts to enhance ACOs in a variety means, including by requiring CMS to allow all ACOs to prospectively assign beneficiaries, and by permitting ACOs to give beneficiaries cash incentives to seek primary care.[94] Those enhancements might not matter if new changes proposed by the Administration go into effect. The changes would require all ACOs to accept risk of loss, not just bonuses, after two years instead of the six-year window now allowed; this would likely result in fewer ACOs remaining in the program.[95]

Although at times the Administration and Republican leaders have looked favorably on ACOs, they have shown less enthusiasm for payment reform initiatives that move away from the fee-for-service model.[96] Moreover, their perspective seems contrary to the integration project. Under their vision, health insurance and health care are individual matters, and each person should have to pay only for the care that he or she wants. So, for example, Republican Congressman John Shimkus explained his support for repealing the ACA's essential benefits requirement by asking, "What about men having to purchase prenatal care?"[97] To Shimkus, prenatal care was simply an individual service that should only be financed by those who use it.

That vision is antithetical to public health's population perspective, and the integration project. If health is purely personal, and individuals should pay only for their own needs, ACOs, AHCs, and any initiative that seeks to align provider incentives with the population goals are destined to remain limited in their reach and impact.[98] As a consequence, efforts to align health care with broader community health metrics will remain marginal, except perhaps in communities with high concentrations of Medicaid beneficiaries. If integration exists only for underserved and vulnerable communities, it will inevitably remain the exception, rather than the rule.

Current Implementation Challenges

Assuming that improving the community's health is a shared goal for health departments and health-care providers, implementing the integration project might alleviate some of the reciprocal challenges both face in addressing SDOH. That is, health departments have the capacity but not the resources to address SDOH; health care providers have the resources but not the capacity.

Underfunded and often claimed to be in disarray, state and LHDs continue to have primary responsibility for securing public health, in part through promulgating and enforcing health codes.[99] Their efforts have led to significant improvements in sanitation, declines in vaccine-preventable diseases,[100] development of laboratory capacity,[101] and control of infectious diseases such as tuberculosis, and have helped improve the public's health during the last 150 years.[102] In recent decades, LHDs have also been at the forefront of tobacco-control efforts, as well as new interventions aimed at reducing consumption of unhealthy foods.[103] Many, but not all of these achievements, rely on departments' legal authority.

One reason why integration is essential for addressing the community's health is that few health care administrators have the skills and capacities to work across the current clinical-community divide. Public health leadership for implementing integration would include training on ways to establish community-based connections and navigate patient care across

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clinical and non-clinical settings. And public health practitioners can work with clinicians to detect social needs and develop strategies for addressing them in the community. For example, an important aspect of the AHC Model is that it relies on a still untested screening tool to detect social needs in clinical settings.[104] Public health input can contribute to successful SDOH screening and implementation strategies.

Most health care providers remain in the private sector. Although they have far more resources than LHDs, they lack legal powers, as well as the constitutional restraints and political oversight to which LDHs are subject.[105] This raises the question: what happens to health departments as they move toward implementing integration with their larger, better-resources health care partners?

One possibility is that health care providers (and insurers) will assume greater responsibility (and provide more resources) for population-focused initiatives that do not require the exercise of legal authority. For example, provider-led collaborations, or even fully-integrated entities, may support healthy eating campaigns, vaccine clinics, and social services to assist patients with housing or public benefits.[106] If these initiatives are identified and planned in collaboration with LHDs, they may free-up department resources,[107] allowing officials to focus more fully on efforts that require legal authority (for example, code enforcement) that only they can undertake. Under this scenario, integration would result in a complementary and supportive division of efforts aimed at improving the health of a community.

But there are less rosy scenarios. One is that public health departments will increasingly adopt the perspectives of their more influential (and wealthy) provider-partners. Of course, this would not be a totally new development. Already, LHDs offer individual, clinical health services, especially to underserved populations, and public health has long viewed health problems through an individualistic lens. This perspective became especially influential during the late twentieth century as non-communicable diseases were associated with individual behavior choices.[108]

Despite embracing a broader population perspective that emphasizes SDOH and the need for health equity,[109] it is possible that as health departments join forces with health care providers, they may begin to adopt health care's narrower definition of population and more individualistic focus. (This seems especially likely if public health entities rely on funds from the health care sector to support their activities.) This could potentially lead departments to emphasize interventions that operate relatively downstream. For example, one can imagine enhanced screening programs or healthy eating workshops. While such efforts already exist, the question is whether LHDs' increased reliance on and collaboration with providers will lead to an over-emphasis of such efforts in lieu of more upstream efforts that are designed to address the economic and social roots of health inequities.[110]

A second possibility, which may co-exist with the first, is that integration will leave LHDs with fewer, not more resources. According to Leider and colleagues, many leaders of large urban health departments are worried about just such a possibility. One stated, "The main thing that we've talked about is that the ACA does medicalize some public health issues and at the same time pull some discrete funding away from public health agencies."[111] The continuous threats to the Prevention and Public Health Fund suggest that such concerns are very real. As health care providers undertake more community health efforts (with or without collaboration from health departments), support for LHDs may erode even further.

In response to budgetary restraints, LHDs may pull back and focus on core functions, such as infectious disease control.[112] This would be problematic because, as suggested above, health departments' mission, perspective, and toolkits are distinct from those of health care providers. No matter how robust the public input and collaboration, ACOs, AHCs, and like collaborations cannot inspect nursing homes, abate nuisances, declare and respond to public health emergencies, or promulgate new regulations in response to new problems. Nor are these new entities, no matter how innovative, subject to the same legal and democratic oversight as are LHDs. They do not have to respect constitutional rights, and their priorities are not subject to rejection at the ballot box. In addition, because large hospitals and provider groups play a major role in these organizations, AHCs and ACOs would face numerous potential conflicts of interest. In particular, they remain subject to perverse incentives that may discourage them from tackling some population health problems.[113] The extent and impact of these conflicts merits future research as integration proceeds.

The Future of Public Health

The integration project contributes to the wide-ranging debate among public health advocates, practitioners, and policymakers as to how the public health system can best be organized to meet expected population health challenges. Our analysis thus has important implications for the future of public health. The parlous state of the governmental public health system is one reason for considering integration as a long-term survival strategy, especially at the local level. Within state health and human services depart-

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ments, it would be appropriate to consider how public health can be integrated fully into the health care and human services responsibilities. From that perspective, the public health system will either change from within or have change imposed upon it. Integration is one possible option.

Even if integration were to develop further, health departments would almost certainly retain primary responsibility for infectious disease surveillance and response. This might allow health departments to focus on the IOM's three core public health services — policy development, assessment, and assurance.[114] As part of its policy development responsibilities, health departments would also retain their legal and regulatory authority.

Our concern is that the current discussion about the governmental public health system's future is based on nostalgia rather than pragmatic and realistic expectations of future possibilities. The fact that health systems might seriously begin to absorb the population health role reinforces the need to expeditiously develop a sustainable future role for the public health system. In short, although the integration project holds much promise for providing new support and collaboration for health departments, the danger remains that public health agencies will find themselves eclipsed, rather than enhanced. If so, population health will suffer.

Note

The authors have no conflicts to disclose.

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