Public-health labs and the 110th Congress

Public-health laboratories rely on federal support for the development and preservation of their capability and capacity to provide diagnostic services in support of “public health.” This support comes primarily from the Centers for Disease Control and Prevention (CDC), but also includes other federal agencies. The change in congressional leadership produced its first impact when the House and Senate conferees agreed to a budget resolution that increased the overall funding for discretionary health (which includes funding for CDC) by $3 billion over FY2007. This agreement on the amount of spending allowed the House and Senate Appropriations Committees to provide more robust funding for the program lines of interest to the public-health laboratory community.

Following agreement on the budget resolution, the House and Senate Appropriations Committees produced Labor-Health and Human Services (HHS) appropriations bills that would increase funding for CDC over both the amount provided in FY2007 and the amount included in the President’s budget request, with specific increased funding in program areas like West Nile virus, tuberculosis, and the environmental-health laboratory that are important to public-health laboratories. As a whole, the funding provided would greatly improve the capacity and capability of public-health laboratories.

The vote margin of the House passage of its Labor-HHS appropriations bill in July — with the funding increases intact — fails however, to answer the question about the success of an effort to sustain or override the threatened presidential veto of the bill. Further, the prospect of a presidential veto is likely to lead to innovative approaches to provide funding in the manner Congress intends. While the process is far from over, the public-health laboratories welcome the prospect of improved federal support in FY2008. In addition to appropriations, Congress is actively pursuing authorizing legislation that improves newborn screening diagnostics and follow-up.

The Newborn Screening Saves Lives Act, S 634 and HR 1634, includes specific provisions that authorize the CDC’s quality-assurance program for the first time and includes a section directing the Secretary of HHS to produce a contingency plan that will enable continued newborn-screening operations when disasters strike.

The Healthy Communities Act of 2007, S 1068 recognizes the importance of significantly increasing state and local biomonitoring laboratory capacity, and provides $50 million in federal support annually for that effort. S 1068, with its focus on building public-health laboratory biomonitoring capacity as well as its strong focus on environmental-health research presents a tremendous opportunity for state and local government to more effectively address chronic and disparate health needs.

Also, there is considerable congressional interest in advancing legislation that improves domestic and global tuberculosis-elimination efforts will also be of significant benefit to public-health laboratories in large measure because federal funding for tuberculosis diagnostics has not increased since 1995. Recent reports on the increased prevalence of drug-resistant strains of tuberculosis highlight the need to improve diagnostics in ways that reduce the time that is required for accurate results.

The challenge of the workforce shortage continues to be an issue for public health and public-health laboratories and passage of S 1882, the Public Health Preparedness Workforce Development Act would make measurable progress in this area.

Increasing congressional awareness of the interaction between public-health laboratories and the Environmental Protection Agency in support of EPA’s preparedness efforts continues to be an important focus for the Association of Public Health Laboratories (APHL). Appropriate funding for the Water Security Initiative, Water Laboratory Alliance and the development of the Environmental Laboratory Response Network are the cornerstones of this initiative.

APHL is extremely pleased to have been actively involved with Congress in its deliberations on these and many other issues, and we look forward to continuing to provide guidance and assistance.

Key congressional public-health facts and findings

- The ability of the public-health system to prevent, respond to, and recover from bioterrorism, acute outbreaks of infectious diseases, or other health threats and emergencies depends upon the existence of adequate numbers of well-trained public-health professionals in federal, state, local, and tribal public-health departments. The public-health system has an aging staff nearing retirement with no clear pipeline of highly skilled and capable employees to fill the void.
- The ratio of public-health workers to the population has dropped from 219 per 100,000 in 1980 to 158 per 100,000 in 2000, while responsibilities of such workers have continued to expand.
- Retirement rates in some state public-health agencies are as high as 20% as of June 2007, and are projected to be as high as 45% by 2008. Nearly 50% of the federal employees in occupations critical to United States biodefense will be eligible to retire by 2012.
- Public-health nurses, with an average age of 50, comprise the largest segment of the public-health workforce. In one state, nearly 40% of the public-health nursing workforce is eligible for retirement as of June 2007.
- As of June 2007, approximately 42% of the epidemiology workforce in state and territorial health departments lacks formal academic training in epidemiology.
- Thirteen state public-health laboratories are without doctoral-level molecular scientists on staff, and 23 have only one. A majority of state health laboratories report they do not have enough staff on board to provide surge capacity in case of a public-health emergency, such as a bioterrorist attack.
- More than 50% of the states cite the lack of qualified individuals or individuals willing to relocate as being a major barrier to preparedness. A Health Resources and Services Association study reported difficulty with recruiting more educated, skilled public-health providers to work in traditionally medically underserved areas, such as rural populations. Public-health agencies continue to identify unmet need for public-health workers who are bilingual and culturally competent.
- Lack of access to advanced education, including baccalaureate nursing and graduate studies, is a significant barrier to upgrading the existing public health workforce, particularly in rural areas.

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