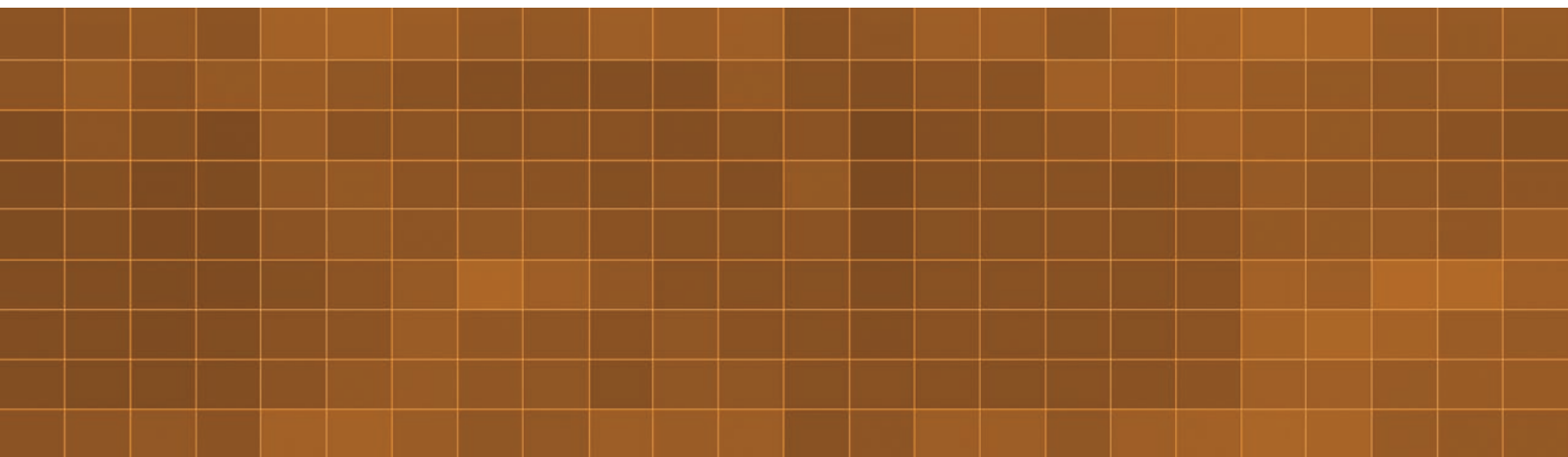


sixty-five
65
years



2007 State Public Health
Workforce Survey Results



2007 State Public Health Workforce Survey Results

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Acknowledgements

Research, production and publication of this report were supported by cooperative agreement number U50/CCU3133903 and U50CD313903 from the Centers for Disease Control and Prevention. ASTHO is grateful for their support. Opinions in this report do not necessarily represent the official policy of the CDC.

ASTHO would like to extend its sincere thanks to the members of the ASTHO Public Health Workforce Survey Working Group chaired by Terry Dwelle, North Dakota Department of Health. The following people were invaluable to the development of the survey and this report: Ron Bialek, Public Health Foundation; Joan Cioffi, Centers for Disease Control and Prevention; Art Cohen, Public Health Consultant; Librada Estrada, National Association of County and City Health Officials; Kristine Gebbie, Columbia University School of Nursing; Dana Jefferson, State of Delaware, Office of Management and Budget; and Kathy Vincent Alabama Department of Public Health. ASTHO would also like to thank Leslie Scott, National Association of State Personnel Executives, for her assistance and support with the survey development. Special thanks go to Robert Delany, Virginia Department of Health, and Jon Fisher, South Carolina Department of Health and Environmental Control, for their assistance with the pilot survey and their valuable feedback from the state health agency human resource perspective.

Lastly, ASTHO would also like to thank all the state public health agencies who responded to this survey, without their help, this report would not be possible.

This report was researched and written for the Association of State and Territorial Health Officials by Adam Reichardt, MPA, and Melissa Lewis, MPH.

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The Association of State and Territorial Health Officials is the national non-profit organization representing the state and territorial public health agencies of the United States, the U.S. territories, and the District of Columbia. ASTHO's members, the chief health officials in these jurisdictions, are dedicated to formulating and influencing sound public health policy, and assuring excellence in state-based public health practice.



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I. Executive Summary

A 2003 survey of the shrinking public health workforce revealed a growing trend toward shortages in the public health workforce. Data from a recent 2007 survey of ASTHO members confirm that little has changed in the past several years and that state governmental public health still faces a workforce crisis. Despite ongoing efforts, the state public health agency workforce is graying at a higher rate than the rest of the American workforce and state health agencies continue to be affected by workforce shortages. These trends combine to create critical challenges to the ability of states to effectively respond to threats to the public's health.

The 2007 ASTHO State Public Health Workforce Survey revealed three major areas of concern:

A Graying Workforce

- The average age of a public health worker in state government is 47, an increase of about 1.08 years when compared to respondents of the 2003 survey.
- The average age of *new hires* in state health agencies is 40.
- Twenty percent of the average state health agency's workforce will be eligible to retire within three years.
- By 2012, over 50% of some state health agency workforces will be eligible to retire.

A Continuing Shortage of Workers

- A severe shortage of nurses in public health remains a key concern.
- Most states continue to be affected by shortages in other public health classifications, including epidemiologists, laboratorians, and environmental health workers.
- States have also identified shortages in nutritionists, dieticians, public health physicians, and social workers.

Barriers in Overcoming the Crisis

Certain barriers directly affect state public health workforce shortages:

- Budget constraints.
- Lack of competitive wages for public health careers.
- Lack of interest by recent graduates for public health careers.
- Lack of visibility of public health careers.
- Bureaucratic processes in the selection and hiring of qualified candidates that is often affected by broad, state-based employment practices.

In addition to current worker shortages, the graying workforce is expected to result in a high number of retirees within the next few years. This can result in a gap in both the leadership and institutional knowledge of state health agencies.

As the 2007 survey shows, workforce planning, recruitment, and retention strategies are major focus areas for state health agencies. Other strategies, such as rehiring retirees and succession planning, are being used to alleviate the impact of retirement on state public health.

A rapid exodus of state health agency employees due to retirement has not yet occurred. However, the aging of the workforce, combined with increasing retirement eligibility does signal the need for immediate resources, continued dialogue, and innovative solutions to ensure an adequate, competent public health workforce.

In response to the findings of the 2007 survey, ASTHO recommends a multidimensional, long-term approach to strategic workforce development. ASTHO and its partners will continue to advocate with policymakers for innovative solutions to the workforce crisis and will promote the need for a renewed investment to assist public health agencies. Suggested approaches include:

- Communicating the public health workforce crisis to a wider audience.
- Advocating for increased resources to states and localities to further develop their workforce activities.
- Studying public health workforce needs through quantitative research and enumeration.
- Actively replenishing the pool of available workers by marketing public health careers and highlighting the benefits of working in public health.
- Improving the competitiveness of compensation in public health sectors.
- Building partnerships within and outside the public health system.
- Fostering innovative strategies to counter the workforce shortage.

II. Introduction

The U.S. governmental public health workforce is vital to improving the health of the American public. In state government alone, over 100,000 workers are charged with achieving the public health mission of, “fulfilling society’s interest in assuring conditions in which people can be healthy.”¹ State health agency (SHA) employees focus on improving health outcomes in their states through a wide variety of activities, ranging from HIV/AIDS counseling, testing, and surveillance to bioterrorism and emergency preparedness. Much of the work in public health prevents problems from occurring, and rarely receives public recognition. There is an old adage in public health, “When public health works best, it is invisible—it’s the disease you didn’t get, the accident you didn’t have, the disaster that didn’t happen.”² Yet, the importance of public health and those intimately involved in advancing the mission of public health can not be overstated. As the Institute of Medicine noted in 2003, “At no time in the history of this nation has the public health mission of promoting the public’s health and safety resonated more clearly with the public and the government than now.”³ The foundation of this important mission is the human capital employed in the variety of sub-fields that make up governmental public health.

Unfortunately, public health workforce trends continue to indicate a waning of this vital resource. Recent studies show an aging workforce in dire need of revitalization with some professional areas already experiencing shortages. Over the past twenty years, the ratio of public health workers per 100,000 Americans decreased by ten percent.⁴ Between 2003 and 2004, the number of state and local public health workers decreased by more than 6,000 full-time equivalent (FTE) workers.⁵ The leadership turnover in governmental public health is expected to be even more severe. To exacerbate the problem, many younger individuals graduating from accredited schools of public health are not entering into careers in governmental public health.^{6,7} According to the Association of Academic Health Centers, “State action on workforce issues is critical not only in resolving shortages but also in developing and sustaining a workforce for the future.”⁸

Thanks to several national, state, and local efforts, these startling trends in public health workforce have been elevated to the attention of leaders and policymakers. In 2003, ASTHO, the National Association of State Personnel Executives, and the Council of State Governments surveyed state health officials on public health workforce trends. Their findings indicated a growing public health workforce shortage. The survey indicated that by 2008 retirement rates in some state public health agencies could be as high as 45 percent, and the average age of a state health employee would be nearly 47.⁹ In 2004, The Council of State and Territorial Epidemiologists (CSTE) conducted an overall assessment of the capacity of the epidemiological workforce and found that, “The current number of epidemiologists is far below the perceived ‘estimate of need’ to provide essential services of public health across epidemiology program areas.”¹⁰ A 2005 Health Resources and Services Administration study of six states found that, “beyond budget constraints, recruitment difficulties were attributed to general shortages of workers within an occupation (e.g., registered nurses, nutritionists), non-competitive salaries, and lengthy processing time for new hires.”¹¹

Leadership in public agencies is also facing a major crisis. Within the next few years, many public health organizations face leadership turnover of 50 percent or higher.¹² An analysis of State Health Official (SHO) appointment dates shows their median tenure to be 2.25 years. A 2005 ASTHO study found that among senior deputies, the staff level in a state health agency that most often represents the ‘next-in-charge’ below the state health official, the average age was 50.6 years. Nearly 20 percent of senior deputies were eligible to retire in 2005.¹³

National advocacy efforts have brought increased attention to the workforce situation. Starting in 2004, ASTHO, along with several key public health partners, advocated for a public health workforce

scholarship and loan repayment program. Bipartisan support in the U.S. Senate sponsored a bill entitled the *Public Health Preparedness Workforce Development Act of 2004*. In 2006, provisions from the Workforce Development Act were included in a bill passed by Congress and signed by the President. *The Pandemic and All-Hazards Preparedness Act of 2006* encourages public health professionals to enter employment in a federal, state, or local public health agency through a loan repayment program.

Recent national efforts surrounding performance standards and accreditation have also focused on strengthening the governmental public health system. As more tools are developed to measure performance and accountability in serving the public, a robust, capable public health workforce will be required to meet more rigorous standards. Specific disciplines in public health have addressed strengthening their capacity through the development of competencies. Most recently, CSTE, in partnership with the CDC, developed the *Applied Epidemiology Competencies for Governmental Public Health Agencies*, “to improve the practice of epidemiology within the public health system. The document: 1) defines the discipline of applied epidemiology; and 2) describes what skills four different levels of practicing epidemiologists working in government public health agencies should have to accomplish required tasks.”¹⁴ Other areas such as the directors of chronic disease programs and the maternal child health program directors have also focused on competencies, while others have focused on training, mentoring, succession planning, and leadership development. For example, The Association of Public Health Laboratories’ (APHL) National Center for Public Health Laboratory Leadership prepares current and emerging laboratory leaders with the skills critical to success in a rapidly evolving field.¹⁵

Despite these efforts, trends in the public health workforce remain unchanged. In 2007, ASTHO, supported by a grant from the CDC, deployed a survey to the state health agencies to revisit data from the 2003 workforce survey and determine if there are:

- Changes in the direction of the trends
- Any new emerging trends
- Strategies being used or explored that could mitigate shortages

The updated survey was developed through an iterative process guided by a working group of members, partners, and subject-matter experts. The results of the 2007 survey, provided as an aggregate in this report, underscore the workforce shortage problem and present solutions currently employed in some states that may be helpful to other states as they continue to meet this challenge. The data also demonstrates the continued need for further funding and broader policy input to solve continuing worker shortages.

The report examines specific characteristics of the state health agency workforce including:

- Demographics and trends: 2003 – 2006
- Workforce planning
- Recruitment
- Retention
- Retirement
- Workforce shortages

This report also offers recommendations for how policymakers can assist state health agencies in responding to workforce challenges. Further studies, with in-depth analyses of specific topic areas and innovative practices, will be published in the future as a result of this survey.

Since 2003, significant efforts in developing the public health workforce and meeting the challenges it faces have been taking place. ASTHO hopes that continuous data collection, strong partnerships, and national advocacy for policy solutions will help to reverse the trends. Success of the public health mission requires a capable, prepared public health workforce contributing to the ultimate goal of improved health outcomes for the American public.

III. Survey Methodology

On January 31, 2007, ASTHO sent the State Public Health Workforce Survey to the 50 states, the District of Columbia, and the six U.S. territories (American Samoa, Guam, Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Puerto Rico, and the Virgin Islands). The survey was developed by a working group made up of practitioners and experts from the states, local public health, academia, and federal representatives. It was vetted through ASTHO members and partners via conference calls and electronic mail.

Surveys were distributed electronically to the human resource/personnel director of the state or territorial health agency. Respondents had one month to complete the survey. Follow up was conducted by ASTHO staff. By May 31, 2007, ASTHO had received 44 responses representing from 43 states and the District of Columbia, and a corresponding 90 percent of the U.S. population (267,729,164 people).¹⁶ The data used in this report corresponds to data collected between January and June 2007. States were asked to review and update their profiles during the period October to December 2007. This information is available in the appendix.

IV. Findings of the 2007 Workforce Survey

A. Demographics & Trends: 2003 - 2006

State governments employ a large number of the U.S. population. According to the U.S. Department of Labor, Bureau of Labor Statistics, 4,527,514 individuals work in state government.¹⁷ According to the 44 states that reported full-time equivalent (FTE) counts in the ASTHO survey, over 100,000 workers are employed in state public health. This number compares to the NACCHO 2005 estimate of local health departments at 160,000 FTEs.¹⁸

The average state health agency (SHA) employs 2,731 FTEs with the median FTE count at 1,383. The range of FTEs varies, with the smallest SHA employing 152 FTEs and the largest employing 16,721.

Workforce Composition and Classifications

Workers employed in state health agencies across the country make up a wide variety of occupations, representing the multidisciplinary aspect of public health. To demonstrate the diversity of responsibilities in the public health workforce, ASTHO asked respondents to identify the number of employees working in certain occupational classifications. This also helps to determine the extent to which each classification comprises the workforce. Though not all classifications were requested, this proportion of occupational classifications paints a picture of the “make-up” of the state public health workforce. As illustrated in Chart 1, administrative and clerical personnel make up the largest portion of the SHA workforce (34%) followed closely by public health nurses (25%).

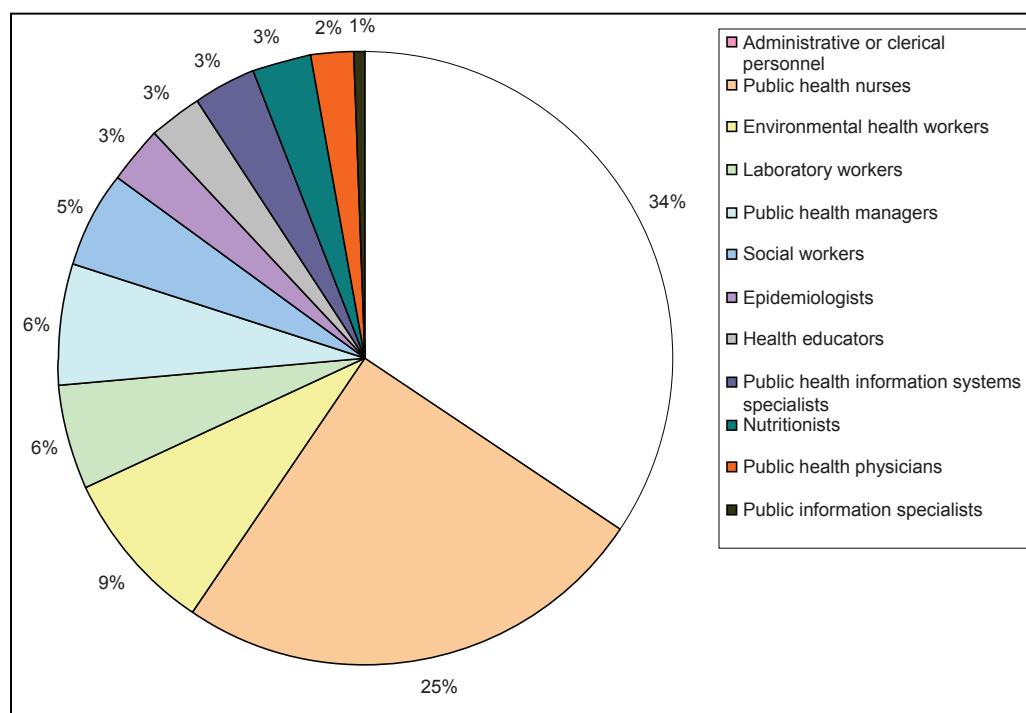


Chart 1: Proportion of specific occupations in state public health

Aging of the State Public Health Workforce

Data from the 2007 ASTHO survey indicates the workforce has continued to age slightly since 2003. The average number of years of service of a state public health employee is 12. The average age of a state public health employee is 47. This is similar to the average age of overall state governmental employees, which is 45.¹⁹ ASTHO found that 20 states (87%) indicated an increase in the average age of their workforce by about 1.08 years (see Chart 2).

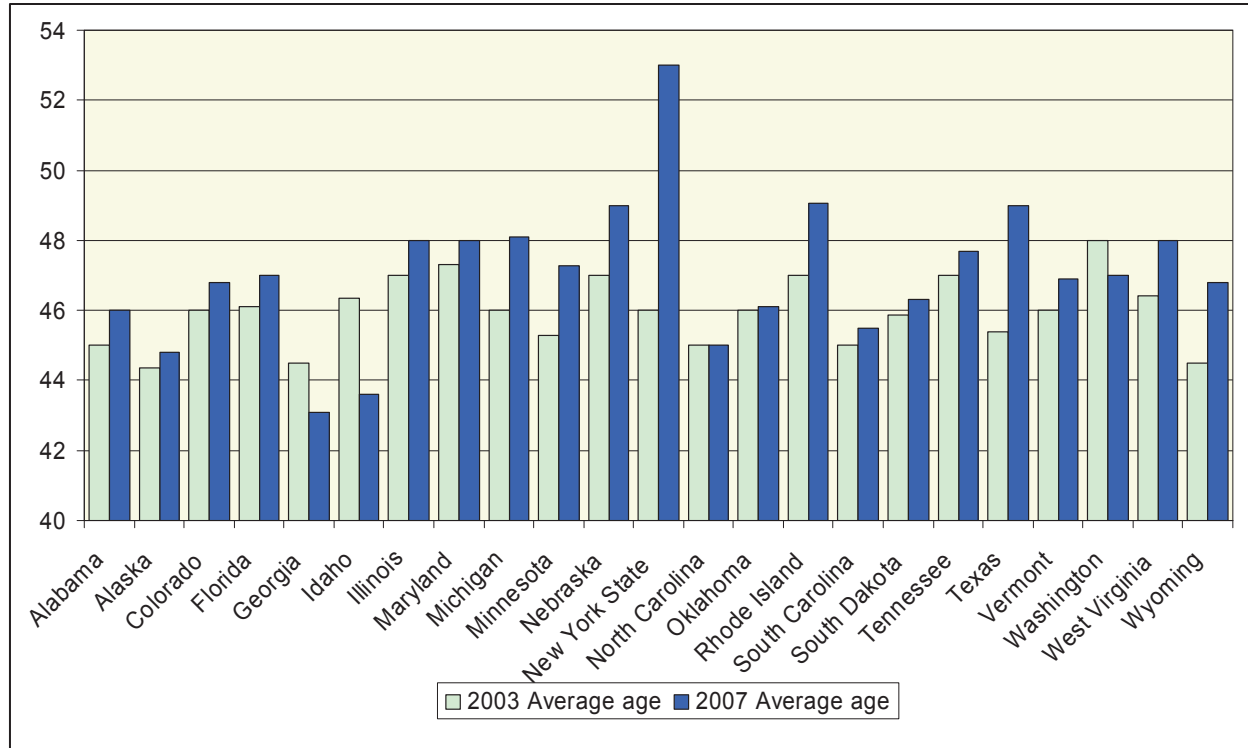


Chart 2: Average age of SHA employees from 2003 and 2007 surveys by state

The 2007 survey results also indicate that the median age of SHA employees is 47 compared to the median age of 40.8 of the overall American workforce. The Bureau of Labor Statistics predicts the median age of the American workforce to rise to 42 years by 2020.²⁰ If trends in the state public health workforce remain unchecked, it may continue to see dramatic aging, with significantly higher numbers of retirement-eligible employees than the rest of the nation.

A significant finding from the 2007 ASTHO survey was that the average age of new hires in state health agencies remained steady at 40 years old. This may signify an older pool of available public health workers or that barriers exist in recruiting larger numbers of younger people into state public health employment.

Turnover and Vacancies

The turnover rate in state health agencies appears to match that of the national average for governmental agencies. ASTHO found that the average turnover rate at a SHA has held steady at 13 percent over the last three years, and hovered between 12.5 and 13.5 percent between 1998 and 2006. This compares to the national average of 15 percent for all government sector workers.²¹

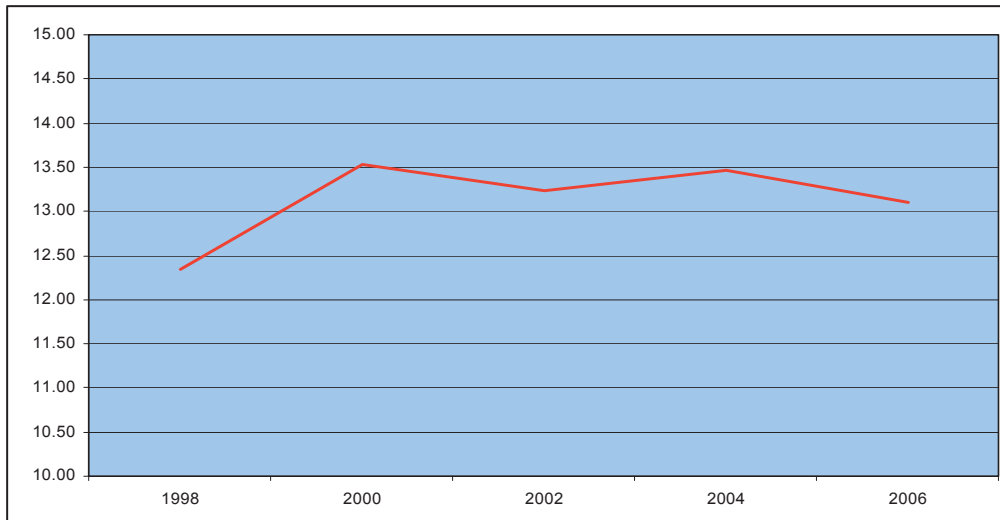


Chart 3: Average turnover rate for SHA 1998 – 2006 (Source: 2003 & 2007 ASTHO Workforce Surveys)

In 2006, the average vacancy rate at a state health agency was 10.89 percent. This is a slight decrease of the average vacancy rate reported in 2003 (11.35%). However, if only the states that responded to both surveys are compared (n=26), there is an increase in the average vacancy rates of 1.6 percent.

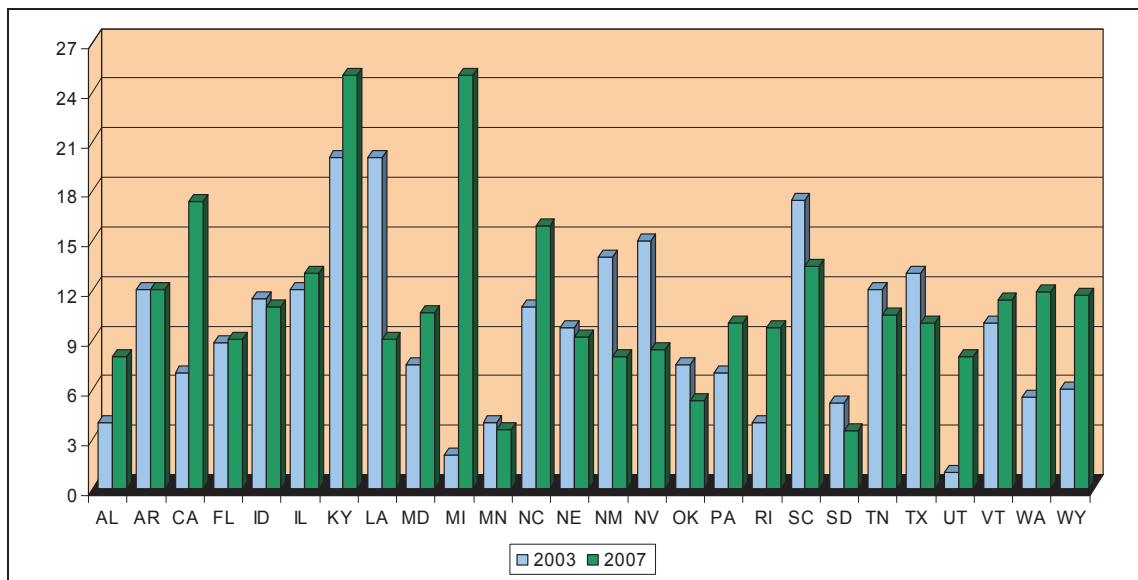


Chart 4: Average vacancy rate 2003 & 2007 by states responding to both ASTHO surveys

In early 2007, respondents reported a total of 13,379 open positions at state health agencies. Of those positions, only 3,997 (30%) were being actively recruited. Respondents cited reasons such as budget shortfalls (i.e. unfunded positions) and hiring freezes as explanations for this recruitment gap.

Demographic trends present both positives and negatives for state health agencies. On the one hand, no dramatic change has occurred in the trends since 2003. On the other hand, there has been little to no improvement in the demographic indicators of the workforce. The data still shows serious cause for concern and the challenge will require more resources than the states can provide to reverse these trends.

B. Workforce Planning

Explanation of Workforce Planning

Workforce planning enables managers to make informed human resources decisions to address worker shortages due to turnovers related to retirement, private sector competition, hiring freezes, etc. According to Leslie Scott, “Workforce planning is critical for state governments, particularly as roughly 30 percent of the workforce is eligible or soon eligible to retire. This, coupled with changing needs of younger generations of workers that have different goals and expectations, makes it critical that state agencies maintain current and effective human capital management strategies that allow them to meet their strategic goals.”²² State health agencies have begun implementing workforce planning strategies to gauge the present and future personnel needs of their organizations in relation to their strategic direction, and to assist in the development and implementation of workforce strategies that ensure “efficient alignment between organizational and human capital needs.”²³

Benefits of Workforce Planning

“Getting the right number of people with the right competencies in the right jobs at the right time.”²⁴

Through workforce planning, organizations base their decision-making on strategic alignment and political climate. Workforce planning analyses inform management of the right number of people, the key functions, and the necessary skill sets that would best enable their organization to meet its strategic objectives.

Benefits include:

- Strategic alignment of workforce and organizational needs.
- Identification of the current workforce profile (demographics, retirement projections, turnover and vacancy rates, competencies, and shortages).
- Identification of gaps in competency or staffing levels of the present and future workforce profile.
- Determination of key human resource functional needs or competencies for the organizational strategic direction rather than focusing on key people.
- Development of strategies to address gaps or surplus in workforce supply and demand.
- Awareness and monitoring of workforce needs and looming issues.
- Strengthening of business processes.
- Linking of workforce requirements with the budgeting process.
- Increase in efficiencies in human resources and workforce development.
- Skills development for current and future workforce.

- Determination of replacement needs for future staffing.
- Increased worker satisfaction.
- Improved employee understanding of job requirements and opportunities for advancement.²⁵

Workforce Planning in State Government

The role of many central human resource agencies in state government is to support the human resource needs of state agencies and serve in a consulting capacity to various agency-level human resource departments. They assist in program development, provide established workforce development tools, and facilitate the training needs of their state's civil service employees.

According to NASPE's 2007 Human Resources Metrics Survey, approximately 82 percent of the responding personnel executives in state government had formal state-wide workforce planning initiatives (n = 34). Among responding states with formal state-wide workforce planning programs (n = 33), 61 percent had established programs within the last five years, and nearly one-third (30%) of the programs were in existence for six to ten years. Only three states had formalized programs instituted over 11 years ago, which account for less than ten percent (9.09%) of all programs.

Workforce Planning at State Health Agencies

Formal workforce planning programs instituted in state health agencies are a recent but common phenomenon. The trends for programs at these agencies are very similar to those of the central state personnel agency. According to the 2007 ASTHO survey:

- Nearly two-thirds (67%) of state health agencies (n=43) instituted workforce planning programs within the last five years.
- Of those programs, 22% (n=27) have existed for up to two years.
- Five states have programs that have lasted six to ten years.
- Three state health agencies, Ohio, North Carolina, and California, have managed workforce planning programs for 11 or more years.

Data from the 2007 ASTHO survey indicates that workforce planning programs are typically not mandated by the central personnel agency or the legislature, but are established independently by the state health agency. Directives are primarily authorized by the senior management of the state health agency.

Twenty-one state health agencies reported that their authority to conduct workforce planning came primarily from the state health official or senior deputy. Thirteen agencies indicated that their state personnel executive initiated the process to create a formalized workforce planning program.

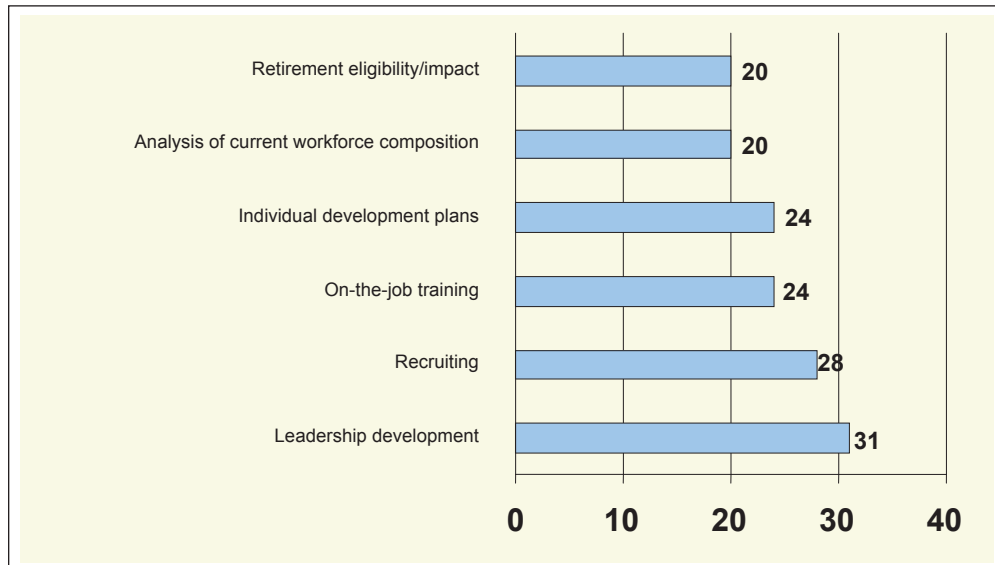


Chart 5: Top workforce planning strategies used in SHAs

The workforce planning activity most frequently used by state health agencies, as shown in Chart 5, was leadership development. Several states send their managers to national leadership training institutes or create their own academies to develop the leadership capabilities of their staff and strengthen their basic management skills. Leadership development allows the agencies to train staff on those skills, attributes, and behaviors desirable to the organization. This strategy is important as agencies prepare for older skilled workers to retire from key positions.

Recruiting was cited as the second most often used strategy. Recruiting staff that can help an organization achieve its strategic goals continues to be a challenge for state health agencies. They compete with the private sector and other governmental agencies, for the same small pool of talented applicants. In order to compete with other hiring agencies, SHAs use web-based recruitment tools, job fairs, direct hire procedures, and academic partnerships/strategic agreements.

On-the-job training was the third activity most cited by states. This is training given to employees in their working environment, using their daily materials and workplace tools.

In summary, most states are engaged in common and affordable activities for their workforce planning programs. Even states that did not report having formal workforce planning programs are gradually incorporating some elements of workforce planning activities. These activities are particularly valuable for

Each year, the Alabama Department of Public Health (ADPH) selects ten scholars to attend the South Central Public Health Leadership Institute (SCPHLI), a year long program of study. SCPHLI is a combination of independent study and on-site sessions. During the course of the program, scholars form teams to work on a project. The ultimate goal of the projects is that they produce a product that could benefit the department.

“Our team chose to create training modules and video on customer service [due to issues that we encountered [with] co-workers/situations. After completing the program [Leadership Academy], we asked our Personnel Department to review and approve the content for statewide dissemination. It has been approved and we will be delivering the training throughout the state to both small and large groups [and] may also be delivered on-line in the future.”

Michele B. Jones, MS
ADPH Training Coordinator

states facing budget restraints. None of the states surveyed employed all the workforce planning strategies listed. They each focused on activities identified as most useful and economical for their needs.

Barriers to Workforce Planning

Survey respondents were asked to identify the greatest challenges to implementing their state's workforce planning activities. Several themes emerged:

- Executive buy-in.
- Not enough human resource staff.
- Lack of measurable goals and objectives.
- Other challenges such as budgetary limitations, time constraints, civil service rules, and lack of ability to provide financial incentives.

These findings underscore the importance of leadership support for workforce planning initiatives. Senior leaders have the authority to offer financial support and link workforce planning activities to departmental budgets (see Chart 6).

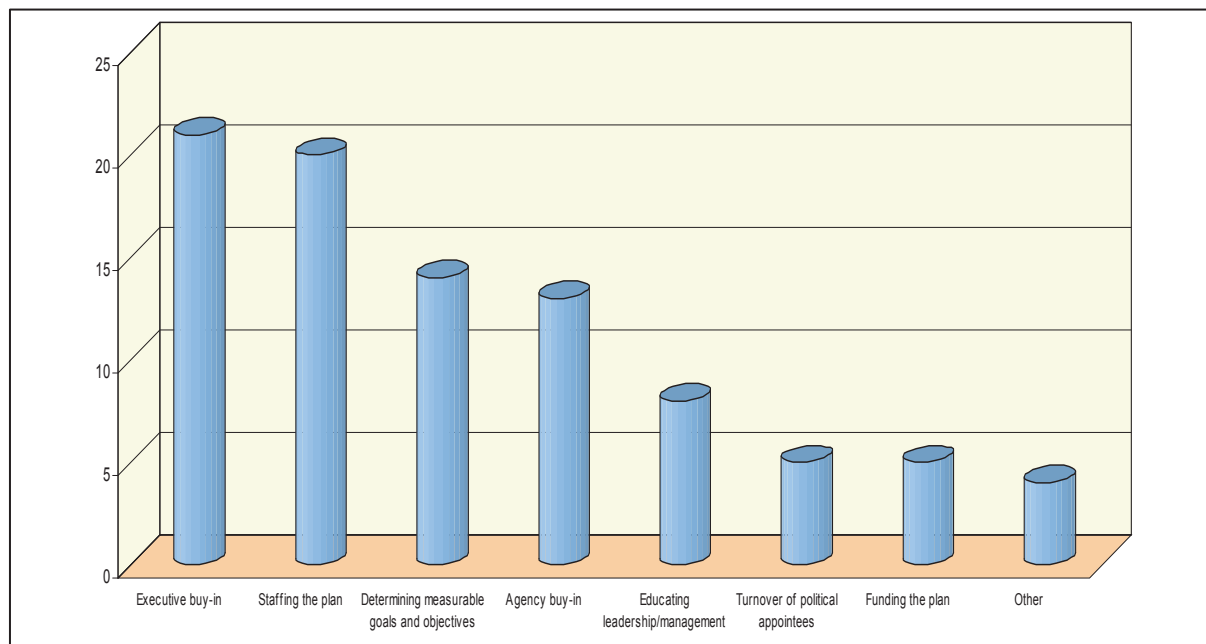


Chart 6: Challenges to implementation of state workforce planning

States without workforce planning programs face the same barriers. Scarcity of resources was the most common barrier followed by financing, staffing, and a lack of agency buy-in. Other identified challenges included a lack of expertise of human resource directors or leadership, time, and adequate staff dedicated to the process.

C. Recruitment

Recruiting talented individuals at all levels continues to be an identified need. Several strategies were identified by survey respondents to recruit qualified candidates. Chart 7 indicates which are used most often.

Web-based recruiting was identified as the strategy used most often. Online recruiting offers easy access to a wide market at a low cost to the agency. Several states use a web-based job board for online recruiting and directly email job announcements to various organizations and universities for circulation.

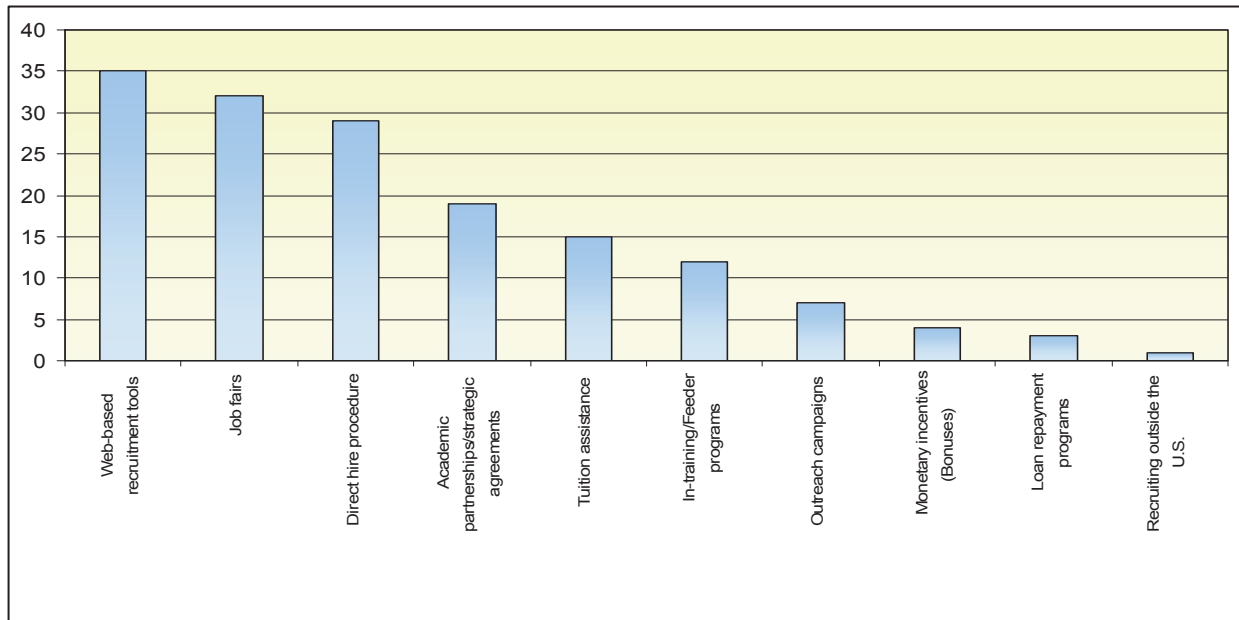


Chart 7: Recruitment strategies used by states

Recruiting at job fairs was cited as the second most used strategy. In addition to traditional job fairs at colleges or universities, some states noted that they also have booths with recruiting materials in various languages at cultural events, such as Asian or Latino festivals.

Within the last few years, states have increasingly used direct hiring procedures to fill critical positions in the agency. Direct hiring is a form of accelerated hiring that allows a unique authority to agencies to offer qualified applicants immediate employment for select positions when there is a severe shortage of candidates or the agency has a critical need.²⁶ A few states mentioned that they were using direct hiring procedures to hire nurses, due to critical shortages.

According to a recent survey by NASPE, 100 percent of respondents (n=33) indicated that their state used targeted recruitment efforts to attract specific talent pools. Nine states (27%) mentioned nursing, or other public health related fields, as specifically targeted job classifications for recruitment.²⁷

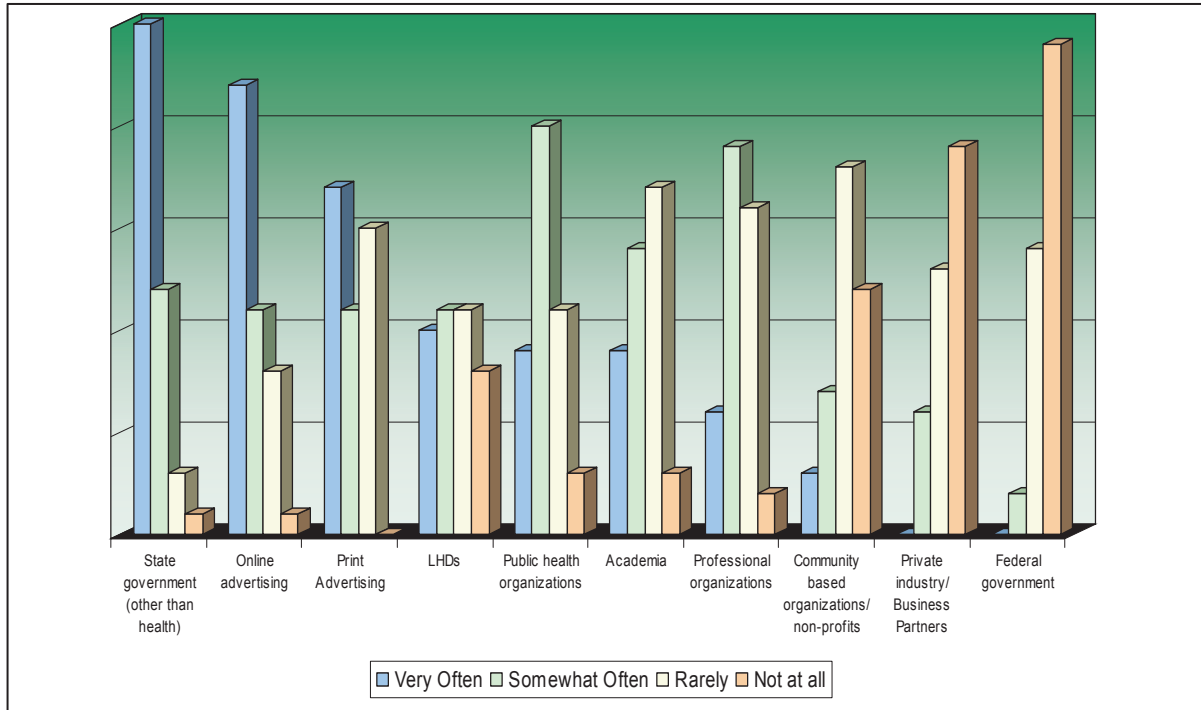


Chart 8. Various recruiting strategies used by states.

Similarly, respondents to the ASTHO survey were asked to what extent their states used certain external recruiting resources. Chart 8 illustrates that SHAs most often look within the state government as a recruitment strategy. Online advertising (e.g. online career networks and classifieds) and print advertising (e.g. newspapers and journals) were cited as sources of recruitment for the states. Local health departments, other public health organizations, and academia (fellowships/campus fairs/internships, public health undergraduate courses, community colleges and secondary schools) were also used. Respondents cited the private sector and the federal government as rarely used recruitment sources.

D. Retention

Retaining quality employees in state public health is necessary not only to maintaining the current workforce, but developing the future workforce as well. As the state public health workforce continues to experience shortages in many professional areas, strategies that promote retention are critical. In the 2007 workforce survey, state health agencies noted several common strategies used to retain their workers. Most often cited were, flexible hours, career development, and rehiring retirees (see section E).

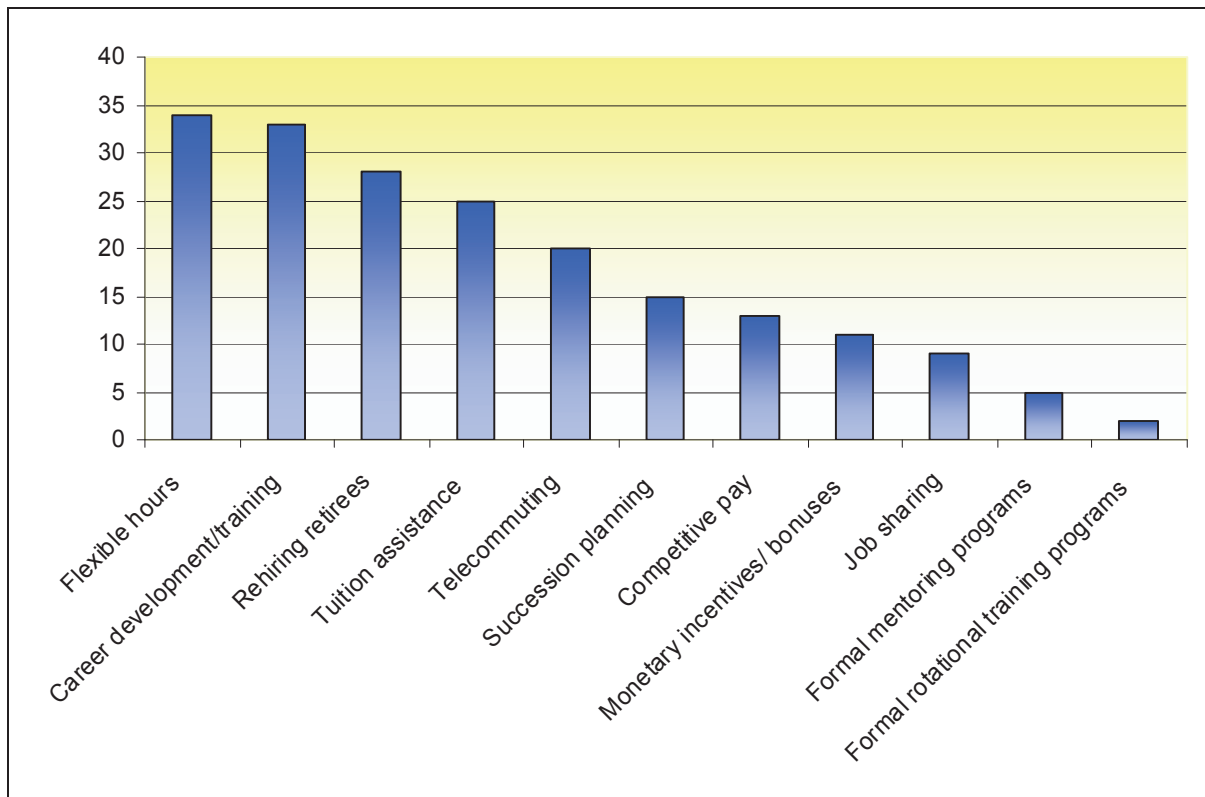


Chart 9: Retention strategies at State Health Agencies

Employee recognition and reward programs, telecommuting, tuition assistance, alternate work schedules and retention bonuses were also noted as successful retention strategies. One state even allows new mothers, depending upon their job, to bring their babies to work for up to six months,

The least used retention strategies included formal mentoring and rotational programs. This trend is not limited to state health agencies. According to a 2006 NASPE survey, only 17% (n= 33) of respondents noted formal mentoring and rotational programs throughout all of state government.

E. Retirement

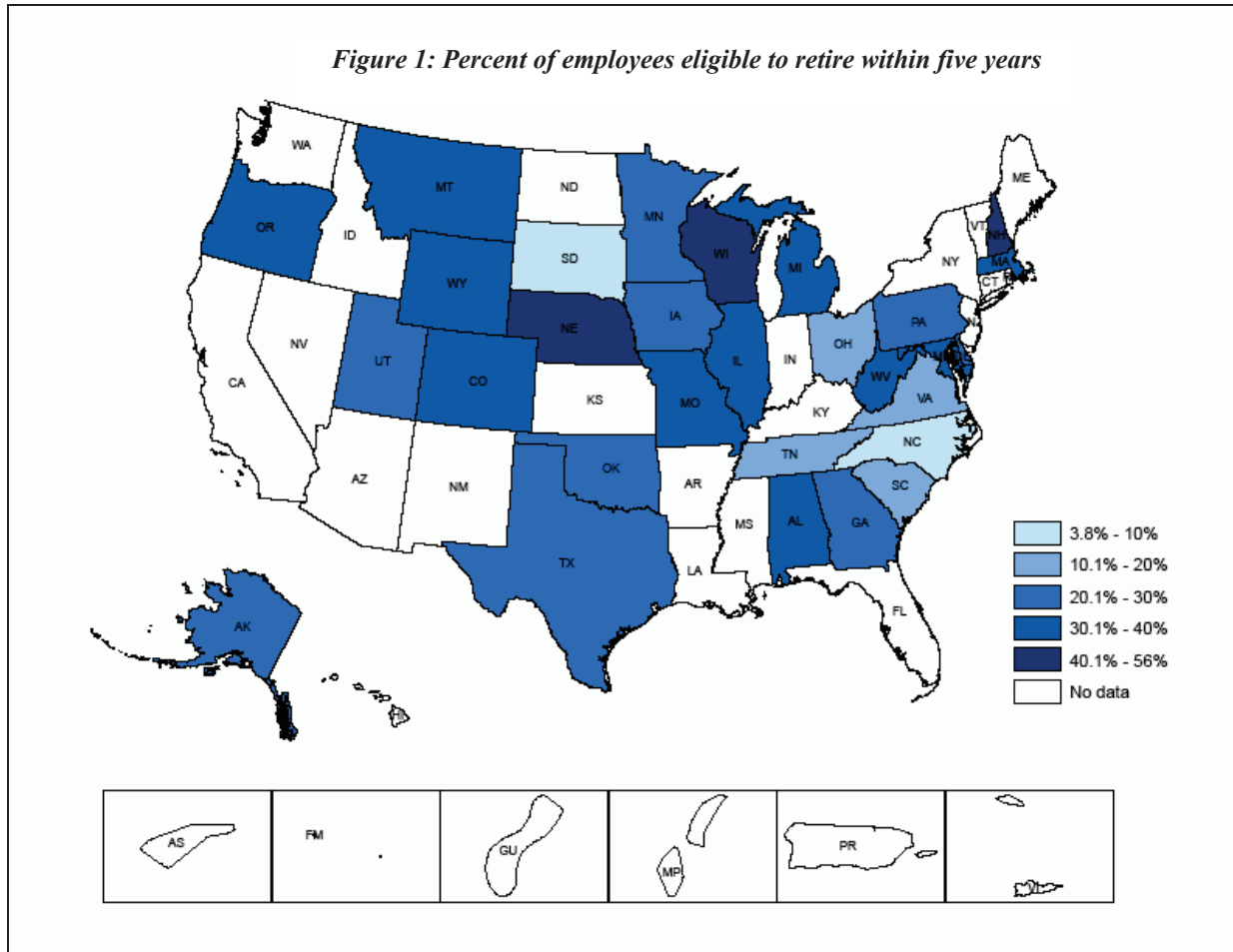
Percent Eligible to Retire

Older workers comprise a large segment of the U.S. labor force. The Bureau of Labor Statistics projects continued growth in the number of retirement-age workers who will continue to work past retirement age.²⁸ According to the AARP Public Policy Institute, “The number of employed men and women aged 55 and older rose by more than 1.3 million in 2005.”²⁹ Approximately one-third (29%) of the public health workforce will be eligible to retire within five years in 28 reporting states. This equates to more than 20,000 state health employees. In some states the aging of the state public health workforce will be even more severe with retirement-eligible workers accounting for more than half of state public health employees (56%).

This is a change from the 2003 ASTHO survey, which indicated that 24 percent of the public health workforce was eligible for retirement, with rates as high as 45 percent at certain state public health

agencies. The 2007 survey findings indicate that although state health agencies have not yet experienced a large departure by retirees, an exodus of highly skilled older workers is inevitable.

The majority of respondents, when asked to project retirement rates at one, three, and five-year intervals, estimated substantial increases of eligibility rates over time. For example, one state will experience a 32 percent increase in public health workers who are eligible for retirement between 2007 and 2012. This trend will significantly impact public health due to the potential loss of institutional knowledge and leadership when older workers retire.³⁰



Percent Who Retire

National trends indicate that older workers are remaining in the workforce longer. “Full-time employment among older workers, especially those aged 65 or above, has actually increased in recent years.”³¹ AARP suggests that higher education levels, increased life expectancy, and an increase in employers creating programs and policies to attract or retain older workers due to labor shortages are all factors that may contribute to older workers postponing retirement.³² For example, in January 2006, fewer than 16% of retirement eligible SHA employees actually retired. This is both a positive and a negative for state health agencies. State public health employees that continue to work after they are eligible for retirement allow SHA to preserve institutional knowledge through mentoring, job shadowing, or succession planning activities. However, when many older employees stay longer it reduces opportunities for promoting other staff and prolongs the inevitable retirement of a large number of people at one time.

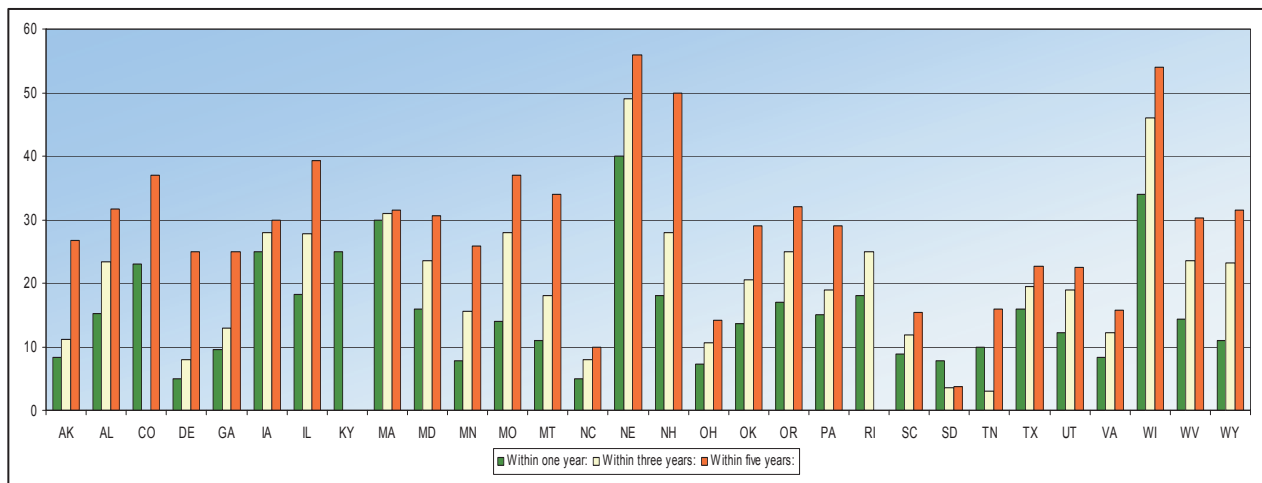


Chart 10: Percent of employees eligible to retire within one, three, and five years

Retirement Policy

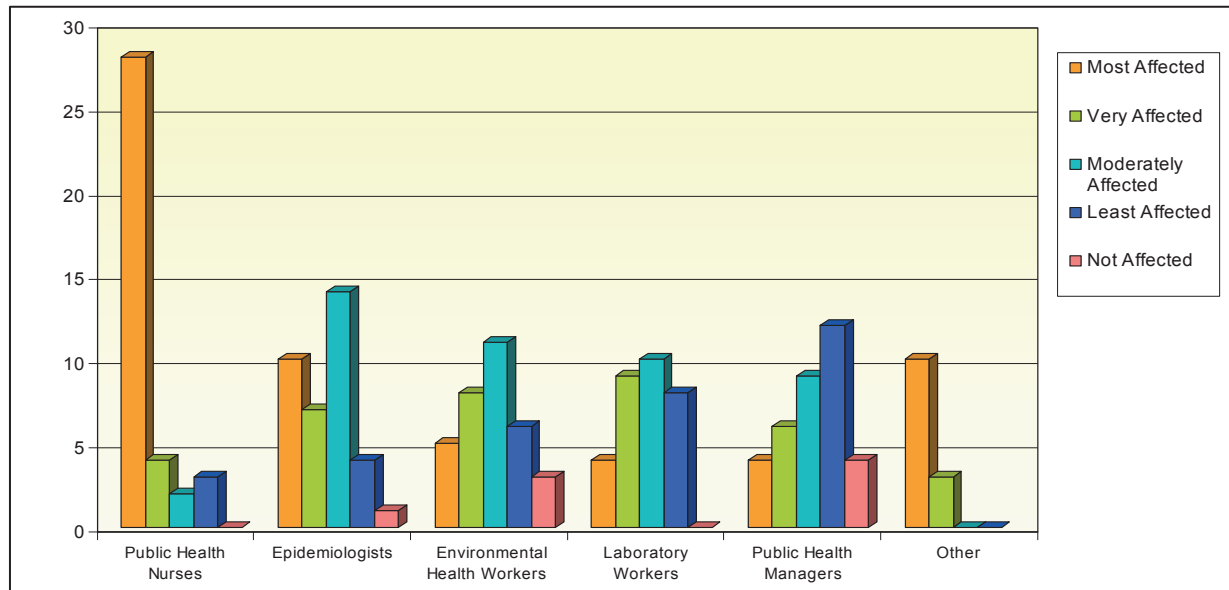
State health agencies have a wide variety of human resource policies relating to retirement and retirees. As older workers prepare to retire, many agencies face the challenge of securing the institutional knowledge and skills of these workers. Some agencies have implemented policies through legislative action or human resource authority to encourage older workers to remain on the job after they retire. Many agencies have become increasingly interested in maintaining relationships with retired staff and preserving their knowledge. Several agencies have developed policies that allow retired employees to return to work without impairing their retirement benefits.

Data from the 2007 ASTHO survey indicates that 88 percent of states are able to rehire retired state public health workers. The three most common job categories for rehire were hourly employees, consultants or contractors with no benefits, and part-time employees with some benefits. Job-flexibility, part-time work opportunities, and non-traditional arrangements were all cited as favorable options by older workers considering their post-retirement choices.³³

In a recent GAO report regarding older workers, “current pension regulations” were cited as a “potential barrier to partial retirement.”³⁴ However, many state health agencies are creating policies that are not punitive to retirees and facilitate the opportunity to return to work on special projects or through special service arrangements.

F. Workforce Shortages

In both the 2003 and 2007 ASTHO surveys, states identified key public health occupation classifications most affected by the workforce shortage. As shown in Chart 11, public health nursing continues to experience the most shortages. Epidemiologists, environmental health workers, and laboratorians are also identified as very-to-moderately affected by workforce shortages. Respondents also identified occupation classes where a shortage may be emerging. Several states identified nutritionists, dietitians, public health physicians, and social workers as workers who are or may shortly be in short supply.



When asked to identify the barriers that remained in overcoming the shortage, responses were

- Budget restraints.
- Lack of competitive wages for public health careers.
- Lack of understanding among recent graduates as to the benefits of public health careers.
- Lack of visibility about the importance of public health careers.
- Bureaucratic processes in selection and hiring qualified candidates.

Until these challenges and barriers are overcome, public health will most likely continue to experience serious workforce shortages.

V. Conclusion & Recommendations

The 2007 ASTHO survey confirms that the public health workforce is aging at a higher rate than the general workforce and that there are not enough trained workers to fill the vacancies left by retirements and other changes. Also, as older more experienced workers retire, a significant leadership gap will continue to grow in governmental public health. The age-related demographic indicators and continuous shortages in public health demand national policy solutions.

ASTHO recommends that local, state, and federal health agencies take a multidimensional, long-term approach to strategic workforce development. This requires strong strategic partnerships between and across public health sectors, as well as outreach to the private sector, academic researchers, policymakers, and the general public.

As countless personal testimonies across the states confirm, a career in public health is personally and professionally rewarding. Public health careers allow individuals to make a difference in the lives of many. However, in the 21st Century, this is not enough. Public health must find new ways to attract graduates and mid-to-high level recruits from the private sector. The security of the nation's health requires solid solutions to rejuvenate the public health workforce and to encourage the next generation of workers to embark on this rewarding career path.

ASTHO and its partners will continue to advance and advocate for innovative solutions to the workforce crisis and renewed investment in public health agencies by:

- Communicating the public health workforce crisis to a wider audience.
- Advocating for increased resources for states and localities to further develop their workforce activities.
- Continuing to study the public health workforce needs through quantitative research and enumeration.
- Identifying activities that replenish the pipeline
- Marketing public health careers and highlighting the benefits of working in public health.
- Supporting improved competitiveness of careers in public health.
- Building partnerships within and outside the public health system.

ASTHO welcomes a dialogue on how to renew the state public health workforce by proposing the following research and policy questions:

- How do public health workforce issues fit into the national voluntary accreditation movement?
- How do we count the state public health workforce?
- How can state public health agencies overcome system constraints to develop innovative recruitment and retention strategies that meet merit system standards?
- Do states with a comprehensive workforce planning program fare better than states that do not?
- How do we market public health careers to increase visibility and invite a broader applicant pool?
- How can we forge new partnerships with corporate partners that create career connections mutually beneficial to the private and public sectors?
- Which workforce development and recruitment strategies create the greatest return on investment?
- What can state public health agencies do collectively promote public health careers?

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2007 State Public Health Workforce Survey Results
FEB 2008
PUB-0712008

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