

Strengthening Local Public Health in Massachusetts

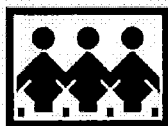
A CALL TO ACTION

Results of a Statewide Workforce Assessment
Conducted for the
Coalition for Local Public Health



Massachusetts Public Health Association
Massachusetts Health Officers Association
Massachusetts Association of Public Health Nurses
Massachusetts Association of Health Boards
Massachusetts Environmental Health Association

Report prepared by
Justeen Hyde, PhD and Alison Tovar, MS



Institute for Community Health

A collaboration of the Cambridge Health Alliance, CareGroup, and Partners Healthcare

June 28, 2006

Executive Summary

Over the last decade, advocacy efforts to improve local public health infrastructure in the United States have been hindered by a lack of basic information about the public health workforce and the resources available to them. In 2005, the Massachusetts Coalition for Local Public Health (CLPH) pooled member resources to fund a statewide survey to gather basic information about the local public health workforce and infrastructure in the Commonwealth. The CLPH commissioned the Institute for Community Health (ICH) to develop and implement this survey. This report is the first complete presentation of the data collected through this study.

Background

Challenges facing public health systems have increased significantly in the years following September 11, 2001. Cuts in funding for local and state public health systems coincided with an increase in expectations for these systems to be involved in emergency preparedness planning and practice. While federal and state officials recognize the critical role that public health officials play in responding to biological agents such as anthrax, smallpox, and virulent strains of influenza, many local public health departments are stretched too thin to meet growing expectations and demands placed on the public health infrastructure. The threat of bioterrorism and other intentional and natural disasters has confronted local, state and federal policy makers with a need to assess and address weaknesses in local public health infrastructure.

Methods:

Self-administered surveys were distributed to local public health authorities in Massachusetts between June and December, 2005. The study was introduced at regional and sub-regional public health emergency preparedness meetings across the state and via direct email to local public health leaders. Completed surveys were sent to ICH and entered into an Access database. Data were analyzed in SAS 9.0.

Results:

A total of 191 out of 352 local public health authorities participated in this study, representing a 54% response rate. Participating public health authorities represent a mixture of rural, suburban and urban communities serving a variety of population sizes across the Commonwealth. Below is a summary of key findings from the study:

Local Boards of Health

- Nearly all participating communities reported having a local board of health comprised of 3-5 members. Only 26.7% of all board of health members included in this survey have participated in a training and education program offered by the Massachusetts Association of Health Boards. As one of the only training programs for local boards of health in the state, this finding raises concerns that the many board members do not have the resources or skills to make informed decisions about local public health issues.

Public Health Budgets

- Local public health authorities rely primarily on municipal funds to support programs and services. Despite an increase in expectations and responsibilities placed on local public health authorities over the last 3 years, the majority of communities reported very small increases in municipal funding for public health services.
 - Public health departments serving communities with populations of less than 40,000 (88% of sample) reported an average increase of 3% in municipal funding between 2004 and 2006. This small increase is likely to reflect cost of living salary adjustments and is

insufficient to cover the costs associated with the expansion of responsibilities for local public health authorities.

- Public health departments serving communities with populations greater than 40,000 (12% of sample) reported the greatest increases in municipal funding over the last 3 years. However, the reported 10% average increase is still insufficient to support the hiring of additional staff to meet expanding demands and responsibilities.
- With the exception of communities with populations less than 5,000 residents, most local public health authorities receive some funding from private, state, and federal contracts and grants. Larger communities (>40,000) bring in more outside funding than smaller ones.

Staffing Patterns

- There are vast differences across the state with respect to staffing of local public health departments. Approximately 63% of communities with populations of 10,000 or less reported having no full time public health staff to serve their residents. This stands in stark comparison to communities with populations of 20,000 or more, all of whom reported at least one full time staff member.
- Many essential public health services, especially in smaller communities, are contracted out to private individuals and agencies.
- A number of communities may not be providing essential public health services to their community because of gaps in staffing.
 - 12% of all participating public health authorities do not have a public health director, agent or commissioner.
 - At least 23% of reporting municipalities are not able to offer services provided by public health nurses (e.g., flu vaccine clinics, health screenings, etc).
 - Gaps in public health services are greatest among communities with populations of 10,000 or less.

Descriptions of Essential Personnel

- Nearly one-fifth (18%) of the public health workforce will be eligible to retire in the next 2 years. Unless efforts are made to increase the entry of public health nurses, inspectors and other personnel into the municipal workforce, many communities will not have the staffing resources to provide residents with essential public health services.
- There is little consistency across participating municipalities in the educational requirements and salary rates for essential public health personnel. There is a trend towards greater educational requirements and salary rates for public health personnel serving larger communities, but the variability remains great across all population sizes.

Additional Staffing Needs

- Approximately 45% of all reporting public health authorities believe that they do not have enough staff to meet the needs of the public and fulfill their responsibilities to local and state officials. An additional 26% reported only sometimes having enough staff to perform expected responsibilities.
- When asked about additional public health staff needed to meet local and state needs, 46% requested additional inspectional services staff and 27% reported needing public health nurses and administrative support staff.

Discussion

The data presented in this report provides a snapshot of the capacity and resources of local public health authorities in Massachusetts. In general, we found vast differences in the local public health infrastructure across the Commonwealth; the most striking differences are

between smaller and larger communities and between departments in the eastern and western parts of the state. Differences include disparities in staffing patterns, formal education of public health personnel, and annual budgets. The findings raise questions about the modest increases in municipal funding for local public health authorities over the last three years. In particular, are the increases sufficient to support the capacity of the public health workforce to meet expanding responsibilities mandated by local, state and federal entities? With nearly three-quarters of participants reporting that they do not or only sometimes have enough staff to fulfill their obligations to the public, further investigation of the gap between financial resources and local capacity is needed. Finally, the data presented here coincide with other studies that have found an aging public health workforce. Nearly one-fifth of all public health personnel included in this study will be eligible to retire in the next two years. This finding begs the question of whether or not there are sufficient numbers of trained individuals entering the local public health workforce to fill the gaps that are likely to occur over the next few years.

The need for a stronger public health infrastructure is not merely a local concern, but one that spans across local, state and federal jurisdictions. Basic information on local public health authorities is needed to inform thoughtful and sustainable plans for improvements in the infrastructure and capacity of public health systems. Despite some basic limitations, the results of this survey represent an important step towards the achievement of these goals. We hope that the data will be used to support current advocacy efforts and lay the foundation for future inquiries into the resource, education, and capacity needs of the local public health authorities in Massachusetts.