

Factors Associated with Local Public Health Department (LHD) Performance A Summary of the Research Literature

A growing body of research adds depth and rigor to the 2010 recommendations of the State Community Health Services Advisory Committee (SCHSAC) report “Updating Minnesota’s Blueprint for Health.” Factors most consistently and strongly associated with local health department (LHD) performance include population size served, financing, staffing and organizational structure. This research, which is highlighted below, is relevant in Minnesota where community health boards have considerable discretion in the organizational structure of local health departments, and population size, staffing, and per capita expenditures vary widely across the state.

Population Size: Many studies have linked population size with LHD performance. The optimal population size emerging from the research literature ranges between 50,000-500,000, however a recent study suggested that a minimum of 100,000 may provide additional cost savings and efficiencies. This study concluded that LHDs that serve populations smaller than 100,000 are at a serious cost disadvantage when it comes to delivering local health services and projected that cost-savings could be realized when such entities consolidated into cross-jurisdictional entities.

LHD Expenditures: Two recent studies have linked increases in LHD per capita expenditures with significant decreases in morbidity and mortality (all-cause, infant, cardiovascular disease, diabetes, influenza and cancer). Because these studies tracked change over time, these studies are especially strong and provide some of the first evidence of cause and effect. One of these studies found that for each 10% increase in per capita local public health spending there was a decrease in mortality rates, ranging from 1.1-6.9% depending on the mortality rate examined.

LHD Funding Sources: Evidence suggests that higher jurisdiction taxes per capita are associated with increased performance on the 10 Essential Public Health Services (EPHS). In addition, those LHDs that receive more funding from federal and state sources also appear to receive more funding from local sources (e.g., local tax levy). Higher performing counties tend to have a greater percentage of total revenues from local taxes, higher taxes per capita and higher tax rates.

LHD Staffing: While previous cross-sectional studies have found associations between staffing levels and LHD performance, a recent longitudinal study linked increased LHD staffing to decreases in cardiovascular disease mortality. One study suggests that LHDs that serve larger jurisdictions are able to capitalize on higher levels of staff, even if per capita staffing levels are comparable to those in smaller jurisdictions. A 2010 national profile of local health departments reported that LHDs that serve larger jurisdictions employ staff representing a wider range of occupations.

Organizational Structure: Combined jurisdictions appear to be more effective than single city or single county entities. These jurisdictions may be capitalizing on increased population served or there may be inherent benefits to a cross-jurisdictional approach in addition to those offered by population size. No published studies were found that examined the potential association between performance and how a LHD is organized (e.g., stand-alone health department or within a human services agency).

Additional factors associated with LHD performance include director qualifications, partnerships, community characteristics and organizational leadership. These factors have not been linked to performance as consistently as the factors discussed above. Future studies that examine these factors over time and in the context of LHD performance, as well as measures of population health, would provide important information for stakeholders and policymakers.

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