Policy Brief

Consolidation of Local Health Departments in Ohio: Motivations and Impacts

Frequently Asked Questions (FAQs) and Answers from a Public Health Practice-Based Research Network (PBRN) "Quick Strike" Study

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By:

Matt Stefanak
Josh Filla
John Hoornbeek

Center for Public Policy and Health,
College of Public Health, Kent State University

And

Michael Morris

University of Arkansas for Medical Sciences,
Faye Boozman College of Public Health

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Disclaimer

This report and the results presented have been prepared to meet information needs expressed by policymakers in Ohio. We anticipate making further refinements to this work over time to improve upon the methods used and the findings presented. For more information on subsequent findings, please feel free to contact the Center for Public Policy and Health at Kent State University, 330-672-7148.

Project Purpose

Provide information on the motivations for and impacts of local health department "consolidations" to inform discussions of local health department mergers at the state and local levels in Ohio.

Executive Summary

Since 2001, there have been twenty cases of local health departments merging their public health services in Ohio.[1] Our study examines implications of consolidation for local public health expenditures, workforce and service delivery. This research blends data obtained through interviews conducted with senior county health department officials (17 of 20) and statistical analyses of administrative data found in the Annual Financial Reports (AFR) maintained by the Ohio Department of Health.

Findings from our study indicate that health departments often seek to save money (82%) and improve services (65%) through consolidation, and that overall city government factors such as budget deficits and the structure of the city leadership are influential in promoting consolidations. In addition, the interviewees report that their consolidations have been successful in achieving these goals more than 90% of the time. Consistent with findings from our interviews, analyses of AFR data indicate that consolidation is associated with a significant reduction in per capita total expenditures (13.9%).

Analyses of AFR records also corroborate assertions that the consolidations did not lead to increases in the tax burden for public health services on the county jurisdictions. Almost half (8/17, or 47%) of the responding officials acknowledge some form of service loss associated with consolidation, although many of them reported that the service losses were not negative ones. Our data also suggest that there were cases of changes in total health department staffing levels following consolidation. However, employee layoffs occurred in only three of the sixteen cases where data were reported. Overall, 88% of the reporting county senior health officials (15/17) said that they thought that the consolidation was "a good idea" in their particular cases.

[1] This figure includes only cases of "voluntary" consolidation, and does not include cases where municipal health departments are merged because cities fall below the 5,000 population threshold that is required for the existence of a "city" health department.

Background

Public health officials in Ohio are exploring new ways of providing services. These efforts result from two significant changes in the public health environment. First, public health officials at the county and municipal levels have seen their budgets tighten as a result of declining revenues associated with the recent recession and cuts in aid from higher levels of government. Second, there is a growing emphasis on ensuring that local health departments have the capacity to provide ten public health services that have been identified as essential by the Institute of Medicine (IOM) and other professional organizations. To demonstrate this capacity, health departments in Ohio and elsewhere are being asked to apply for and obtain accreditation by the Public Health Accreditation Board (PHAB). These changes are forcing local public health officials to look beyond their own jurisdictional lines to increase capacities and improve their ability to provide efficient and effective public health services.

Through queries of the Ohio Department of Health and local public health professionals in Ohio, we identified a total of 20 "consolidations" of local health departments in Ohio since 2001. While the specific legal forms of these consolidations varied, nearly all of them involved merging services provided by city health departments into services provided by county health departments. We conducted a multi-method review of the motivations for and impacts of these consolidations. Analyses of Annual Financial Report (AFR) data from health departments in the state of Ohio were blended with interviews of senior county health officials[2] with knowledge of 17 of these 20 "consolidations", a sample of about 85% of the voluntary consolidations that have occurred in Ohio over since 2001. To a significant degree, these interviews were aimed at addressing frequently asked questions (FAQs) raised by practicing public health officials in the state of Ohio. They included questions related to the motivations that drove the decision to consolidate, the impacts of the consolidation related to finances, services, and staff, as well as about issues relating to the transition from multiple health departments into a single entity.

[2] These officials include county health commissioners (present and former) and administrators currently leading consolidated health departments.

Frequently Asked Questions (FAQ) and Answers

1. Why merge?

   We asked the senior county health officials we interviewed to indicate what the original stated goals were for the consolidations in which their departments were involved. Our results indicated that saving money was a stated goal in 82% (14/17) of the cases and improving services was a goal in 65% (11/17) of the consolidations. Increasing capacity was reported to be a stated goal in 35% (6/17) of the cases, and respondents indicated that increasing efficiency was a goal in 24% (4/14) of the consolidations. Three respondents (18%) highlighted other goals related to their organizations' consolidation process. Only two out of 16 reporting senior county health officials (13%) indicated that the original stated goals of their consolidations changed over time.

   The majority of those we interviewed believed that they achieved the stated goals of their consolidation. Of the 14 respondents who indicated that achieving cost savings was a goal, 13/14 (93%) indicated that they felt that goal was achieved. One respondent indicated that they did not know if that goal had been met by the consolidation process. One hundred percent (100%) of those who indicated that achieving efficiency (4/4) and improving service (11/11) were goals believed those goals were met. And finally, 5/6 (83%) of those who felt building capacity was an original stated goal felt that goal had been achieved.

   It is important to note that these findings rely on perceptual data provided by individuals managing the consolidated health departments, and that the perceptions of health department leaders may be different than the perceptions of other audiences.

   However, our analyses of AFR data provide additional insights relevant to the issue of "why merge" or "what promotes consolidation" among local health departments in Ohio. Between 2002 and 2011[3], all of the consolidations that occurred among local health departments were mergers between cities and the health department of the county in which the city is located. Consistently the most powerful predictors of consolidation that we were able to examine in our analytical models developed with AFR data were characteristics about the city government. We found that cities with general fund deficits had 5.6 times greater odds of merging than other cities. Similarly, cities with "strong mayor" style systems, where there would potentially be a powerful policy advocate for consolidation, had 2.9 times greater odds of consolidating than did other city health departments. Rather strikingly, the financial condition of the city health department itself, as reflected by reliance on reserve funds to fill gaps created by current year expenditures exceeding current year revenues, was not significantly associated with consolidation.

2. Would merging health departments result in lower costs?

   More than 80% (14/17) of the senior county health officials in our interview sample reported that a goal of their consolidation was to achieve cost savings. More than 90% (13/14) of these respondents reported perceived cost savings within one year of the merger. The savings reported for the first year after consolidation varied from relatively small amounts of money associated with the reduction in senior management salaries to more than $1 million for the recent merger of the Akron and Summit County health departments.

[3] There was one city health department to city health department merger between the city of Barberton and the City of Norton in 2001, but that merger was not included in our analyses of AFR data between 2002 and 2011.

Analyses[4] of AFR data confirm cost savings identified by those we interviewed, as they indicate a significant decrease (13.9%) in per capita total expenditures for consolidated vs. non-consolidated health departments. However, focusing specifically on reported administrative costs, our analyses of AFR data found no statistically significant difference in per capita administrative expenditures between the health departments that consolidated and those that did not consolidate. Taken together, our quantitative and interview findings suggest that recent consolidations of city and county health departments in Ohio do appear to reduce the cost of providing public health services. However, because of the limited size of our sample, we would encourage further research on the impacts of consolidation on administrative costs.

3. How would the quality of services currently being offered by each health department be affected by consolidation into one health department?

   While our data do not directly measure service quality, about 65% (11/17) of the reporting departments suggested that service improvement was a goal of their consolidation. Notably, senior county health officials in all eleven of these departments indicated that they believed their service improvement goals were achieved. Still, almost one-half (8/17, or 47%) of the responding departments also acknowledged that some form of service loss was experienced as a result of the consolidation. The majority of the service losses identified, however, were not reported to be negative changes. Additional research on the impacts of consolidation on public health services is appropriate to expand upon the perceptual information presented above.

4. Would a merger or contracting result in job loss?

   Nineteen percent (3/16) of the reporting senior county health officials said that public health workers were laid off as a result of their consolidation[5]. Some of the officials we interviewed noted that there were decreases in staffing levels, but -- other than the three cases noted above -- these other reported job losses appear traceable to voluntary attrition rather than layoffs.

5. Does a combined health department generate more revenue and does this increased revenue cover the additional cost of providing services to the consolidating city?

   All of the reporting senior county health department officials (16/16) indicated increases in revenues from tax based sources (state aids, local levies, and contracts with the cities) after the consolidation. Only one of the responding senior county health officials said the costs of new service provision for the cities involved in the consolidation exceeded the new revenues that were obtained. By contrast, our analyses of AFR data indicate that per capita revenues post-consolidation were not significantly different than in the period prior to consolidation. However, this combination of findings is likely due to the difference in the starting point for comparison used in the AFR analysis versus the interviews. In the AFR analyses we combined the total revenues from the city and county health departments in the pre period and compared those

[4] There were a total of 20 consolidations that occurred between health departments in Ohio between 2001 and 2011. Due to the data required for modeling, only consolidations occurring between 2002 and 2011 are considered in the statistical models. Interview data and findings report on the full period, 2001-2011.

[5] It is noteworthy that, in one case, the layoffs occurred in an adjacent county which lost jurisdiction over one city that integrated its operations with those of another county.

revenues to the consolidated county totals in the post period. By contrast, respondents in the interviews were responding to a question about their county health department, pre and post consolidation. If one uses only the county health department revenues in the pre period as the basis for comparison using the AFR data, there is a clear increase in revenues after consolidation. While the AFR data analyses did not provide any service measures that would allow us to directly examine the question of increased revenues covering the increased costs of providing services to the newly formed health department jurisdiction, there were no significant changes observed in the rate of health departments drawing on reserve funds between the pre and post consolidation periods. This combination of empirical findings appears to suggest that the contractual revenues provided by the cities are covering the services delivered to their citizens, as was perceived to be the case by the senior county health officials we interviewed.

6. Are counties with one combined health department able to attract more state and federal grants?

   While our analyses from the AFR data were not able to directly address the issue of grants, they did indicate that there was a significant decrease associated with consolidation in terms of the amounts of nonlocal revenue generated by health departments in the year of and the first year after consolidation. This decrease appears to be transitory as there are indications that by the second full year post consolidation nonlocal revenues are no longer significantly lower than in the pre-consolidation period. This is consistent with results from our interviews that asked whether external grant revenues increased in the year following the consolidation. Only 23% (3/13) of the responding department officials indicated that external revenues increased within one year after the consolidation. One potential explanation for these findings that was revealed during our investigation is that the process of consolidation appears to yield the potential for organizational disruptions that result from the process of merging two administrative units, and this may interrupt or inhibit successful efforts to gain external revenue during the period immediately following consolidation. Additional research is appropriate to further address these issues and particularly to consider the longer term effects of consolidation on external revenues for public health services.

7. Would a consolidation between a combined health department and a city health department lower the cost for public health services for the townships and municipalities that are already a part of the combined department?

   Our interview questions yielded responses related to the impact of health department consolidations on the tax burdens for public health services of residents of both original jurisdictions – the county health department and the city health department. All of the respondents who gave a definitive answer (16/16) indicated that residents of the original county jurisdictions did not see their tax burdens for public health services increase post-consolidation.[6]

   However, while all respondents agreed that the consolidations did not lead to increases in the tax burden for public health services within the county jurisdictions, all of them (16/16) also said that the tax burdens of residents in the county jurisdictions were not reduced. Thus, our interviews suggest that while the consolidations that occurred did not end up costing township and municipal residents within the county jurisdictions more money, the consolidations do not appear to have resulted in reduced taxes for public health services either.

[6] One respondent answered "I don't know".

The perceptions of the county health officials were substantiated in the findings from our analyses of AFR data. Per capita revenue from local tax sources, including general revenue, inside millage, and public health levies, were not found to be significantly different before and after consolidation.

8. Is there other evidence about the costs and benefits of consolidating public health services?

Our interviews also yielded perceptual evidence of other benefits associated with consolidation, although further research is appropriate in this area. Among the health department officials in our sample, more than 90% (16/17) reported that existing public health services were at least maintained during the first year of transition to a consolidated department, and more than 80% (14/17) of responding senior county health department officials indicated that public health services improved after two years. All of the health departments providing substantive responses (8/8) reported that public health services were positively impacted five years after of consolidation.

The senior county health officials we interviewed also expressed generally positive views regarding the impacts of consolidation on public health capacities. Nine of the seventeen departments indicated that their department's capacity to provide public health services increased as a result of consolidation, while seven of the seventeen departments reported that their capacity had "stayed about the same." Only one of the seventeen departments reported that their capacity decreased as a result of the consolidation.

While the nature of our data imposes significant limits on the claims that can be made about the impact of consolidation on service quality and public health capacities, they do yield rather consistent evidence of financial advantages, as well as hints of potentially positive impacts on services and capacities. Perhaps not surprisingly therefore, about 88% of our substantive responses (15/17) indicated that the senior county public health officials we interviewed believed that consolidating city and county health departments was a "good idea" in their particular cases.

9. Would a merger make operations more efficient?

While our study did not generate the public health service data that would be needed to make claims about the effect of consolidation on the efficiency of public health department operations, it did yield perceptual information related to perceived impacts of consolidation on health department efficiency. While this information cannot be relied upon to make empirical claims regarding consolidation and efficiency, the reported perceptions may be of interest.

While only 4 of 17 (24%) of respondents indicated that enhancing efficiencies was an original stated goal of their consolidations, all four felt that goal was achieved post-consolidation. Some respondents cited a reduction in administrative positions as a means of enhancing the efficiency of the local health system. Others cited lower administrative costs related to the operation of two separate agencies. One respondent indicated that consolidation allowed the county to streamline the process of acquiring grant funding. In other cases, respondents felt that the provision of public health services had become more efficient in their counties because they were able to maintain the same level of services or improve services provided to the public with less staff.

According to those we interviewed, in some cases the mix of services provided in the communities affected by the consolidation changed. Forty-one percent (7/17) of respondents indicated that the service mix changed in either of the jurisdictions affected by the consolidations. Of those seven who indicated a change in the mix of services, six out of seven (86%) indicated that this change was positive.

In short, the insight and anecdotes provided above do not provide proof of a relationship between consolidation of public health departments and an increase (or decrease) in operational efficiency. However, the information reported may be valuable to stakeholders interested in the perspectives of senior county health officials who have experienced the process or lived with the consequences of a consolidation.