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Impacts of Local Health Department Consolidation:

A Summary of Recent Research Nationally and in Ohio



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Kent State University
Center for Public Policy
and Health (KSU-CPPH)

Kathryn Bland
Marissa Bland
Josh Filla
John Hoornbeek

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I. Introduction

Health officials around Ohio are exploring the idea of consolidating local health departments (LHDs). This document summarizes *potential* benefits to be achieved from LHD consolidation in terms of monetary savings and efficiencies, as well as public health service improvements. Potential costs associated with consolidation-related transition processes are also highlighted. The information presented is based on a review of scholarly and professional literature pertaining to the impacts of LHD consolidation nationally and in Ohio. It is important to emphasize, however, that the benefits and costs of LHD consolidation are situation specific. Those working toward LHD consolidations in their own communities should look specifically at their own situations to ascertain likely benefits and costs in their particular circumstances.

II. Background

Changing Public Health Threats and Practices

The public health threats facing American citizens have been changing in recent years, and they have been accompanied by efforts to adapt public health strategies to new public health problems. For example, as traditional public health threats associated with communicable diseases and sanitation needs have been addressed over the past century or so, new problems associated with chronic disease and unforeseen emergencies have taken on greater importance. National, state, and local public health leaders have been working to adapt public health practices to address these changing threats and problems, often in resource constrained environments.

The vast majority of health departments in the United States are *local* health departments (LHDs) which serve local communities. Most of these LHDs are relatively small, serving fewer than 100,000 persons. However, there is reason for concern that smaller LHD's may not be able to provide the full range of essential public health services that are needed for local communities (Mays et al., 2006; Kodrzycki, 2013). Strategies for engendering improved public health service provision in this context include transitioning health department roles away from exclusive reliance on direct services toward more active roles in facilitating local health services from a wide range of sources. This kind of approach appears more viable now than in the past due to the Affordable Care Act (ACA) and the incentives it provides for health service providers to respond to community health needs.

Other approaches related to enhancing public health services and to addressing changing public health threats include accreditation programs that build the capacities of state and local health departments, collaborations among LHDs, and LHD consolidation. The Public Health Accreditation Board (PHAB) is a nonprofit organization dedicated to working to “promote and protect” the overall health of the public by standardizing performance and quality measures for all public health departments within the United States (PHAB, 2015). These standards and measures include 12 domains that provide guidance to public health departments wishing to apply for accreditation. The standards outlined by PHAB are vigorous, and require resources and effort to achieve. Collaborations among LHDs enable sharing of resources to meet targeted public health service needs. And consolidating LHDs enables the integration of existing institutions in ways that may enhance planning and coordination beyond what can be achieved through targeted collaborations.

The Landscape of Health Departments Nationally

According to the National Association of City and County Health Officials (NACCHO), there are approximately 2,800 LHD's in the United States (NACCHO, 2013). More than half of these health departments (61%) serve fewer than 50,000 persons and more than three-quarters of them (77%) serve fewer than 100,000 persons (NACCHO, 2013).

In recent years, a number of these smaller health departments have begun to discuss the idea of consolidating their operations. Indeed, the numbers of health departments sampled by NACCHO in its regular LHD surveys appears to have diminished somewhat in recent years (NACCHO, 2005 and 2013), and this trend could reflect – at least in part – a trend toward consolidation at the national level. However, because the NACCHO survey is not specifically designed to identify and canvas all LHDs in the country, there is no definitive data (that we are aware of) on national trends in LHD consolidation over time.

The Landscape of Health Departments in Ohio

There is more complete information available on LHDs and consolidation in the State of Ohio than there is nationally. In 1919, there were 180 LHDs in the State of Ohio (AOHC, 2012). As of 2013, there were 125 LHDs in Ohio (Morris et al, 2013; ODH, 2015).

There have been efforts to document LHD consolidations occurring in Ohio. Morris and Hoornbeek and their colleagues documented 20 voluntary LHD consolidations in Ohio between 2001 and 2013 (Morris et al, 2013; Hoornbeek et al, 2015). These consolidations yielded a 13% reduction in the number of health departments in the State of Ohio between 2001 and 2013. Since 2013, there has been at least one additional LHD consolidation, and it involved the Portage County and City of Ravenna Health Departments (Sever, 2015).

The Ohio Revised Code (ORC) provides four ways in which a merger of health departments may occur in Ohio. The four options are presented below (ORC, 2015):

1. Union of City with General Health Districts (ORC 3709.07)
2. Election for Union Into Single General Health District (ORC 3709.071)
3. Contract between Boards of Health (ORC 3709.08)
4. Formation of single city health district from two or more districts (ORC 3709.051)

All four of these legal mechanisms are available to health departments considering merging in the State of Ohio.

There is reason that to believe that the trend toward consolidation will continue in Ohio. In 2012, the Association of Ohio Health Commissioners (AOHC) released a report recommending that all LHDs be capable of delivering a minimum array of core public health services (AOHC, 2012). The AOHC recommended that LHDs unable to provide these core services collaborate or consolidate with other LHDs to enable them to achieve this level of service provision. In that same year, the state budget bill authorized the Director of the Ohio Department of Health (ODH) to withhold federal and state funds from Ohio LHDs that had not applied for accreditation by 2018 and/or achieved it by 2020 (CDC, 2014) These recommendations and policy changes are likely to further encourage LHD consolidation in Ohio in the coming years.

III. The Impacts of LHD Consolidation: Evidence from Recent Research

Over the last decade or so, there have been a number of scholarly and professional research studies seeking to improve our understanding of LHD consolidation and its impacts. These studies have provided reasonably strong evidence that LHD consolidation can yield monetary savings and cost-efficiencies, and at least suggestive evidence that LHD consolidation can enable public health service improvements. However, there has also been research suggesting that LHD consolidation can have disruptive effects on LHD operations during the transition to a new and consolidated organization. Selected findings in these areas are presented below.

Cost-savings and Public Health Service Efficiencies

- Local public health services appear to be subject to “economies of scale”, meaning that (per unit) costs of providing services tend to go down as the volume of services delivered increases (Santerre, 2009; Kodrzycki, 2013; Bernet & Singh, 2015).
 - The “minimum efficient scale” (MES) for public health services has been estimated to be about 100,000 persons served (Santerre, 2009), and this suggests that consolidating LHDs serving communities with populations below this level can lead to greater efficiencies in service provision.
- LHD consolidations between 2001 and 2013 in Ohio resulted in reduced expenditures, post consolidation, for LHDs that had consolidated in comparison to similar non-consolidating LHDs (Hornbeek, Morris, Stefanak, Filla, Prophan, & Smith, 2015).
 - This analysis controlled for other relevant factors: characteristics of populations served, local public spending, urban-rural location, and trends over time.
 - City budgets appear to have often benefited from the reduced expenditures.
- The consolidation of three LHDs in Summit County Ohio (City of Barberton, City of Akron, and Summit County Health District) was reported to yield about \$1.5 million in savings in the year immediately following its consolidation in January of 2011 (Hornbeek, Budnik, Beechey, and Filla, 2012).
 - The vast majority of these savings accrued to the City of Akron (Hornbeek, Budnik, Beechey and Filla 2012).

Public Health Service Improvements

- Larger public health departments tend to be more equipped and able to perform essential activities or services compared to their smaller counterparts (Mays et al. 2006).
 - LHD consolidation “may hold promise for improving the performance of essential services” (Mays et al, 2006).
 - The greatest potential for improved services may be for smaller local health departments, whereas larger jurisdictions would only have a modest increased in improved efficiency and performance (Mays et al. 2006).
- 75% (12/16) of Senior Local Health Officials (LHOs) in Ohio who were interviewed about their departments’ consolidation with a neighboring LHD reported service improvements within one year (Hornbeek et al, 2015; Morris et al, 2013).

- This perceived public health service improvement figure increased to 82% (14/17) after two years and 100% (8/8) after five years (Hornbeek et al, 2015; Morris et al, 2013).
- Stakeholders may experience greater ease in dealing with public health authorities after their consolidation, due to reduced competition between the health departments (Hornbeek, et al, 2012).

Transition Effects of LHD Consolidation on Health Department Operations

- While LHD consolidation may save money, it may also depress external revenue generation in the short term (Morris, Hornbeek, Stefanak, & Filla, 2015).
 - However, this effect appears to be due to operational disruptions occurring during the transition to a new and consolidated LHD, and the statistical effect appears to disappear after the first two years post consolidation (Morris, Hornbeek, Stefanak, & Filla, 2015).
- Summit County Public Health (SCPH) staff members reported substantial disruptions in their operations during the first year of their transition to a new and consolidated health department (Hornbeek, Budnik, Beechey, & Filla, 2012).

IV. Conclusion

The research conducted to date suggests that consolidating LHDs can yield financial and public health service improvements. However, it also suggests that these benefits are variable across cases and that LHD consolidation processes can be disruptive to normal LHD operations. As a result, those involved in LHD consolidation processes should conduct assessments tailored to their particular circumstances in order to understand likely impacts. And, if they proceed with consolidation, they should engage in careful planning to manage potentially disruptive transition impacts. Thus, while there are useful lessons that can be learned through the research findings summarized above, each situation is unique and local officials will need to assess their own circumstances in order to make good judgments about consolidating LHDs in their communities.

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