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Answering the Call to Integrate: An Editorial

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ABSTRACT

These editorial comments attempt to provide some contextual background to the primary focus of the study by Carlton and Erwin in the March 2015 issue of Frontiers in Public Health Services and Systems Research, integration of health care and public health (executives). The purpose is also to provide a critical assessment of the value of evidence about strategies for integration, identified by the stakeholders in these two industries. Findings from the Carlton and Edwin study have provided important clues and have stirred the pot enough to start a much-needed dialogue. The research has provided some questions as well as answers, paving a path for future research questions and the study of those questions.

Keywords
Health care, public health, strategies, emerging trends in public health, health departments, integration, collaboration
Public health agencies continue to strive for the efficient delivery of essential public health services in this post-recession era still marked with reduced budgets and workforce. In order to remain relevant and efficient, it is imperative that these agencies fully understand the current realities surrounding public health practice and policy. These realities are marked by some emerging public health developments and trends, harnessing which is critical to successfully navigate these difficult times. Of these trends, the integration of health care and public health is perhaps the most important, as discussed later. Other cross-cutting emerging public health trends include regionalization/cross-jurisdictional sharing, quality improvement, accreditation of public health agencies, the use of health informatics, foundational capabilities of health agencies, evidence-based decision-making, Health in All Policies, and the implementation of the Affordable Care Act (ACA).

The central goal of public health is to assure the health and well-being and eliminate subgroup differences in health outcomes across the U.S. Improving health outcomes is also (or it should be) the goal of health care. A consistent relationship between affordable high-quality primary care and improved health outcomes has been already documented by many studies. The improved health outcomes due to adequate supply of care also include reduced disparities in health across racial and socioeconomic groups. So one might argue that (at least in theory) public health and healthcare are pursuing some of the same goals, and therefore it is mutually beneficial to join hands in pursuing those goals.

The situation is more favorable for integration of the two traditionally siloed fields now than ever before, due to changes in both public health and health care. For public health, for instance, building and leveraging partnerships with important community stakeholder such as healthcare providers, is an important requirement of the national voluntary accreditation through the Public Health Accreditation Board (PHAB). On the healthcare side, due to requirements of ACA, this traditionally uninterested partner (from a public health point of view) is now interested in collaboration for community health needs assessment (CHNA). For the nonprofit hospitals, CHNA necessitates incorporating input from a broad range of community stakeholders, including health departments. A recent study showed that slightly more than half of local health departments (LHDs) currently collaborate with nonprofit hospitals in their community health assessment (CHA), which is an encouraging development. Developments such as ACA and PHAB accreditation are beginning to create an environment that is conducive for integration. However, systematic integration and interdependence will require much stronger forces.

The paper by Carlton and Erwin in the March issue of *Frontiers in Public Health Services and Systems Research* has underscored the value of the integration of public health and health care in the backdrop of ACA, citing an IOM report among other sources. In this context, they have identified several strategies to facilitate such integration, using qualitative interviews with multiple stakeholders from both industries. This research has provided some important clues and has started a much needed dialogue. Yet, to curious minds, it has raised some questions as well as given some answers. For instance, all 17 participants in the qualitative study have recommended for focusing on specific, targeted issues where there is shared interest among potential collaborators, and it appears to be a good direction. Much like quality improvement (QI), where little QI (or QI for individual projects) can eventually routinize into big QI (or agency-wide QI), the premise is that project-specific integration can routinize into industries-
wide integration. Why will the two industries strive for integration, and what will be the stages of diffusion of this innovation, remains to be seen.

Another popular recommendation is to involve payers and business partners. The questions remain: Who are these business partners and how will the health departments—struggling to continue essential public health services delivery—find time and resources to build bridges if they are not convinced these bridges go somewhere desirable? Leverage ACA and market forces also sounds really a convincing strategy, but an overwhelming majority of small local health departments might not be affected by ACA. More often than not, these small health departments do not provide clinical services and will not know how to leverage market forces.

To the authors’ credit, however, they have noted the limitation that their study might have urban selection bias. This study has put together important initial pieces of a much bigger puzzle that will require searching and applying best empirical evidence and theoretical perspectives from other fields that have completed the transition of integration. The recommendation to develop and support a convening agency is perhaps the most valuable of all strategies identified by Carlton and Erwin. Only a large-scale policy creating the interdependence of health care and public health, requiring cooperation from both sides through well-defined incentives for compliance, and disincentives for lack of compliance, will serve as a glue to bring about the desired level of integration. Those policies must attempt to shift the healthcare focus from profitability and industrial complex approach, conventionally the defining characteristics of healthcare, to prevention and population health, customarily the turf for public health.

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