The Changing Public Health Landscape

Findings from the 2017 Forces of Change Survey

November 2017

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National Association of County & City Health Officials

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Economic and infrastructure challenges are among today's greatest contributors changing the public health landscape

Since 2008, the National Association of County and City Health Officials (NACCHO) has periodically surveyed local health departments (LHDs) to assess the impact of the Great Recession.

NACCHO recently expanded the survey to address more generally the forces that affect change in LHDs, including the emergence of new infectious diseases and a growing need for collaboration across sectors.

This expanded assessment is called the Forces of Change survey.

The Forces of Change survey helps to identify infrastructure challenges, as well as opportunities to strengthen public health capacity.

Although the economic situation is slowly improving for many LHDs, one in five still reported a lower budget in 2017 than in 2016.

In addition to these budget realities, LHDs also face diverse workforce recruitment challenges, including barriers to providing qualified candidates with competitive salaries.

Some LHDs are adapting to the changing public health environment by exploring new opportunities for collaboration with community partners. For example, many LHDs reported partnering with the healthcare and education sectors to address issues including opioid and tobacco use.

An additional factor influencing LHD operation is the emergence of infectious diseases in the United States, such as Zika virus, which compels a further focus on prevention and response activities to ensure prepared and resilient communities.

NACCHO uses these findings to raise awareness about these issues among leaders in Congress, federal agencies, and other organizations involved in decisions driving public health funding and policymaking.

Methods

NACCHO distributed the Forces of Change survey to a statistically representative sample of 948 LHDs in the United States from February to April 2017. This sampling strategy allows national and state-level estimates, if sufficient response was received from a state.

A total of 615 LHDs completed the survey for a response rate of 65%.

NACCHO generated national statistics using estimation weights to account for sampling and non-response. Some detail may be lost in the figures due to rounding.

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.nacchoprofilestudy.org/forces-of-change**

LHDs are grouped in the analysis by a variety of characteristics

Throughout this report, data are presented based on different subgroup analyses.

Statistics are compared across the size of the population served by the LHDs. Small LHDs serve populations of less than 50,000 people. Medium LHDs serve populations of 50,000 to 499,999 people. Large LHDs serve populations of 500,000 people or more.

Data are also often presented by type of governance, which is the LHDs' relationship to their state agency. Locally-governed LHDs are agencies of local government. State-governed LHDs are local or regional units of the state health agency. LHDs that are governed by both state and local authorities are referred to as shared governance.

An additional subgroup by which data are presented is United States census region. LHDs are designated as being in the Northeast, South, Midwest, or West based on the state in which they are located, per the U.S. Census Bureau classifications.

Statistics are also compared across LHD jurisdiction by degree of urbanization. To account for the various geographic jurisdictions an LHD serves, each LHD is assigned a Rural-Urban Commuting Area Codes (RUCAs) designation based on the zip code of their primary physical or mailing address. Each LHD has a single classification, even though some jurisdictions include census tracts with differing degrees of urbanization. LHDs designated as urban are located in zip codes with a RUCA of 1-3, and LHDs designated as rural are located in areas with a RUCA of 4-10.

United State Census Bureau. Census Regions and Divisions of the United States. https://www2.census.gov/geo/pdfs/maps-data/maps/reference/us_regdiv.pdf.
Health Resources and Services Administration's (HRSA) Office of Rural Health Policy (ORHP), Department of Agriculture's Economic Research Service (ERS), WWAMI Rural Health Research Center (RHRC). Rural-Urban Commuting Area Codes (RUCAs). http://depts.washington.edu/uwruca/ndex.php

01 Budget Cuts and Job Losses

Economic forces continue to affect local public health capacity and the resiliency of communities nationwide.

The effects of the Great Recession and changes in federal budget priorities continue to pose major challenges for some LHDs. Substantial funding cutbacks from federal, state, and local sources have undermined the ability of LHDs to provide essential services to their communities.

Since 2008, NACCHO has administered web-based surveys to LHDs across the United States to assess the impact of economic forces on LHDs.

Results consistently demonstrate LHD funding challenges and the negative impacts these challenges have on LHD infrastructures.

While the proportion of LHDs reporting budget cuts and job losses decreased in recent years, LHDs have not kept up with the general economic recovery and continue to face financial hardships. The cumulative impacts of these challenges on LHD capacity persist.

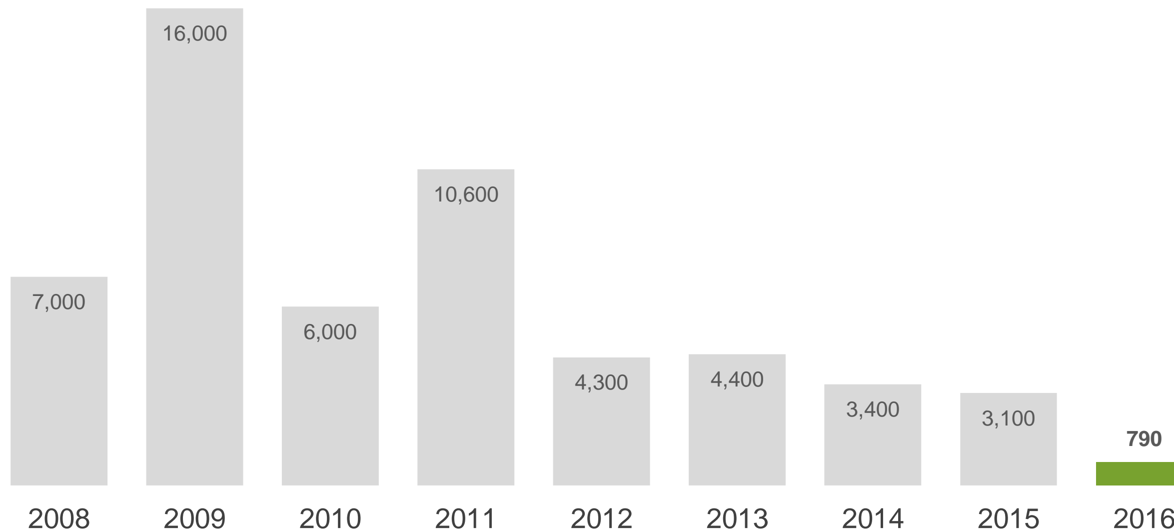
Since the Great Recession, the fewest number of jobs lost was reported in 2016

Since 2008, LHDs have eliminated a cumulative total of 55,590 jobs due to layoffs or attrition because of hiring freezes or budget cuts.

In 2016, LHDs reported an estimated 800 jobs lost. Of those, 600 were due to layoffs, and another 200 were due to attrition.

This estimate is much lower than any of the reported evidence in previous years, indicating that LHD staffing levels are rebounding.

Number of jobs lost

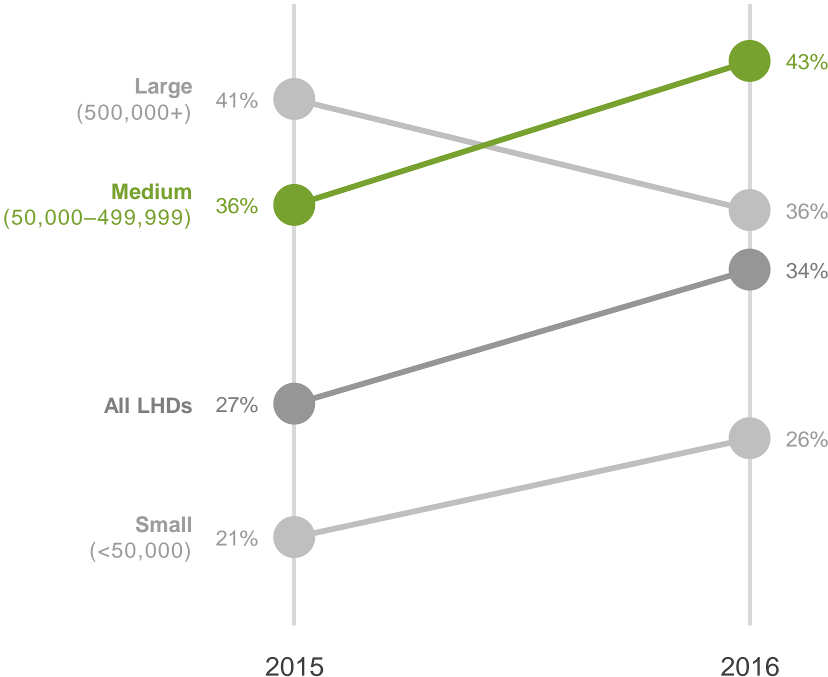


Medium LHDs were most likely to experience job losses over the past year

Overall, one-third of LHDs lost at least one staff position due to layoffs or attrition in 2016.

More small and medium LHDs reported job losses in 2016 than in 2015. Medium agencies, however, were most likely to experience job losses over the past year.

Large LHDs serve nearly half of the U.S. population. Fortunately, fewer large LHDs reported workforce reductions in 2016 than in 2015. This decrease in job losses is important for the health and safety of many communities.



n(2015)=1,780–1,778
n(2016)=570–585

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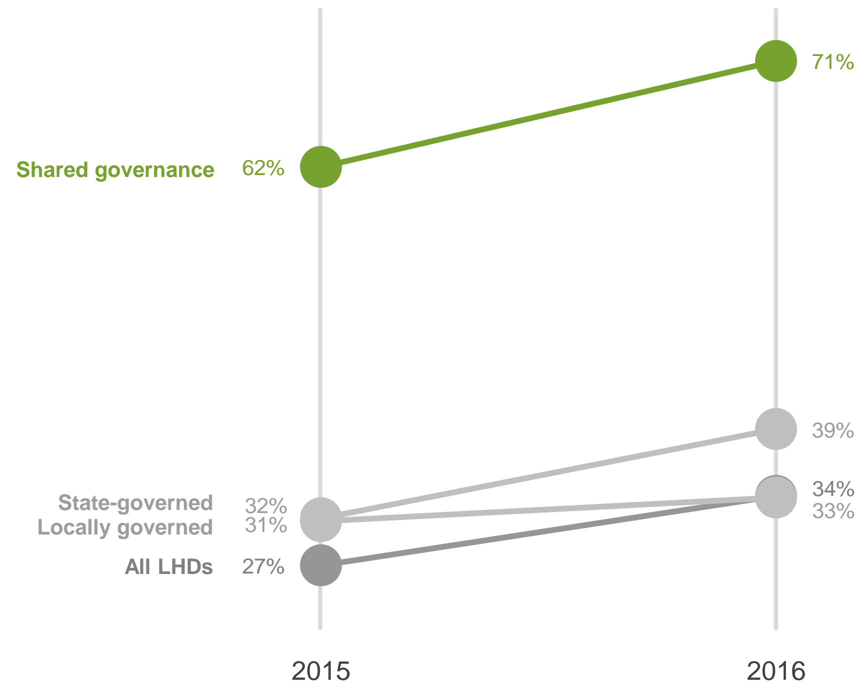
Most LHDs with shared governance continued reporting job losses

More LHDs, regardless of governance, reported workforce reductions in 2016 than in 2015.

The majority of LHDs governed by state and local authorities (i.e., shared governance) reported job losses in 2016, with a 9% increase in the number of LHDs compared to 2015. These LHDs continued to report higher job losses than their governing counterparts.

Similarly, more state-governed LHDs reported decreased workforce capacity in 2016 than 2015.

The proportion of locally governed LHDs experiencing job losses was relatively steady between 2015 and 2016.



n(2015)=1,780–1,778
n(2016)=570–585

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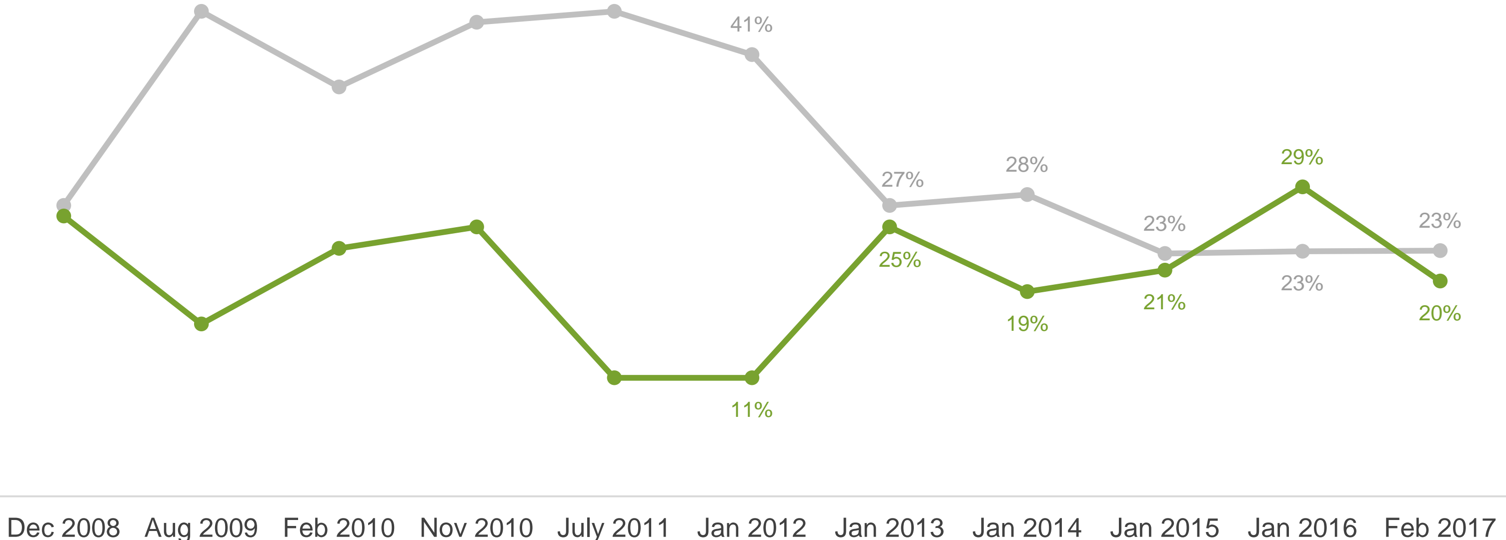
Fewer LHDs reported budget increases over the past year, but one in five LHDs continued to experience budget growth

NACCHO has tracked budget cuts at LHDs over the past nine years. In 2016, nearly one in four continued to report a lower budget in the current fiscal year compared to the previous fiscal year. In addition, fewer LHDs reported an increase in their budget for their current fiscal year compared to their previous fiscal year.

While the number of agencies reporting budget cuts has tapered recently, most LHD budgets also have not grown.



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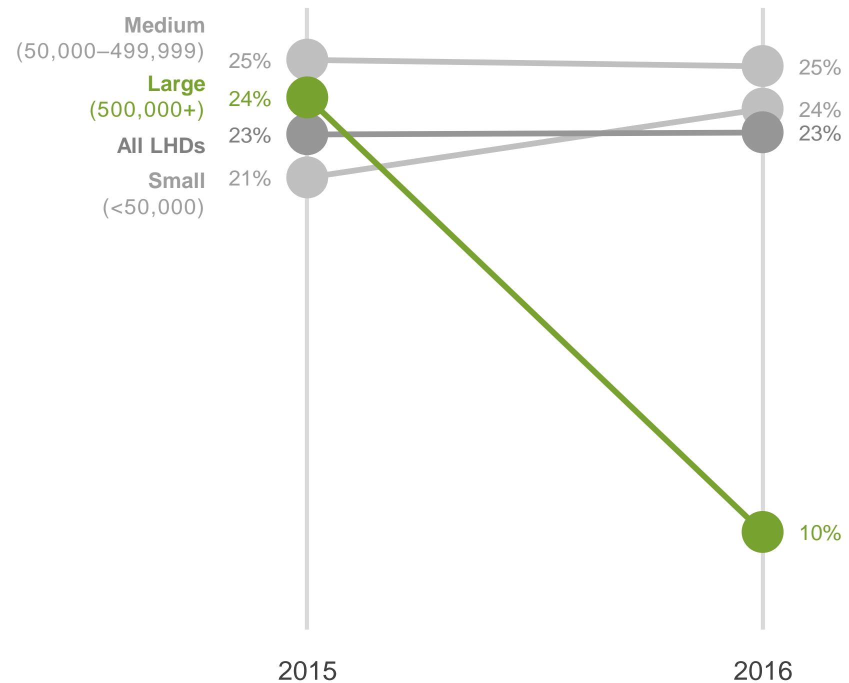
Large LHDs were the least likely to report a decreased budget

Overall, nearly one in four LHDs experienced a decrease in their budget over the past fiscal year.

Substantially fewer large LHDs reported a budget decrease for their current fiscal year compared to their previous fiscal year. This improvement, however, did not indicate that large LHDs experienced budget growth.

Slightly more LHDs serving small populations reported budgetary restrictions in their current fiscal year.

The percentage of medium LHDs reporting budget cuts, however, remained the same over the past year.



n(2015)=1,665
n(2016)=588

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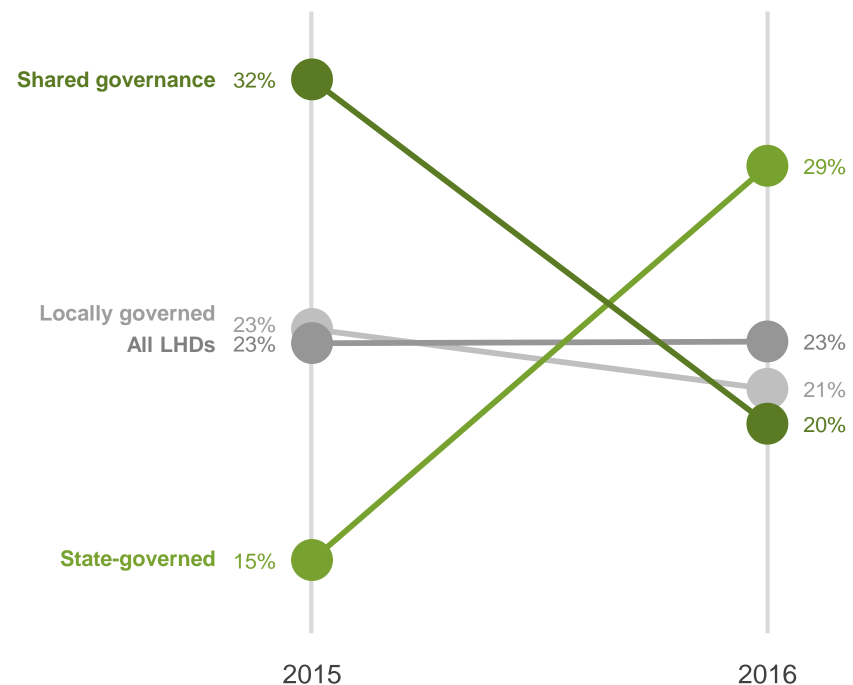
The percentage of state-governed LHDs reporting budget cuts nearly doubled from 2015 to 2016

Overall, the percentage of LHDs reporting budget cuts remained the same over the past year.

Fewer LHDs with shared governance reported a budget decrease for their current fiscal year compared to their previous fiscal year. This improvement, however, did not necessarily indicate that these LHDs experienced budget growth.

Locally governed LHDs also reported fewer budget cuts, but the decrease in the percentage of LHDs was minimal.

The percentage of state-governed LHDs reporting budgetary restrictions for their current fiscal year nearly doubled from 2015 to 2016.



n(2015)=1,665
n(2016)=588

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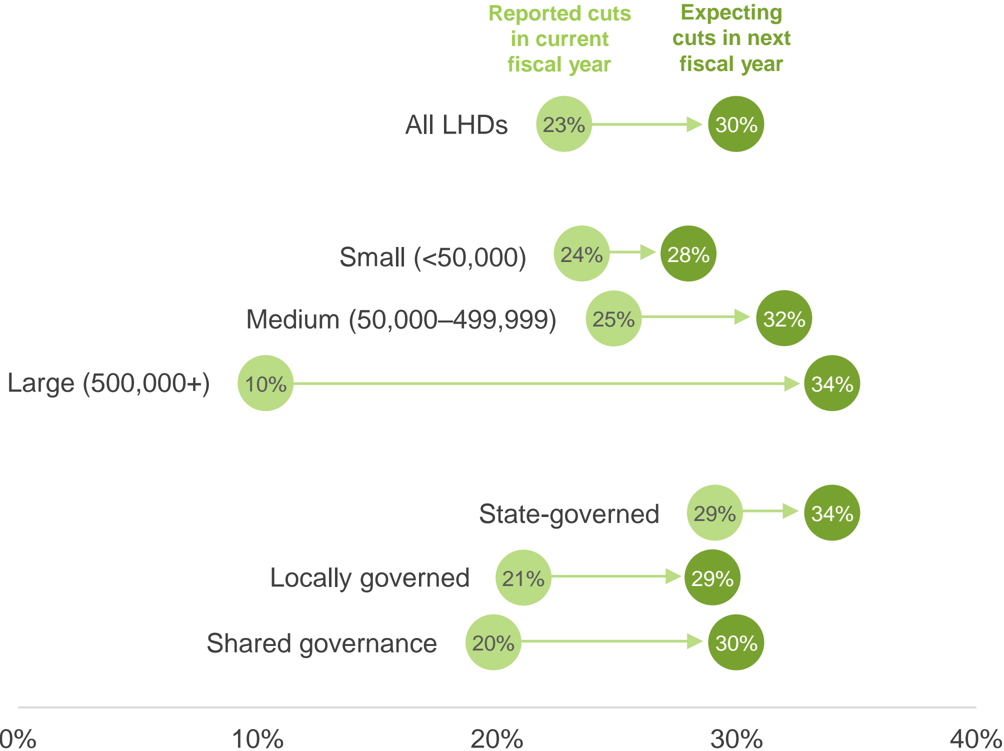
Nearly one-third of LHDs reported anticipating cuts for the next fiscal year



Nearly one-third of all LHDs foresee budget cuts in their next fiscal year, representing an increase in LHDs compared to those that reported budget cuts in their current fiscal year. This potential increase in LHDs with lower budgets may be a result of a variety of reasons, such as ongoing funding shortages or a known decrease in the amount of grant funding to be awarded.

While agencies serving different-sized populations expect a lower budget next year, large LHDs may experience the greatest impact. Three times the percentage of large LHDs that reported cuts this fiscal year are expecting cuts next fiscal year.

Likewise, a greater percentage of locally governed LHDs and LHDs with shared governance expect their budget for the next fiscal year will be lower than their current budget.

n=567–588

Discussion

Ongoing budget cuts and workforce reductions are jeopardizing the basic services that LHDs provide and on which many communities rely.

In 2016, LHDs received a reprieve from staffing cuts. Although more LHDs reported at least one job lost in 2016 than in 2015, fewer than 1000 jobs overall were lost for the first time since the Great Recession began. This may be attributed to the improvements in funding LHDs have experienced.

The cumulative effect of jobs lost since 2008, however, threatens the ability of LHDs to provide basic services ensuring the health, safety, and resilience of their communities.

For the past four years, the percentage of LHDs experiencing budget cuts or increases remained consistent. Although the proportion of LHDs reporting budget cuts is lower now than when the recession first began, nearly one in four LHDs continues to be affected by budgetary restrictions.

Sufficient and consistent funding is critical to ensure LHDs' ability to address various health needs in their communities, and LHDs have been able to capitalize on this by maintaining their workforce in recent years.

Despite the slight reduction in budget cuts and job losses in 2016, LHDs predict future budgetary restrictions. Unfortunately, LHDs have not yet had the opportunity to rebound completely from the long-term outcomes of the recession. This, in combination with shifts in state and federal budgets, may cause LHDs to be cautious with future budget and workforce expectations. LHDs foresee once again facing hardships as they continue serving and caring for the people in their jurisdictions.

02 Zika Prevention and Response

The Zika virus was first discovered in Africa 70 years ago, but it began to spread worldwide at an unprecedented rate in early 2015.

Zika became a nationally notifiable condition in the United States in 2016 due to the population's risk of infection. A total of 42,450 cases of Zika has been reported in the continental United States and its territories.

In addition to the 224 Zika virus cases spread locally through mosquitoes, the continental United States population has experienced an influx of travel-related cases. Since 2015, a total of 5,168 cases has been confirmed from those returning from affected areas.

Zika is particularly dangerous for pregnant women, posing an increased risk of microcephaly in the fetus.

Zika disproportionately affects specific United States localities, uniquely positioning LHDs to drive prevention and response efforts.

LHDs' prevention and response activities include public health surveillance; public and partner education (about sexual transmission prevention, traveler risks and protection measures, clinical care guidelines, and risk communication); vector control; maternal and child health surveillance (including rapid detection and follow-up of birth defects); and lab testing (i.e., conducting/coordinating lab testing and testing blood products to prevent blood transfusion-transmitted Zika virus infections).

Centers for Disease Control and Prevention (CDC). Zika Cases in the United States. https://www.cdc.gov/zika/reporting/case-counts.html.

Large LHDs were likely to be in jurisdictions that have a mosquito specie carrying the Zika virus

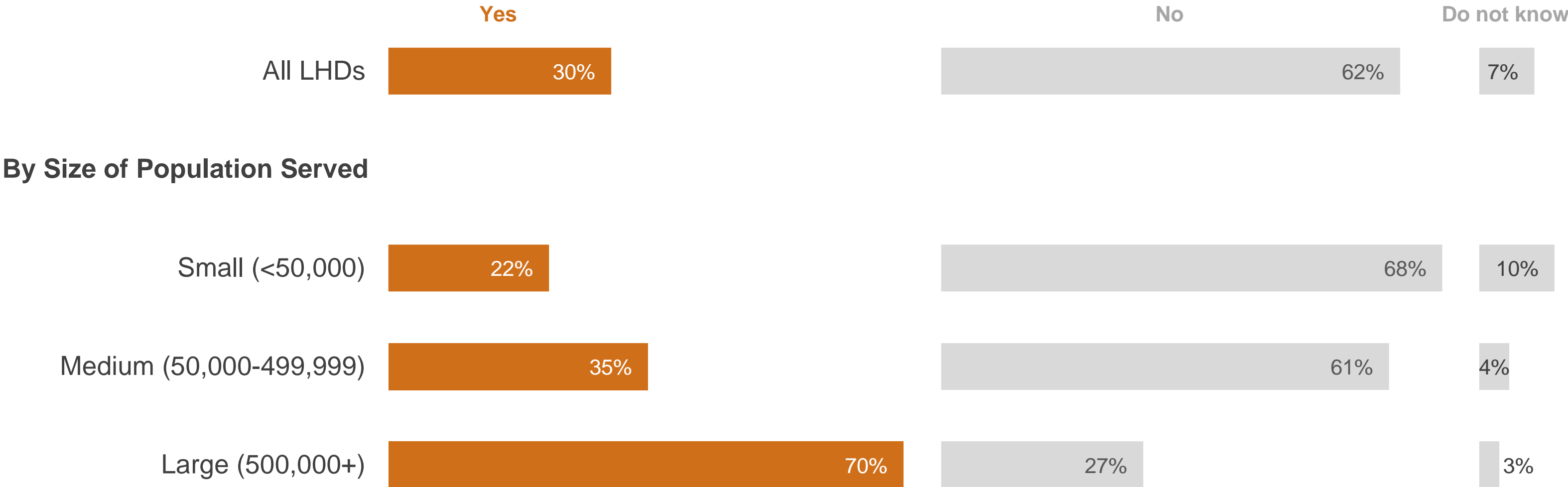
The Zika virus is transmitted locally through two species of the *Aedes* mosquito: *A. aegypti* and *A. albopictus*.

In most LHD jurisdictions, these mosquito species were not present.

Large LHDs were very likely to be in a jurisdiction where these mosquito species are present, increasing the population's risk for local infection.

Many small and medium LHDs, however, reported being located in jurisdictions without local mosquito-borne transmission risk.

Percent of LHDs reporting presence of a mosquito specie carrying the Zika virus



n=612

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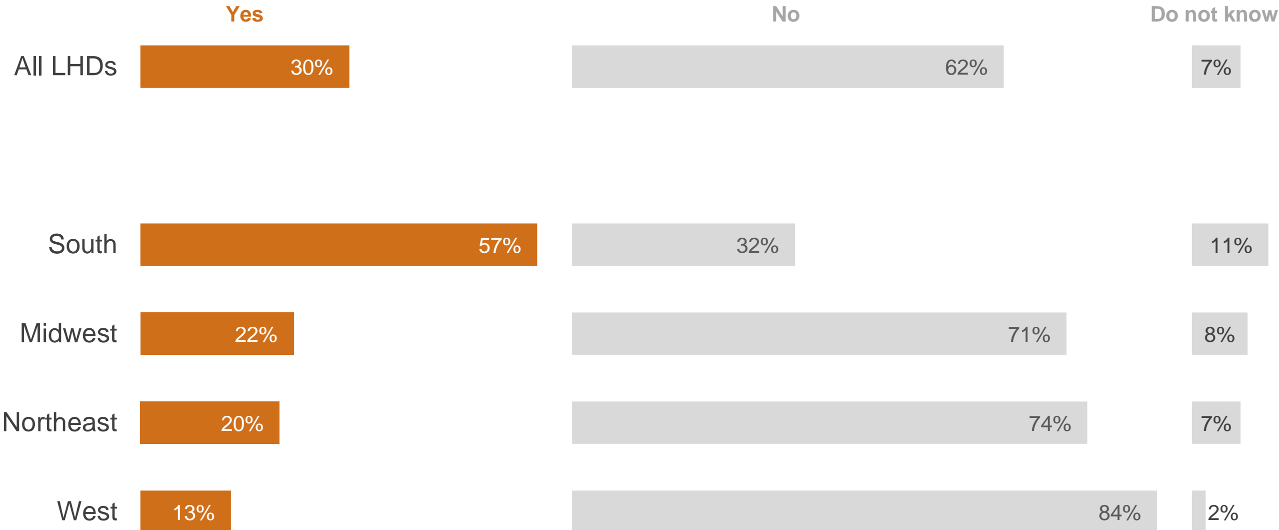
Most LHD jurisdictions in the Southern U.S. had a mosquito specie carrying the Zika virus

The *A. aegypti* and *A. albopictus* mosquito species are found primarily in the southern U.S. As a result, more than half of LHDs in southern states reported being in jurisdictions where a Zika-carrying mosquito specie exists.

Although the majority of LHDs in all other regions indicated not being in communities with a high risk of local mosquito-borne Zika virus transmission, one in five agencies in the Midwest and Northwest were in jurisdictions with the *A. aegypti* or *A. albopictus* mosquito species.

Percent of LHDs reporting presence of a mosquito specie carrying the Zika virus



n=612

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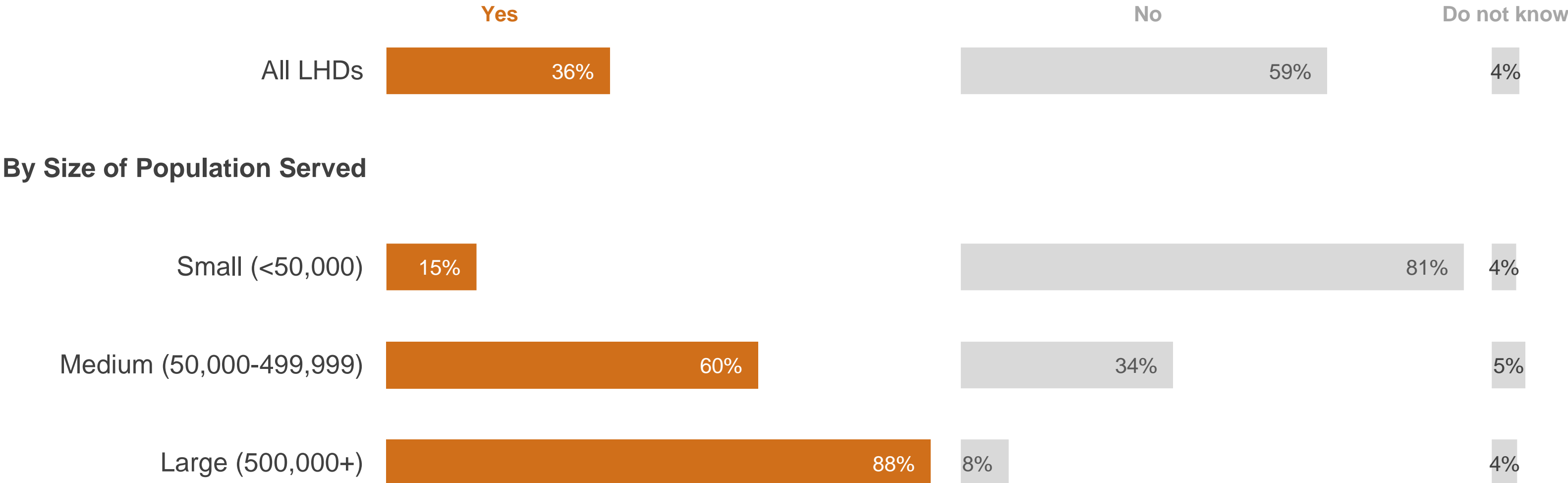
Large and medium LHDs were likely to have confirmed travel-related cases of Zika in their jurisdictions

In addition to local mosquito-borne transmission, the Zika virus can also be spread by people returning from affected areas. More than 5,000 of these travel-related cases have been confirmed in the U.S. over the past two years.

The majority of LHDs reported being in communities without confirmed travel-related cases of Zika.

However, confirmed travel-related cases have been reported in nearly 90% of large jurisdictions, putting these communities at substantial risk for spreading the Zika virus.

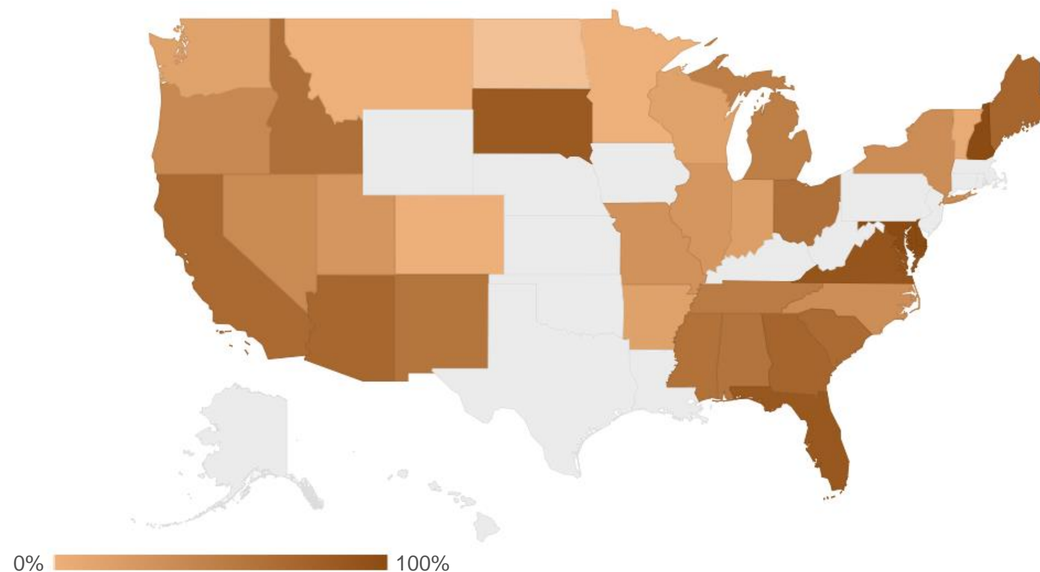
Percent of LHDs reporting confirmed travel-related cases



n=611

The Zika virus was disproportionately present in southern and eastern states

Percent of LHDs reporting presence of the Zika virus



Zika can be present in a community either through the *Aedes* genus of mosquitoes or confirmed travel-related cases.

All LHDs in three states reported the presence of Zika in their jurisdictions: Delaware, Maryland, and New Hampshire. Furthermore, more than 90% of LHDs in Florida and Virginia reported Zika presence.

No LHDs in North Dakota, however, indicated that Zika was present in their communities.

This disproportionate prevalence of Zika in jurisdictions across the U.S. drives the need for an effective local response. LHDs must prioritize the issues impacting their communities and appropriate their resources to address immediate concerns.

n=611–612
States with no LHDs (HI and RI) and insufficient response rates (AK, DC, CT, IA, KS, KY, LA, MA, NE, NJ, PA, OK, TX, WV, WY) are indicated by the light grey color in this map.

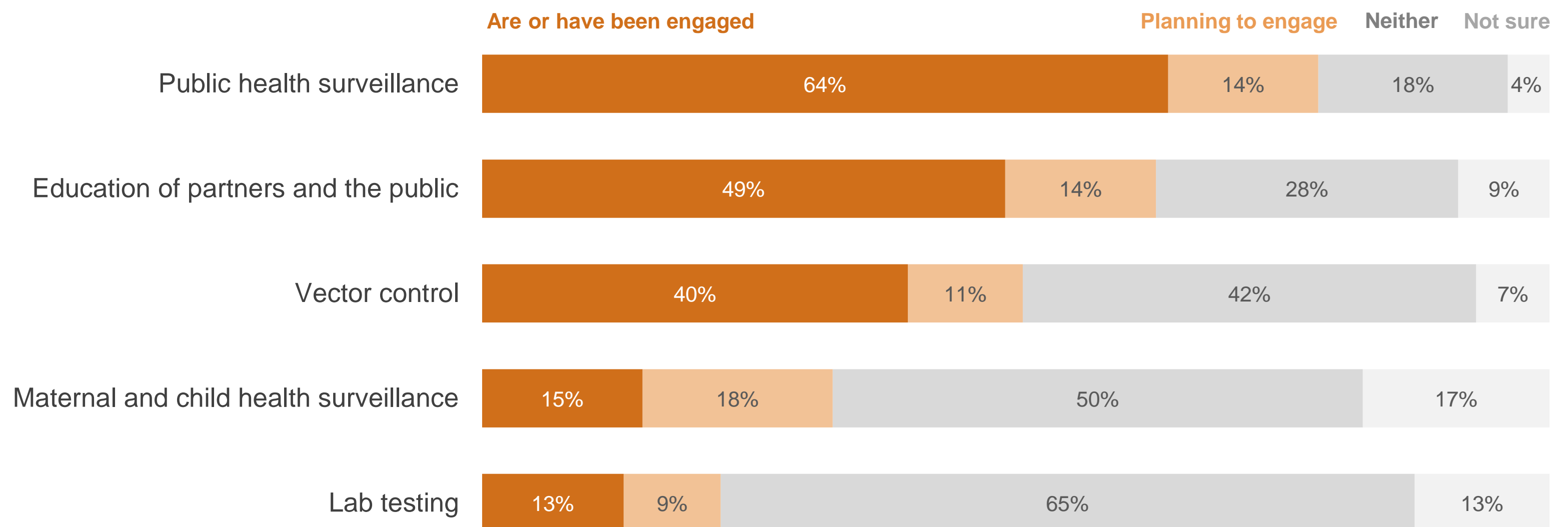
LHDs most commonly provided public health surveillance services to prevent and respond to Zika

The majority of LHDs (78%) either engaged in or planned to engage in public health surveillance activities in response to the Zika virus.

Similarly, more than half of LHDs have or will engage in education activities for their partners and the public, including education about sexual transmission prevention, traveler risks and protection measures, clinical care guidelines, and risk communication.

Most LHDs did not engage in maternal and child health surveillance or lab testing activities related specifically to the Zika virus. This may be a result of the low risk for infection that many jurisdictions experience.

Percent of LHDs



n=597–605

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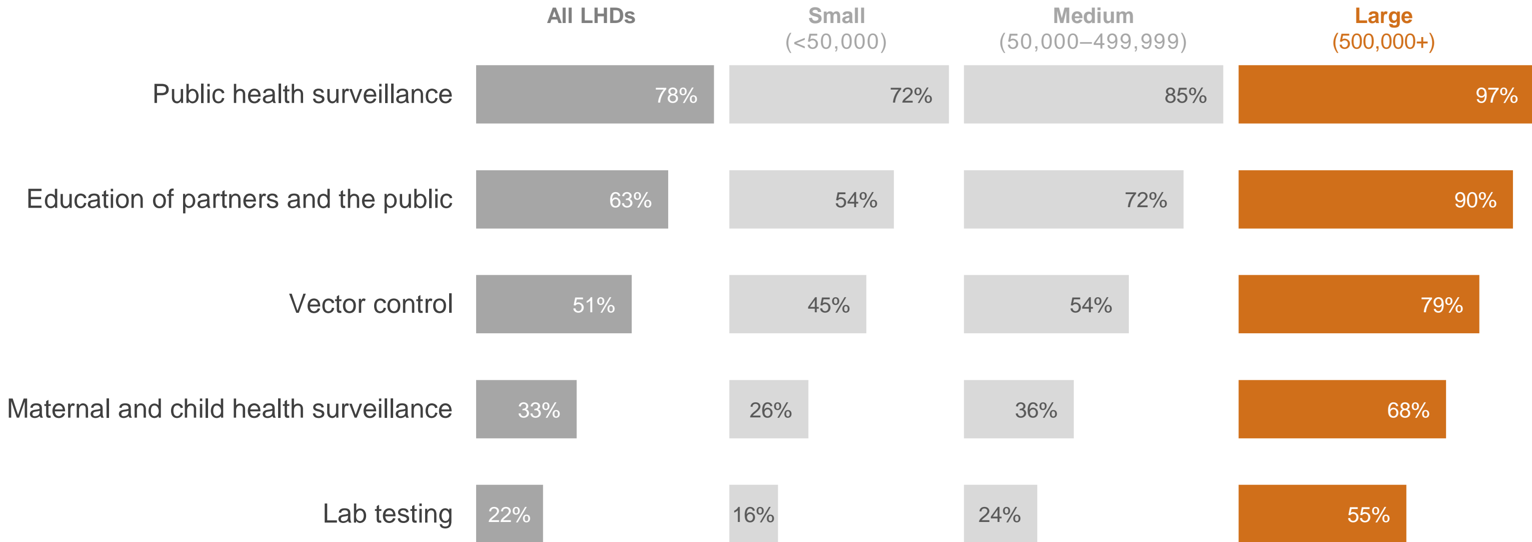
Large LHDs were most likely to provide prevention and response services related to Zika

Most LHDs provide services related to public health surveillance, community education, and vector control in their jurisdictions as a way to prevent and respond to the Zika virus.

Large LHDs, however, are more likely to provide all services compared to small and medium LHDs. In particular, large agencies are more than twice as likely as LHDs in other jurisdictions to perform maternal and child health surveillance or lab testing services. This may be attributed to large jurisdictions having a higher presence of the Zika virus.



n=597–605

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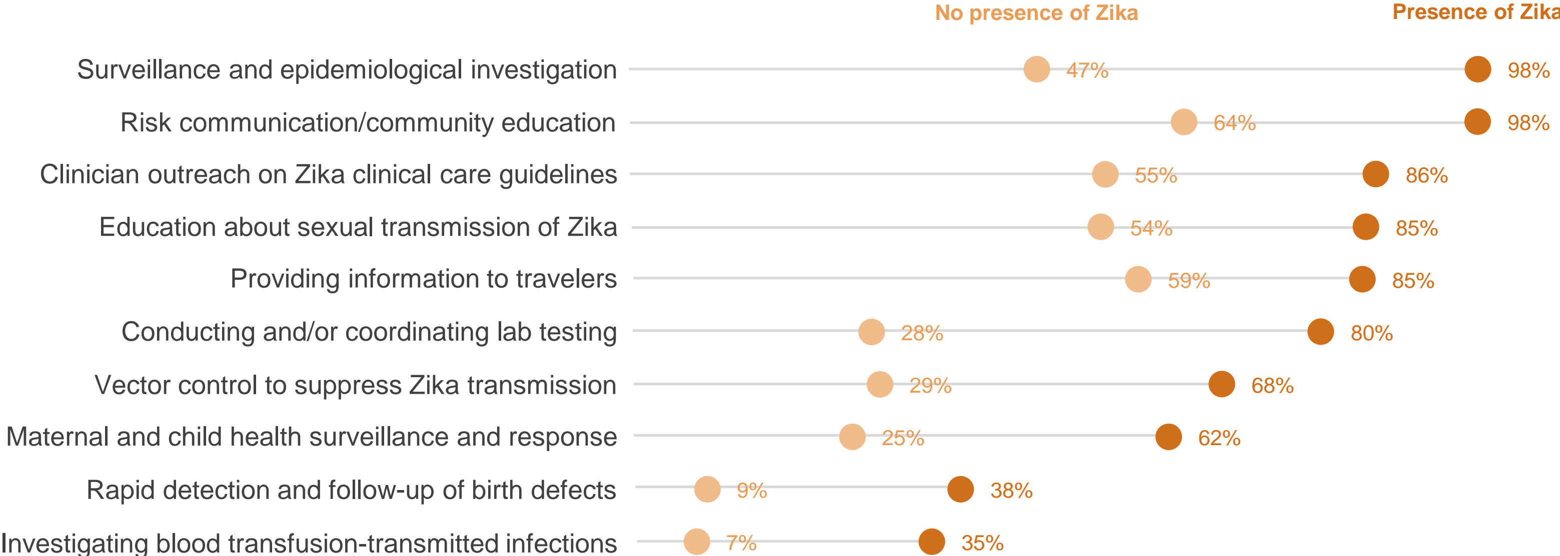
LHDs in jurisdictions where Zika was present were much more likely to provide prevention and response services

As expected, LHDs in jurisdictions where the Zika virus was present reported being much more likely to perform related prevention and response activities than LHDs in jurisdictions with minimal transmission risk.

When Zika was present, an average increase of 36 percentage points in the percent of LHDs providing these services was reported. Lab testing and epidemiological investigation showed the largest differences (52% and 51%, respectively).

The smallest reported difference in service provision was related to educating travelers about risk and prevention—only an increase of 26 percentage points between agencies in jurisdictions without Zika to those with the virus.

Percent of LHDs reporting “are or have been engaged”



n=102–229

Discussion

Emerging infectious diseases threaten the health, safety, and resilience of communities across the United States, requiring that LHDs have the resources for effective prevention and response.

Although most LHDs did not report Zika presence over the last year, those in large jurisdictions and in the southern United States experienced an increased risk of transmission—whether through mosquito-borne infection or travel-associated cases.

This can be attributed to the presence of the *Aedes* mosquito genus in southern United States regions, as well as travel hubs being located in more populous jurisdictions.

This disproportionate risk across communities drives LHDs to focus activities on Zika-related prevention and response. Large LHDs, for example, are more than twice as likely to provide some Zika-related services as LHDs serving smaller populations.

This difference in service provision likely reflects both a higher presence of the Zika virus and a likelihood of more resources, such as staff and funding, to perform these activities in large jurisdictions.

LHDs consider the context of their jurisdictions when making decisions about the services they provide or cut back. Therefore, LHDs must be prepared for changing local preparedness environments as infectious diseases continue to emerge and threaten the safety of communities.

03 Multi-Sectoral Partnerships

As LHDs face a range of increasingly complex health challenges, working in multi-sectoral partnerships is becoming an important strategy for improving community health.

Multi-sectoral partnerships include a wide range of public, private, and volunteer organizations.

Population health is a shared responsibility. Poor health outcomes are often exacerbated by social determinants of health, including education levels and homelessness.

As such, these social determinants must be addressed in collaboration with many entities outside of public health and healthcare, including government, business, non-profits, consumers, and philanthropic organizations.

LHDs benefit from these traditional and non-traditional partnerships by leveraging diverse expertise, skills, and resources.

Identifying how LHDs engage with partners and the barriers to this engagement adds to the growing evidence base on the effectiveness of multi-sectoral partnerships.

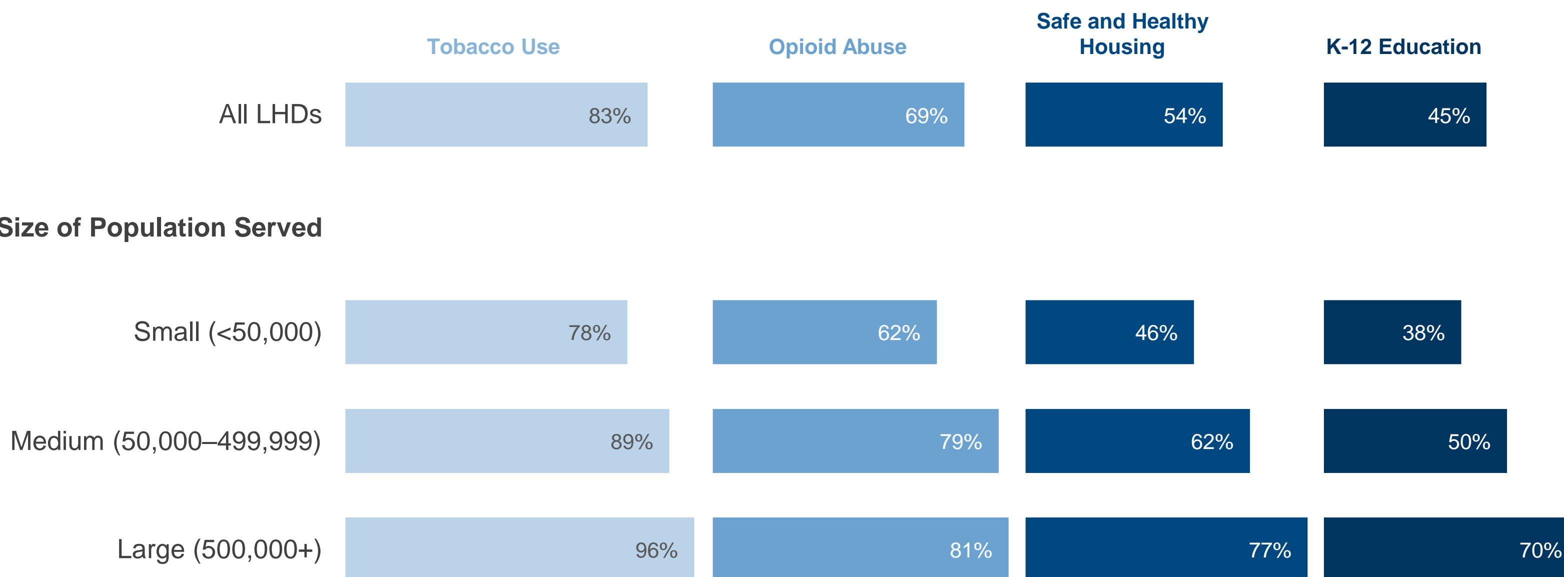
LHDs were likely to partner on preventive efforts addressing tobacco use and opioid abuse

The majority of LHDs reported engaging in partnerships to address substance use and housing issues.

Overall, agencies were more likely to be involved in multi-sectoral partnerships to work on tobacco and opioid use issues compared with safe and healthy housing or K-12 education.

LHDs serving large populations were more likely to be involved in these partnerships than LHDs serving smaller populations. This may be an indication that large LHDs have more resources (e.g., staff, time, funding) to foster such partnerships.

Percent of LHDs reporting engagement in partnership



n=571–588

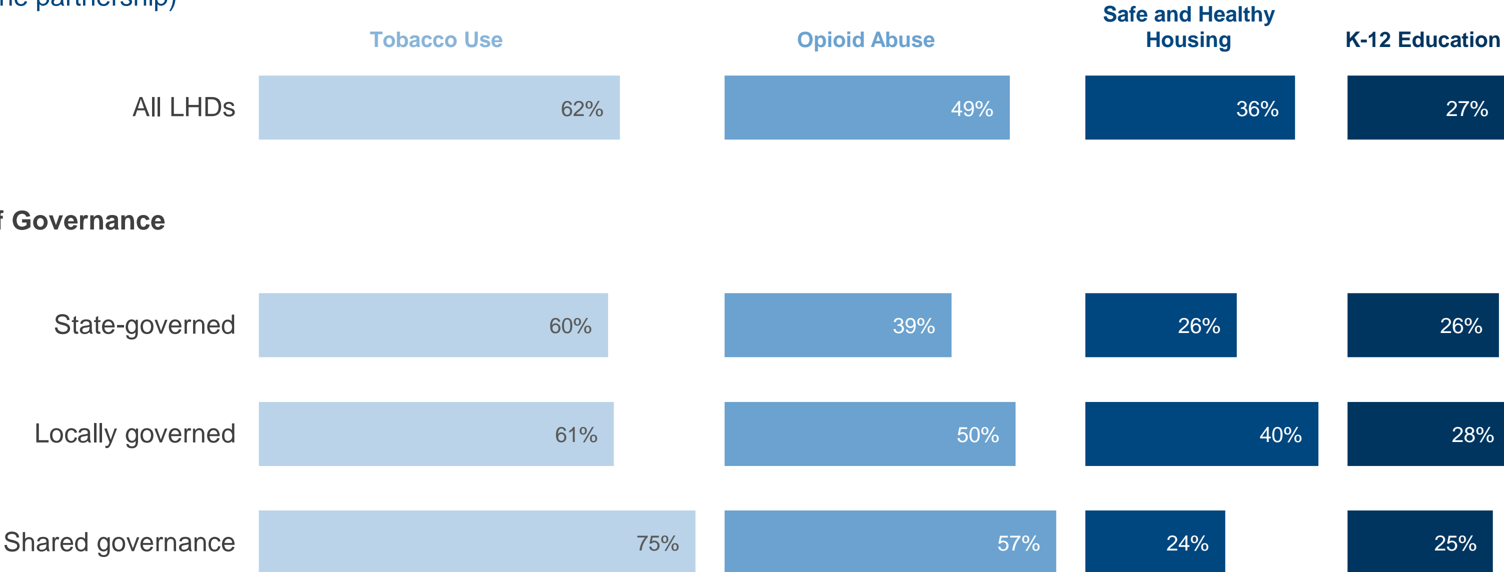
LHDs were most likely to lead or convene partnerships related to tobacco use

LHDs were more likely to lead or convene partnerships on tobacco use than opioid abuse, safe and healthy housing, and K-12 education—with more than half of LHDs reporting this high level of engagement for tobacco use-focused collaborations.

LHDs with shared governance reported being more likely to lead or convene multi-sectoral partnerships on tobacco use, as well as on opioid abuse.

Locally governed agencies, however, were more likely to lead or convene these partnerships on safe and healthy housing and K-12 education. The level of collaboration may be driven by whether the issue is focused locally versus statewide.

Percent of LHDs reporting leading or convening partnership (of those that engage in the partnership)



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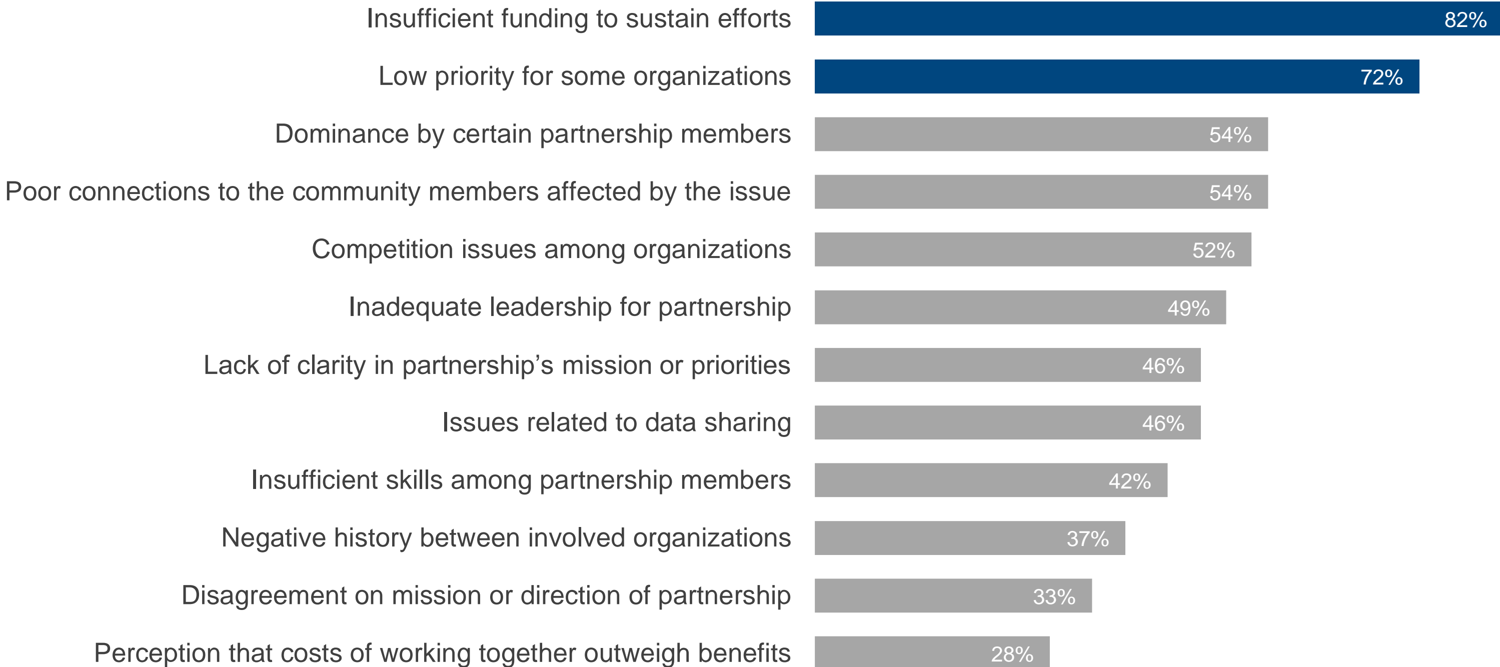
Insufficient funding and low priorities were barriers for LHD involvement in multi-sectoral partnerships

The majority of LHDs reported that insufficient funding to sustain partnerships efforts was a top barrier to working with other organizations.

Many LHDs also reported that partnership activities were a low priority for other organizations, limiting effective collaboration.

Percent of LHDs reporting "major" or "minor" barrier to partnerships



n=592–598

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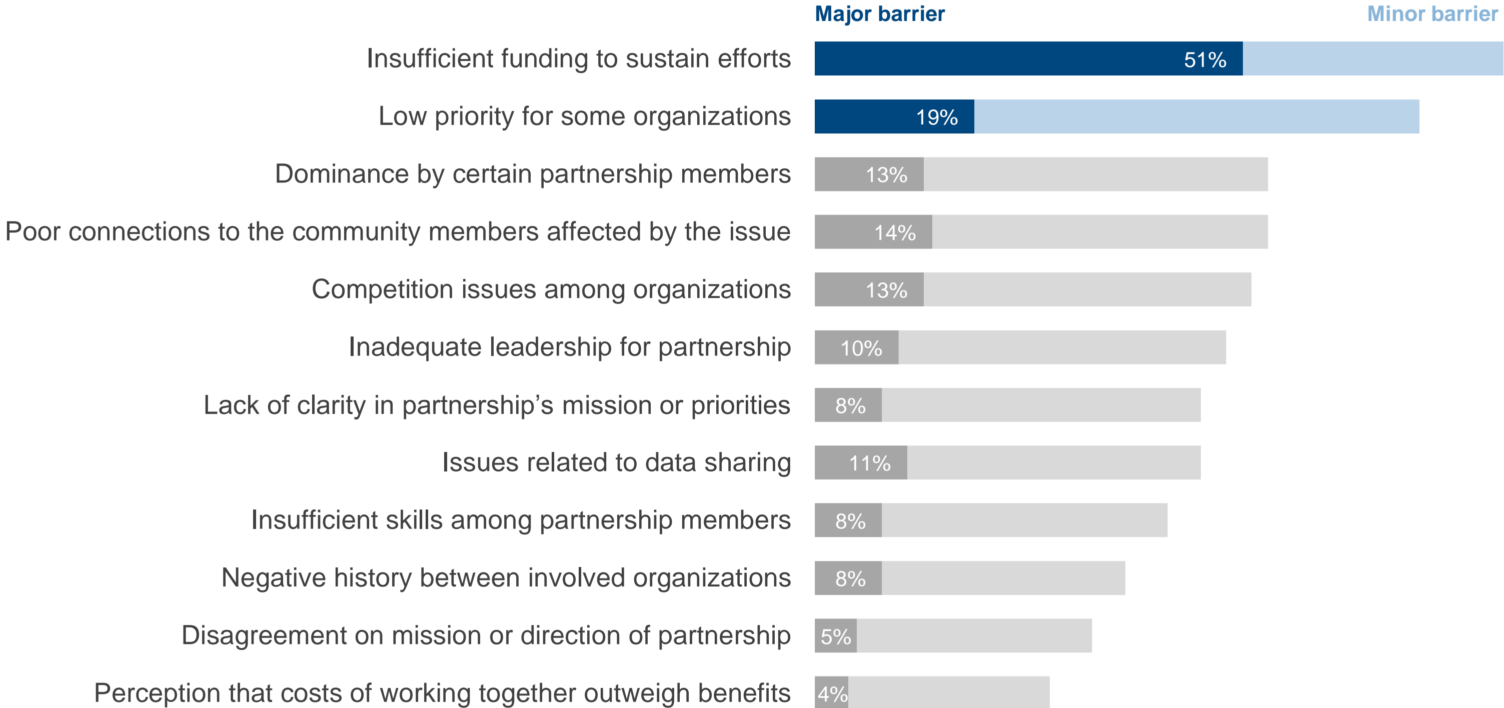
Insufficient funding was a major barrier to engagement in multi-sectoral partnerships

Insufficient funding to sustain partnerships was overwhelmingly the most common major barrier reported by LHDs, with more than half indicating this made it difficult to effectively engage in collaborative efforts.

In addition, nearly one in five agencies reported that low prioritization of partnership activities was a major barrier to working with other organizations.

Percent of LHDs reporting “major” or “minor” barrier to partnerships



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Discussion

Multi-sectoral partnerships play an increasingly critical role in the movement to improve health, equity, and economic prosperity.

The adoption of multi-sectoral partnerships indicates that one entity cannot achieve major health improvement alone. LHDs appear to be very engaged in these relationships when they advance specific activities with an apparent public health impact on their community.

While safe and healthy housing and K-12 education impact public health, LHD partnerships are more likely to address more localized issues, such as tobacco and opioid use.

However, funding and competing priorities are a major roadblock to these partnerships. As LHDs continue to face financial hardships in providing services to their communities, securing additional funding to support partnership activities is critical to ensure improved public health and safety.

In addition to funding, LHDs are faced with limited interest from potential partner organizations due to competing priorities. If partners do not contribute the necessary effort to support the collaboration, it can be difficult for the LHD to shoulder its effectiveness.

Continued support—both technical and financial—is needed to ensure that LHDs can adapt to the changing public health system and continue to increase their involvement in multi-sectoral partnerships on issues that disproportionately affect their communities.

Fawcett S, Schultz J, Watson-Thompson J, Fox M, Bremby R. Building multisectoral partnerships for population health and health equity. Prev Chronic Dis 2010;7(6). http://www.cdc.gov/pcd/issues/2010/nov/10_0079.htm.

04 Workforce Recruitment

NACCHO's Profile study indicates the total number of LHD employees decreased by 23% between 2008 and 2016. In response to the shrinking workforce, national public health agencies identified workforce recruitment as a priority.

Each LHD has a different workforce size and composition. Some LHDs have only a few staff performing a large breadth of job responsibilities, while others employ thousands of specialized professionals.

An effective public health workforce includes a diverse range of occupations, such as administrators, clinical staff, epidemiologists, environmental health specialists, and health educators.

Bolstering LHD workforce capacity is essential for protecting and improving the health of the public.

Gaps in skills result from a limited workforce. These gaps are worsened by the barriers LHDs experience in hiring public health professionals, including being unable to provide competitive pay and attract candidates with the appropriate competencies.

Addressing these challenges and growing the LHD workforce is crucial to ensuring safe and healthy communities.

Specialized positions were the most difficult for LHDs to fill

Percent of LHDs reporting "very" or "extremely" difficult to hire (of those that employ the position)

Many LHDs reported experiencing the most difficulty hiring specialized clinical staff, including advanced practice nurses, physicians, and public health nurses.

Nearly one-third of agencies also had recruitment challenges when hiring epidemiologists and nutritionists.

Positions that require less advanced education and training, such as community health workers and health educators, seemed to be easier to fill for LHDs.

n=176–492
Technical note: The data shown on this page represent LHDs that employ the positions presented.

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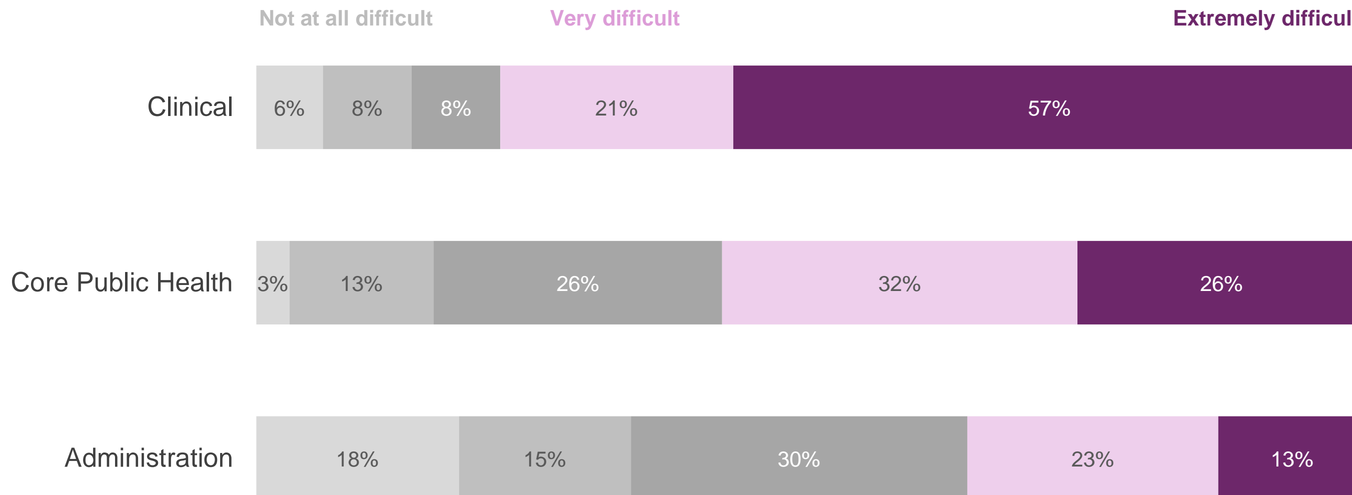
LHDs reported the most difficulty with hiring clinical staff

The majority of LHDs (78%) reported that the most difficult positions to fill were clinically-based (i.e., physicians, advanced practice nurses, public health nurses).

More than half of agencies also indicated that positions providing core public health functions (i.e., community health workers, environmental health specialists, epidemiologists, health educators, nutritionists) were “very” or “extremely” difficult to fill. The least difficult positions for LHDs to fill were administrators (i.e., top executives, mid-level managers).



n=136–492
Technical note: The data shown on this page represent LHDs that employ the positions presented.

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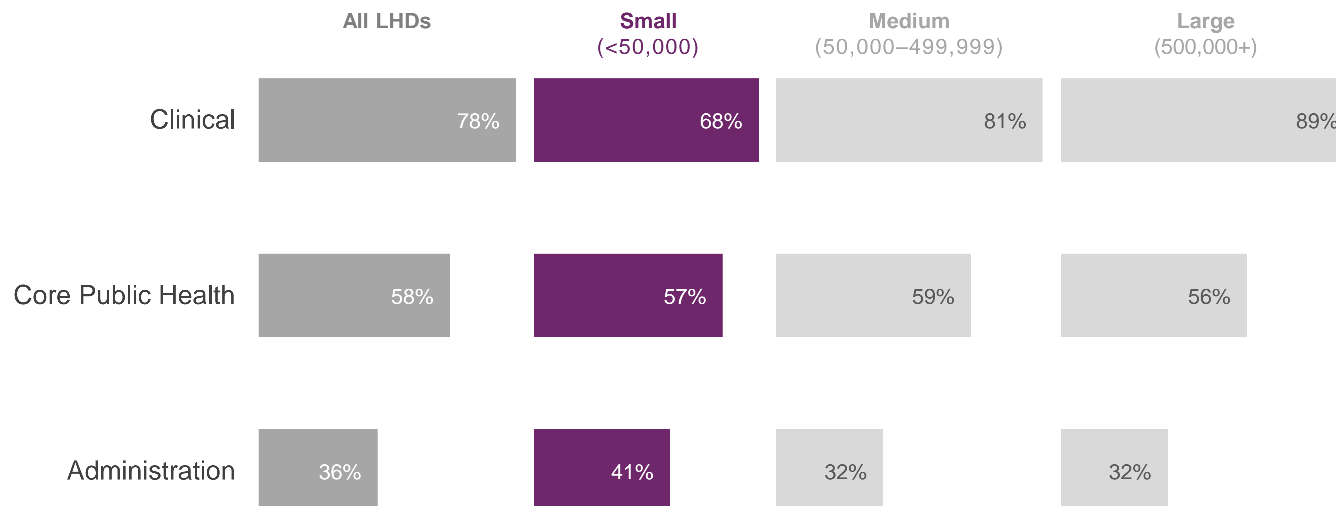
Small LHDs were least likely to experience difficulty with filling clinical positions

Although many LHDs serving small populations reported some hiring burden for clinical positions, these agencies were substantially less likely to experience difficulties compared to LHDs serving larger populations.

Small LHDs, however, had a more difficult experience hiring administrators compared to agencies of other sizes.

The level of difficulty in filling core public health positions was similar across LHDs serving different population sizes.

Percent of LHDs reporting "very" or "extremely" difficult to hire (of those that employ the position)



n=106–270
Technical note: The data shown on this page represent LHDs that employ the positions presented.

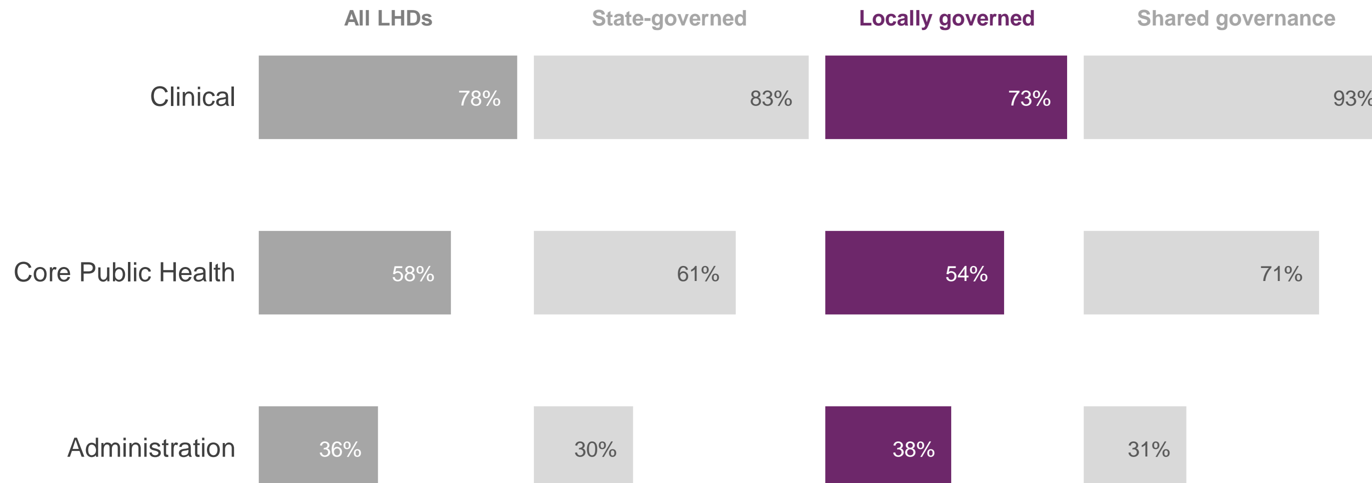
Locally governed LHDs were least likely to experience difficulty with filling clinical and core public health positions

Nearly three-quarters of locally governed LHDs experienced difficulty filling clinical positions, but the percentage of LHDs was less than their governing counterparts.

Locally governed LHDs also reported limited challenges filling positions that play a core public health role compared to agencies with state or shared governance.

LHDs with local governance, however, reported slightly greater recruitment burden when hiring administrators than their governing counterparts.

Percent of LHDs reporting "very" or "extremely" difficult to hire (of those that employ the position)



n=106–270
Technical note: The data shown on this page represent LHDs that employ the positions presented.

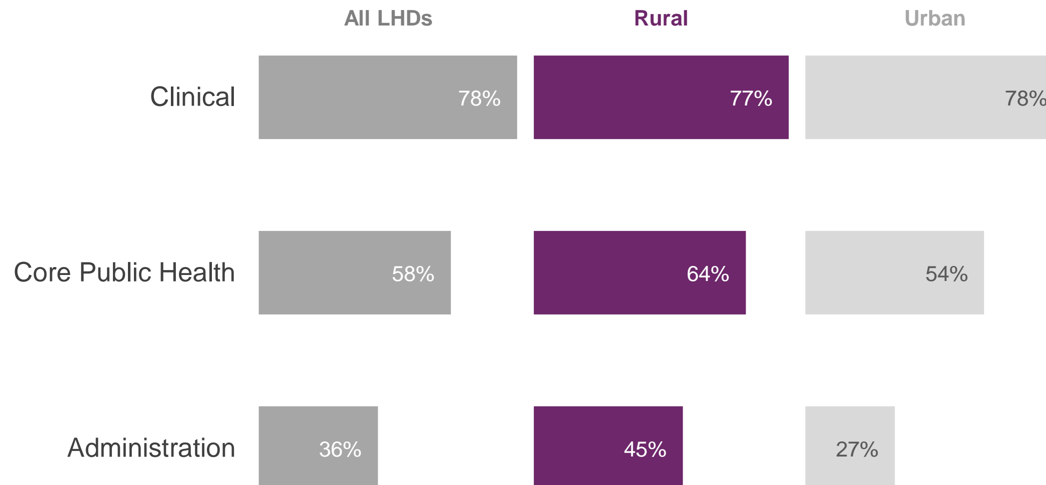
LHDs in rural jurisdictions had a slightly more difficult time filling some positions than those in urban communities

The level of difficulty experienced by rural and urban LHDs was similar for hiring clinical staff, such as physicians and nurses.

More LHDs in rural jurisdictions, however, faced challenges related to filling core public health and administrative roles. Rural LHDs had nearly twice as difficult an experience hiring administrators compared to urban-based LHDs.

These workforce recruitment difficulties may be a result of fewer resources to provide competitive pay and benefits or an inability to attract candidates to rural geographies.

Percent of LHDs reporting “very” or “extremely” difficult to hire (of those that employ the position)



n=106–270
Technical note: The data shown on this page represent LHDs that employ the positions presented.

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More LHDs reported difficulty in filling clinical and environmental health positions compared to five years ago

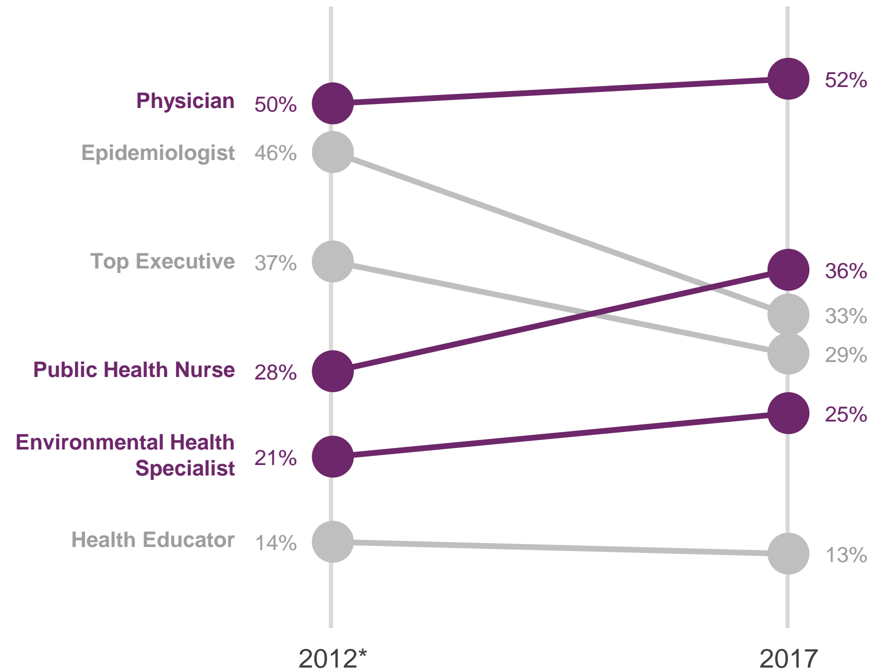
In recent years, LHDs indicated an increased hiring burden for specialized staff, including physicians, nurses, and environmental health specialists.

Since 2012, LHDs have experienced greater challenges to hiring public health nurses, with 8% more agencies reporting "very" or "extremely" difficult.

LHDs indicated, however, that epidemiologists and top executives were becoming easier to hire.

Health educators remained the easiest position to fill over the past five years.

Percent of LHDs reporting "very" or "extremely" difficult to hire (of those that employ the position)



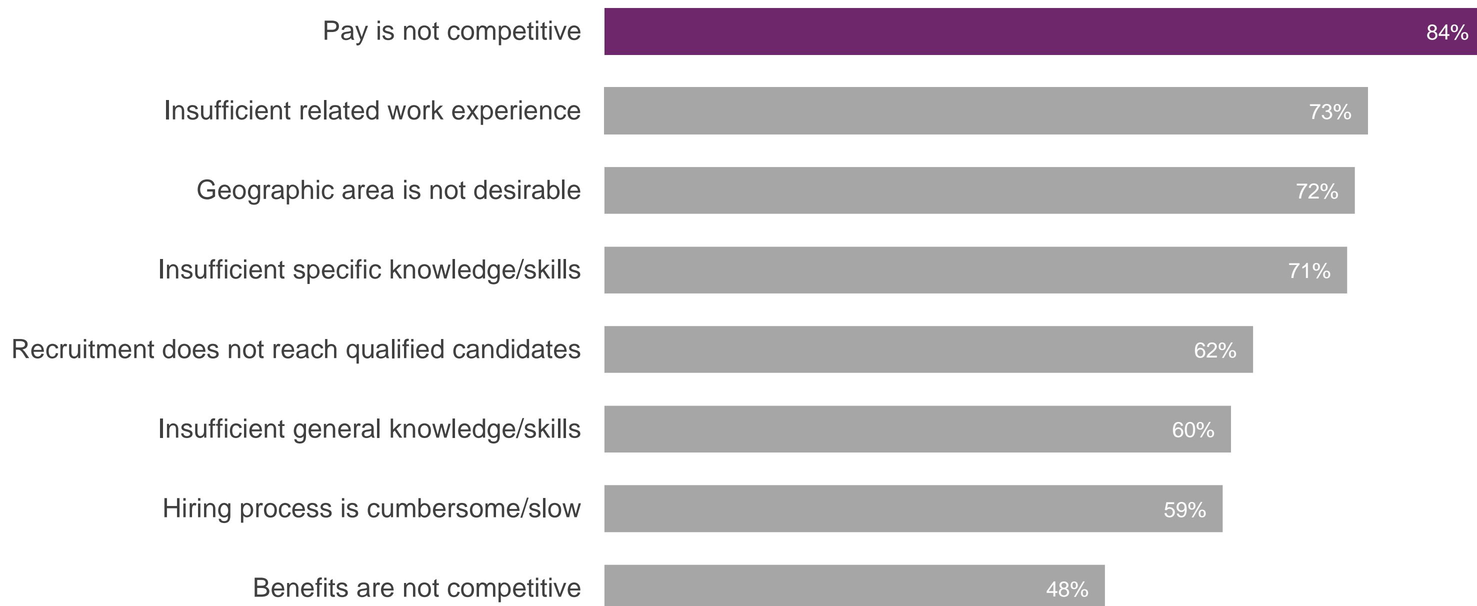
n(2017)=176–492
Technical note: The data shown on this page represent LHDs that employ the positions presented.
*Data from: Darnell J, Cahn S, Turnock B, Becker C, Franzel J, Miller Wagner D. Local Health Department Workforce Recruitment and Retention: Challenges and Opportunities. 2013. http://slge.org/wp-content/uploads/2013/12/Local_Health_Dept_Workforce_Challenges_Opportunities_14-305.pdf.

LHDs reported a diverse range of barriers to hiring staff

Most LHDs indicated that the inability to offer competitive pay was a barrier to hiring staff.

Additionally, more than half of LHDs experienced other diverse workforce recruitment barriers, including both candidate-based barriers (i.e., insufficient work experience and knowledge/skills) and agency-based barriers (i.e., slow processes, ineffective recruitment channels, uncompetitive pay/benefits, undesirable location).

Percent of LHDs reporting “major” or “minor” barrier to hiring

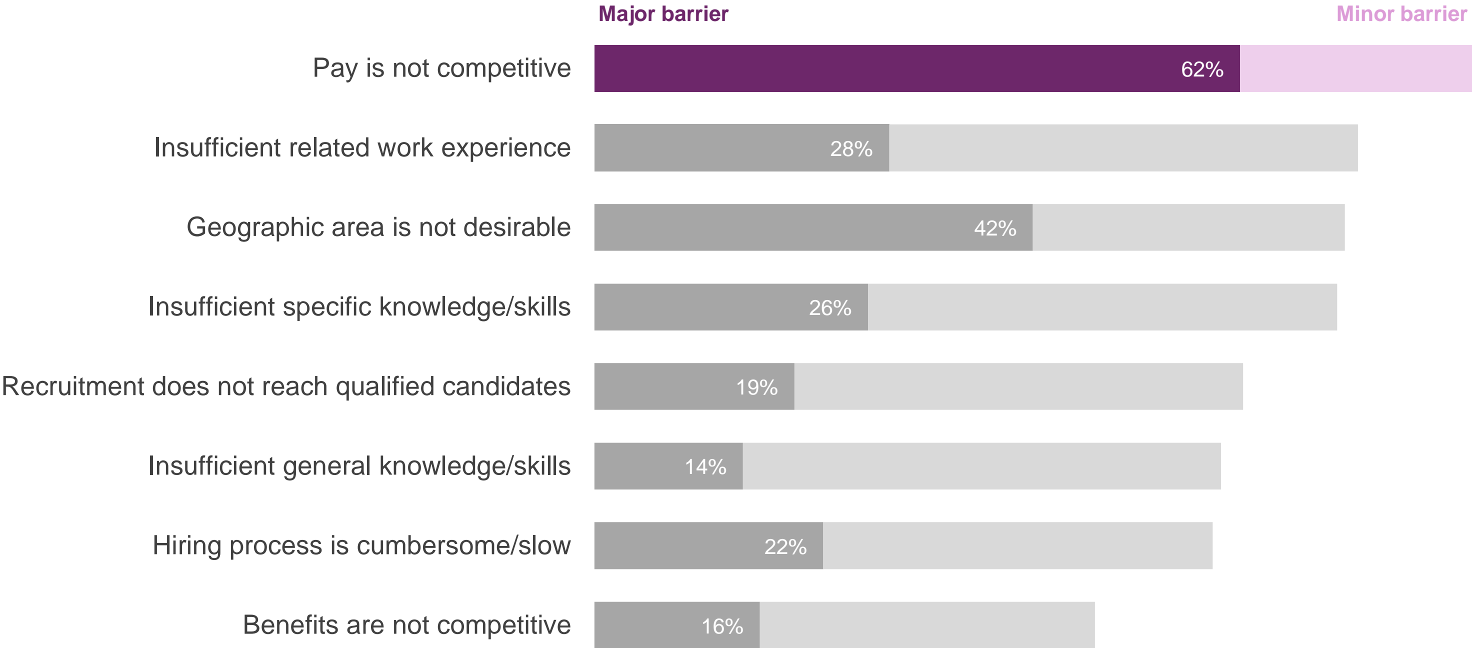


n=592–598

LHDs reported low pay as the most common major barrier to hiring staff

Nearly two-thirds of LHDs indicated that their inability to offer competitive pay was a major barrier to workforce recruitment. In contrast, many LHDs did not report uncompetitive benefits as a major barrier, signaling that agencies may be better able to provide staff with incentives other than salary.

Percent of LHDs reporting "major" or "minor" barrier to hiring



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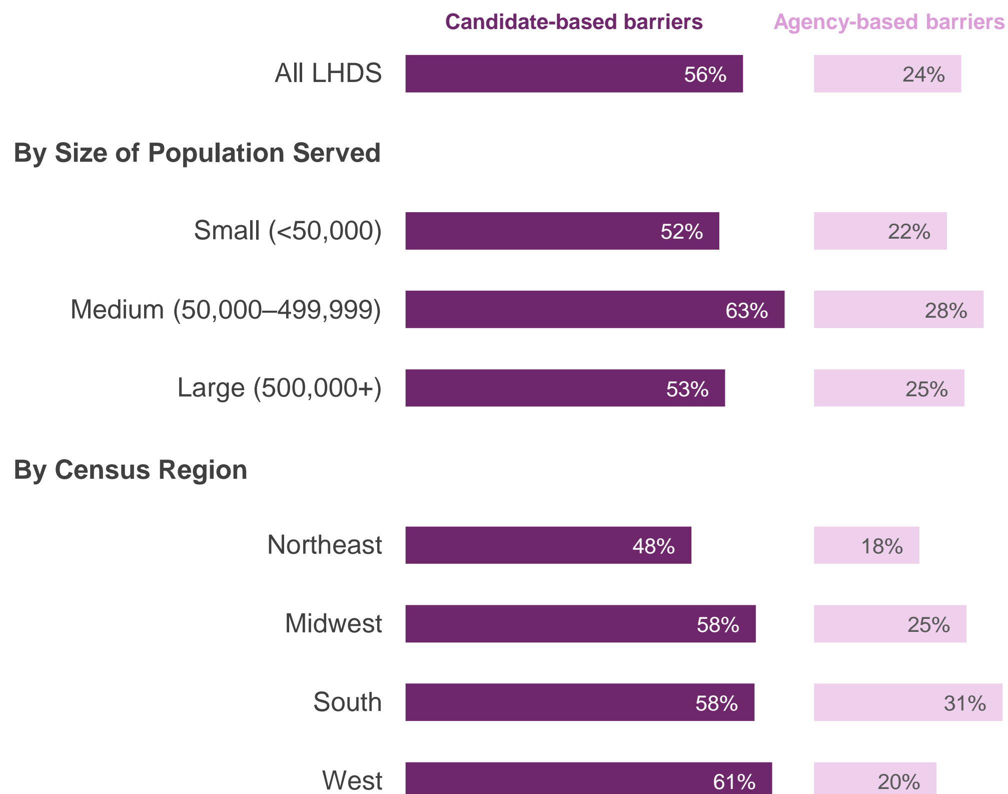
LHDs indicated that candidate-based issues were the most common challenges to workforce recruitment



Overall, more LHDs reported recruitment barriers related to insufficiencies of the candidates themselves rather than in agency processes and procedures.

LHDs serving medium-sized populations were slightly more likely to experience candidate-based and agency-based barriers compared to LHDs serving other population sizes.

Less than half of LHDs in the northeast region of the U.S. reported hiring challenges related to candidate competency and experience.

LHDs in southern states, however, were the most likely to indicate agency-based challenges—driven by low pay and ineffective hiring practices.

n=579

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Discussion

Recruitment challenges continue to plague the local public health workforce, negatively impacting LHD capacity to protect and improve the health of their communities.

In recent years, LHDs have struggled to recruit their workforce—particularly for specialized roles. Hiring clinical staff, including nurses and physicians, has been especially difficult for LHDs. Although LHDs serving small populations have the least difficulty in staffing clinical positions, nearly two-thirds of these agencies still reported clinical positions as “very” or “extremely” difficult to fill.

LHDs experience a diverse range of barriers during the recruitment process. Most agencies indicate uncompetitive pay is the most significant challenge to overcome.

In addition, more LHDs reported candidate-based recruitment barriers than agency-based barriers. Because hiring specialized staff is difficult, so too is recruiting candidates with sufficient specialized experience, knowledge, and skills.

The Great Recession and changing federal budget priorities resulted in budget, staffing, and programmatic cuts for many LHDs who have not yet been able to fully recover. LHDs struggle to deliver services with limited resources, and lack of available staff due to recruitment barriers further exacerbates the problem.

LHDs need support to creatively and collaboratively overcome workforce recruitment challenges—to bolster their ability to protect and improve public health outcomes.

Thank You

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The contents of this document are solely the responsibility of NACCHO and do not necessarily represent the official views of the sponsors.

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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 with local health departments.

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