Recessions, Risks, and Reforms: Changes in Interorganizational Efforts to Improve Public Health

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Recessions, Risks and Reforms: Changes in Inter-organizational Activities to Improve Public Health

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Research questions of interest

- To what extent do health care organizations contribute to public health production?
- Have these contributions changed in response to the recession and health reform implementation?
- How do health care and public health contributions interact to influence quantity, quality, and cost of delivery?
  - Complementarities/Synergies
  - Substitutions/”Cannibalization”
Why inter-organizational contributions are important

Other organizations may:

- Complement or substitute for PH agency work
- Extend the reach of PH agencies
- Bring new resources and expertise

Improve quality
Enhance efficiency
Reduce disparities
Why inter-organizational contributions are important

Also some potential problems:

- Lack of clarity/accountability about responsibilities
- Duplication, competition, or rivalry
- Gaps in service due to incomplete coordination
- Instability in contributions over time
  - Diminished quality
  - Inconsistent service
  - Inefficiency/waste
Forces of change

Public Health Delivery Systems

- Hospital community benefit regs
- Funding constraints
- Accountable care organizations
- Patient centered medical homes
- Employer wellness incentives
- Health insurance expansions
- Health information exchange
- Accreditation
Data: public health production

National Longitudinal Survey of Public Health Systems

- Cohort of 360 communities with at least 100,000 residents
- Measured from local public health official’s perspective:
  - **Scope**: availability of 20 recommended public health activities
  - **Network**: types of organizations contributing to each activity
  - **Effort**: contributed by designated local public health agency
  - **Quality**: perceived effectiveness of each activity
Data: community & market characteristics

- **Area Resource File**: community and market characteristics
- **NACCHO Profile data**: public health agency characteristics
- **Medicare Cost Report** data files: hospital ownership, market share, uncompensated care
- Hospital data aggregated to hospital service areas (HSAs) and linked with survey data
Analytic Approach

Dependent variables:

- **Quantity**: Percent of recommended PH activities performed in the community
- **Quality**: Perceived effectiveness of PH activities
- **Resources**: Local governmental expenditures for PH activities

Independent variables:

- **Contribution scores**: percent of activities contributed by each type of organization
- **Network influence**: degree centrality, betweenness centrality
Analytic Approach

Estimation:

- Log-transformed Generalized Linear Latent and Mixed Models
- Account for repeated measures and clustering of public health jurisdictions within states
- Instrumental variables to address endogeneity of contributions

\[
\ln(\text{Quantity/Quality/Cost}_{ijt}) = \sum \alpha_z \ln(\text{Contribution}_{zijt}) + \beta_1 \text{Agency}_{ijt} + \beta_2 \text{Community}_{ijt} + \mu_j + \phi_t + \epsilon_{ijt}
\]

\[
\ln(\text{Contribution}_{z,ijt}) = \sum \alpha_z \ln(\text{Betweenness}_{zijt}) + \beta_1 \text{Agency}_{ijt} + \beta_2 \text{Community}_{ijt} + \mu_j + \phi_t + \epsilon_{ijt}
\]

All models control for type of jurisdiction, population size and density, metropolitan area designation, income per capita, unemployment, racial composition, age distribution, educational attainment, physician availability, and public health agency governance.
## Analytic Approach

### Network Analytics:

- Two-mode networks (organization types X activities) transformed to one-mode networks with *tie strength* indicated by number of activities jointly produced

- **Betweenness centrality** measures used as instruments: for how many activities does each organization lie on the shortest path connecting each pair of other organizations

<table>
<thead>
<tr>
<th>Orgtype</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>LHD</td>
<td>X</td>
</tr>
<tr>
<td>Hospitals</td>
<td>X</td>
</tr>
<tr>
<td>Physician practices</td>
<td></td>
</tr>
<tr>
<td>CHCs</td>
<td>X</td>
</tr>
<tr>
<td>Insurers</td>
<td></td>
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<tr>
<td>...</td>
<td></td>
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</tbody>
</table>
Results:
Delivery of recommended public health activities

<table>
<thead>
<tr>
<th>Year</th>
<th>Assurance</th>
<th>Policy</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
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</tbody>
</table>

- 1998: 0% delivery
- 2006: 10% delivery
- 2012: 5% delivery

↑ 10% between 1998 and 2006
↓ 5% between 2006 and 2012
Results: organizations contributing to local public health production

<table>
<thead>
<tr>
<th>% Change 2006-2012</th>
<th>Scope of Production 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>-50%</td>
<td>-50%</td>
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<tr>
<td>-30%</td>
<td>-30%</td>
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<tr>
<td>-10%</td>
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<td>10%</td>
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<tr>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

- Local health agency
- Other local government
- State health agency
- Other state government
- Hospitals
- Physician practices
- Community health centers
- Health insurers
- Employers/business
- Schools
- CBOs
Do other organizations complement or substitute for local public health agency effort?

Results from Multivariate GLLAMM Models

- Hospitals
- Insurers
- Employers
- Physicians
- CHCs
How do other organizations affect the total supply of public health activities?

Results from Multivariate GLLAMM Models
How do other organizations affect the quality of public health activities?

Results from Multivariate GLLAMM Models

- CHCs
- Physicians
- Employers
- Insurers
- Hospitals
How do other organizations affect local public health agency expenditures?

Results from Multivariate GLLAMM Models

- CHCs
- Physicians
- Employers
- Insurers
- Hospitals
Conclusions

- Public health contributions by health care organizations appear more recession-resistant than governmental contributions.

- Employer and CHC contributions appear to offset LHD efforts (substitution).

- Hospital contributions appear to complement LHD efforts and may expand overall supply and quality of services.

- No evidence for LHD cost offsets attributable to health care contributions.
Policy and Practice Implications

- Public health delivery has become increasingly reliant on nongovernmental & health care contributions
- Increased resiliency during economic shocks
- Heightened need for coordination, monitoring, and accountability
- Vulnerability to instability in contributions over time
- May not lower overall resource use
Limitations and Next Steps

- Organization types – lacking institutional granularity
- Single perspective – local health officials
- Future possible comparisons:
  - CTG and CMMI sites
  - Hospital community benefit activities
  - CHA and CHIP implementation
  - PHAB accreditation
For More Information

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