NACCHO
National Association of County & City Health Officials

[RESEARCH BRIEF]
May 2014

Changes in Local Health Department Services: Findings from the 2014 Forces of Change Survey

Background

Local health departments (LHDs) are involved in various activities that contribute to the goal of creating and maintaining healthy environments and communities. Several factors, such as shrinking budgets, the implementation of the Patient Protection and Affordable Care Act (ACA), and changing community health needs, can have an impact on the type and scope of services provided at LHDs. This research brief describes changes to LHD services from 2013 to 2014 and the extent to which program areas have been expanded or reduced.

Methods

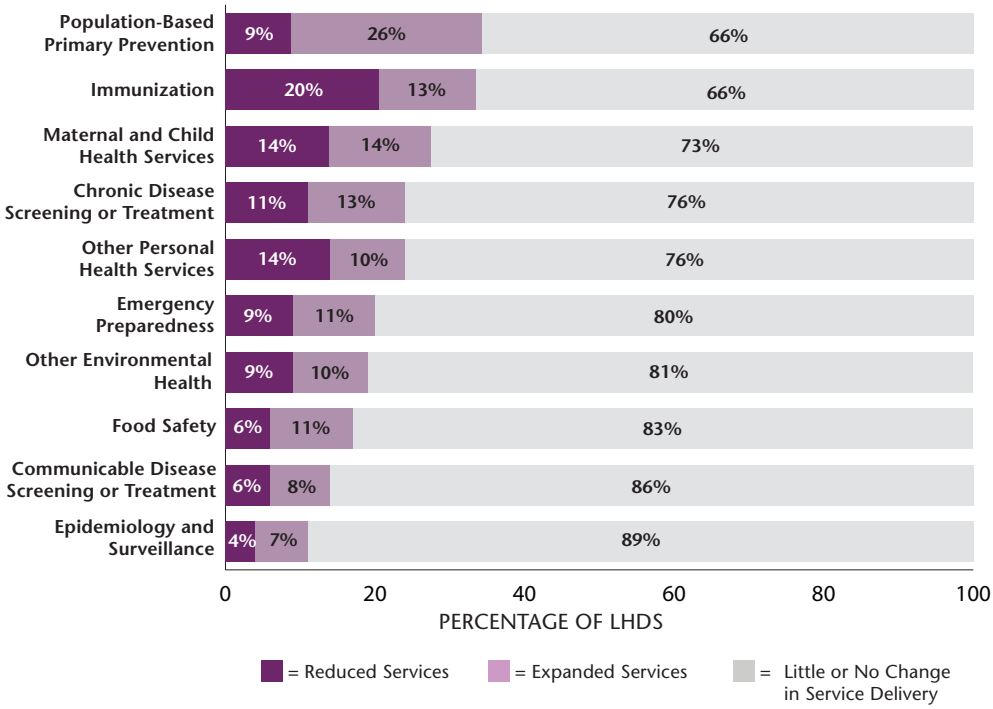
The National Association of County and City Health Officials (NACCHO) distributed the Forces of Change Survey to a statistically representative sample of 957 LHDs in the United States from January to February 2014. A total of 648 LHDs completed the survey (response rate of 68%). NACCHO generated national statistics using estimation weights to account for sampling and non-response. All data were self-reported; NACCHO did not independently verify the data provided by LHDs. A detailed description of survey methodology is available on NACCHO's Forces of Change webpage at www.naccho.org/topics/research/forcesofchange.

In the survey, LHDs first selected the types of services or functions they provided at any time during calendar year 2013. Then respondents qualitatively characterized changes in overall service delivery (reduced, little or no change, expanded) for each service they provided. In this research brief, the percentage of LHDs that reported changes in services are based on those LHDs that provided that particular service (which ranged from 354 for chronic disease screening or treatment to 620 for emergency preparedness).

Results

In 2013, LHDs reported the most changes in the scope or scale of services in population-based primary prevention, immunization, and maternal and child health program areas (Figure 1). LHDs were more likely to expand than reduce services in population-based primary prevention, were more likely to reduce services in immunization, and were equally likely to expand or reduce services in maternal and child health. Most LHDs reported little or no change in epidemiology and surveillance services (89%) or communicable disease screening or treatment (86%) offered.

FIGURE 1: Percentage of LHDs that Reduced or Expanded Services, by Program Area

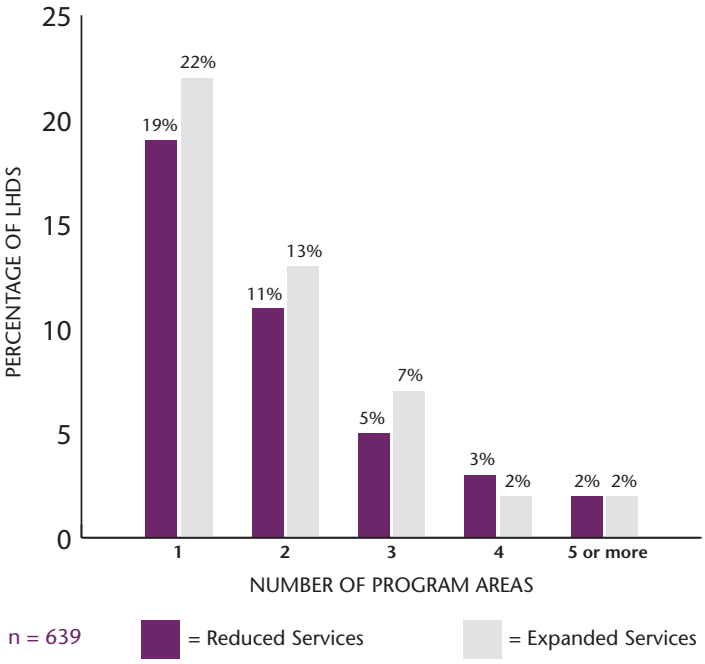


n ranged from 354 to 620

Note: Due to rounding, percentages may not add up to 100 percent.

During 2013, 40 percent of LHDs reduced services and 47 percent of LHDs expanded services in at least one programmatic area (not shown). Overall, LHDs reported expansions in more program areas than reductions (Figure 2). Few LHDs reduced or expanded services in more than three program areas.

FIGURE 2: Number of Program Areas Reduced or Expanded



n = 639 = Reduced Services = Expanded Services

A larger percentage of LHDs that serve large populations (greater than 500,000 people) reported reducing services in various program areas than LHDs that serve medium and small populations (Figure 3). Similarly, a greater percentage of LHDs that serve large populations reported expanding services in population-based primary prevention (37%), other environmental health (25%), other personal health (22%), or communicable disease screening or treatment (17%) compared to LHDs that serve medium and small populations. Contrary to this trend, LHDs serving large populations were less likely to report expanding immunization services than LHDs serving medium and small populations.

Government Authority of LHDs

LHDs vary in their relationships with their state health agency. Some LHDs are local or regional units of the state health agency (referred to as state-governed LHDs), others are agencies of local government (referred to as locally governed LHDs), and others are governed by both state and local authorities (called shared governance). Refer to the following figure online for more details on how LHD governance varies across the United States: http://bit.ly/1hHXHbd.

FIGURE 3: Percentage of LHDs that Reduced or Expanded Services by Size of Population Served

PROGRAM AREA	SIZE OF POPULATION SERVED					
	<50,000		50,000–499,999		500,000+	
	REDUCED	EXPANDED	REDUCED	EXPANDED	REDUCED	EXPANDED
Immunization	16%	14%	24%	13%	39%	10%
Communicable Disease Screening or Treatment	6%	7%	3%	8%	18%	17%
Maternal Child Health Services	12%	9%	14%	19%	21%	16%
Other Personal Health Services	14%	9%	12%	8%	28%	22%
Population-Based Primary Prevention	11%	17%	5%	33%	14%	37%
Other Environmental Health*	9%	9%	7%	10%	13%	25%

n ranged from 392 to 611 *Other than Food Safety

More LHDs governed by both state and local authorities (shared governance) reported reducing services in immunization (27%), communicable disease screening or treatment (12%), maternal and child health (29%), other personal health (30%), and population-based primary prevention (18%) than locally governed LHDs or units of the state health department (Figure 4). A greater percentage of locally governed LHDs were more likely to report expanding services in immunization (16%), other personal health services (12%), and emergency preparedness (12%). LHDs that are units of the state agency were least likely to report service reductions or expansions.

FIGURE 4: Percentage of LHDs that Reduced or Expanded Services by Type of Governance

PROGRAM AREA	TYPE OF GOVERNANCE					
	State		Local		Shared	
	REDUCED	EXPANDED	REDUCED	EXPANDED	REDUCED	EXPANDED
Immunization	18%	8%	21%	16%	27%	6%
Communicable Disease Screening or Treatment	3%	3%	6%	9%	12%	14%
Maternal Child Health Services	9%	5%	13%	15%	29%	23%
Other Personal Health Services	4%	4%	15%	12%	30%	5%
Population-Based Primary Prevention	6%	29%	8%	24%	18%	29%
Emergency Preparedness	2%	8%	12%	12%	8%	11%

n ranged from 392 to 620

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Discussion

Slightly more LHDs reported expanding services in at least one program area (47%) than reducing services (40%). Overall, LHDs reported more expansions than reductions in population-based services. In particular, nearly three times as many LHDs reported expanding population-based primary prevention services than reducing services. Similarly, more LHDs reported service expansions in food safety and epidemiology surveillance. Conversely, for most areas of clinical services (with the exception of immunization), the percentage of LHDs expanding and reducing services was similar. This likely reflects both the differences in budget realities facing these LHDs and different choices that LHDs are making about their role in the changing healthcare landscape.

The percentage of LHDs reducing immunization services was much larger than the percentage expanding these services (20% versus 13%). This trend was especially pronounced in LHDs serving more than 500,000 people, with nearly four times as many LHDs reporting reduced than expanded immunization services.

Larger LHDs were more likely to report changes in their service delivery, both by expanding and reducing services, than smaller LHDs. For most services, LHDs that are units of the state agency were least likely to report service reductions or expansions compared to locally governed LHDs or those with shared governance.

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For more information, please contact the Research & Evaluation Team at research@naccho.org.

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The mission of the National Association of County and City Health Officials (NACCHO) is to be a leader, partner, catalyst, and voice for local health departments.

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