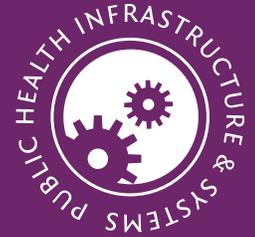


Local Health Department Job Losses and Program Cuts



The National Association of County and City Health Officials (NACCHO) surveyed a sample of local health departments (LHDs) nationwide in the months of July and August 2009 to measure the impact of current economic conditions on LHDs' budgets, workforce, and programs. The findings show that LHDs—the front line protecting the public's health—are severely strained by increasing budget and workforce cuts to the point that they are being forced to eliminate or reduce vital programs.

Budget Cuts Are Worsening

Across the country, 45 percent of LHDs are experiencing cuts to their current budgets (Figure 1); this is up from 27 percent in a survey that NACCHO conducted in late 2008. In 20 states, more

than half of LHDs have experienced budget cuts in the current fiscal year, and in 13 of these states, more than 75 percent have a lower budget this year than last year (Figure 2).

FIGURE 2: Percentage of LHDs with Budget Decreases in 2009 Compared to Previous Year

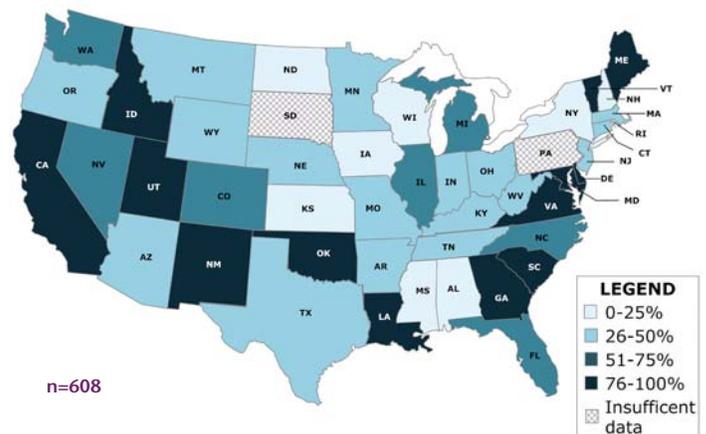
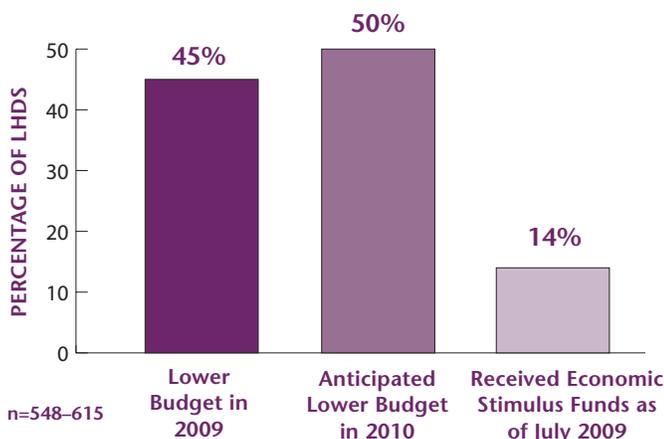


FIGURE 1: Budget Cuts of LHDs and Receipt of Economic Stimulus Funds

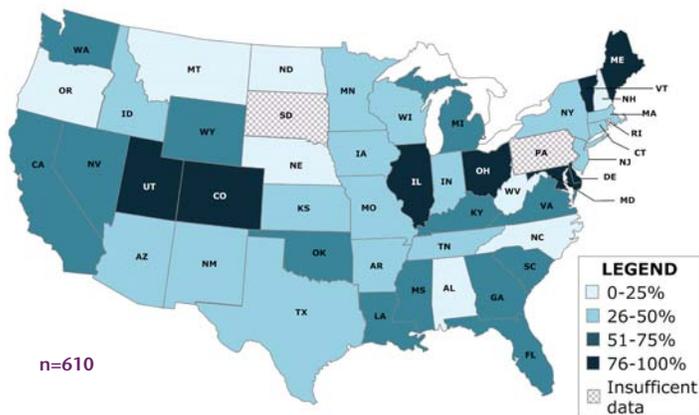


Methodology

In the months of July and August 2009, NACCHO surveyed 990 LHDs. These LHDs were selected as part of a statistically random sample, designed to provide both national and state-level estimates. A total of 623 LHDs distributed across 48 states responded, for a response rate of 63 percent. All statistics reported were developed using appropriate weights to account for both sampling and non-response. LHDs provided additional information through a series of open-ended questions. For additional technical documentation, please visit the NACCHO Web site at www.naccho.org/advocacy/lhdbudget.cfm.

Moreover, half of LHDs expect that their budget in the coming year will be less than the current year (Figure 1). In eight states, more than three-fourths of LHDs expect budget cuts in the coming year (Figure 3).

FIGURE 3: Percentage of LHDs Expecting Budget Decreases Next Year Compared to 2009



One LHD described the outlook, saying, “The future is looking even bleaker as grants are being cut and costs of programs continue to escalate. For the 2010 budget, I believe we will have very hard decisions to make regarding services ... Something will have to be eliminated, and the results will be more costly.”

While LHDs of all sizes have suffered in the economic downturn, those that serve large populations are particularly vulnerable. More than 60 percent of LHDs serving populations of 500,000 or more people have experienced budget cuts in the current year, and almost as many expect budget cuts in the coming year (Figure 4).

“I believe we will have some very hard decisions to make regarding services. Something will have to be eliminated, and the results will be more costly.”

Cuts to state funding have a multiplicative effect in some program areas. First, they prevent LHDs from taking advantage of available federal dollars. As one LHD noted, “We anticipate a 10 to 45 percent cut in many programs, with concurrent loss of federal funding because of the state’s

FIGURE 4: Percentage of LHDs with Budget Cuts and Percentage Receiving Economic Stimulus Funds, by Size of Population Served

Size of Population Served by LHD	Lower Budget in 2009	Anticipated Lower Budget in 2010	Received Economic Stimulus Funding*
Small (< 50,000)	43%	47%	11%
Medium (50,000–499,999)	48%	53%	19%
Large (500,000+)	62%	59%	26%
Overall	45%	50%	14%

*As of July 2009.

n=548–615

inability to match federal dollars.” In addition, cuts to staff time may result in reduced LHD revenue from inspections, clinic fees, and reimbursable services, further threatening the financial base of the agency. An LHD employee explains, “We had a double hit.... We are trying to squeeze five days of work into four days. We can’t do it. Our productivity is down, and when you’re not out doing home visits and reimbursable services, you lose revenue that way too.”

“We have always done more with less, but looking into the eye of a pandemic with limited resources is both challenging and disconcerting.”

While resources are being whittled away, many LHDs report that the need for services has increased as a result of job losses and foreclosures. One LHD explains, “The economic downturn has strained family finances.... Many who once had steady employment and incomes have had to turn to Medicaid; the Women, Infants, and Children Program; and other programs for the first time, even as those programs face increasing budget constraints.”

With H1N1 influenza and other public health challenges looming, the erosion of public health infrastructure could not be more untimely. One LHD states, “The challenges faced in 2009 are a double whammy in that budgets are being cut and furloughs are being implemented during the midst of a pandemic of H1N1 influenza. We have always done more with less, but looking into the eye of a pandemic with limited resources is both challenging and disconcerting.”

Job Losses Are Accelerating

A previous NACCHO survey documented the loss of 7,000 LHD jobs in 2008. Job losses occurred at a higher rate in the first half of 2009 (January 1–June 30) when LHDs lost approximately 8,000 staff positions over six months (Figure 5). Nearly half of

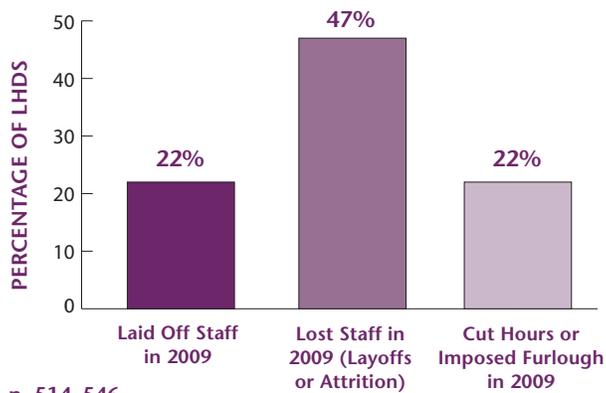
FIGURE 5: Estimated Number of Jobs Lost and Employees with Hours Reduced (January–June 2009)

	NO. OF PEOPLE	% LHDS AFFECTED
Layoffs	3,000	22%
Attrition	5,000	39%
Total affected through layoffs & attrition	8,000	47%
Hours cut	3,000	19%
Mandatory furlough	9,000	7%
Total affected through hours cut or furlough	12,000	22%
Total affected through staff loss or hour cuts	20,000	51%

n=514–546

LHDs either laid off employees or lost them through attrition and have been unable to replace them due to budget limitations (Figure 6).

FIGURE 6: Workforce Cuts of LHDs (January–June 2009)

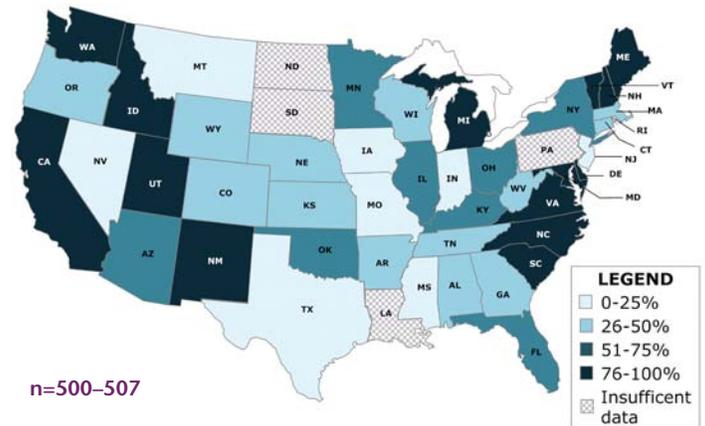


n=514–546

In 22 states, over half of LHDs lost staff. In 14 states, over 75 percent of LHDs lost staff positions due to layoffs or attrition (Figure 7).

In addition to staff lost through layoffs, an additional 12,000 LHD employees were subjected to reduced hours or mandatory furloughs (Figure 5). In four states, more than half of LHDs had to institute reduced hours and furloughs (Figure 8).

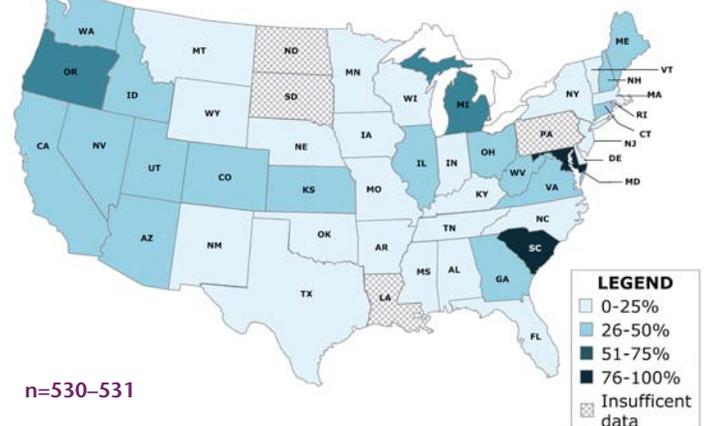
FIGURE 7: Percentage of LHDs that Lost Staff Due to Layoffs or Attrition (January–June 2009)



Staffing cuts strain LHDs as they seek to respond to public health emergencies such as an H1N1 pandemic. In particular, LHDs report having cut nursing staff that would have been involved in vaccination campaigns and community educators and outreach specialists who could otherwise have mobilized community based groups to respond to the threat of pandemic flu. One LHD reports that it had “less staff to respond to a public health emergency and no surge capacity to respond to a mass vaccination campaign such as we

“Reductions in staff over time have left us with very limited resources to respond to a public health emergency such as we now find ourselves facing with the potential H1N1 pandemic.”

FIGURE 8: Percentage of LHDs that Lost Staff Time Due to Reduction of Hours or Mandatory Furlough (January–June 2009)



anticipate for the H1N1 influenza. Reductions in staff over time have left us with very limited resources to respond to a public health emergency such as we now find ourselves facing with the potential H1N1 pandemic.”

Staff loss and pay cuts have also taken a toll by affecting the morale of the remaining public health workforce. “At one point, we had five mental health counselors,” says one LHD. “Now we have three, and with this contract, we’ll have to lay off one, or even two. We are handling a case load of 175–200 people. The thought of one person trying to handle that is overwhelming. The staff are trying to not be emotionally ruined by this. At first, they joked about hoping they weren’t the one to get laid off. Now they hope that they’re not the one that has to stay and be faced with that.”

In addition, the loss of staff through layoffs and attrition contributes to a loss of institutional knowledge. One LHD says, “The current and projected future financial situations have hidden impacts. Attrition causes the agency to lose experience and knowledge that is not transferred to new employees.” In addition, as community outreach programs are scaled back, the connection of LHDs with the community is diminished. One LHD was fortunate in that the programs they eliminated were picked up by other organizations but lamented that “the impact is that public health no longer has feelers into these areas of the community.”

“Now we have three [mental health counselors], and ... we’ll have to lay off one, or even two. We are handling a case load of 175–200 people. The thought of one person trying to handle that is overwhelming.”

Even when LHDs have the ability to hire new people into existing positions, the atrophy of wages and benefits poses an obstacle to hiring and retaining employees. “Our food sanitarian . . . does not have any benefits [and receives] low wages,” says one LHD. “The food sanitarians usually stay about four to six months and then leave for better pay elsewhere. We no more than get them trained, and then they leave.”

The erosion of the public health workforce has affected large LHDs even more than smaller ones. Nearly 70 percent of the largest LHDs (those serving 500,000 or more people) lost staff in

the first six months of 2009, compared to 37 percent of small LHDs (those serving fewer than 50,000 people). Similarly, a third of the largest LHDs cut staff hours or imposed mandatory furloughs, compared to 19 percent of the smallest LHDs (Figure 9).

FIGURE 9: Percentage of LHDs with Workforce Cuts (January–June 2009), by Size of Population Served

Size of Population Served by LHD	Laid Off Staff in 2009	Lost Staff in 2009 (Layoffs or Attrition)	Cut Hours or Imposed Furlough in 2009
Small (< 50,000)	19%	37%	19%
Medium (50,000–499,999)	27%	64%	26%
Large (500,000+)	23%	69%	33%
Overall	22%	47%	22%

n=514–546

Budget Cuts Are Reducing Public Health Services

Over the past 12 months, 55 percent of LHDs have made cuts to important public health programs such as maternal and child health, environmental health, and emergency preparedness (Figure 10). In 27 states, more than half of LHDs have had to make cuts to their programs, and in 15 states, more than 75 percent of LHDs cut programs for budgetary reasons (Figure 11).

FIGURE 10: Program Cuts of LHDs in Past 12 Months (approximately July 2008–June 2009)

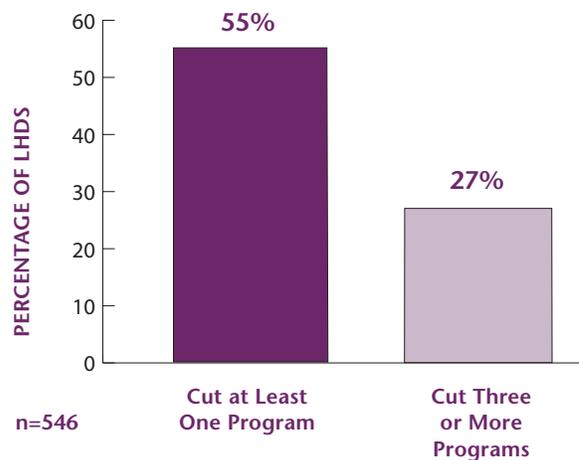
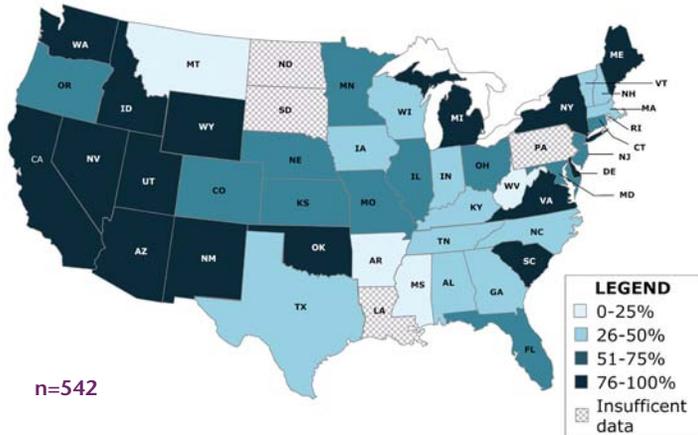
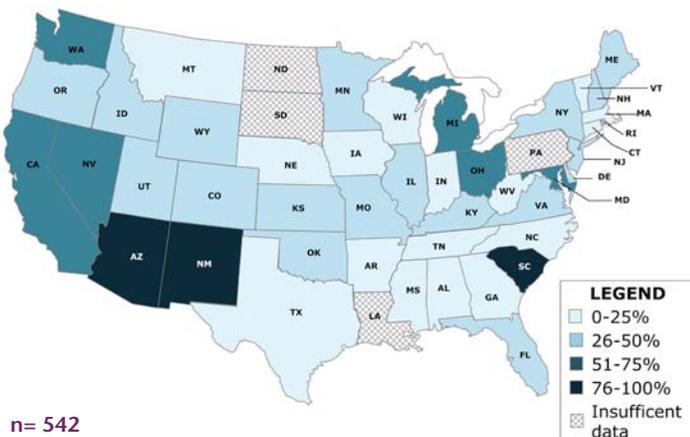


FIGURE 11: Percentage of LHDs with Program Cuts in Last 12 Months (approximately July 2008–June 2009)



In some LHDs, programmatic cuts have been even more severe. More than a quarter of LHDs have been forced to make cuts in three or more program areas (Figure 10). In nine states, more than half of LHDs have made cuts to three or more programs (Figure 12).

FIGURE 12: Percentage of LHDs with Cuts to Three or More Programs in Last 12 Months (approximately July 2008–June 2009)



As with budget and workforce cuts, programmatic cuts were most common among larger LHDs. For example, more than half of LHDs serving populations of 500,000 or more had to cut three or more programmatic areas, while the same was true for about one in five LHDs serving populations of fewer than 50,000

“We are at bare bones and have already tried the creative solutions.”

people (Figure 13). However, small LHDs tend to have fewer programs, and cuts to these programs may cause significant hardship for the communities they serve.

FIGURE 13: Percentage of LHDs with Program Cuts in Past 12 Months (approximately July 2008–June 2009), by Size of Population Served

Size of Population Served by LHD	Cut at Least One Program	Cut Three or More Programs
Small (< 50,000)	52%	21%
Medium (50,000–499,999)	59%	34%
Large (500,000+)	71%	53%
Overall	55%	27%

n=546

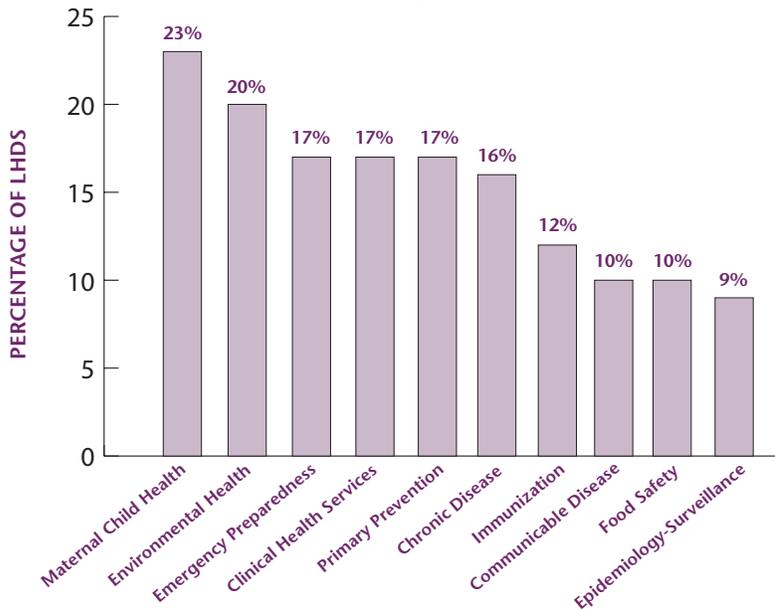
These cuts have not only affected innovative new programs, but they have also crippled the core public health functions of LHDs. As one LHD explains, “We are at bare bones and have already tried the creative solutions.” For example, nearly a quarter of LHDs have cut maternal and child health programs, including WIC programs or early intervention programs to identify and treat developmental delays. Nearly one in five LHDs

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has cut environmental health programs such as environmental hazard investigation, well water inspection, or rabies control. Other programs commonly facing cuts include emergency preparedness, clinical health services, population-based primary prevention (such as programs to increase physical activity or healthy eating in order to prevent disease), and chronic disease screening or treatment (Figure 14).

One LHD reports that “In two or three weeks, we’re going to have to make more reductions. We’ll close down services—like our lead poisoning prevention program, home services for ages zero to three, early diagnosis and developmental delays, and children’s immunizations.”

FIGURE 14: Percentage of LHDs that Cut Program Areas in Past 12 Months (approximately July 2008–June 2009), by Program Area



n=546

“At the local level, we feel that we are currently patching together bits and pieces of our programs instead of reinforcing and enhancing what we have struggled to build.”

With the public health infrastructure already strained by budget and workforce cuts, LHDs express concerns about the effect of responding to emerging public health threats such as H1N1 influenza or carrying out other core LHD activities. “We are simply spread too thin,” describes one LHD, “Our response to normal situations is delayed from three days to a week. In regards to a public health emergency, I do not have sufficient manpower to respond first to that situation and secondly to maintain normal function. Too few people are wearing too many hats.” Another LHD says, “The deal breaker in this will likely be pandemic influenza where we use up people and resources without the ability to regroup or restock.”

Relationships built with the community over time are quickly damaged when LHDs are hobbled from providing core services in a timely manner. One LHD provides this example: “At present, [we are] dealing with a severe shortage of back-to-school vaccines ... it is seriously hurting our credibility in the community. New laws [were] passed to add new vaccines to school requirements. [But] there is no vaccine to give.” Similarly, another LHD says, “We continue to be asked to do more with less, be it medical supplies, pharmaceuticals, testing supplies, office supplies, or travel. It is difficult to explain to patients that we can no longer provide the care that they have come to expect.”

Attempts to shave public health costs in the short term may ultimately drive up public costs in the long term. Examples cited by LHDs include cuts to home-based services that help seniors stay in their own homes rather than moving to nursing homes or the reduction of immunization services. “Prevention is so hard to prove sometimes, but look at the stats regarding the numbers of childhood deaths from vaccine preventable diseases and how they have drastically dropped,” says one LHD. “Reduce the number of us out in the field striving every day to protect our nation’s children from these horrible, preventable diseases, and you will see these diseases come back with a vengeance.”

When public health programs such as these are eliminated, there is often no other organization that can provide the services. “We’re the front line,” says an employee at one LHD. “There’s nobody else out here that’s doing the things that need to be done.”

The elimination of programs may also cause families to postpone or forgo needed interventions, and seeking similar services in the private sector may add prohibitive costs. One LHD comments, “Families and social services agencies in need of comprehensive child developmental assessment services must travel between 30 and 80 miles to receive comparable services. The remaining service providers are understaffed and have significant waiting lists.”

“What’s most alarming to me now is that if we can’t provide these services, there’s no one else that will be doing it.”

Many LHDs that are able to retain parts of key programs report strain on their programs and personnel as demand outstrips available supply. One LHD states, “At the local level, we feel that we are currently patching together bits and pieces of our programs instead of reinforcing and enhancing what we have struggled to build.”

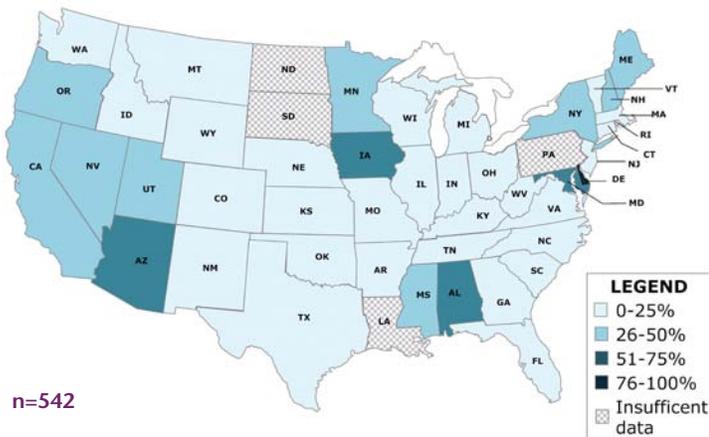
“What’s most alarming to me now is that if we can’t provide these services, there’s no one else that will be doing it,” says another LHD. “The people we serve and the needs they have don’t go away. People will end up going to the police department and the emergency room—they’ll be shifting to other service sectors that are not prepared to help them. In the end, that does not save money.”

In addition to increasing long-term costs, a failure to provide basic public health services may have other serious consequences. One LHD says, “I sit on an infant mortality review board as a member. There has been a trend recently of infant deaths due to possible sudden infant death syndrome or asphyxia.... These cases are acutely disturbing, [and] they may also have been prevented by a local public health nurse visit.”

Economic Stimulus Money Has Not Yet Reached Most LHDs

The American Reinvestment and Recovery Act (ARRA) provided \$787 billion in funds to stimulate the economy, including \$1 billion for prevention and wellness activities. However, as of July 2009, only 14 percent of LHDs had received ARRA funds (Figure 1). Large LHDs are more likely to have received funds than smaller ones; for example, about a quarter of LHDs serving 500,000 or more people received ARRA funding, compared to 11 percent of LHDs serving fewer than 50,000 people (Figure 4). In only five states did more than half of the LHDs receive ARRA funding in this time period (Figure 15).

FIGURE 15: Percentage of LHDs that Received Economic Stimulus Funding as of July 2009



The primary activities for which LHDs described receiving ARRA funds for were immunization campaigns and maternal and child health programs. One LHD reported, “We provide home visitation services for children zero to three with disabilities and did not have adequate state or federal funds to pay salaries through the end of the year. Stimulus funds ... [will] eliminate a need to furlough staff.”

Because of ARRA, some LHDs received funding for grants that had previously been denied due to lack of funding. That funding helped a few LHDs to secure greater support from state and local sources. For example, one reports, “Last fall we applied for a \$3 million Housing and Urban Development (HUD) Lead Hazard grant, and although we had a competitive application, they had more applications than funds. Through the American Reinvestment and Recovery Act we were able to receive the HUD lead hazard grant. As a result we will be remediating lead in 150 homes and have hired 3.5 employees to assist with the program. The HUD grant leveraged over \$5 million in local funding in hard and in-kind funds.”

“The people we serve and the needs they have don’t go away. People will end up going to the police department and the emergency room—they’ll be shifting to other service sectors that are not prepared to help them. In the end, that does not save money.”

Survey respondents described several barriers to the distribution of funds at the local level. First, the trickle down of funding through various levels of government resulted in delays. Second, the focus areas of some funding streams were specific and therefore unable to be used to fill gaps in existing programs. Third, securing some kinds of ARRA funding required the personnel capacity to write and submit a proposal with a quick turn-around time.

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Conclusion

LHDs are the front line of public health and are the organizations best equipped to prevent and respond to conditions that threaten the health of communities, from outbreaks of infectious disease to contaminated water supplies to unsafe food handling practices in restaurants or schools. It is their job to respond quickly and effectively to public health emergencies such as an H1N1 pandemic. LHDs regularly offer cost-efficient preventive services that can reduce future public expenditures on medical care in the long term. LHDs often provide a medical safety net for people affected by economic hardship.

The findings from this study show that LHDs are severely strained by increasing budget and workforce cuts, to the point that they are being forced to eliminate or reduce vital programs that protect the public's health. These pressures come even as LHDs are being called upon to take the lead in local H1N1 vaccination campaigns and as the demand for many different services has increased due to adverse economic conditions.

Rebuilding the diminished capacities of LHDs to serve their communities will take far longer than has the recent dismantling of critical public services. It will require a sustained commitment to train and retain a professional workforce and stable funding to ensure that every locality can protect the health of its citizens in all circumstances, both the everyday and the exceptional.

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To read stories from the field about how the economic situation is impacting LHDs across the country, visit NACCHO's Web site at www.naccho.org/advocacy/lhdbudget.cfm.

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