Association of State and Territorial Health Officials (ASTHO) Testimony
Senate Committee on Appropriations
Hearing on Driving Innovation through Federal Investment
April 29, 2014

The Association of State and Territorial Health Officials (ASTHO) is pleased to submit testimony regarding prevention research and challenges moving public health preventive services forward in the face of shrinking state and federal budgets. Many states engage in research activities, such as collecting, exchanging, or reporting data for a study; disseminating research findings for key stakeholders; and, analyzing and interpreting study findings. This research is key to understanding and targeting vital prevention strategies and advancing scientific investigation on the prevention of social, physical and mental health. However, if states are unable to actively implement prevention strategy methods due to budget cuts on the federal level, the health of the nation will continue to be eroded, and scientific innovation in public health will be held ineffective.

State health agencies provide a variety of population-based primary prevention services. While certain areas of prevention programs increased – i.e. STD counseling and partner notification – the percentage of state health agencies directly performing all other services remained the same or decreased from 2010 to 2012, with the overall trend decreasing. State health agencies also provide a variety of clinical services directly to individuals. In 2012 oral health, pharmacy, and substance abuse education/prevention services were the three clinical services performed directly by the greatest percentage of state health agencies. All clinical services showed a decrease by services provided from 2010 to 2012, with the exception of home healthcare. Both domestic violence victim services and sexual assault victim services showed large drops, and performance of rural health clinical services also dropped 17 percent from 2010 to 2012.

Federal, state and local government budget cuts are jeopardizing a decade of significant gains made by state and territorial health agencies (SHAs). Critical SHA programs and services have been cut or reduced, staff positions have been eliminated, and many staff have been laid off or furloughed. ASTHO has been following this trend since 2008 when it initiated a longitudinal study to investigate the impact of budget cuts on SHAs and the people they serve. The current estimated loss of public health personnel on the state and local level is 50,600 over the past 5 years. The average number of vacant positions at state health agencies is 303, and the average number of vacant positions has increased in recent years from 282 to 304.

Federal dollars on average make up roughly 50 percent of all state public health department revenue, with some as high as 75 percent. Consequently, an average of only 27 percent of state health department dollars comes from state/territory general funds. With some states struggling

and many just starting to turn the corner on the recession, it is difficult for states to make up any additional loss in federal funding for their public health programs. Many states public health departments have faced multiple funding reductions on both the state and federal level. Federal support of vital public health services is key to maintaining a healthy nation. As an example, some of the overall duties of public health departments on a day to day basis are:

Chronic disease. This includes chronic disease prevention such as heart disease, cancer, and tobacco prevention control programs, as well as substance abuse prevention. Also included are disease investigation, screening, outreach, health education, Safe and Drug-Free Schools, health education related to chronic disease, and nutrition education (excluding WIC).

Infectious disease. This includes TB prevention, family planning education and abstinence programs, and AIDS and STD prevention and control. It also encompasses immunization programs (including the cost of vaccine and administration), infectious disease control, veterinary diseases affecting human health and health education, and communications related to infectious disease.

Injury prevention. Including childhood safety and health programs, safety programs, consumer product safety, firearm safety, fire injury prevention, defensive driving, highway safety, mine and cave safety, on-site safety and health consultation, workplace violence prevention, child abuse prevention, occupational health, safe schools, boating and recreational safety.

WIC. This includes all expenditures related to the WIC program, including nutrition education and voucher dollars.

Environmental health. Included here are lead poisoning programs, non-point source pollution control, air quality, solid and hazardous waste management, hazardous materials training, radon, water quality and pollution control (including safe drinking water, fishing advisories, swimming), water and waste disposal systems, mine and cave safety, pesticide regulation and disposal, nuclear power safety. This also includes food service inspections and lodging inspections.

Improving consumer health. This includes all clinical programs such as funds for Indian healthcare, access to care, pharmaceutical assistance programs, Alzheimer's disease, adult day care, medically handicapped children, AIDS treatment, pregnancy outreach and counseling, chronic renal disease, breast and cervical cancer treatment, TB treatment, emergency health services, genetic services, state/territory assistance to local health clinics (prenatal, child health, primary care, family planning direct services), refugee preventive health programs, student preventive health services, and early childhood programs.

All-hazards preparedness and response. Included are disaster preparedness programs, bioterrorism, disaster preparation, and disaster response including costs associated with response such as shelters, emergency hospitals and clinics, distribution of medical countermeasures (vaccination clinics and points of distribution/pods).

Quality of health services. This includes quality regulatory programs such as health facility licensure and certification, equipment quality such as X-ray, mammogram, etc., regulation of emergency medical system such as trauma designation, health related boards or commissions administered by the health agency, physician and provider loan program, licensing boards and oversight when administered by the health agency, provider and facility quality reporting, institution compliance audits. Also included is the development of health access planning and financing activities.

Health data. Include surveillance activities, data reports and collections costs, report production, analysis of health data (including vital statistics analysis), monitoring of disease and registries, monitoring of child health accidents, and injuries and death reporting.

Health laboratory. Included are costs related to administration of the state/territorial health laboratory including chemistry lab, microbiology lab, laboratory administration, building related costs, supplies.

Vital statistics. This includes all costs related to vital statistics administration including records maintenance, reproduction, generation of statistical reports, and customer service at the state/territory level.

States are currently attempting to hold harmless many of the programs they already administer. While there is little room to implement new and innovative preventive health services, states are certainly not maintaining the status quo in delivering public health programs. Even with limited federal and state resources, state public health is moving forward in advancements such as improving birth outcomes, reducing the costly and deadly burden of healthcare-acquired infections, and strengthening the linkage of care between public health and the healthcare system. Public health is also adapting to new challenges in the face of decreased funding. For example, public health is taking on the new challenge of e-cigarettes while continuing to combat the ongoing public health challenge of traditional cigarettes. Also, while immunization funds have decreased, more and more vaccines have been added to the list of appropriate immunizations. While it is vital for prevention research to continue to pave the way for ways in which we can dramatically improve health outcomes, without additional federal investments it will be difficult for state public health to move the needle in dramatic fashion.

Public health is credited with adding 25 years to the life expectancy of people in the United States in the last century. Over the past 50 years, public health successes have included immunizations, healthier mothers and babies, fluoridation of our nation's public water systems, motor vehicle safety, infectious disease control, safer and healthier foods, and workplace safety to name a few. Public health will always continue to strive to meet the next challenge, but states will need the investments from their federal partners in order to forge ahead in protecting the health of all Americans.

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The Association of State and Territorial Health Officials (ASTHO) is the national non-profit organization representing the state and territorial public health agencies of the United States. For more information on federal government relations, please contact Chris Gould, cgould@astho.org, 571-318-5402.