

## Local Health Department Job Losses and Program Cuts: Findings from the January 2012 Survey

The National Association of County and City Health Officials (NACCHO) surveyed local health departments (LHDs) nationwide in January and February 2012 to measure the impact of the economic recession on LHDs' budgets, staff, and programs. Results of the study, the seventh in a series, show that many LHDs continue to struggle to serve their communities in the face of ongoing fiscal constraints.

### METHODOLOGY

In January and February 2012, NACCHO surveyed 957 LHDs, selected as part of a statistically random sample designed to provide both national and state-level estimates. A total of 663 LHDs distributed across 47 states participated for a response rate of 69 percent. Data in this study were self-reported; NACCHO did not independently verify the data provided by LHDs. An overview report, state-level tables, and supporting documents are available at [www.naccho.org/lhdbudget](http://www.naccho.org/lhdbudget).

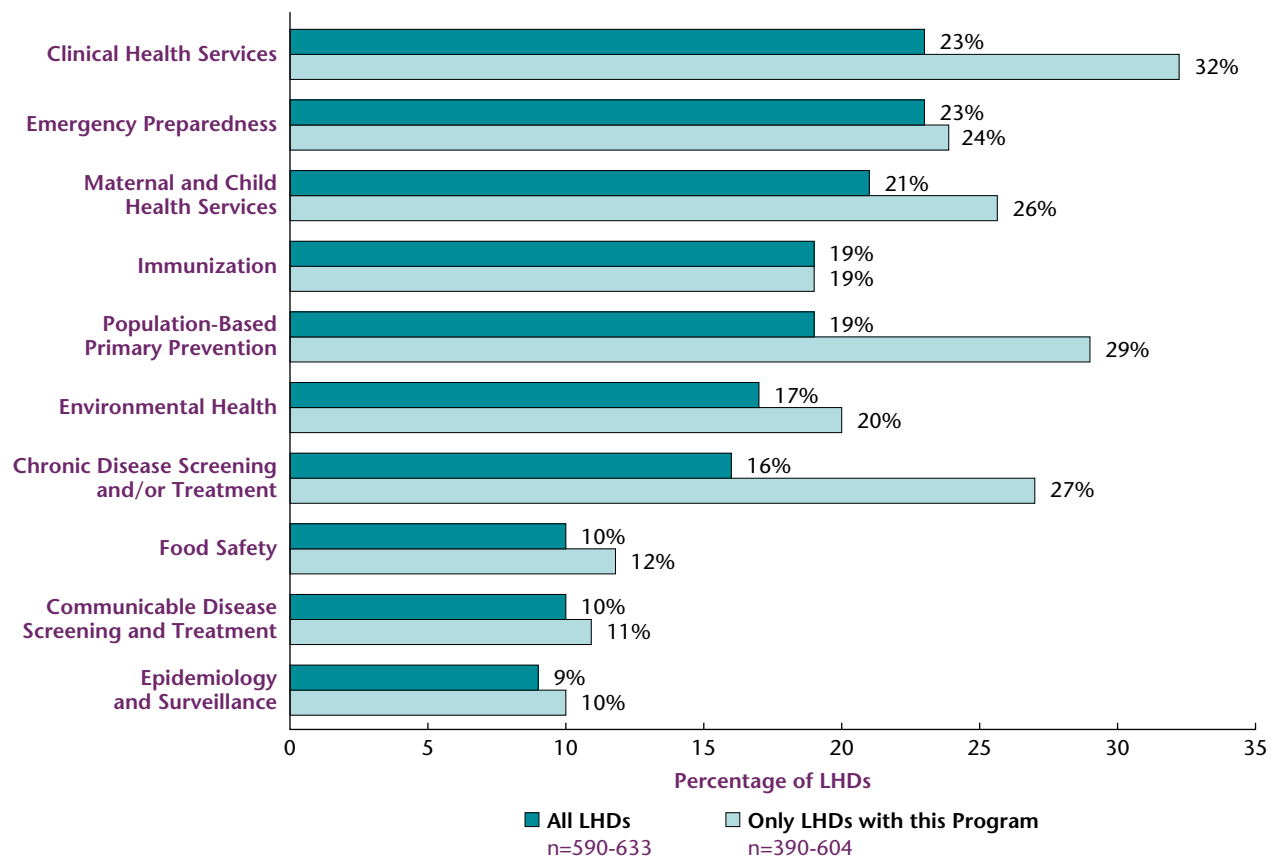
### PROGRAM CUTS ARE AT THEIR PEAK

During 2011, 57 percent of all LHDs reduced or eliminated services in at least one program area, a larger percentage than in any 12-month period since the recession began in 2008 (Figure 1). Clinical health services (e.g., comprehensive primary care and mental health services) were among the hardest hit and the most vulnerable to cuts (Figure 2). All LHDs, regardless of whether or not the LHD offered

FIGURE 1. Percentage of LHDs with Program Area Cuts over Time



**FIGURE 2. Percentage of LHDs that Reduced or Eliminated Programs (2011)**



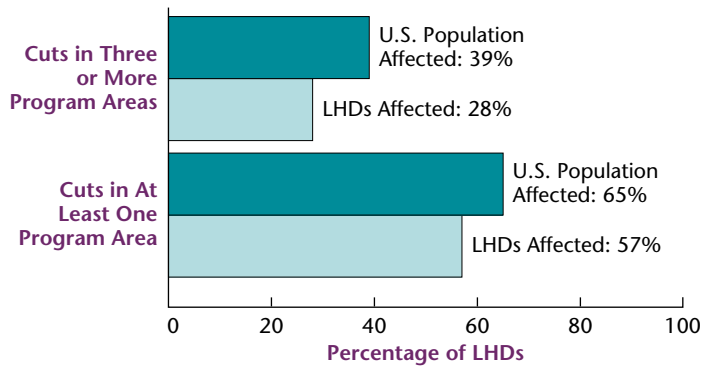
the program area in question during 2011, are included in the dark teal bars. These data indicate which program areas are most often cut in communities nationwide. The light teal bars include only those LHDs that offered each program area in question at some point during 2011. These data shed light onto which

program areas are most vulnerable to cuts. Understood this way, clinical health services, emergency preparedness, and maternal and child health programs are among the areas most often cut, while clinical health services, population-based primary prevention, and chronic disease screening and treatment are among the most vulnerable.

Nearly two-thirds of the U.S. population lives in a jurisdiction that reported reductions to at least one program area, and 39 percent of the U.S. population lives in a jurisdiction reporting a decrease to three or more program areas (Figure 3). More than half of LHDs in 26 states made cuts in at least one program area during 2011 (Figure 4).

**More than half of LHDs in 26 states cut at least one program during calendar year 2011.**

**FIGURE 3. Percentage of LHDs Affected by Cuts to Program Areas and Percentage of Population Living in Jurisdictions of Affected LHDs (2011)**



n=627

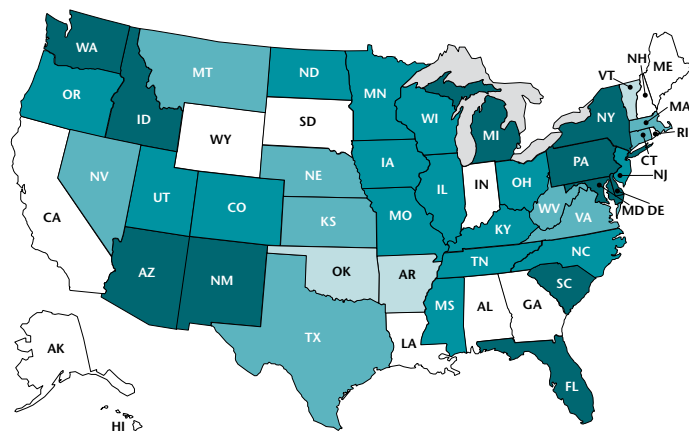
As LHD leaders look ahead, many anticipate more program cuts. “With funding shortages, we will [need] to make some cuts in programming in the near future, more so than we have in the past,” predicts one health official. Even those who have been able to avoid service reductions consider themselves at risk. “So far, we are holding our own,” reports another health official, “[but] if the financial cuts continue, it will have a huge impact on the services that we can offer.”

## PROTECTING THE COMMUNITY DESPITE ONGOING CHALLENGES

LHDs have used various strategies since the recession began to minimize the negative impact of cuts on service to their communities, and some LHDs are more likely to use certain strategies than others (Figure 5). As the size of the population served by the LHD increases, so does the likelihood that the LHD attempted to increase revenues, used technology to become more efficient and/or reduce costs, and partnered with non-LHD organizations. Conversely, there is an inverse relationship between size of population served and partnering with other LHDs, as small LHDs were the most likely to form these relationships.<sup>1</sup>

“With funding shortages, we will [need] to make some cuts in programming in the near future, more so than we have in the past.”

**FIGURE 4. Percentage of LHDs with Program Area Cuts, by State (2011)**



**Percentage of LHDs**  
 0–25% 26–50% 51–75% 76–100% □ Insufficient Data  
 n=627

Governance type exerts its own influence on the likelihood that LHDs implemented certain strategies.<sup>2</sup> State-governed LHDs were much less likely to manage cuts by trying to increase their revenues than were either locally-governed LHDs or LHDs with a shared governance structure. Only 49 percent of state-governed LHDs tried this strategy compared to 84 percent of locally-governed LHDs and 91 percent of LHDs whose governance is shared between local

<sup>1</sup> All differences are statistically significant (alpha=0.05) even after controlling for governance type.

<sup>2</sup> All differences are statistically significant (alpha=0.05) even after controlling for size of population served.

**FIGURE 5. Percentage of LHDs Using Various Strategies to Mitigate Negative Impact of Cuts, by Size of Population Served and Governance**

		Increasing Revenues <sup>a</sup>	Hiring Contractors	Using Technology	Working with LHDs <sup>b</sup>	Working with Non-LHDs <sup>c</sup>
Size of Population Served	Less than 50,000	72%	30%	55%	51%	53%
	50,000–499,999	83%	43%	66%	39%	63%
	500,000 or more	85%	58%	78%	27%	80%
Governance	State	49%	32%	56%	79%	58%
	Local	84%	37%	63%	34%	59%
	Shared	91%	49%	60%	53%	60%
All LHDs		77%	37%	61%	44%	59%

n=657

<sup>a</sup> Increasing revenues: pursuing new funding streams, charging fees for service, billing insurance

<sup>b</sup> Working with LHDs: contracting or sharing staff or equipment with another LHD

<sup>c</sup> Working with non-LHDs: contracting or sharing staff or equipment with a non-LHD organization

and state authorities. However, state-governed LHDs are the most likely to work with other LHDs—79 percent of them did this, compared to 34 percent of locally-governed LHDs and 53 percent of LHDs with a shared governance structure. Governance type does not affect the likelihood of having worked with non-LHDs or of having used technology.

combined with data from previous studies, LHDs collectively shed almost 40,000 employees since 2008 (Figure 6).

**FIGURE 6. Estimated Number of LHD Job Losses (2008–2011) and Job Losses and Additions (July–December 2011)**

Job Losses (Layoffs and Attrition) (2008–2011)	
2008	7,000
2009	16,000
2010	6,000
<u>2011</u>	<u>10,600</u>
Total	39,600
Job Losses and Additions (July–December 2011)	
<i>Losses</i>	
Layoffs	2,200
<u>Attrition</u>	<u>3,000</u>
Total	5,200
<i>Additions</i>	
New positions	1,200
<u>Vacancies filled due to lift of hiring freeze</u>	<u>500</u>
Total	1,700

Ongoing fiscal constraints forced LHDs to eliminate over 5,000 staff positions during the second half of 2011.

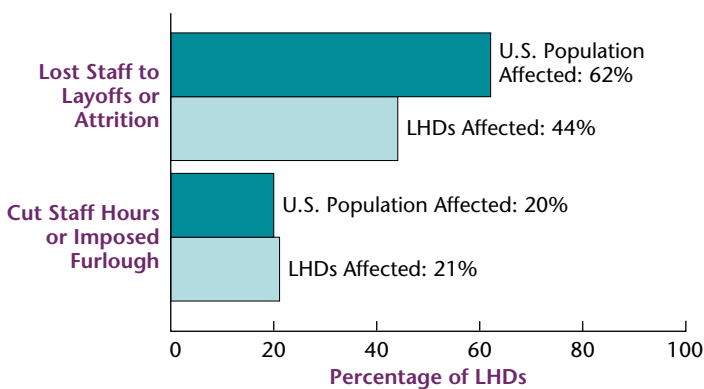
## A DWINDLING WORKFORCE

Ongoing fiscal constraints forced LHDs to eliminate over 5,000 staff positions during the second half of 2011 alone, more than three times as many positions as they gained. When

Forty-four percent of LHDs nationwide lost at least one staff person due to layoffs or attrition, and 62 percent of the U.S. population lives in an affected jurisdiction (Figure 7). More than half of LHDs in 17 states lost staff, including Idaho, Florida, Mississippi, and Maryland, where more than three-fourths of LHDs experienced workforce reductions (Figure 8).

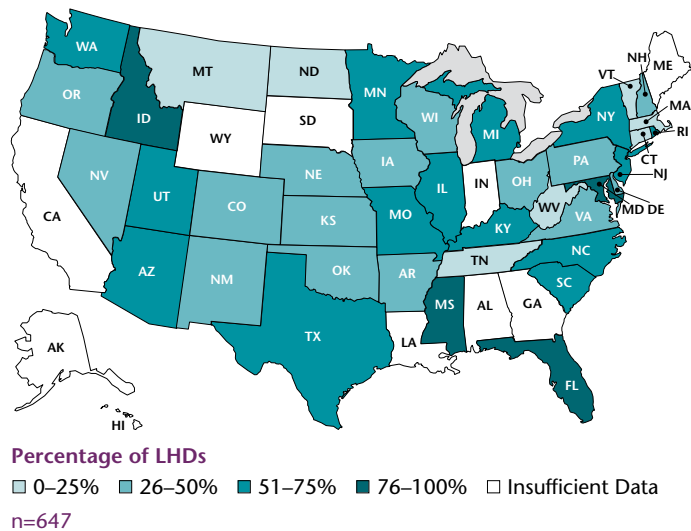
**Forty-four percent of LHDs nationwide lost at least one staff person due to layoffs or attrition, and 62 percent of the U.S. population lives in an affected jurisdiction.**

**FIGURE 7. Percentage of LHDs Affected by Job Losses and Cuts to Staff Hours or Imposed Furlough, and Percentage of Population Living in Jurisdictions of Affected LHDs (2011)**



n=628-647

**FIGURE 8. Percentage of LHDs that Lost Jobs Due to Layoffs or Attrition, by State (2011)**



In terms of size of population served, workforce reductions disproportionately impacted certain LHDs in 2011. While only nine percent of LHDs that serve small populations laid off at least one staff person, the same is true of 25 percent of LHDs that serve medium-sized populations and of 40 percent of LHDs that serve large populations (Figure 9). Similarly, three out of every 10 LHDs that serve small populations lost at least one staff person to attrition; well more than half (57 percent) of LHDs that serve medium-sized populations and fully two-thirds of LHDs that serve large populations suffered the same fate.

**FIGURE 9. Percentage of LHDs with Staff Losses Due to Layoffs and Attrition, by Size of Population Served**

Size of Population Served	Layoffs	Attrition	Layoffs and/or Attrition
Small (less than 50,000)	9%	30%	33%
Medium (50,000-499,999)	25%	57%	63%
Large (500,000 or more)	40%	66%	75%

n=636-647

When staff losses do occur, LHDs that serve larger populations report more reductions than do LHDs that serve smaller populations (Figure 10). The median LHD that serves a large population lost eight employees due to layoffs and attrition in 2011, five more staff than the median LHD that serves medium-sized populations. The median LHDs serving small populations lost just one staff person in

2011. However, since LHDs serving smaller jurisdictions have smaller workforces, one might expect the impact of each lost position to be greatest among these LHDs.

Health officials continue to experience many workforce challenges, including low staff morale, an inability to offer competitive wages that retain and attract qualified staff, and time constraints that restrict the ability of staff to conduct essential public health activities.

**FIGURE 10. Median Number of Layoffs and Jobs Lost to Attrition, Overall and by Size of Population Served (for LHDs with Job Losses)**

Size of Population Served	Layoffs and Attrition
Small (less than 50,000)	1
Medium (50,000–499,999)	3
Large (500,000 or more)	8
All LHDs	2

n=284

As one health official laments, “My staff has not had a raise in three years. The morale is low. I have a [half time position] open that I am unable to recruit for due to the fact that my professional nursing staff are now paid approximately \$10 less an hour than if they were employed in the hospital, clinic, or long-term care in my community.”

Too often fiscal constraints place LHD leaders in positions where they must choose the

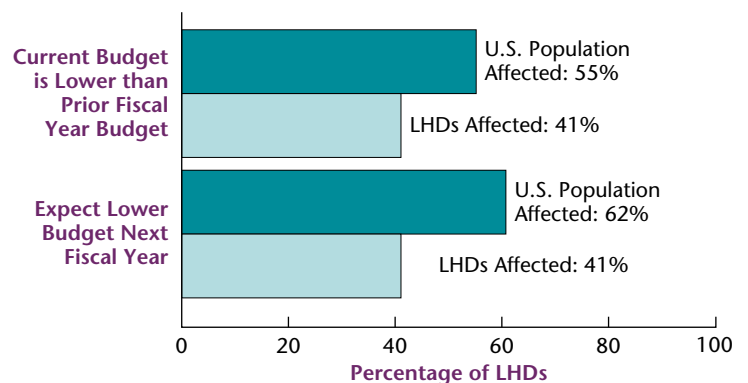
**“We are currently faced with the decision to eliminate staff and curtail hours or furlough staff,” explains one LHD director, who also notes that he “will not have funds to complete the fiscal year.”**

“lesser of two evils.” This is particularly challenging when all options negatively impact staff. “We are currently faced with the decision to eliminate staff and curtail hours or furlough staff,” explains one LHD director, who also notes that he “will not have funds to complete the fiscal year.”

## STILL NO LIGHT AT THE END OF THE BUDGET TUNNEL

Funding is the engine driving these workforce and program reductions, and the fiscal situation remains bleak for many LHDs and the communities they serve. When asked in early 2012, 41 percent of LHDs said their current fiscal year budget was less than that of the previous fiscal year, and 55 percent of U.S. population lives in one of these affected jurisdictions (Figure 11). Estimates of budget reductions have been relatively stable over the past five waves of this study, ranging from 38 percent to 45 percent. If the projection of LHDs is any indication, similar estimates can be expected in the near future: when NACCHO asked LHDs in January 2012 how they expect their budgets to look next year, 41 percent said they expect cuts.

**FIGURE 11. Percentage of LHDs with and Expecting Budget Cuts, and Percentage of U.S. Population Living in Jurisdictions of Affected LHDs (Current vs. Prior Fiscal Year)**

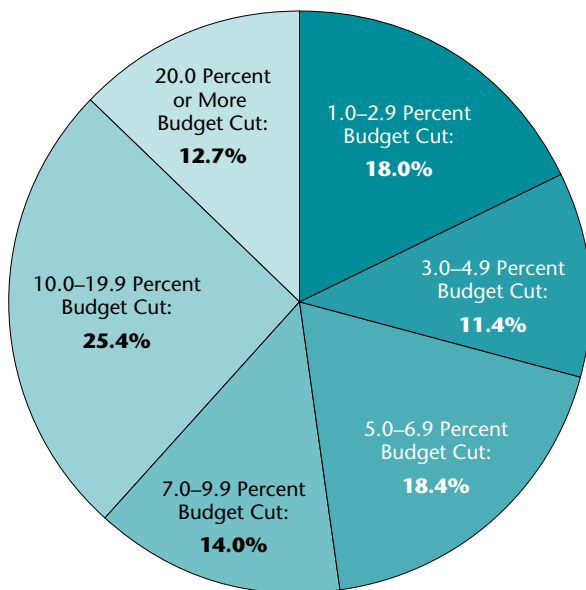


n=619–651

When LHDs do experience budget cuts, they can be severe (Figure 12). Thirty-eight percent of affected LHDs in this study lost at least 10 percent of their budgets between the current and prior fiscal years and more than half (52 percent) lost at least seven percent. Thirteen percent were hit especially hard, noting that their current fiscal year budget was at least 20 percent lower than the prior fiscal year budget.

**“Next year will present a large challenge and even threatens our continuance. In 25 years I’ve not confronted this level of threat to our existence as a going entity. Our situation is dire.”**

**FIGURE 12. Magnitude of Budget Loss as Percentage of Total LHD Budget (LHDs that Have Experienced Budget Loss)**



Some LHD leaders expecting cuts described the future they anticipate. “Fiscal year 2013 is shaping up to be the worst fiscal year for us,” said one health official. “...We may have to reduce or eliminate certain programs, should the financial situation worsen.” The outlook of another official is even gloomier: “Next year will present a large challenge and even threatens our continuance. In 25 years I’ve not confronted this level of threat to our existence as a going entity. Our situation is dire.”

## MANDATORY FEDERAL FUNDING FOR PUBLIC HEALTH IN JEOPARDY

Recent legislation offers further cause for concern. The Prevention and Public Health Fund (The Fund) is a dedicated investment in community prevention and state and local public health capacity. The Fund was enacted in 2010 as part of the Patient Protection and Affordable Care Act to provide \$15 billion over its first 10 years. In February 2012, the Fund was slashed by \$6.25 billion. Twice in 2011 and again in May 2012, the U.S. House of Representatives passed bills to completely eradicate this critical source of revenues. However, the Senate has not advanced similar legislation, and the President previously vowed to veto legislation that would eliminate the Fund if passed by Congress.

Those who support elimination of The Fund pursue relatively small short-term cost savings at the expense of even greater savings in the future. A report released by Trust for America’s Health (TFAH) in July 2008<sup>3</sup> finds that a small strategic investment in disease prevention could result in significant savings in U.S. health

<sup>3</sup> <http://healthyamericans.org/reports/prevention08/>

## [ RESEARCH BRIEF ]

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care costs. In its report, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities*, TFAH concluded that an investment of \$10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than \$16 billion annually within five years. This is a return of \$5.60 for every \$1. Policymakers need to recognize the long-term return on investment that public health promises.

### CONCLUSION

Looked at one way, the fiscal climate at LHDs throughout the nation has changed little over the past few years. In each wave of this study since August 2009, about 40 percent of LHDs nationwide had a lower budget in the current fiscal year than in the prior fiscal year, about 45 percent of LHDs consistently experienced job losses, and the proportion of those that cut at least one program has hovered around 50 percent.

Looked at another way, a bad situation that began in 2008 continues to deteriorate. Although a similar percentage of LHDs report losses from study to

study, cuts in one period often compound cuts in prior periods. For example, if an LHD cuts its food safety program each year and never expands it, restaurant inspections conducted in the community may occur less frequently.

A health official who participated in this study had the following insight: "A wise person once said, 'public health is working at its best when it is invisible.' Unfortunately, our 'invisibleness' is now working against us when we continue to cry out for our need for funding."

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