Written Testimony of
Jeffrey Levi, PhD
Executive Director
Trust for America's Health

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December 10, 2008

Good morning. My name is Jeffrey Levi, and I am the Executive Director of Trust for America's Health (TFAH), a nonpartisan, nonprofit organization dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority. I would like to thank the members of the Committee for the opportunity to testify on this very important issue -- the role of prevention and public health as a component of the health reform debate. Senator Harkin, your leadership and that of Chairman Kennedy, give great hope to those of us in the public health community that this round of health reform discussions will really be about the health of Americans, not just about health care.

TFAH believes that America must provide quality, affordable health care to all. A strong public health system and public policies focused on disease and injury prevention should be a cornerstone of a health reform plan. I want to focus on seven critical points related to prevention and health reform in my testimony today:

1. Universal, quality coverage and access to health care is critical to protecting and promoting the health of Americans.
2. Investment in *both* community-based and clinical prevention is critical to ensuring that universal coverage is as cost-effective as possible.
3. Stable and reliable funding for core public health functions and community-based prevention is essential.
4. A national prevention plan that harnesses the potential of existing federal programs across the government is long overdue.
5. The public health workforce must be strengthened to maximize the potential of public health to contribute to better health and lower health care costs.
6. The concept of quality assurance and evidence based interventions should be extended to all public health programs, including community-based prevention.
7. A reformed health care system must be prepared to react to and mitigate the consequences of a public health emergency.

Universal Coverage.

Any health reform plan must assure universal, quality coverage and access to health care to give all Americans the opportunity to be as healthy as they can be. All individuals and families should have a high level of services that protect, promote, and preserve their health, regardless of who they are or where they live. Full coverage of preventive services, without copayments or deductibles will maximize the potential of evidence-based prevention. But coverage alone is insufficient. A reformed system must also assure access to care. State and local health departments often provide direct primary care and/or clinical preventive services to significant portions of the population, and therefore, need to be assured adequate funding streams if that role continues in a reformed system.

Clinical and Community-Level Prevention

As we chart a new course for our nation's health care system, it is important that we look for ways to achieve greater cost efficiency. America spends $2.2 trillion on health care each year, far more than any other nation, while spending a few cents on every dollar on public health. Clearly, we must begin to control these skyrocketing health care costs, but achieving better health outcomes must be the driving force behind our investments and choices. With that in mind, disease prevention must be at the center of our efforts. Two important components that Congress should consider in a prevention-centered health reform initiative are clinical and community-level prevention programs.

Expanding clinical preventive services, including immunizations, screenings and counseling, could save many lives. A report by the Partnership for Prevention found that increasing the use of just five preventive services would save more than 100,000 lives each year in the United States.[1] To maximize our investment in prevention, it is essential that we support both clinical and community-level prevention programs, as the two work hand-in-hand. Many clinical preventive interventions require a strong community-level base to be effective. For example, a doctor can encourage a person to be more physically active, including writing a prescription for a person to get more exercise. However, unless a person has access to a safe, accessible place to engage in activity, he or she will not be able to "fill" this prescription.

Community prevention can also be very cost effective. Earlier this year, TFAH released a report, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities,* which examines how much the country could save by strategically investing in community-based disease prevention programs. The report concludes 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 $1.00 spent. The economic findings are based on a model developed by researchers at the Urban Institute and a review of evidence-based studies conducted by the New York Academy of Medicine. The researchers found that many effective prevention programs cost less than $10 per person, and that these programs have delivered results in lowering rates of diseases that are

[1] Partnership for Prevention. *Preventive Care: A National Profile on Use, Disparities, and Health Benefits.* August, 2007. http://www.prevent.org/content/view/129/72/

related to physical activity, nutrition, and smoking cessation. The evidence shows that implementing these programs in communities reduces rates of type 2 diabetes and high blood pressure by five percent within two years; reduces heart disease, kidney disease, and stroke by five percent within five years; and reduces some forms of cancer, arthritis, and chronic obstructive pulmonary disease by 2.5 percent within 10 to 20 years, which, in turn, can save money through reduced health care costs to Medicare, Medicaid and private payers.[2]

To take advantage of this potential return on investment, TFAH recommends the creation of **community makeover grants**, an infusion of funding to be used to support rapid implementation of the policy, programmatic and infrastructure improvements needed to address the social determinants of health and reduce chronic disease rates. These grants would build upon existing programs with a more significant investment in a coordinated set of population-wide interventions aimed at helping to keep people healthier for a longer time and ensuring that universal coverage is as cost-effective as possible. These grants would have a strong evaluation component, and their ultimate success would be measured by the change in prevalence of chronic disease risk factors among members of the community. (See Appendix A for a full description of this grant proposal.)

We strongly recommend that these community makeover grants be initiated as soon as possible--*prior to* implementation of the reformed health system to assure that as many Americans as possible are as healthy as they can be as they enter the reformed health care system. An initial investment of $500 million, especially if targeted at underserved communities with high rates of uninsurance, could reach tens of millions of Americans and dramatically improve their health status.

Stable and Reliable Funding for Prevention.

We strongly urge Congress to ensure that any health care financing system that is developed as part of health reform will include stable and reliable funding for core public health functions and clinical and preventive services. A strong public health system is necessary to help promote better health, monitor the health of the country, and protect people from health threats that are beyond individual control, including bioterrorism, foodborne disease outbreaks, and natural disasters. The nation must adequately fund federal, state, and local public health departments and programs so that they can fulfill their responsibility for protecting the health of the public. Public health needs a predictable, sustainable funding stream. Effective implementation of community-level prevention programs requires providing support to community organizations and coalitions that directly carry out this life-saving work.

To that end, TFAH recommends the creation of a trust fund mechanism to support clinical and community-based prevention, along with related public health functions. There are various approaches that could be taken to assuring this reliable funding stream for prevention. One example would be the creation of a Wellness Trust, an independent entity that would become the primary payer for preventive services and would recommend priority prevention activities. A Wellness Trust would put prevention and wellness at the center of our healthcare system. S.

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[2] Trust for America's Health. *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities.* July 2008. http://healthyamericans.org/reports/prevention08/.

3674, introduced by Senator Clinton, and H.R. 7287, introduced by Congresswoman Matsui, are variations of this concept and would vastly improve access to clinical and community preventive services, information and resources.

A National Prevention Plan

We can also promote prevention through leadership, planning and modest structural changes at little to no cost -- by focusing existing federal programs on health promotion. **TFAH recommends that public health and prevention be elevated throughout the federal government by creating a national prevention strategy.** The strategy will outline a few priority national prevention goals and direct all federal agencies and departments to consider how their budgets, policies and programs influence health. The National Strategy to Combat Pandemic Influenza serves as a good example of the way in which federal agencies, under White House leadership, can coordinate their efforts to deal with a public health threat. A national prevention strategy would serve a similar coordinating role. It could be overseen and evaluated by a newly created public health board, which could serve as an independent voice on science and public health. Such a board would ensure that the strategy is properly coordinated and that progress toward achieving interim chronic disease reduction goals is being made. Since a broad range of policies, ranging from transportation to agriculture to education, all influence the public's health, it is important that we develop a strategy to organize and coordinate government-wide prevention efforts involving an array of departments and agencies not all traditionally involved in public health.

Better coordination of health programs and policies is also necessary within the Department of Health and Human Services (HHS). There is currently no senior official with medical, scientific, and public health expertise with the authority to assure consistency in policy and coordination among the various agencies addressing health and public health issues, and to champion the allocation of necessary resources and require accountability for such investments. To address this problem, Congress should consider creating the position of Undersecretary for Health (USH) in the Department of Health and Human Services to whom all the Public Health Service (PHS) agencies, the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Centers for Medicare and Medicaid Services (CMS) would report. This would ensure better coordination within HHS, which will be essential as the new administration implements policy and programmatic changes. (See Appendix B for a full description of this proposal.)

The Public Health Workforce

In order to assist in the implementation of the structural and funding recommendations addressed above, we need a well-trained workforce. There is a well-documented shortage of healthcare workers, and it is very important that we continue to provide financial incentives to encourage individuals to enter the healthcare workforce. At the same time, we are also facing shortages in the public health workforce.

A 2007 survey by the Association of State and Territorial Health Officials (ASTHO) found that the state public health agency workforce is graying at a higher rate than the rest of the American workforce, and workforce shortages continue to persist in state health agencies. This workforce

shortage could be exacerbated through retirements: Twenty percent of the average state health agency's workforce will be eligible to retire within three years, and by 2012, over 50 percent of some state health agency workforces will be eligible to retire.[3] Further, according to a 2005 Profile of Local Health Departments conducted by the National Association of County and City Health Officials (NACCHO), approximately 20 percent of local health department employees will be eligible for retirement by 2010.[4]

Public health departments serve an important function by helping to promote health and prevent disease, prepare for and respond to emergencies and potential acts of bioterrorism, investigate and stop disease outbreaks, and provide other services such as immunizations and testing. Yet, the average age of new hires in state health agencies is 40, according to the 2007 ASTHO survey. Public health needs a pipeline of young workers.

Thus, TFAH recommends that as Congress addresses the overall workforce shortage in the health sector, the public health workforce must be included in such efforts. Specifically, we recommend that Congress provide financial incentives such as loan repayment, scholarship assistance, or retraining opportunities to encourage individuals to work in governmental public health. Congress should also provide funding for a regular enumeration of the public health workforce, as well as a dissemination of public health workforce training, recruitment, and retention tools. This will enable us to have the necessary data available to establish a baseline that we can use to measure the impact of workforce initiatives. Congress should also continue its revitalization of the Commissioned Corps to ensure that our nation's premier public health professionals have the resources they need to serve our nation most effectively.

It is important to note that the workforce problem is being exacerbated dramatically by the current economic downturn. Even prior to consideration of health reform, TFAH urges that steps be taken to address the workforce crisis as part of the economic stimulus package for two reasons. First, many states and localities have been forced to cut back on their staffing because of budget shortfalls. One survey by the National Association of County and City Health Officials, showed that more than half of local health departments have lost positions either due to layoffs or attrition. Second, as we develop workforce retraining programs as part of the stimulus package, there is an opportunity to train workers for community-level prevention work that would dramatically improve our ability to implement prevention programs. (See Appendix C for a full description of TFAH's workforce recommendations.)

Quality Assurance for Evidence-Based Prevention

TFAH believes that our investment in prevention should be based on evidence-based interventions with a strong level of accountability for outcomes. Every effort should be made to ensure the country and communities are investing in the most effective programs possible. To that end, we recommend creating, within the Centers for Disease Control and Prevention, a ***Public Health Research Institute***, that would build the evidence base for prevention and help

[3] ASTHO. 2007 State Public Health Workforce Survey Results. http://www.astho.org/pubs/WorkforceReport.pdf.
[4] NACCHO. Profile of Local Health Departments. http://www.naccho.org/topics/infrastructure/profile/resources/2005reports/index.cfm.

develop the new field of public health systems and services research, which is committed to providing a strong evidence base for all public health activities.

In order to control costs and use federal funding most efficiently, it is essential that we promote accountability and measure progress toward improving health outcomes. All federal programs should set aside sufficient funding to evaluate their effectiveness so that we can target our resources and maximize our investments in public health.

Preparedness

A final area to be addressed is emergency preparedness. Funding for state and local preparedness and hospital preparedness has decreased year after year. Especially at a time when states are cash-strapped, federal funding for preparedness is necessary to protect our safety. **TFAH urges Congress to ensure that a reformed health care system will be prepared to react to and mitigate the consequences of a public health emergency.** The health system must contribute to critical public health functions such as surveillance, surge capacity, reimbursement for preparedness and response, and community resilience. Congress should provide ongoing financial support for health facilities to build the capacity to manage a sudden increase in demand. Toward that end, Congress should consider linking hospital reimbursement to emergency preparedness by offering bonus payments or other financial incentives to hospitals that meet a certain baseline of preparedness. A consistent level of funding for preparedness must be achieved, and as we consider health reform, we must remember the essential link between our preparedness and our health.

Conclusion

In conclusion, TFAH believes that these seven elements are critical to assure that a reformed health system is truly about the health and wellness of the American people – assuring that they are as healthy and as productive as they can be. Focusing on prevention will not only reduce the burden on the reformed health care system, but it will assure that we have a healthier, more economically competitive workforce. In this time of economic crisis, a focus on prevention and wellness is that much more important.

Thank you again for the opportunity to testify -- and thank you again for your continued leadership in assuring that prevention is central to this health reform effort.

Attachments: Appendices A, B, and C

APPENDIX A: COMMUNITY MAKEOVER GRANTS OUTLINE

Goal: Provide funding for a comprehensive, coordinated approach to community-based population-level prevention activities in order to reduce chronic disease rates, address health disparities, and develop a stronger evidence base demonstrating the effectiveness of wide-scale, rapid implementation of community-based prevention activities.

Rationale: Communities across the nation are eager to combat the epidemics of obesity and chronic disease. Research has shown that effective community level prevention activities focusing on nutrition, physical activity and smoking cessation can reduce chronic disease rates and have a significant return on investment. A report from Trust for America's Health entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* 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 $1.00 spent. The Centers for Disease Control and Prevention funds a number of programs that focus on chronic disease prevention; yet currently, there is no one program that funds the planning, wide-scale implementation and evaluation of a holistic, coordinated approach to prevention that engages key stakeholders from all sectors of a community.

The Community Makeover Program would build on the strategies and approaches of a number of CDC's programs (REACH, Steps to a Healthier US, Pioneering Healthier Communities, the School Health Program) to provide and fully fund a unified, comprehensive prevention strategy for a community or state. Demand for this program is expected to be high, and the program will likely encourage state and local investment, as well. When CDC puts out a solicitation for community funding, for every community the agency funds, at least 10 communities cannot be funded. Furthermore, when states and communities receive funding from CDC, they are able to leverage additional local funds. For example, in Minnesota a $5 million investment by CDC has led to a $47 million investment by the state.

Timeline: 5 years

Funding: CDC would provide grants for the planning, implementation, evaluation, and dissemination of best practices for community makeover grants. CDC would also provide training for key policymakers at the state and local level regarding effective strategies for the prevention and control of chronic diseases. Grantees would receive an infusion of funding for rapid implementation of a variety of programs, policies and infrastructure improvements that would enhance access to nutrition and activity and promote healthy lifestyles. To the extent permissible by law, grantees would be expected to leverage funding from other federal, state, local governmental or private funding. Grantees would be encouraged to provide

in-kind resources such as staff, equipment or office space. When awarding grants, CDC would be permitted to consider an applicant's ability to leverage support from other sources. CDC would also be required to consider the extent to which a grantee's application addresses social determinants of health. CDC would be permitted to provide preference to low-income communities addressing disparities when awarding funds.

Funding would be based on the population of the community, up to $10 per person per year.

Sites: Competitive grants would be awarded to governors, mayors, and/or a national network of a community based organization. The number of grants should be limited, based on funding available, so that meaningful change can be supported.

Activities:

(A) Planning:
Grantees would be required to develop a detailed community makeover plan, including all of the policy, environmental, programmatic and infrastructure changes needed to promote healthy living and reduce disparities. Communities or states previously funded through the Pioneering Healthier Communities, REACH, Steps to a Healthier U.S., Achieve Program, the Division of Adult and Community Health, the Division of Nutrition, Physical Activity and Obesity, or an equivalent privately funded program would be given preference for funding. To formulate the community makeover plan, they would convene key constituencies in a community or state, such as elected officials, urban planers, public health representatives, businesses, media, educators, parents, religious leaders, city/state transportation planners, local park and recreation directors, public safety/law enforcement, food companies, insurance carriers, community organizations, community or other foundations, and other stakeholders.

Grantees would be required to coordinate their planning and programming with other programs in their community or state that focus on chronic disease prevention, including those listed above, in addition to Safe Routes to Schools, farm to cafeteria programs, and other nutrition and physical activity programming. Grantees would also be expected to work with other programs funded by CDC, and to detail their evaluation methodology. The community makeover plan would be submitted to CDC for approval, and CDC would provide ongoing technical assistance.

Key areas of focus for the plans would include all of the following:

- creating healthier school environments, including increasing healthy food options and physical activity opportunities;
- creating the infrastructure to support active living and access to nutritious foods in a safe environment (examples include: green space, such as parks, walking and biking paths, farmers' markets, street lights, sidewalks, and increased public safety);

- developing and promoting programs targeted to a variety of age levels to increase access to nutrition, physical activity and smoking cessation, enhance safety in a community, or address any other chronic disease priority area identified by the grantee;
- reducing barriers to accessing nutritious foods and physical activity;
- assessing and implementing worksite wellness programming and incentives;
- working to highlight healthy options at restaurants and other food venues; and
- prioritizing strategies to reduce racial and ethnic disparities, including social determinants of health.

(B) Implementation:
Grantees would be fully funded to implement community makeover plans. CDC would convene grantees at least annually in regional and/or national meetings to discuss challenges, best practices and lessons learned. Using the Healthy Communities model and processes developed at CDC as a guide, grantees would be required to develop models for replication. Pending successful evaluation, they would be required to serve as mentors for other states and communities.

(C) Evaluation:
The effectiveness of the program would be measured by the change in prevalence of chronic disease risk factors among members of the community. Decreases in weight and fat consumption and increases in minutes of physical activity and fruit and vegetable consumption could be used as measures for children whose schools participate in the community makeover plan, as well as for adults who participate in physical activity and nutrition programs. Other process measures, such as the number of restaurants that highlight healthier options on menus or the number of participants who self-report that they have increased their physical activity levels, could also be used. CDC would provide a literature review and framework for the evaluation, and grantees would work with an academic institution or other entity with expertise in outcome evaluation and be required to report to CDC on the evaluation of their programming and to share best practices with other grantees. Community specific data from the BRFSS would be used to assess changes in risk factors and health behaviors across communities.

APPENDIX B: UNDERSECRETARY FOR HEALTH

Proposal: Create the position of Undersecretary for Health (USH) in the Department of Health and Human Services to whom all the Public Health Service (PHS) agencies[5], the Office of the Assistant Secretary for Preparedness and Response (ASPR), and the Centers for Medicare and Medicaid Services (CMS) would report. The USH position would assume the elevation of the current position of Assistant Secretary for Health (ASH), which currently is a scientific advisory position, but until 1996 had line authority over the PHS agencies.

Rationale: There is currently no senior official with medical, scientific, and public health expertise with the authority to assure consistency in policy and coordination among the various agencies addressing health and public health issues, and to champion the allocation of necessary resources and require accountability for such investments. At a minimum, the USH should oversee the PHS agencies and ASPR; ideally CMS would also report to the USH. While the Deputy Secretary provides some level of administrative coordination, one of the biggest challenges facing HHS is to restore the scientific integrity of policy making and assure that there is coordination among the various public health and safety net programs.

Process: Creating the USH, with authority over PHS, CMS and ASPR, would require new legislative authority. In the meantime, the Secretary has the authority to restore the line authority of the ASH over the PHS agencies. This would send a strong signal about the need for scientific leadership and coordination and would make the position of ASH more attractive to potential nominees. The Secretary should take this action immediately as a precursor to legislative action creating the USH.

Examples of Lack of Coordination: There has been no health/scientific official to resolve or address:

- Ongoing difficulties in assuring coordination of preparedness activities between ASPR and CDC;
- Poor coordination between CDC and CMS with regard to best approaches for addressing hospital-acquired infections;
- Coordination of Medicaid and HRSA safety-net programs (community health centers, the Ryan White program) to assure seamless provision of care and maximize access to services;
- Consistency and appropriate divisions of labor between NIH and CDC with regard to prevention research;
- Coordination of mental health and health care services provided by HRSA and SAMHSA;
- Challenges to the scientific judgment of agency officials on questions such as the efficacy of condoms; and
- Coordination and consistency of programs, grants, and policies affecting state and local governments as developed across the health agencies.

[5] The Public Health Service agencies are: Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, and the Substance Abuse and Mental Health Services Administration.

APPENDIX C: PUBLIC HEALTH WORKFORCE

U.S. Public Health Service Commissioned Corps

- Establish a dedicated funding stream for the Commissioned Corps under the management and fiscal control of the Surgeon General. Currently, the Commissioned Corps does not receive an annual appropriation. The salaries of the physicians, pharmacists, environmental health experts, nurses, and other Corps officers are paid by the federal agency in which they serve. Without an established funding stream, recruitment for the Corps is difficult. Members of the Corps must volunteer their time and often pay out-of-pocket for recruitment materials or trips, and new recruits must find their own commission. A dedicated funding stream for the Corps would centralize payment for salaries and recruitment.

- Lift the cap on the number of active duty, Regular Corps members. The Commissioned Corps consists of approximately 6,000 officers who serve in the Regular Corps and the Reserve Corps. At present, the Regular Corps has a congressionally mandated cap of 2,800, which has almost been reached. There are nearly 3,200 Reserve Corps members, also on active duty, who work in similar jobs and receive the same pay and benefits as Regular Corps members. Many new enrollees enter the Reserve Corps with hopes of securing a slot in the Regular Corps since only these Corps members are eligible for promotion to the highest ranks. They are less likely to lose their jobs in a force reduction. Additionally, an estimated 25 percent of those entering the Corps in previous years came from the armed services, as all of the federally commissioned uniformed services have equal pay, rank, and retirement benefits. As the cap is approached, there is a disincentive for new recruits and members of the Armed Forces to join the Corps and for Reserve Corps members to remain in the Corps.

- Establish a new "ready reserve" component within the Corps. The Commissioned Corps needs a highly skilled and well-trained reserve in place that is able to respond to emergencies and urgent public health threats, along similar lines as the uniformed services' reserve. The ready reserve would be comprised of retired Corps members who would keep their day jobs, submit to an appropriate number of drills and training throughout the year, and would be available and ready to be deployed on short notice. Additionally, ready reserve members would backfill routine positions at federal agencies when active Corps members are deployed. Current Corps structure does not provide for someone to fill in and resume the responsibilities of an active member's day job when he or she is deployed. Ready reserve members could also be used in underserved communities to assure access to care, particularly for vulnerable populations.

- Create health and medical response (HAMR) teams to be federal first responders deployed in the event of a terrorist attack, natural disaster, or other public health crisis. HAMR teams would consist of full-time Corps members who would organize, train, and be equipped to provide public health preparedness and response throughout the year. When not responding to a crisis, members could also be sent to state and local public

health departments with severe workforce shortages. They would still be paid by the federal government so as not to further burden state public health budgets.

- Incentivize retired Corps members to move into faculty positions in public health related disciplines. Many academic institutions across the country are experiencing faculty shortages in the public health field. Retired Corps members could alleviate this shortage and also inform students about the Corps. An existing program, "Troops to Teachers", could be modified to include teaching in the public health field, thus addressing the faculty shortage and encouraging students to pursue a career in governmental public health.

Public Health Research Institute

A new Public Health Research Institute should be established to conduct and coordinate the following services:

- Identify and disseminate public health best practices and provide information about career categories, skill sets, and workforce gaps. With this information, states and localities will be better informed to make decisions about policies and program implementation. The institute would also help ensure greater accountability for the use of tax dollars.

- Conduct a public health workforce enumeration survey to determine current distribution of jobs including trend lines, wages, benefits, training, and pathways to enter public health. The institute would be responsible for conducting an enumeration survey every two years and publicizing information about career categories, skill sets, and workforce gaps.

- Address complex issues such as social determinants of health and generate data on health outcomes.

- Build on existing partnerships within the federal government while also considering initiatives at the state and local levels and in the private sector. Accountability measures will be established. The institute will evaluate and report on federal, state, and local public health workforce initiatives, as well as those in the private sector.

Interagency Advisory Panel

- Various federal government agencies play a role in workforce policy. For example, most federal dollars expended on job training and workforce development are overseen by the Department of Labor. The Department of Education also coordinates with the Department of Labor on workforce efforts through various loan and grant programs. The Department of Health and Human Services, the Department of Defense, the Veterans Administration, the Environmental Protection Agency, and the Department of Transportation are all involved in the public health workforce area.

- To ensure that there is a comprehensive public health workforce strategy, an interagency advisory panel to coordinate workforce development at all levels of government should be created. The purpose of the panel would be to:
    - Help link federal, state, and local public health workforce development;
    - Coordinate recruiting and training efforts; and
    - Coordinate technical assistance to expand the public health workforce.

- The interagency advisory panel should also be replicated at the state level.

Area Health Education Centers

- The public health workforce needs an influx of better trained and younger workers. State public health departments have an 11 percent vacancy rate and face looming mass retirements.

- Area Health Education Centers (AHEC's) are federally funded programs that link university health science centers with community health delivery systems to provide training sites for students, faculty, and practitioners.

- A few states, such as Connecticut, have used some of their AHEC funds to establish Youth Health Service Corps initiatives which train and then place high school students as volunteers in community health agencies. The students, who may include those enrolled in vocational and technical education, not only provide some relief to the workforce shortage problem, but may also help develop a pipeline for future public health workers. Under the Youth Health Service Corps model, an AHEC may partner with not only health entities, but also programs such as Learn and Serve America, a part of the Corporation for National and Community Service.

- All AHECs should be required to establish Youth Health Service Corps initiatives to assist in the recruitment of young people into health fields.

Community Colleges and Vocational Schools

- State and local public health departments should partner with community colleges and vocational and technical education and job corps centers to identify candidates for the field. Since nearly 40 percent of community college attendees are first generation college students, and many are nontraditional students, they are an ideal group to target for recruitment. Course offerings at community colleges are very flexible, making it easier to partner with state or local public health departments to address needed training.

- Health-focused career academies and health apprenticeship programs should be established at vocational and technical education centers. Health departments should partner with Tech-Prep programs and Job Corps centers where they exist, to help diversify the public health workforce.

State and Local Workforce Boards

The federal *Workforce Investment Act* of 1998 established state and local workforce boards to oversee, coordinate, and improve state and local employment and training programs. Currently, the composition of these boards warrants reform. The following are recommendations:

- All boards should include members representing the public health field in order for public health to be part of overall workforce development in all states and local communities.

- State and local workforce boards should establish initiatives that encourage the development, implementation, and expansion of health sector programs.

November 18, 2008

The Honorable Harry Reid
Senate Majority Leader
S-221
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
H-232
Washington, DC 20515

The Honorable Mitch McConnell
Senate Minority Leader
S-230
Washington, DC 20510

The Honorable John Boehner
House Minority Leader
H-204
Washington, DC 20515

Dear Majority Leader Reid, Speaker Pelosi, and Minority Leaders McConnell & Boehner:

From first responders to scientists searching for ways to prevent disease, our public health workforce is vital to protecting our nation's health and economy. But our public health workforce is in crisis. There is a serious shortage of public health workers with the expertise needed to meet the depth and breadth of the responsibilities they are expected to carry out.

We are writing to express our support for inclusion of funding for job creation, recruitment and training in a potential stimulus package. In particular, we request that support for the state and local public health workforce be a specifically permissible use of any funding that may be allocated for infrastructure and job training priorities. We believe that in addition to providing funds for infrastructure projects that can immediately create jobs, the stimulus can serve as a vehicle to promote long-term growth and economic development by helping to build a pipeline of well-trained workers, including those entering the public health workforce.

A 2007 survey by the Association of State and Territorial Health Officials (ASTHO) found that the state public health agency workforce is graying at a higher rate than the rest of the American workforce, and workforce shortages continue to persist in state health agencies. This workforce shortage could be exacerbated through retirements: twenty percent of the average state health agency's workforce will be eligible to retire within three years, and by 2012, over 50 percent of some state health agency workforces will be eligible to retire. Further, according to a 2005 Profile of Local Health Departments conducted by the National Association of County and City Health Officials (NACCHO), approximately 20 percent of local health department employees will be eligible for retirement by 2010.

Public health departments serve an important function by helping to promote health and prevent disease, prepare for and respond to emergencies and potential acts of bioterrorism, investigate and stop disease outbreaks, and provide other services such as immunizations and testing. Yet, the average age of new hires in state health agencies is 40, according to the 2007 ASTHO survey. Public health needs a pipeline of young workers, and the stimulus offers an important opportunity to begin to cultivate interest in public health among the nation's youth.

Governmental public health can be an important career pathway for displaced workers whose jobs have been eliminated. Public health offers a wide array of possibilities, from epidemiology

to information technology (IT) to environmental engineering. Retraining workers to tailor their skills to public health careers would help stimulate job growth and improve the quality of life in communities that are currently underserved due to habitual vacancies in state and local health departments.

As you develop a stimulus package and consider broad infrastructure projects, we ask that you consider the public health workforce to be an important dimension of state and local infrastructure. A sustainable public health workforce is crucial to our economic development and quality of life. Thank you for your attention to this request.

Sincerely,

American Public Health Association
Association of State & Territorial Dental Directors
Association of State and Territorial Directors of Nursing
Association of State & Territorial Health Officials
Association of State & Territorial Public Health Social Workers
Commissioned Officers Association of the U.S. Public Health Service
Council of State and Territorial Epidemiologists
National Alliance of State and Territorial AIDS Directors
National Association for Public Health Statistics and Information Systems
National Association of Chronic Disease Directors
National Association of County and City Health Officials
State and Territorial Injury Prevention Directors Association
Trust for America's Health

December 2008

Preliminary Findings: NACCHO Survey of Local Health Departments' Budget Cuts and Workforce Reductions

Background

The National Association of County and City Health Officials (NACCHO) surveyed 2,422 local health departments nationally in November–December 2008 to assess the impact of current economic conditions on local health departments' budgets and workforce. The survey, to which 1,079 local health departments distributed across 46 states responded, found that a majority of respondents are experiencing adverse impacts and expect those to continue next year.

Jobs Provided By Local Health Departments are Dwindling

In 2008, more than half of local health departments have either laid off employees or lost them through attrition and have been unable to replace them due to budget limitations. About one-third predict layoffs in 2009. Among the largest health departments, 84 percent reduced their staff in 2008, and 45 percent expect to lay off staff in 2009. Extrapolating the survey results to all local health departments, there has already been an estimated total loss of between 3,000–6,000 local public health workers nationally, and those numbers will increase in 2009.

Local Health Departments' Budgets are Eroding

Nationally, 27 percent of local health departments are working under a current budget that is less than the previous year, and 44 percent expect to do so next year. The impact falls disproportionately on health departments serving large jurisdictions, of which two-thirds expect next year's budget to be lower than this year's. For local health departments in large jurisdictions that experienced budget declines this year, the median budget reduction was $1.5 million.

The burden of declining budgets also is falling disproportionately on health departments in certain states. More than 50 percent of the local health departments in nine states (Arizona, California, Florida, Georgia, Oklahoma, Pennsylvania, South Carolina, Virginia, and Vermont) have already experienced cuts. More than 80 percent in 10 states anticipate cuts next year (Arizona, California, Florida, Georgia, Idaho, Pennsylvania, South Carolina, Virginia, Vermont and Washington).

TABLE 1: PERCENTAGE OF LOCAL HEALTH DEPARTMENTS REPORTING STAFF REDUCTIONS (BY JURISDICTION POPULATION)

	Percentage of Local Health Departments that:			
Jurisdiction Population	Laid Off or Lost through Attrition in 2008	Laid Off Staff in 2008	Lost Positions through Attrition in 2008	Expect to Lay Off in 2009
All LHDs	*53%*	*21%*	*46%*	*32%*
<25,000	31%	15%	21%	21%
25,000–49,999	46%	15%	41%	25%
50,000–99,999	62%	19%	56%	40%
100,000–499,999	77%	34%	70%	51%
500,000+	84%	40%	83%	45%

TABLE 2: PERCENTAGE OF LOCAL HEALTH DEPARTMENTS REPORTING DECLINING BUDGETS (BY JURISDICTION POPULATION)

	Percentage of Local Health Departments Reporting Declining Budgets	
Jurisdiction Population	Current budget compared to prior year	Next year's budget compared to current year
All LHDs	*27%*	*44%*
<25,000	22%	38%
25,000–49,999	19%	38%
50,000–99,999	25%	45%
100,000–499,999	37%	55%
500,000+	44%	67%

FOR MORE INFORMATION, CONTACT:

Donna Brown, JD, MPH
Government Affairs Counsel
dbrown@naccho.org

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

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NACCHO is the national organization representing local health departments. NACCHO supports efforts that protect and improve the health of all people and all communities by promoting national policy, developing resources and programs, seeking health equity, and supporting effective local public health practice and systems.

1100 17th St, NW, 2nd Floor Washington, DC 20036
P (202) 783 5550 F (202) 783 1583

www.naccho.org