

Privatization of local health department services: Effects on the practice of health education.

By: Daniel L. Bibeau, Kay Lovelace and Jennifer Stephenson

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Abstract:

Local health departments (LHDs) are changing service delivery mechanisms to accommodate changes in health care financing and decreased public support for governmental services. This study examined the extent to which North Carolina LHDs privatized and contracted out services and the effects on the time spent on core functions of public health and activities of health educators. Questionnaires were mailed to the senior health educators in all LHDs. Sixty-nine responded, and 68% of LHDs had not privatized any services other than laboratory and home health. Clinical services were more commonly privatized than nonclinical services. Respondents perceived that privatization produces more time for LHDs to address the core public health functions and for health educators to engage in appropriate professional activities. Health educators in LHDs that had not privatized were more likely to be concerned about potential negative effects. This study suggests that privatization has generally had a positive effect on the roles of health educators in North Carolina LHDs.

Keywords: local health departments | health education | north Carolina | privatization of health | health educators | public health

Article:

Public health interventions have had a greater impact on the overall health of the American people than those implemented by traditional medicine;¹ these interventions have resulted in 25 of the 30 years in increased average life span during the 20th century.² Public health organizations (including state and local health departments) accomplished this change by taking a population-based approach to disease prevention and communicable disease control.^{3,4} With this approach, organized health education within local health departments became an important component of public health interventions in the early 1900s.⁵ At first, health education began with the employment of publicists by city and county health departments to develop better public relations.⁶ Early health education campaigns used pamphlets, health conferences, hygiene

museums, health journals and reports, and didactic teaching that centered on individual change.⁵ Eventually, the profession developed a broader community-based approach to health education.⁷ Today, health education strategies targeting social, policy, and environmental as well as individual changes are commonplace.^{8,9}

Although health educators have been traditionally involved in community collaboration and broader health promotion interventions, much of the work that they have undertaken in local public health departments (LHDs) has been individually focused. There are several explanations for this. First, some health educators developing individually focused interventions were trained in programs that emphasized individual behavior change. Second, clinically trained professionals, such as nurses, are sometimes hired into health educator positions and continue the individually focused approach in which they were trained.¹⁰ Third, individually targeted health education interventions were often initiated as an enhancement to the clinical services LHDs began to offer when fee-for-service medical care did not meet the substantial medical and social needs of uninsured, underinsured, or poor individuals.¹¹

Recently, societal and governmental trends, including changes in public health financing and a general distrust of government among the citizenry, have forced LHDs to reevaluate their mission and the clinical services they provide.¹²⁻¹⁴ As a result, LHDs have sought alternative delivery mechanisms that decrease or eliminate their internal role in providing a variety of clinical health services.^{14,15} Specifically, many local officials have considered internal strategies such as restructuring and external strategies such as partnerships with other public and private organizations, contractual agreements, and privatization of LHDs' clinical services to reduce their costs and increase their efficiency.¹⁶⁻¹⁸ When services are privatized, previously public services are now provided through a private agency or organization. True privatization occurs when multiple private providers bid to have the opportunity to provide the service. Formal contractual agreements may be established in a similar fashion; however, there is no competitive bidding for the contract, and the provider may be either a private or public agency.¹⁸

Because health education services are often offered as part of LHD clinical services, partnerships, contractual agreements, and privatization of clinical services might be expected to affect the way in which health education is delivered. First, because health education services are not directly reimbursed and take resources, including personnel, time, and physical space, contracting agencies may be reluctant to keep health education services. Second, the competencies of professionally trained health educators may be recognized within many LHDs in North Carolina because of the state's history of health education practice, its focus on Healthy People 2000, and its behavioral risk factor surveillance system.¹⁹ However, other organizations may not be aware of the distinctive competencies of health educators. These organizations may assign health education roles to other personnel such as nurses and dieticians.

There is concern that privatization of LHD services may also have an indirect negative effect on health educators' roles within LHDs. In many communities, clinical services bring in Medicaid funding that subsidizes other services such as health education. It is not clear if the privatization of services will take away needed revenues for wrap-around (e.g., health education, nutrition, and socialwork) and prevention services and positions.^{20,15} Or a potential positive consequence may be that health educators will have more time to focus on community-level interventions or on populations other than patients.²⁰ Privatization of LHD clinical services also raises questions about what will happen to the public's perception of LHDs' visibility and image as LHDs change how they deliver services. Although LHDs provide an infrastructure of services essential to the health of the public, many people view LHDs primarily as a provider of medical care to the poor.²¹ If clinical services are privatized, will public health departments become even less visible? Or will such a change allow LHDs to increase their visibility or improve their image?

Although LHDs are initiating changes in service delivery, little is known about the effects of the changes on the structure, services, and personnel of LHDs. This study sought to describe such effects. Specifically, we investigated the extent to which LHDs in North Carolina had privatized or contracted out services. Second, we investigated the impact of privatizing and contracting out services on public health activities—specifically, the activities of health educators related to the 10 responsibilities of graduate-level health educators²² and how LHDs carry out the core functions of public health (assessment, policy development, and assurance).¹ Third, we examined health educators' concerns about the effects of privatization and contracting out services on their jobs and their organizations.

METHOD

Procedure

We mailed questionnaires to the highest ranked health educator in the 83 local health departments in North Carolina that employed health educators. When a clear hierarchy did not exist, the regional health education consultant serving that LHD identified the health educator with the most experience. The health educators receiving the questionnaires were instructed to obtain help from their health director if they did not know the answers to all of the questions. Respondents were also informed that their responses would remain confidential; however, an identifying number was used to track responses. Using Dillman's confidential mail survey method,²³ which included a reminder postcard and a second mailing of the survey, if necessary, 69 health educators completed and returned the questionnaire for a response rate of 83%.

Measures

We developed the survey instrument as follows. First, we reviewed the literature on privatization and developed a semistructured interview schedule to determine what issues privatization has raised for health education in LHDs. Second, we interviewed key informants—specifically, the state director of health education and six health education directors in counties that had

undergone or anticipated undergoing privatization—to obtain input on the impact of privatization on health education in LHDs. Interviewees identified the following issues: potential changes in the health educator’s role, potential loss of health education services at local health departments, the need for health educators to work collaboratively with other organizations, and potential changes in the amount of time that the LHD spent addressing specific aspects of the core functions. Third, based on these interviews and the literature on privatization, the core public health functions, and the health education roles and responsibilities, we developed a draft questionnaire and pilot tested it with six state-level health education consultants and 10 high-ranking health educators in North Carolina LHDs. We asked them to comment on the survey’s content, especially the applicability, appropriateness, clarity, and sensibility of the questions in regard to the impact of privatization on health education practice in LHDs and on the ability of local health educators to answer them; thus, the respondents could assess item and format appropriateness in yielding data that would answer the research questions. Fourth, based on their feedback, we revised and sent the questionnaire to the study sample. Some of the individuals participating in the pilot test also completed the final questionnaire. Since the study was descriptive, this should not be a threat to the validity of the data. Next, we describe specific measures.

Services provided and privatized. Based on feedback from the key informants, we adapted a recommended list of LHD services²⁴ for North Carolina LHDs. For each service listed, we asked three questions (shown in Table 1): (1) whether the service was provided, (2) whether the service was contracted out or privatized (hereafter referred to as privatized), and (3) whether LHD health educators were a part of the service at the health department.

Impact of privatization on health education and public health. We asked respondents about the demonstrated and perceived impact of privatization on health education. First, when privatization occurred, we asked if the number of health educators increased, decreased, or stayed the same and whether their roles or the organization of health education services changed as a result of the privatization. Second, we asked about their perceptions of how the amount of time all health educators in their LHD spend on the 10 responsibilities of graduate-level health educators²² (shown in Table 2) would or did change as a result of privatization. An additional question asked about time spent on coalition building. We chose the 10 responsibilities of graduate-level health educators rather than the 7 responsibilities of entry-level health educators because there are several graduate-level degree programs for health educators in North Carolina, and three of the state job classifications for health educators prefer a graduate-level degree. Third, we asked respondents about their perceptions of the impact of privatization on the amount of time the LHD as a whole spent or would spend on the 10 organizational practices of public health (shown in Table 3).²⁵ (We split the assurance practice of informing and educating the public into two questions—one for education through patient education and one for education through population-based programs. We also separated the policy development practice of advocating and building constituencies for public health and identifying resources into two distinct concepts.)

Five-point Likert-type scales (where 1 = much less time and 5 = much more time) were used for the latter two sets of questions. Fourth, using items developed from the literature and the interviews with key informants, we asked about their concerns about health education in LHDs as a result of privatization (1 = not at all concerned and 5 = extremely concerned). Finally, we asked respondents about their perceptions of changes in the LHD's visibility (1 = less visible to 5 = more visible) and image (1 = worsen image to 5 = improve image) as a result of privatization of services.

Analysis

We used descriptive statistics to examine the provision and privatization of services, the participation of health educators in services, and the changes in health education full-time equivalents (FTEs) and structure. To look at perceptions of the impact of privatization on health education and local health departments, we grouped LHDs as either having privatized at least one service (referred to as LHD-P) or as having privatized no services (referred to as LHD-NP). We did not count LHDs that privatized only laboratory and/or home health services in the LHD-P category for two reasons. First, health educators were least likely to participate in these services (3% and 12%, respectively); second, regional and local key informants indicated that the privatization of these services would have very little impact on health education. The interviewees also said that laboratory services were privatized primarily due to Clinical Laboratory Improvement Amendments (CLIA) regulations and because home health had never been part of LHDs in many locales. This categorization resulted in 22 LHDs privatizing at least one service (LHD-P) and 47 LHDs having privatized no services (LHD-NP). One-way analysis of variance (ANOVA) was used to determine differences in health educators' perceptions based on their membership in the LHD-P or LHD-NP category. ANOVA is not always recommended for the analysis of ordinal-level data, but in this case, it was appropriate to use because the following conditions were met: (1) the study is descriptive in nature and the rejection or acceptance of hypotheses is not an issue, and (2) the distributions approach normality (there is a reasonable spread of responses along the 5-point scales used) and the sample size is reasonably large (greater than 10 in each group). In such cases, ANOVA is a robust procedure.²⁶

RESULTS

Respondents and Health Departments

Sixty-nine health educators responded to the survey for a response rate of 83%. The respondents were Public Health Educator IIs (71%) (PHE IIs must have 2-5 years of experience plus managerial responsibilities), Public Health Educator IIIs (7%), Public Health Educator Is (6%), and others, including health education specialists or supervisors/managers (16%). Health educators were from health departments representing one county (n = 63, 91%) and multiple-county (n = 6, 9%) health departments. Twenty-eight LHDs (40.6%) served populations of less than 50,000 people, 22 (31.9%) served 50,000 to 100,000 people, and 19 (27.5%) served more

than 100,000 people. Jurisdiction sizes ranged from rural counties serving 8,066 individuals to larger urban areas serving more than 600,000 individuals.

Most LHDs organized their health education services as a separate division within the department (n = 38, 56%). However, several health education programs were also located within or as part of population-focused programs (e.g., adult health, child health, maternity/family planning, WIC, community health promotion) in 34% (n = 23) of the counties or within nursing programs (n = 4, 6%).

Services Provided and Privatized by LHDs

Table 1 shows the frequencies of LHDs providing and privatizing specific services, as well as the frequencies with which health educators participated in these services at the LHD. As can be seen in this table, LHDs were most likely to provide infectious disease/sexually transmitted disease clinics (97%), family planning clinics (96%), and environmental services (96%). LHDs were least likely to provide nonclinical chronic disease services (39%), school health clinics (48%), and home health services (49%). Laboratory services (20%), prenatal care clinics (16%), and home health services (14%) were the most frequently privatized services. Least frequently privatized were injury control and prevention, environmental services, and management services; each was privatized by the one LHD in North Carolina that has privatized all services except those mandated by public health law.

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Table 1 also shows the services in which health educators were most frequently involved. These were community health promotion (97%), family planning clinics (77%), and prenatal care clinics (68%). Health educators were least involved in laboratory services (3%), home health (12%), school health clinics (26%), and WIC–nutrition services (26%).

Impact of Privatization on Health Education

In the LHDs-P (n = 22), privatization had the least impact on the structure of health education services and the most impact on health education roles. Only 4 of 22 health educators (18%) from LHDs-P reported changes in how health education services were organized; there was not a consistent pattern in how the organization of health education within the LHDs changed. Overall, privatization has had a limited impact on the number of FTE health education employees within the LHD. The number of health educators increased in 4 (18%) of the LHDs-P and decreased in only 1 (5%). Most LHDs-P reported no change (n = 17, 77%) in the number of full-time health educators.

One-third of the health educators in the LHDs-P (n = 7, 32%) reported role changes for health educators in their departments. These changes included expanded roles for health educators, more focus on health promotion instead of direct patient education, more focus on marketing of

health department services, more focus on health outcomes, and more focus on community outreach and community organizing. Thus, for the most part, these role changes had health educators focusing on more community-oriented skills and responsibilities than before privatization. Two respondents relayed what they saw as negative experiences and stated that public health was becoming more business oriented; it was focusing more on generating revenue than on the task of health education.

Perceptions of the impact of privatization were also explored. Table 2 shows that all respondents believed that privatization of LHD services would increase the amount of time that all health educators in their LHD would spend on the 10 responsibilities of graduate-level health education. Respondents believed that health educators' time would increase the most for coalition building, acting as a resource in health education and assessing individual and community needs for health education. An ANOVA showed that there were no significant differences between the means of the LHDs-P and the LHDs-NP.

As shown in Table 3, both LHD-P and LHD-NP health educators believed that privatization would allow LHDs more time to focus on core functions of public health. Respondents believed that LHDs would have the greatest increase in time for setting priority health needs, evaluating public health programs and providing quality assurance, and managing the resources and the organizational structure of the LHD. Based on the ANOVA, there were statistically significant differences between the LHD-P and LHD-NP group means for the organizational practices of advocating and building constituencies for public health ($p < .003$) and for managing resources ($p < .014$). Health educators from LHDs-P perceived that more time could be spent on these practices as a result of privatization than did the health educators from LHDs-NP.

As shown in Table 4, health educators also had concerns about the potential changes in LHDs due to privatization. Generally, all health educators were very concerned about the private sector having a different mission than public health. They were also concerned about the contracted provider not devoting adequate time for health education programming and the potential for layoffs. Based on the ANOVA, there were statistically significant differences between the LHDs-P and LHDs-NP regarding less demand for health education services ($p < .0001$), health education being phased out ($p < .004$), layoff possibilities ($p < .01$), and fewer resources available for health education services ($p < .0061$). In each case, health educators from LHDs-P were less concerned about the impact of privatization on health education than those from LHDs-NP.

DISCUSSION

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Our data lead to five observations. First, privatization of services (this includes contracted services) is occurring in North Carolina local health departments, although the rate of privatization is still relatively low. Excluding the one health department that had privatized all

services except vital statistics and environmental health, the average number of services privatized per LHD was 1.01. Excluding laboratory and home health, the average number per LHD was .66 services. Furthermore, 68% of the responding LHDs had not privatized any services, except for possibly home health or laboratory.

Second, privatization of clinical, rather than nonclinical, services was most likely to occur. One-sixth of the responding LHDs reported that they had privatized prenatal care clinics. Other prenatal care services, dental, and family planning clinics were also more likely to be privatized or contracted out than nonclinical services. Privatization of prenatal clinics may be due, in part, to issues regarding malpractice insurance. However, since health educators are heavily involved with prenatal clinics and family planning services, privatization of these services has more potential to have an impact on their job responsibilities.

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Third, privatization of LHD services is having some impact on health education positions and roles in LHDs. Considering only those health departments that had privatized at least one service other than home health or laboratory services (LHD-P), most LHDs retained (77%) or increased (18%) the number of full-time health education positions. Health educator positions were lost in only one LHD. One-third of the respondents indicated role changes (e.g., increased professional opportunities such as more focus on the marketing of LHD services and more focus on community outreach and organizing) when LHDs privatized services. Therefore, to date, privatization and contracting out of LHD services appear to have a positive or neutral effect on the employment of health educators and the practice of health education in North Carolina.

Fourth, health educators believed that privatization will increase or has increased the amount of time all health educators in the LHD can devote to carrying out the graduate level health education responsibilities and the time LHDs can spend on the core functions of public health. The privatization of clinical services, found in this sample, may have freed up time for personnel to focus on the core functions. When there were statistically significant differences, LHD-P health educators perceived that their LHDs would have more time to spend on some of the core functions of public health than those in LHDs-NP. A possible explanation for the difference in the perceptions of respondents from LHD-Ps and LHD-NPs is that the former are likely to base their perceptions on the changes that have occurred while the latter are only basing theirs on their speculation about future effects.

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Fifth, those health educators who had not experienced privatization seemed to be more concerned about its impact than those who had. Specifically, health educators in LHDs-NP had more concern than health educators in LHDs-P about a decreased demand for or the phasing out of health education services, potential layoffs, and fewer resources for health education. These data suggest that the anticipated unknown outcomes related to privatization may be what results

in the most concern among LHD-NP health educators. From our sample, it appears that privatization and contracting out of services could be viewed as an opportunity for health educators to become more effective in LHD roles and engage in more varied health education skills, both within and outside the LHD.

IMPLICATIONS FOR PRACTICE

Given that LHDs may continue to privatize or contract out some of their clinical services, health educators could spend time making a case for how they want to spend their time in the postprivatization period. This should be done in a way that best serves the constituency of their LHD. Health educators, when they have been trained in public health–oriented professional programs, can exercise leadership in the change process accompanying privatization to help the department consider how to best address the health of the community. For example, LHDs could be forming deep, long-lasting partnerships with community-based organizations¹⁴ to address public health problems and their multiple and interconnected medical, social, and economic causes.⁸ With their training in communication, community development, and organizing and their philosophical orientation to “start where the people are,”²⁷ health educators can interpret community strengths, needs, and interests to others in the health department and thus serve as leaders in developing authentic partnerships with grassroots community organizations. When communities see that their priorities are listened to, trust that facilitates long-term cooperative relationships is more likely to develop.²⁸

Privatization of services to which they were formerly assigned may also provide health educators with the opportunity to demonstrate their skills at building interorganizational relationships and community advisory groups such as those required by a wide variety of public health programs. Now Project ASSIST, COMMIT, HIV/AIDS programs funded by the Ryan White Care Act, Healthy Start, and WIC mandate community participation through an advisory group or a community coalition.²⁹ Moving services to the private sector will necessitate that LHDs pay conscious attention to making sure that their constituents’ needs are met. With their focus on coordinating the provision of health education services and cultural competency, health educators may facilitate much of this work.

This study also has implications for the professional preparation of health educators. In the very rapidly changing environment currently faced by the public health system, it is increasingly important for health educators to understand system and organizational change and how to take advantage of that change.³⁰ Among the other skills that may be needed are the ability to work within the public and private sectors at the same time and skills in framing the needs of clients and communities to private agencies and organizations in a way that is compatible with those organizations’ missions and goals.

LIMITATIONS AND FUTURE RESEARCH

This study has several aspects that limit generalization of the findings. First, we do not know the bias that resulted from nonresponse. We do know that three of the nonresponders were new in their roles at their LHDs, did not know the answers to the questions asked, and felt the time that would be taken to complete the questionnaire was unreasonable. The nonrespondents included 1 large urban LHD and 13 small to mid-sized LHDs.

Second, we measured health educators' perceptions of how much time they would have available to carry out specific responsibilities, rather than how their time for these responsibilities actually changed. Nonetheless, responses from those in the LHD-P group should be based on the reality of their experience of going through privatization. Thus, there is some indication rooted in reality that health educators will have more time to spend on the health education responsibilities and the core functions of public health. Even though there were not statistically significant differences between health educators in LHDs-P and LHDs-NPs in their perceptions about changes in time for the health education responsibilities and the core functions of public health, those in LHDs-P had higher mean scores on every item. Since there was an obvious trend in the data, these issues should be investigated with more respondents to increase the study's power. Furthermore, the reader should be cautioned about drawing strong inferences from these data because the purpose of the ANOVA analyses was not to test hypotheses but to describe what was happening in regard to privatization and contracting out of services in North Carolina. In future studies testing hypotheses, analytic techniques developed for ordinal data would be more appropriate.

Third, we do not know the extent to which the respondents had direct knowledge about all the factors leading to privatization and experience in the decision process. However, since 94% of the respondents had at least 2 to 5 years of experience as a health educator and managerial responsibilities, it is likely that they were aware of these factors. Also, many respondents were supervisors of health education units; these individuals typically report to the health director and are likely to have exposure to policy discussions regarding changes in the LHD.

A fourth limitation is that we received responses from only selected health educators (generally senior rank) who may have very different perceptions and a greater sense of job security than those of lower rank and less tenure as an employee in their LHDs. A fifth limitation in regard to the study's potential generalizability is that the state of North Carolina has a long history of hiring professionally trained health educators in its local health departments. Nationally, the median number of health educators (plus public information specialists) in health departments serving jurisdictions of less than 100,000 people is 0.10. In the current sample, 50 LHDs (72.5% of the sample) served jurisdictions of less than 100,000 people; all had at least 1 health educator. Although we did not ask about the professional training of the respondents, discussions with faculty in health education training programs verify that the use of professionally trained health educators in local health departments in their states is substantially different. Thus, future studies should examine the effects of privatization in other states.

A final and important limitation is that our questions regarding health educators' roles and responsibilities are limited to that of the 10 responsibilities of graduate-level health educators. Future studies should include finer-grained measures that address health educators' roles and responsibilities in community-level interventions.

We have a set of recommendations to address some of the limitations above and to further what can be learned about the effects of privatization on health education in LHDs. In future studies, researchers may consider measuring actual time spent on health education responsibilities and the core functions of public health. These data, if collected, could provide a valuable source of information about what health educators in LHDs are currently doing and how their roles are changing over time. It would be prudent, if resources exist, to include a mixture of more and less experienced health educators in such a study to capture the range of activities in which they participate and the changes in those activities. For states, the data would also be useful for planning continuing education and consultation for LHD health educators. At the organizational level, such data could help guide local health departments in the most effective use of health education positions; at the policy level, it could be used to inform policy makers about the potential benefits to be gained from health educators. For professional preparation programs, it may also be useful to assess current responsibilities by using the competencies and subcompetencies as a means of obtaining a finer-grained analysis of the impact of privatization on health education practice in LHDs. These data would be very useful in informing curriculum changes.

Another factor that may affect what happens to health education in LHDs is the process through which the privatization or contracting out of services occurred. For example, some LHDs may privatize services as a result of strategically considering their mission and how the services fit within their mission and then carefully plan for the changes. In contrast, some LHDs may privatize services based on edicts from county officials or emergency situations such as a loss of funding. In the first case, privatization may be primarily a positive experience since the LHD presumably had time to proactively plan for and use the changes in the services provided. In the latter case, privatization may be a negative experience because of the lack of control perceived by departmental employees, and it may have more of a negative effect on what the LHD is able to accomplish. Collecting process data such as these may help us understand and document any changes that occur to health educators and health education practice in LHDs. Future studies should also look at the effects of privatization over time. Such an event may have long-term consequences that are not discernable at the beginning of the process.

With data such as suggested above, we can gain a clearer understanding of the changes occurring in public health and how health educators are affected by and can contribute to these changes. We began this process due to anxieties observed among health educators in North Carolina regarding the potential privatization of LHD services. Our findings suggest that this anxiety may be misplaced and that health educators may benefit from privatization. In effect, the health educators who took part in this study believed that they would have more opportunity to employ

the skills and knowledge of the profession. We recognize that the situation for health educators in LHDs in North Carolina may be different than in the rest of the country where, in general, health education as a profession is less firmly established. In North Carolina at the time of this study, privatization may well open the door for health educators to use more of their skills and knowledge in promoting the health of the communities they serve.

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