Discussion Paper

A Perspective on Public–Private Collaboration in the Health Sector

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INTRODUCTION

Between 1927 and 1932, the Committee on the Costs of Medical Care (the committee)—an independent, multi-disciplinary body funded by contributions from eight foundations and assisted by professional associations, local and state health departments, and the U.S. Public Health Service—conducted the first comprehensive examination of health and medical care in the United States (Committee on the Costs of Medical Care, 1932). This landmark study produced a series of 27 publications of remarkable depth and quality. The final report summarized the committee’s findings, conclusions, and recommendations for improving the organization, financing, and delivery of medical services and the health of America’s population. One of the committee’s central conclusions about making improvements at the community and national levels was (1932, p. 147):

The outstanding need is for effective leadership…. Obviously there must be continued study of the diseases and conditions which are responsible for sickness and disability as well as a survey of all agencies, groups, and individuals which provide services. Private medical services and public health work are so closely related that, in such a survey, it is folly to deal with them separately.¹

This principle—so apparent to a distinguished panel of 48 civic and health care leaders in 1932—largely was overlooked for decades. In recent years, the importance of effective communications and collaboration among nongovernmental health delivery organizations, the public health sector, and other key stakeholders who share interest in improving community health has been re-discovered. It has become abundantly clear that our nation spends a large and growing proportion of our resources on health care, but the outcomes in terms of access to services, the quality of those services, and the health of our population do not match other countries whose expenditures per capital are much lower (Bradley and Taylor, 2013; Moses et al., 2013). There is increasing recognition that restraining the growth in health expenditures and improving the health of our nation’s population will require approaches that address the full array of factors that affect health status and more collaboration among the public health sector,

¹ Italics added for emphasis.
health delivery organizations that traditionally have focused on acute care services, third-party
payers, and many other key stakeholders.

However, in our complex society, awareness of problems and the need for change often do not
translate readily into acceptance, conviction, and action. In this paper, we will share our
perspectives—shaped by our collective experiences in public health, private health delivery
organizations, and academic medical centers—on the theme of multi-sector collaboration: why it
is imperative, obstacles that can impede it, and some thoughts about how these obstacles can
be addressed.

THE CASE FOR PUBLIC–PRIVATE COLLABORATION IN IMPROVING
COMMUNITY HEALTH

The term “collaboration” refers to relationships in which two or more parties work together
voluntarily to serve a mutual interest. Collaboration can take many forms, ranging from highly
informal and non-binding—such as a simple agreement to exchange information on a particular
topic or issue—to formal partnerships that involve the creation of new organizational entities,
joint investments, and legal agreements with long-term commitments (Beatty et al., 2015;
Pestronk et al., 2013). The spectrum is wide. All types of collaboration along that spectrum
have the potential to be beneficial, but none are easy to initiate and maintain. Evidence shows
that a substantial proportion of collaborative alliances and partnerships from many sectors do
not succeed (Prybil et al., 2014).

Perhaps it was the inherent difficulty of establishing and sustaining collaborative arrangements
that require joint commitment, effort, and trust to be successful that inhibited the development of
public–private collaboration envisioned by the committee so many years ago. However, many
other factors also contributed to the schism between the public health and health care sectors
that evolved between the 1930s and the 1990s. Among these were the emergence and growth
of employer-sponsored health insurance plans such as Blue Cross and Blue Shield during and
after World War II with a virtually exclusive focus on medical and hospital services; the creation
of public programs, including Medicare and Medicaid, that infused enormous amounts of
resources into the medical and hospital sectors; stunning developments in medical science and
technology that created great public interest and generated demand for new medical
procedures; and the growing post–World War II asymmetry in funding, prestige, and societal
perceptions of private-sector medicine and hospitals in relation to the public health sector. Over
time, the combination of these developments contributed to growing differences in priorities,
weaknesses in mutual understanding and cultural rifts (Reiser, 1996; Starr, 1982).

By the 1990s, the gulf between the public health and health care sectors and the resulting
dysfunctions were becoming apparent. The adverse consequences of this fragmentation and

2 The spectrum of collaborative arrangements among two or more parties is wide, with infinite variations
of purpose and formality. See, for example, Beatty et al., 2015, and Pestronk et al., 2013.
3 For an overview of the separation between the public and private sectors of health care in America
between the 1930s and the 1990s, see Reiser 1996, and Starr, 1982.
the importance of building strong bridges between public health and health care prompted the creation in 1994 of the Medicine/Public Health Initiative, a joint endeavor of the American Medical Association and the American Public Health Association (Reiser, 1997). A basic intent of this initiative was to examine the reasons why medicine and public health were functioning as “separate and virtually independent components of the American health system” and to identify opportunities for closer working relationships between these two sectors (Lasker and the Committee on Medicine and Public Health. 1997, p. 2).

In subsequent years, a series of reports by the Institute of Medicine (IOM) (2002, 2012, 2015a), the Robert Wood Johnson Foundation (RWJF) (2013), Trust for America’s Health (2013), and other organizations advocated strongly for collaborative models that have the potential to generate collective impact. The logic for this argument is described below.

First, the focus on the medical needs and treatment of individual patients that has characterized our nation’s health enterprise for decades, while worthy, is inadequate by itself. It must be supplemented by greater attention and allocation of resources to population health approaches that are designed to assess, improve, and maintain the health of entire communities or defined population groups (Stoto, 2013).

Second, making long-term impact on restraining our nation’s health expenditures and improving the health status of families, communities, and society at large will demand concerted attention to the full range of factors—behavioral, educational, environmental, genetic, and socioeconomic—that affect them (Schroeder, 2007; Taylor et al., 2015). Improving access to health care services and the efficiency and quality of those services are essential but, by themselves, are insufficient strategies.

Third, there is growing, nationwide support for the “Triple Aim”—originally formulated by the Institute for Healthcare Improvement in 2008—as an expression of the overall direction for improving health and health care in America (i.e., striving simultaneously to enhance the patient care experience, improve the health of populations, and reduce our nation’s per capita health costs) (Whittington et al., 2015). It seems clear there is increasing readiness for change within the public and private sectors of American society.

Finally, to effectively design, implement, and sustain approaches that recognize the multiple determinants of health outcomes and address the “Triple Aim” will require much better communications and coordination among health delivery organizations, the public health community, and key stakeholders in business, education, government, and other sectors than has prevailed in our country in the past. As stated recently by Alan R. Weil (2014, p 33), Editor-in-Chief of the journal Health Affairs:

4 This monograph—prepared by the New York Academy of Medicine in conjunction with the American Medical Association and the American Public Health Association in response to a charge by the Robert Wood Johnson Foundation—is an invaluable source of information and insights about the early connections between public health and medicine, how they grew apart, and the importance of reuniting them.

5 For an excellent overview of population health concepts and definitions, see Stoto, 2013, especially pp. 2-3.
What does it take to harness community resources to overcome poor health outcomes? In a word: collaboration. Just as health does not arise from a single factor, healthy communities emerge from concerted efforts that stretch across public and private sectors and break down barriers between the long-standing silos of different government agencies and programs.

In the United States, it is clear that greater attention and resources must be devoted to promoting a safer environment, healthier lifestyles, the prevention of illness and injuries, early detection and treatment of health problems, as well as improving the quality and efficiency of medical and hospital services. These daunting challenges cannot be met without real commitment, excellent communications, and close collaboration between the public and private sectors and the active engagement of key community stakeholders. Unfortunately, these vital attributes have been all too rare in the past and—while progress is being made—still are not prevalent today. Why is this the case? What are some of the main obstacles to multi-sector collaboration in the health field and what are some ways these obstacles have been, or can be, addressed?

**OBSTACLES TO MULTI-SECTOR COLLABORATION AND STRATEGIES FOR OVERCOMING THEM**

While there are many reasons to encourage and expand collaboration involving private health care delivery organizations, the public health sector, and other stakeholders, there also are obstacles that must be addressed to enable it to occur and endure. These include conceptual and language barriers, the challenges of building and maintaining collaborative arrangements, financial and public policy impact, and demonstrating evidence of impact.

**Conceptual and Language Barriers**

Good communications among the parties is an essential ingredient in building effective relationships in all types of situations. Good communications, in turn, are dependent on mutual understanding of key concepts and terms. There is abundant evidence that communications, mutual understanding, and collaboration between the public health and health care sectors have been hampered over the years by major differences in their respective interpretation and use of basic concepts and terminology.

A classic illustration involves the concept of population health and the multiplicity of interpretations of this concept among various sectors and groups. In the public health sector, the term “population health” generally is construed to mean the “health outcomes of a group of individuals including the distribution of such outcomes within that group” (Kindig and Stoddard, 2003). The public health community recognizes that access and quality of medical and hospital services affect the health status of population groups, but put forth *evidence-based* arguments that demonstrate the larger, overall impact of education, environment, and other socioeconomic

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6 See, for example, Lasker and Weiss, 2003; Mays and Scutchfield, 2010; and Shortell, 2013.
factors. While there surely is variation in their perspectives, many in the medical, hospital, and accountable care organization communities have tended to view the concept of “population health” and “population health improvement” in relation to the patients served by their organization or attributed to it by Medicare, Medicaid, or private health plans (Casalino et al., 2015; Sharfstein, 2014).

The concepts and wording that we use and what they mean to us are instrumental in building effective communication, understanding, and collaboration. There is a great need for recognizing and addressing the language issues and barriers that continue to exist within and between the public health and health care sectors. As stated by Professor Lloyd Michener, Duke University, at the IOM’s workshop on collaboration between health care and public health in February 2015, “[i]n many cases … primary care and public health use the same words but with different meaning” (IOM, 2015a).

The recent publication of Vital Signs: Core Metrics for Health and Health Care Progress by the IOM (2015c) and the publication of From Vision to Action: Measures to Mobilize a Culture of Health by RWJF (2015) are excellent examples of progressive, pragmatic steps that should be taken to establish a common language and build mutual understanding throughout the health field. In combination, these documents provide a solid foundation for public- and private-sector organizations to identify the measures of health they wish to address, establish targets, and assess progress. Having standard measures and definitions will facilitate benchmarking, comparative evaluation, and mutual understanding among the parties that are involved in striving to improve community health.

**Collaborative Arrangements Are Challenging to Build and Maintain**

Effective collaboration among organizations and groups has substantial potential to yield benefits for all parties. However, collaboration involving multiple organizations and groups is not easy. Studies over many years in the business, health, and other sectors show that, in the aggregate, approximately half of alliances, coalitions, and partnerships that involve two or more independent organizations coming together voluntarily do not succeed (Booz & Company, 2012; Chao et al., 2014; Foroohar, 2014; Kaplan et al., 2010; Prybil et al., 2014). For example, a recent study of 661 cross-sector collaborative initiatives focused on improving various aspects of community health in communities across the country found that only 297 (45 percent) were determined to be successful (Mattessich and Rausch, 2014).

However, the evidence indicates the success rate varies in accord with the extent to which voluntary alliances, coalitions, and other forms of collaborative arrangements (“partnerships”) incorporate certain key characteristics. If these characteristics are instilled and sustained, the evidence suggests that up to 80 percent can succeed. The critical characteristics include (Prybil et al., 2014):

- **Vision, Mission, and Values.** The partnership’s vision, mission, and values are clearly stated, reflect a strong focus on improving community health, and are firmly supported by the partners.
• **Culture.** The partners demonstrate a culture of collaboration with other parties, understand the challenges in forming and operating partnerships, and enjoy mutual respect and trust.

• **Goals and Objectives.** The goals and objectives of the partnership are clearly stated, widely communicated, and strongly supported by the partners and the partnership staff.

• **Organizational Structure.** A durable structure is in place to carry out the partnership’s mission and goals. This can take the form of a corporate entity, an affiliation agreement, or other less formal arrangements such as community coalitions.

• **Leadership.** The partners jointly have designated well-qualified and dedicated persons to manage the partnership and its programs.

• **Performance Evaluation and Improvement.** The partnership regularly monitors and measures its performance using established goals, objectives, and metrics and employs the findings to make continuous improvements.

Financial and Public Policy Constraints

While the nationwide shift from fee-for-service to value-based payment systems is well underway, very few public or private purchasers of medical and hospital services provide financial incentives or support for multi-sector collaborative initiatives focused on improving community health. Meanwhile, local and state health departments generally continue to be lightly funded and are supported largely by categorical funding with strict conditions regarding their purposes and use. Most health departments face great challenges in fulfilling their core responsibilities with the limited (and often declining) resources that are available; flexible funds tend to be scarce and this can constrain their level of engagement in collaborative initiatives.

The result is that the leaders of public health agencies, hospitals, health systems, and other community stakeholders who share a commitment to create and implement a multi-sector collaborative focused on improving community health must design and implement their own funding strategies. The available evidence suggests that identifying and maintaining sufficient and sustainable funding is a principal challenge for nearly all voluntary multi-sector collaborative initiatives (IOM, 2015b; Wilson, et al., 2014). Federal and foundation grant support can provide important start-up funds and/or short-term financial support for multi-sector collaborative ventures, but rarely are durable sources of support provided for ongoing operations.⁷

It is clear that identifying one or more “anchor institutions” with a strong commitment to the mission of a particular multi-sector collaborative and a willingness to make a long-term financial

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⁷ Recent examples of new programs related to community health improvement include the “Spreading Community Accelerators Through Learning and Evaluation Initiative” sponsored by the Institute for Healthcare Improvement that is intended to assist 24 communities in “developing skills and strategies to improve the health of their communities.” See http://www.ihi.org/engage/initiatives/100millionhealthierlives/pagesscaleinitiative.aspx (accessed October 29, 2015). The “BUILD Health Challenge” sponsored by the Advisory Board Company, de Beaumont Foundation, Colorado Health Foundation, The Kresge Foundation, and RWJF will provide funds for 18 community-based projects that “aim to improve health in low-income communities.” See http://www.buildhealthchallenge.org/awards (accessed October 29, 2015).
commitment to it can be a key strategy to financial sustainability. In some instances, nonprofit hospital and health systems are serving this important role as one dimension of their institutional duty to provide community benefit. In other settings, a health department or business corporation can assume this responsibility. For example, in Portland, Oregon, Intel is taking a leadership role in a collaborative effort to improve health outcomes and contain health care costs in that metropolitan area (McDonald et al., 2015).

With respect to public policy, it is our view that our society’s interests would be served by the establishment of more public–private alliances, coalitions, and formal partnerships. In many states, current policies and regulations complicate or impede collaboration of this nature. We believe collaborative arrangements should be encouraged and facilitated by governmental agencies at the local, state, and national levels. This can take many forms, including active involvement and, when possible, financial support by local and state government; the development of state-level policies and regulations that promote hospital–public health cooperation and collaboration such as those that have been implemented in several states including Maryland, Minnesota, New York, Ohio, and others (IOM, 2015a); and federal-level policies and programs that stimulate the development and operation of successful, public–private partnerships.

Evidence of Impact

Across the country, there are many examples of multi-organization, multi-state, and multi-sector collaborative arrangements that have achieved results. For instance:

- Established in 2004, Kaiser Permanente’s National Community Health Initiative has stimulated and provided economic and non-economic support for local, multi-organization collaboratives in more than 50 communities within Kaiser Permanente’s service area. While these collaboratives vary in structure, objectives, and programs, all are focused on improving the health of the community they serve.

- The Multi-State Collaborative—with support from the Milbank Memorial Fund—was established in 2009 and now includes 18 states working together to transform the existing primary care delivery system through payment reform involving all payors. The participating states are diverse and achieving payment reform is extremely challenging, but this Collaborative has demonstrated a commitment to its daunting mission and sustainability. Having the Milbank Memorial Fund as an “anchor institution” clearly has been invaluable.

- The ASTHO Million Hearts Learning Collaborative is a broad-based, multi-state initiative established in 2013 to assist in accomplishing the U.S. Department of Health and Human Services goal of preventing 1 million heart attacks and strokes by 2017. This Learning

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8 For example, in a recently-completed study of 12 highly successful collaborative partnerships involving nongovernmental hospitals, public health departments, and numerous other stakeholders, including school systems, businesses, governmental agencies, etc., the participating hospitals or their parent health system collectively provided 70 percent of the partnerships’ total funding for the most recent fiscal year for which financial information was available (Prybil et al., 2014, pp. 26-27).

Collaborative is intended to improve hypertension control; identify and build networks and cross-section partnerships to control hypertension; test models of collaboration between public health and health care; implement quality improvement processes to influence practice and policy; and focus on systems, sustainability, and spread. This public–private initiative already is having positive, evidence-based impact.

- In 2013, the Nashville (Tennessee) Area Chamber of Commerce and the Nashville Area Metropolitan Planning Organization (MPO) launched the Nashville Region’s Vital Signs, a collaborative initiative intended to identify issues of special importance to the community as a whole and initiate strategies to address them. The growing impact of chronic conditions and access, cost, and quality of health services soon emerged as issues of great importance. In response, the Chamber of Commerce and MPO, public health and health system leaders, and the state’s largest health insurer designed and conducted a comprehensive study of the region’s health status and costs. The resulting report “encompasses core metrics and analyses covering an extensive set of population health categories that track well against the recent [IOM] recommendation of 15 core metrics categories … and provides meaningful and actionable data for our stakeholders” (Schulz, 2015, p. 2).

This initiative is another illustration of the business community taking a leadership role in identifying community-wide health issues and instituting constructive action to address them. Leadership of this nature has great potential to have major impact and should be strongly encouraged and supported by public health and health care leaders in communities across the country.

- The Committee on Institutional Cooperation (CIC) is a voluntary coalition of Big Ten universities that has existed for many years and has worked on numerous issues of common interest to these institutions. In 2014, CIC and the state health departments in states where Big Ten schools are located launched an initiative to address health disparities and the social determinants of health. In collaboration with the Minnesota Department of Public Health and other state and federal public agencies, the “CIC Health Disparities Project” will examine the determinants of disparities, identify appropriate interventions, and participate in prioritizing actions and advancing health equity (CIC, 2014).

The CIC’s leadership in partnership with the Minnesota Department of Health and other organizations is an example of the important role that educational institutions can (and should) play in identifying and addressing health-related problems and opportunities for improving population health.

- A recently completed study funded by grants from RWJF, Hospira, Inc., and Grant Thornton LLP identified and examined 12 successful partnerships involving hospitals, public health departments, and numerous stakeholders who share a commitment to improving the health of the communities they serve. The study ascertained key lessons learned from the collective experience of these successful collaborations and formulated 11 evidence-based
recommendations to assist the leaders of public and private organizations in building strong, multi-sector partnerships focused on improving community health (Prybil et al., 2014).

These examples illustrate the scope and diversity of the hundreds of public–private collaboratives focused in various ways on improving the health and well-being of America’s families and communities. It is clear this is a monumental task that will require the active engagement of multiple stakeholders at the community, state, and national levels. Even with strong collaboration between the public health and health care communities, the challenges simply are too big to be met successfully by only health sector organizations. To have enduring impact on improving the health and well-being of families and communities, we believe it is imperative to secure and maintain the active involvement and leadership of the business, education, and government sectors.

A fundamental issue, however, is widespread limitations in the existence of clear objectives, metrics, and processes for evaluating the performance and effectiveness of collaborative arrangements at the local, state, and multi-state levels. Although collaborative arrangements focused in various ways on improving community health are plentiful, the existence of objective evidence of their impact is thin (Lasker and Weiss, 2003; Porterfield et al., 2015; Roussos and Fawcett, 2000). Even the recent study of 12 successful hospital–public health partnerships—which had been selected from 157 nominees—showed that many were finding the development of meaningful metrics and objective measurement of their partnerships’ impact on improving community health to be among their major challenges.

To deserve and generate sustainable funding and to maintain community respect and support, multi-sector collaboratives must define their missions and objectives clearly, establish metrics and processes measuring their performance in relation to them, and provide evidence-based reports that demonstrate they are achieving results and making a positive impact. If they are unable to do so, they cannot expect to justify financial investments and sustainability.

CONCLUDING REMARKS

The nation’s entire health sector is in a period of transformational change. The public health community has embraced a “health in all policies” approach and across the country this approach is being reflected in a broad range of new models and initiatives. Among the major changes taking place in health care delivery and financing are the shift from fee-for-service to value-based payment systems, consolidation of health insurance companies into giant entities, and the growing integration of hospitals and physicians into large health systems, both nonprofit and investor-owned. Growing awareness of the need for better communications and more public–private collaboration is an important and promising feature of this transformation.

Many creative and promising multi-sector initiatives are under way. However, much work remains to be done. In many communities across the country, collaboration involving public

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10 For example, the Federal Reserve Bank’s Healthy Communities Initiative is demonstrating how revitalizing low-income communities can also have positive impact on the health status of individuals and
health departments, nongovernmental health delivery organizations, and other community stakeholders is weak. The lessons learned from successful collaborative arrangements must be shared more broadly. There is great opportunity for hospital, medical, and public health associations at the state and federal levels to provide educational programming, policy support, and technical assistance, both to existing collaboratives that want to become more effective and to communities that wish to create new public–private partnerships.

In addition, these associations—in concert with organizations such as the IOM, AcademyHealth, foundations with interest in improving community health, and universities—can be instrumental in encouraging the systematic examination of the impact of public–private collaboration on community health and costs. More and better evidence about the performance and impact of existing collaborative arrangements will be invaluable in guiding future public–private initiatives and generating economic and non-economic support for them.

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