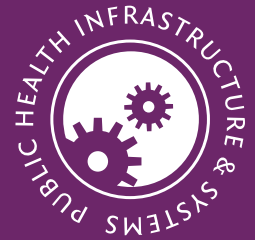


Local Health Department Job Losses and Program Cuts: Findings from January/February 2010 Survey



The National Association of County and City Health Officials (NACCHO) surveyed a sample of local health departments (LHDs) nationwide in the months of January and February 2010 to measure the impact of the economic recession on LHDs' jobs, programs, and budgets. This was the third in a series of nationally representative surveys. The findings show that LHDs have experienced deep job losses and cuts to core funding that are resulting in the reduction or elimination of essential public health services.

Methodology

In January and February 2010, NACCHO surveyed 997 LHDs. These LHDs were selected as part of a statistically random sample designed to provide both national and state-level estimates. A total of 721 LHDs distributed across 48 states participated for a response rate of 72 percent. All reported statistics were developed using appropriate weights for both sampling and non-response. Data in this study were self-reported; NACCHO did not independently verify the data provided by LHDs. Technical documentation and additional findings are posted on NACCHO's website at www.naccho.org/lhdbudget.

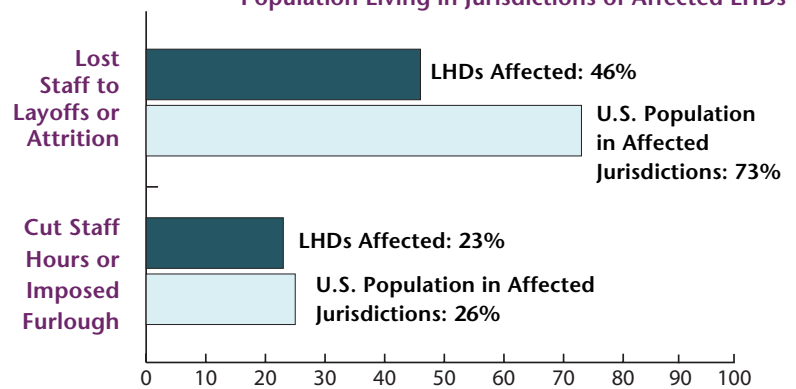
Deep Job Losses on the Front Line of Public Health

LHDs have been described as the country's "best kept secret." As one LHD official states, "Unless there is an outbreak, no one even knows that we exist. We operate diligently and quietly in the background, keeping our community healthy and safe."

This army of silent guardians has taken considerable casualties. In the last six months of 2009, nearly half of LHDs (46%) lost the skilled people needed to protect the health of their communities (Figure 1), representing 8,000

lost jobs. This includes layoffs or attrition, in which employees left and their positions were not filled due to budgetary constraints. When combined with previous NACCHO findings, this results in a cumulative 23,000 jobs lost from 2008–2009,

FIGURE 1: Percentage of LHDs Affected by Job Losses and Cuts to Staff Hours or Imposed Furlough between July 1–Dec. 31, 2009, and Percentage of U.S. Population Living in Jurisdictions of Affected LHDs



n=713-716

From Jan. 2008–Dec. 2009, LHDs lost a cumulative 23,000 jobs due to layoffs or attrition—approximately 15 percent of the LHD workforce.

FIGURE 2: Estimated Number of LHD Jobs Lost and Positions with Hours Cut or Furlough Imposed for 2008–2009

	January–December 2008	January–June 2009	July–December 2009	TOTAL
Jobs Lost to Layoffs or Attrition	7,000	8,000	8,000	23,000
Staff with Hours Cut or Furlough Imposed	Not available	12,000	13,000	Cannot calculate*
n	1024–1061	535–547	713–716	N/A

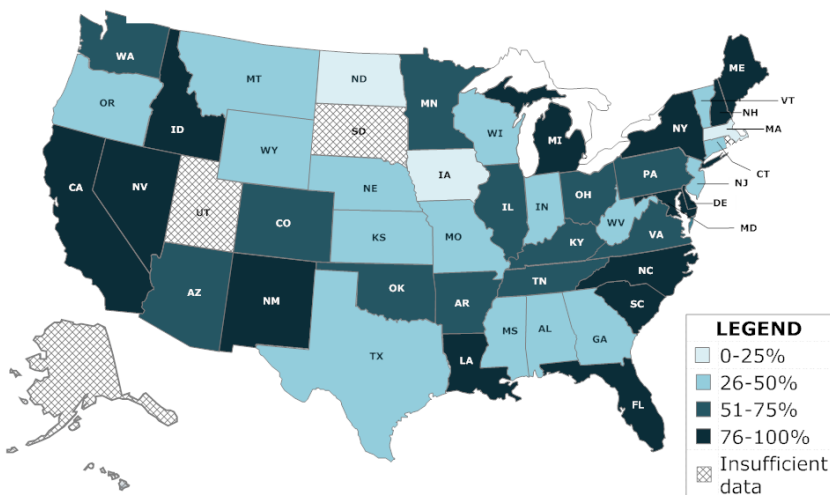
* It is likely that the same LHD employees experienced cuts to their hours and/or mandatory furloughs in more than one of the time periods described. Therefore, it is not possible to present a cumulative total for the number of employees affected by cuts to hours and mandatory furloughs.

approximately 15 percent of the LHD workforce in the country (Figure 2).

From the standpoint of the population potentially affected, LHD job losses appear even more severe. Nearly three-quarters (73%) of the United States' population lived in the jurisdictions of LHDs that lost at least one job in the last six months of 2009 (Figure 1).

In 26 states, more than half of LHDs lost jobs due to layoffs or attrition (Figure 3).

FIGURE 3: Percentage of LHDs that Lost Jobs Due to Layoffs or Attrition (July–December 2009)



n=706

In addition to job losses, an additional 13,000 LHD employees were affected by cuts in working hours or mandatory furloughs resulting from budget cuts in the last half of 2009 (Figure 2).

Budget Cuts and Job Losses Threaten Essential Services

Continued cuts to LHD budgets are undermining LHDs' ability to protect the public from preventable diseases, environmental hazards, and other threats to public health. Half of all LHDs made cuts in at least one program area for budgetary reasons in 2009 (Figure 4). In 25 states, more than half of LHDs cut at least one program area (Figure 5). A quarter (28%) of LHDs had more pervasive cuts, affecting three or more program areas (Figure 4).

Sixty-three percent of the U.S. population lived in the jurisdiction of an LHD that cut at least one service in 2009.

Sixty-three percent of the United States' population lived in the jurisdiction of an LHD that cut at least one service in 2009 (Figure 4).

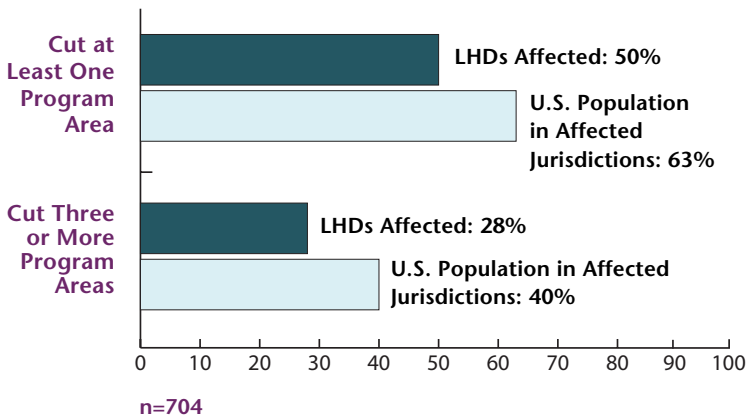
LHDs report that both core services and innovative new programs are at risk of extensive cuts. One LHD official states, "Most local health departments are now asking the question, 'What do we cut in terms of services, even if required, because we can no longer sustain the current level of services with this amount of funding?' Core public health duties are in jeopardy, and the community's health is at stake, which will, in turn, affect the overall economic development abilities of communities over time."

Even state-mandated services are at risk of major cuts in some LHDs. One LHD official explains, "We have received three budget cuts within 18 months and expect more, so mandated services are not receiving adequate funding."

Budget cuts are also crippling effective prevention programs. In 2009, a quarter of LHDs across the country

"Public health has been funded at the same level for the past 10–15 years, but yet, in the last six months, [demand for] services has almost doubled."

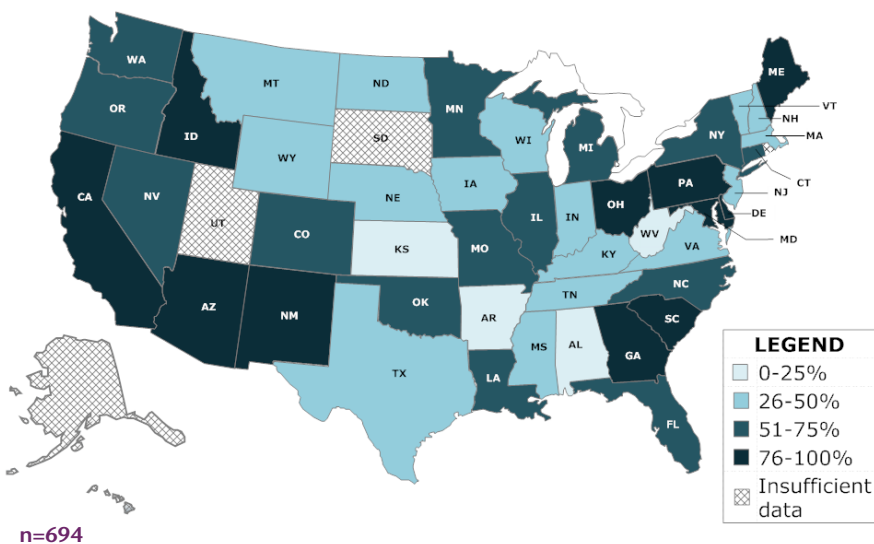
FIGURE 4: Percentage of LHDs Affected by Cuts to Program Areas and Percentage of U.S. Population Living in Jurisdictions of Affected LHDs



made cuts in population-based primary prevention programs such as cost-effective, community-based activities that improve childhood nutrition, increase physical activity, prevent tobacco use, or encourage other healthy choices that reduce the burden of chronic disease (Figure 6). These program cuts represent an important lost opportunity given recent estimates by the Trust for America’s Health that the United States would receive a return on investment over five years of \$5.60 for every dollar invested in prevention.¹

Prevention funding cuts have caused LHDs to respond to crises rather than address situations before problems occur. One LHD official states, “We are getting farther and farther away from true prevention. To stop disease we do contact tracing rather than education and screening. To stop waterborne illness we respond to bad water tests rather than work to make all wells safe. We respond to Child Protective Services referrals rather than run parenting classes.”

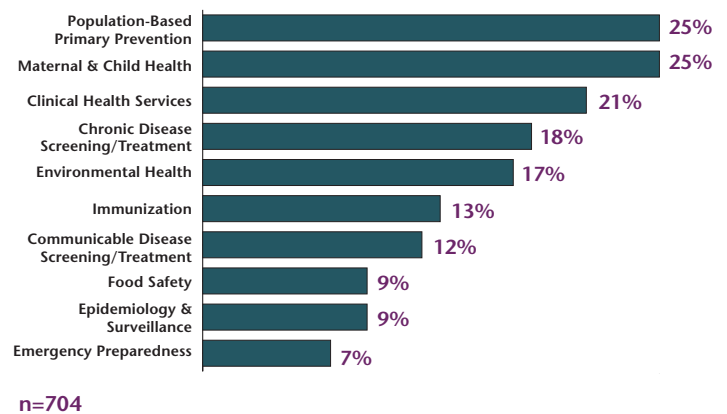
FIGURE 5: Percentage of LHDs with Program Cuts in Calendar Year 2009



“Core public health duties are in jeopardy, and the community’s health is at stake.”

Cuts to LHD programs may lead to greater costs in the long term, because it will be necessary to dedicate public funds to address foodborne outbreaks, vaccine-preventable diseases, poor birth outcomes, avoidable injury, diagnosis of cancer and chronic diseases at more advanced stages, and other similar outcomes. For example, the loss of clinical services in one LHD means that the “most vulnerable populations will seek [care in more costly] emergency room and urgent care settings when prevention and early treatment might have been an option.”

FIGURE 6: Percentage of LHDs with Program Cuts in 2009, by Program Area



In addition to economic cost, cutting LHD programs has a cost in human health and potential. One LHD official reports eliminating a school-based screening program and anticipates that “discontinuing routine screening for vision and hearing will decrease case finding, referral for care, treatment, and remediation of those issues in school-aged children,” thus preventing the early identification and treatment of barriers to learning.

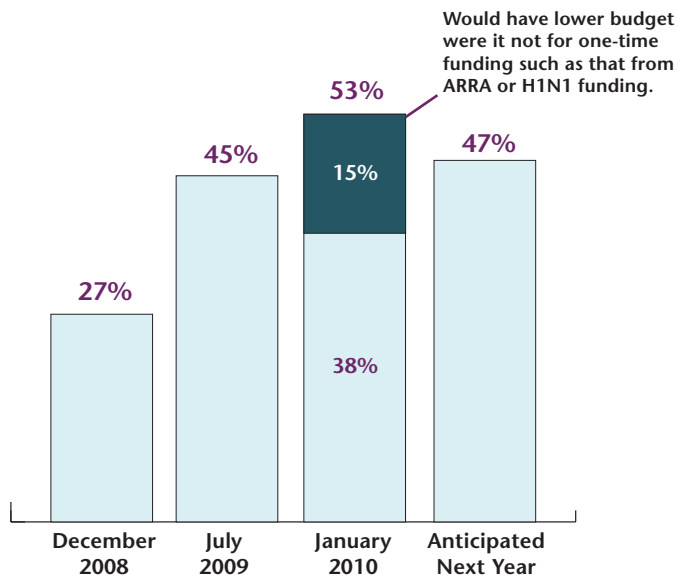
Another LHD official, forced to cut the cervical cancer screening program by two-thirds, thought of the 162 people identified in 2009 with early stages of cancerous growth. He predicts that “with reductions that will be felt fully in 2010, we expect some residents will not have the option for early detection of cancer. This will cause a localized decrease in the survivability of cancer.”

Some cuts weaken essential programs that shield entire communities from disease. For example, nine percent of LHDs have cut food safety programs (Figure 6). One official states, “Everyone who dines in a restaurant within our district could be potentially impacted if the restaurant inspections and complaints are not followed up in a timely manner. This could lead to [an increase in] foodborne outbreaks.”

“We are getting farther and farther away from true prevention.”

Similarly, cuts to communicable disease screening and treatment programs, affecting 12 percent of LHDs in 2009 (Figure 6), increase the likelihood of a resurgence of diseases that public health has long held in check. For example, one LHD official notes that “the threat of a future tuberculosis resurgence is great because infected individuals are not being screened and given preventive therapy.”

FIGURE 7: Percentage of LHDs with Lower Budget in Current Year than Previous Year



n=1079 (December 2008); 613 (July 2009); 696 (January 2010); 718 (Anticipated next year)

Cuts to LHD programs also harm important safety net programs. With the health reform law still years away from providing coverage for the uninsured, LHDs in some communities are uniquely positioned to provide interim services to the most medically vulnerable. However, funding cuts hurt their ability to provide those services. Last year, 21 percent of LHDs reduced

clinical services and 18 percent cut back on chronic disease screening and treatment (Figure 6).

Cuts to LHD clinical services could not come at a worse time. Because of the economic recession, the ranks of the uninsured are swelling. As one LHD official states, “Unemployment in our county is at an all time high with two major [local] manufacturers closing their doors ... leaving employees with no income and no insurance. This is devastating to a rural county that is without a hospital and is already medically underserved.”

Implications for the Local Health Department Workforce

The loss of LHD jobs means the long-term depletion of experience, community connections, and institutional memory. One LHD official states, “We will be laying off long-time employees within the next three weeks. Once we lose our highly trained staff, they rarely, if ever, come back to public health.”

With dramatic cuts to LHD jobs, remaining staff must assume additional workload. Some LHD officials described cuts of half or more of their employees, coupled with an increase in workload for the remaining staff. As one states, “It is hard to retain staff when overworked and overwhelmed.”

Increased workload, cuts to employee hours and compensation, long-term wage freezes, and job insecurity are contributing to an exodus of skilled LHD employees. One LHD official says, “Nurses are leaving for better pay, although they prefer to work in public health.”

“How do we continue to attract public health professionals into our health departments when other [employers] provide financial stability and a brighter future?”

As LHDs look toward future opportunities to rebuild a battered workforce, they are concerned that the severe erosion of salaries and benefits will make it difficult to recruit motivated and skilled people. One LHD official asks, “How do we continue to attract public health professionals into our health departments when other [employers] provide financial stability and a brighter future?”

Cuts to Core Funding are Severe

Looking across the series of Job Loss and Program Cuts surveys, it is clear that cuts to the core funding of LHDs continue unabated. While just over a quarter of LHDs were experiencing budget cuts in late 2008, that percentage had increased to 45 percent by the middle of 2009. In January 2010, 38 percent of LHDs reported budget cuts. When one-time funding from the American Recovery and Reinvestment Act (ARRA, the economic stimulus law) and H1N1 supplemental funding was excluded, an additional 15 percent of LHDs reported a lower budget, for a cumulative 53 percent of LHDs experiencing cuts to core funding (Figure 7). In 26 states, more than half of LHDs were experiencing a lower budget this year compared to the previous year when one-time assistance was excluded (Figure 8).

More than half (53%) of LHDs experienced cuts to their core funding this year.

Among LHDs reporting a reduction in overall budget (including one-time funding), the average (mean) reduction was approximately \$305,000.² The mean reduction varied from \$27,000 for the smallest LHDs to over \$2 million for the largest LHDs (Figure 9). Extrapolating these figures to the total population of LHDs with budget cuts for the current year results in a cumulative \$295 million loss in LHD funding, even after one-time funding.³

FIGURE 9: Magnitude of Budget Loss in Dollars, by Population Category

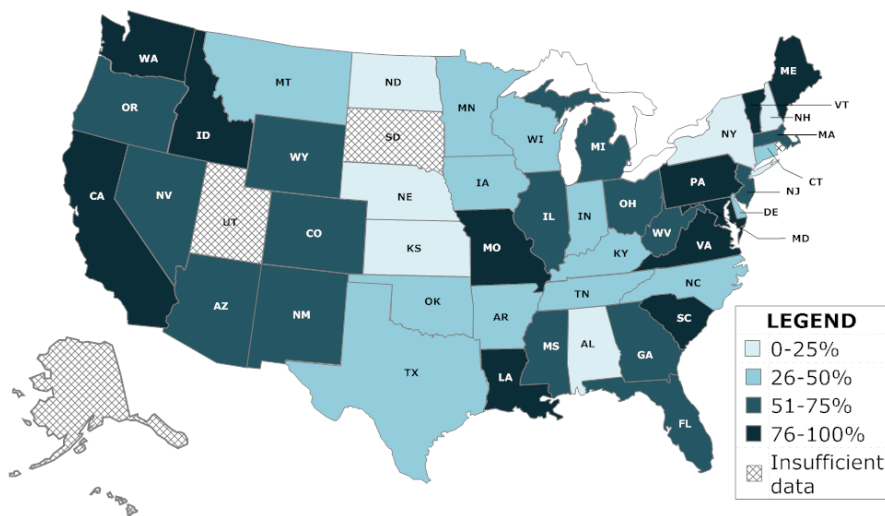
Size of Population Served by LHD	n	Median	Mean	95% Confidence Interval of Mean
<25,000	50	\$20,000	\$27,000	\$19,000–35,000
25,000–49,999	35	\$60,000	\$125,000	\$66,000–184,000
50,000–99,999	31	\$175,000	\$175,000	\$128,000–223,000
100,000–499,999	53	\$334,000	\$535,000	\$370,000–700,000
500,000+	30	\$1,625,000	\$2,341,000	\$1,546,000–3,136,000
OVERALL	199	\$54,000	\$305,000	\$218,000–391,000

n=199

The recession has placed additional burden on LHDs. As one LHD official says, “Public health has been funded at the same level for the past 10–15 years, but yet, in the last six months, [demand for] services has almost doubled.”

When budget cuts are examined as a percentage of overall budget, more than 40 percent of LHDs with budget cuts have experienced a loss of more than 10 percent of their revenue. An additional 34 percent of LHDs have lost between five and 10 percent of their revenue (Figure 10). Even greater losses would be reported were it not for the one-time supplemental funding from ARRA and H1N1 response.

FIGURE 8: Percentage of LHDs with Budget Decreases in 2010 Compared to Previous Year, Excluding One-Time Funding Such as ARRA or H1N1 Funding

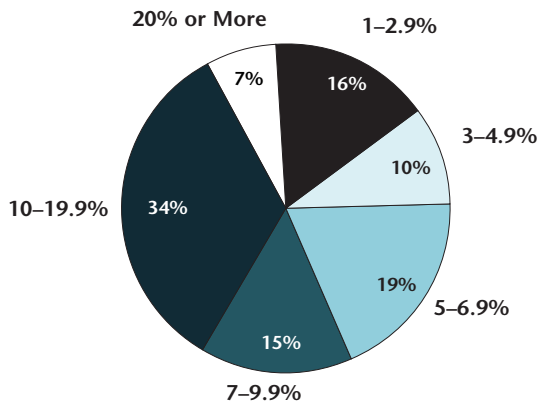


n=687

Although the Job Loss and Program Cuts Survey did not measure cuts to specific funding streams, many LHDs report severe cuts to local and state funding. For example, one LHD official reports, “Over the last couple of years, we have lost almost 100% of our state funding. The only funding that remains are the voter protected funds that the legislature cannot touch.” Another says, “By July 1, 2010, this department will have lost half (or more) of its local funding and at least one-third of its staff.”

The dramatic cuts seen in recent years are particularly damaging because they frequently threaten general use funds that enable LHDs to respond to urgent community needs not covered by disease-specific grants. As one LHD official states, “If we have no flexible funding, we will simply be an agency performing whatever collection of services our grantors require us to perform.”

FIGURE 10: Magnitude of Budget Loss as Percentage of Total LHD Budget, for LHDs that Have Experienced Budget Loss*



n=230

*Due to rounding, the percentages do not add up to 100%.

One-Time Funding has Protected Some LHDs, but Stable, Long-Term Funding is Needed

Funding from ARRA and H1N1 supplemental appropriations have been invaluable in helping to bridge a funding gap and maintain jobs at many LHDs. To date, 42 percent of LHDs have received ARRA funding, and 61 percent of United States' residents live in the jurisdiction of an LHD that has received ARRA funding. In 23 states, more than half of LHDs received ARRA funding (Figure 11). LHDs have used ARRA funding for everything from increasing immunization rates to addressing lead exposure. Many additional LHDs have received H1N1 supplemental funding.

To date, 42 percent of LHDs have received ARRA funding; 61 percent of United States' residents live in the jurisdiction of an LHD that has received ARRA funding.

One-time supplemental funding played a vital role in retaining LHDs' experienced and trained workforce. One LHD official comments, "The only reason we have held our own this year is due to H1N1 funding.

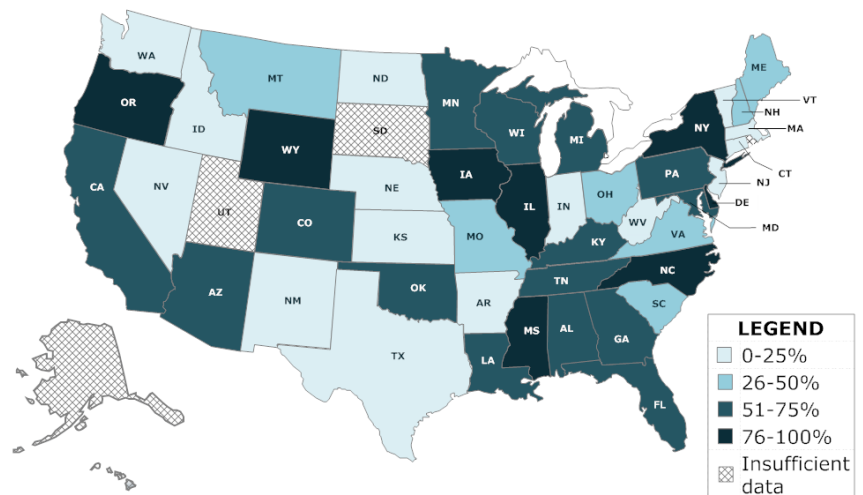
We were able to keep all our program staff by using some of their time to do H1N1 activities. That means less time providing our usual public health activities, but at least we are not losing people. Trying to rehire people once they have left service is extremely difficult."

LHDs have experienced challenges related to the high costs of administering ARRA funding. For example, one LHD official notes, "Our county has ARRA funds earmarked for septic infrastructure issues, but these will be for contractors and homeowners, not for LHD staff hours. We are appreciative of funds that help us assist our community, but the burden of directing those activities still falls to our general budget."

Disease-specific funding, such as that provided for H1N1 influenza response, is an important resource that helps LHDs act quickly in the face of specific emergencies. At the same time, LHDs warn that sustainable funding for core capacity is vital to enable them to respond to a wide array of threats to public health. One LHD states, "At this point, I feel we need funds to help us accomplish our core functions of public health as needed at the local level. H1N1 funding helped with H1N1 influenza response, but it did not assist with testing residential drinking water with old wells or near strip mines, flooding areas, or landfills."

Furthermore, LHDs warn that—in the absence of more stable, long-term funding—the end of ARRA and H1N1 supplemental funding will result in a vacuum, and they anticipate additional jobs lost in 2010 as the funding phases out.

FIGURE 11: Percentage of LHDs that Received ARRA (Economic Stimulus Act) Funding



n=629

“If there are no major epidemics, if no one gets sick in restaurants, if sewage isn’t flowing into the rivers, then little thought is given to the important and constant work of LHDs that keeps it that way.”

Conclusion

LHDs are responsible for the health of the public. Rarely making headlines, an army of local health department workers labors behind the scenes to prevent and respond to disease outbreaks and environmental hazards. They champion evidenced-based programs to address chronic disease and help ensure that children get a healthy start to life and are poised to succeed in school. As one LHD official says, “Since the important work of a health department is usually only seen in what doesn’t happen, it is often disregarded or taken for granted. If there are no major epidemics, if no one gets sick in the restaurants, if sewage isn’t flowing into the rivers, then little thought is given to the important and constant work of LHDs that keeps it that way.”

This third in a series of surveys confirms that LHDs continue to face severe cuts to their jobs, programs, and budgets. ARRA and H1N1 funding have been vital to protect LHD jobs and services. Nonetheless, 23,000 LHD jobs have already been lost over the course of two years, and additional experienced and skilled LHD workers will be lost if funding is not restored. The loss of jobs and program funding is undermining the ability of LHDs to protect the public from preventable diseases, environmental hazards, and other threats to public health.

The recently passed Patient Protection and Affordable Care Act (health reform law) will greatly benefit LHDs and public health. The availability of affordable health insurance will relieve some of the burden on LHDs as “safety net” providers of care. However, in places where there is an inadequate supply of healthcare providers to serve the newly insured or where there are other continuing barriers to access, LHDs will need to continue in this role. The Act also establishes a Prevention and Public Health Fund, a source of additional funds for prevention, public health, and wellness. If these new funds are used, in part, to build core capacities for LHDs, they may help over time to reverse the current erosion of public health protections that only LHDs can provide.

Policymakers can support LHDs by ensuring adequate investment in public health, promoting funding mechanisms that offer LHDs maximum flexibility to respond to urgent needs on the ground, and requiring that a proportion of public health and prevention dollars go to LHDs. Investment in LHDs is one of the most cost-effective ways to ensure the health and vitality of people in all communities across the United States

End Notes

¹ Trust for America’s Health. (February 2009). *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*. Retrieved April 2, 2010 from, www.healthyamericans.org.

² The 95 percent confidence interval for this mean (\$218,000–391,000 ; Figure 9) indicates that one can be reasonably certain that the true mean lies within this range. Its size suggests that there is some variability within the sample but that the magnitude of the budget loss is reasonably certain.

³ The 95 percent confidence interval for this estimate is \$211–379 million.

[Research Brief]

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