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The Affordable Care Act's Public Health Workforce Provisions: Opportunities and Challenges

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About APHA
The American Public Health Association is the oldest and most diverse organization of public health professionals in the world and has been working to improve public health since 1872. The Association aims to protect all Americans, their families and their communities from preventable, serious health threats and strives to assure community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

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EXECUTIVE SUMMARY

A main tenet of the Affordable Care Act (ACA), the health care reform law signed in March 2010, is to transform our "sick care" system into one that focuses on prevention and health promotion. The success of this transformation largely rests on a sufficiently sized, adequately trained workforce that can provide the community and clinical preventive health services that are needed to promote and protect the nation's health.

Despite the importance of public health to the well-being of society, the workforce responsible for ensuring the public's health faces critical challenges, including:

- substantial decreases in funding, resources, and staff,
- inadequate training, and
- inequitable distribution in areas of greatest need.

The recent economic downturn accelerated declines in the governmental public health workforce. Estimates indicate approximately 44,000 governmental public health jobs at the state and local levels, or 19% of the 2008 workforce, were lost between 2008 and 2010.[1,2] Worker shortages and budget cuts mean public health workers have to do more with less, which exacerbates the already difficult task of worker recruitment and retention, and results in reduced public health services. Among state health agencies, nearly nine out of 10 (89%) cut services between 2008 and 2010.[2]

Recognizing this, the ACA included a set of provisions designed to enhance the supply and training of both the health care and the public health workforces:

Health Workforce Training. The ACA reauthorizes existing programs—as well as creates new programs—that provide loan repayment, scholarships, fellowships, residencies, and other support to new and existing public health and clinical health care workers across workplaces and the educational spectrum.

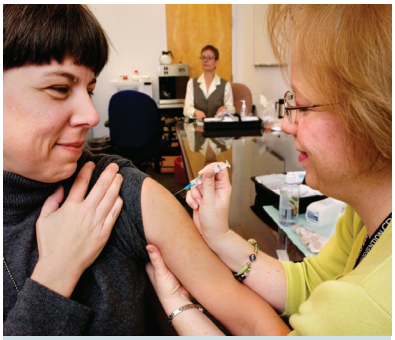
Public Health Infrastructure. The ACA invests in public health infrastructure, providing support for the hiring of public health workers, and enhancing the workforce's capacity to serve the public's needs, particularly in times of health emergencies. Included in these provisions is elimination of the cap on the number of Commissioned Corps members, establishment of the Ready Reserve Corps, and new grants to enhance public health epidemiology and laboratory capacity.

New Public Health Programming. The ACA makes investments in public health and community-based programming to support preventive and health promotion activities that will require trained public health workers. These provisions include Community Transformation Grants and a new home visiting program for new and expectant parents.

Health Workforce Analysis and Planning. The law creates an independent National Health Care Workforce Commission to review current and projected health workforce needs, including those of public health, and to make recommendations to Congress and the Administration on workforce policies. The law also provides support for workforce planning at the state level, and enhances support for the national, state, and regional health workforce analysis centers.

The health workforce provisions in the ACA have the potential to substantially address the training, recruitment, retention, informational, and worker supply needs facing the public health workforce, particularly at governmental health agencies. However, the promise of these provisions will only be fulfilled if they are fully funded. To date only 11 of the 19 provisions described in this document have received funding. And among those that have been funded, the funding levels are substantially lower than authorized (ie. recommended) levels. Furthermore, a majority of the funding has gone towards the clinical care workforce, as opposed to the public health workforce as a whole.

With the fiscal situation only worsening, the future funding situation of the ACA's workforce provisions is very unclear. Public health workers help to create healthier communities—ones with adequate access to preventive health services, and healthy environments at home, school and work. Sustained, adequate funding is needed to make this vision a reality.



Public health workers help to create healthier communities—ones with adequate access to preventive health services, healthy food options at school and work, and a well-educated and prepared workforce to respond to emerging population health threats and natural disasters.

I. Introduction

A main tenet of the Affordable Care Act (ACA), the health care reform law signed in March 2010, is to transform our "sick care" system into one that focuses on prevention and health promotion. The new law sparked an ongoing conversation about how to infuse health promotion and prevention across policies and programs throughout the health care sector. As stated by Senator Tom Harkin, an author of the ACA, "America's health care system is in crisis precisely because we systematically neglect wellness and prevention." The success of these prevention and public health efforts largely rests on a sufficiently sized, adequately trained workforce that can provide the public health and clinical health services that are needed to reorient our public health and health care systems toward prevention. Recognizing this, the ACA included a substantial set of provisions designed to enhance the supply and training of both the health care and the public health workforces. This brief provides a summary of the current challenges faced by the public health workforce, a summary of the ACA provisions that address these challenges, and an examination of key issues moving forward with the implementation of the ACA's workforce provisions.

II. Current Challenges Facing the Public Health Workforce

The public health workforce provides the essential services needed to ensure safe communities and enable individuals to live healthy lives. Despite the importance of public health to the well-being of society, the workforce responsible for ensuring the public's health faces critical challenges, including substantial decreases in funding, resources, and staff; inadequate training; and inequitable distribution in areas of greatest need. This section describes the size and composition of the public health workforce, as well as the trends and challenges facing that workforce as it strives to meet the health needs of the American public.

A. OVERVIEW OF THE PUBLIC HEALTH WORKFORCE

The Institute of Medicine (IOM) defines a public health professional as "a person educated in public health or a related discipline who is employed to improve health through a population focus".[3] While sharing this population-level focus on health, public health workers are employed across multiple types of settings, and represent a range of disciplines, skills, and educational and training backgrounds. Of the estimated 500,000 individuals that constitute the public health workforce, the majority (about 85%) are employed at governmental public health agencies, including the nearly 3,000 local health departments, 56 state and tribal agencies, and the many federal agencies responsible for public health, such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ).[4] The remaining 15% of the public health workforce are employed at nonprofit organizations, academic and research institutions, medical groups and hospitals, and private companies. It should be noted that these numbers are only rough estimates based on agency and employer surveys. Due to its diversity and range of settings, and the absence of funding for enumeration efforts, the exact size and composition of the public health workforce remain uncertain.

The public health workforce includes health educators, program administrators, public health physicians, nurses, veterinarians, dentists, epidemiologists, first responders, food inspectors, laboratory scientists, and environmental health specialists (including sanitarians), among others. Public health workers vary in their educational attainment, ranging in backgrounds from high school to doctoral degrees. Those who have advanced degrees receive training in a range of disciplines and academic settings, including schools of public health, social work, nursing, medicine, allied health, law, public administration, engineering, biology, and journalism.

The public health workforce's focus on population-level health distinguishes it from the health care workforce that provides

Approximately 44,000 governmental public health jobs at the state and local levels, or 19% of the 2008 workforce, were lost between 2008 and 2010 due to the economic downturn.

clinical health care and medical services to treat individuals in clinical settings. That workforce includes physicians, nurses, and allied health professionals such as physical and occupational therapists and radiological technicians. However, there is no clear boundary between public health and health care. For example, many governmental public health staff collaborate with clinicians in the health care sector,[5] and many clinically trained professionals such as physicians and nurses work in public health settings.[3] In addition, nearly 60% of state health officials have a medical degree (M.D. or D.O.).[6] Public health workers, including those employed at governmental agencies and in the private non-profit and for-profit sectors, together with health care workers comprise what can be called the "health workforce."

B. CHALLENGES FACING THE PUBLIC HEALTH WORKFORCE

Despite the importance of public health to the well-being of society, the public health workforce faces critical challenges, including substantial decreases in funding, resources, and staff; inadequate training to address emerging public health needs; and inadequate distribution in areas of greatest need.

Funding problems and worker shortages. Governmental health agencies have suffered from a workforce shortage for over a decade. From 1980, the size of the public health workforce at governmental health agencies is estimated to have decreased by 50,000,[7] despite a 22% (50 million people) increase in population.[8] Achieving in 2020 the workforce ratio of 1980 – 220 public health workers for every 100,000 U.S. residents – would require 700,000 public health workers; the Association of Schools of Public Health (ASPH) projects that the United States will come up short of meeting this goal by 250,000 workers.[7] Although it is not clear that the workforce-population ratio from 1980 is the ideal ratio, the differences in ratios and the dramatic decrease in public health workers over time are striking.

The recent economic downturn accelerated declines in the governmental public health workforce. Estimates indicate that approximately 44,000 governmental public health jobs at the state and local levels, or 19% of the 2008 workforce were lost between 2008 and 2010.[1,2] In the second half of 2009 alone, 46% of local health departments lost skilled public health workers, representing 8,000 jobs lost due to layoffs and attrition, or approximately 5% of the local public health workforce; nearly three-quarters (73%) of the U.S. population live in areas affected by these lost positions.[1] Similarly, according to interviewed experts, in just the last 18 months, public health laboratories witnessed a 10% decrease in their workforce, amounting to 600 laboratory professionals at every level. In addition to job losses, 13,000 local health department employees experienced cuts to working hours or mandatory furloughs in the last half of 2009.[1] One-time funding from the American Recovery and Reinvestment Act (ARRA) and H1N1 supplemental funds helped many health departments bridge funding gaps and maintain jobs in 2009-2010, but these funds are one-time funds. The loss of ARRA and H1N1 funds in the coming year is expected to result in additional job losses.[1]

Remaining workers have increased workloads, and recruitment of new workers is more difficult. Worker shortages and budget cuts mean public health workers at governmental health departments have to do more with less, thereby straining the capacity of the existing workforce and exacerbating the already difficult task of worker recruitment and retention.[9] At governmental health agencies in particular, working conditions can be demanding and difficult, and the salaries and employee benefits at health departments lag behind those in other settings.[9,10] Furthermore, public health agencies face a "graying" workforce. In 2012, nearly

one-quarter (23%) of the current public health workforce, an estimated 125,000 workers, will be eligible to retire.[7,10] By comparison, in 2009, about 88,000 federal employees retired,[11] representing 3% of the total federal workforce of 2.65 million.[12] In 2007, more than half of states reported they had trouble recruiting qualified applicants, particularly nurses.[13] Rural areas have a particularly difficult time recruiting public health nurses, physicians, and dentists when vacancies arise.[14] However, enrollment at master's of public health (MPH) programs has increased,[15] and many Americans report an interest in working in public health at the state or local government levels.[13] It remains to be seen how this growing interest in public health careers affects worker recruitment and retention in governmental, non-profit, and other public health settings.

Lack of training and a career pipeline. Unlike other fields of health such as medicine or nursing, there is no one typical career path or academic preparation for public health.[16] Many public health workers at state, local, territorial, and tribal health departments lack adequate education and training. A 2001 Centers for Disease Control and Prevention (CDC) report found that four out of five public health workers had no formal training for their specific activities.[17] More recently, a 2008 survey found that only 20% of local health departments' top executives held a public health degree.[1] In 2009, about one-third of state health officials had a masters of public health degree.[6] The lack of training in public health at governmental health agencies likely reflects the historical lack of public health training and educational programs, combined with the low proportion of public health graduates who pursue careers in governmental public health. In 2001, the Association of Schools of Public Health (ASPH) reported that there were 29 accredited schools of public health in the United States,[18] with 20,247 applicants; just eight years later, there were 43 accredited schools of public health with 43,368 applicants.[15] In recent years, only 20% of graduates in public health have entered careers at public health departments,[16] contributing to an aging workforce. Although nearly all state health agencies conducted in-house staff training in 2008, only 60% use the IOM-established *Core Competencies for all Public Health Workers*.[6] Further, more than half (57%) of state health agencies' 2009 budget for workforce training and development decreased in 2009, and 30% were anticipating decreases in 2010.[6] Continuous learning or in-service training is less common among local health departments; fewer than half of local health departments have a budget line item for staff training, and fewer local health departments were using the IOM's *Core Competencies* in 2008 than in 2005.[1] Despite the need, there continue to be few training opportunities for the existing public health workforce.[19-22]

Workforce diversity and geographic distribution. There are demonstrated racial, ethnic, and geographic disparities in the public health workforce.[23] Although public health programs have a higher proportion of underrepresented minority applicants and enrollees than other health professions schools, ethnic and racial minority students accounted for fewer than 20% of public health students in 1999, compared to about 28% in the general population.[24] Border counties in particular report unmet needs for bilingual and culturally competent public health staff.[14] Further, few racial and ethnic minority public health workers hold executive positions; in 2008, 93% of local health departments' top executives were White and 98% were non-Hispanic.[1] In addition to exhibiting racial and ethnic disparities, the public health workforce displays significant gaps across geographic areas.[25] A diverse, geographically distributed workforce is needed to meet the health needs of our increasingly diverse population.

C. WORKFORCE SHORTAGES RESULT IN FEWER PUBLIC HEALTH SERVICES

Drastic budget cuts and workforce shortages have forced difficult decisions at state, local, territorial, and tribal public health agencies, often resulting in fewer services. Among state health agencies, nearly nine out of 10 (89%) reduced services between 2008 and 2010, especially programs related to health promotion, disease-specific intervention, and laboratory services.[2] From

July 2008 to June 2009 alone, 55% of local health departments cut at least one public health program; 26% cut three or more.[1,26] These cuts in screenings and other preventive activities will result in higher costs in the long term, as prevention and preventive services save money in the long term.[1] One nationwide survey indicated that, on average, only two-thirds of the core public health activities assessed (including assessment, policy development, and assurance activities) are offered in each community,[27] and several studies have found that the capacity of local health departments to prevent, prepare for, and respond to health threats varies widely across the nation.[9,27,28]

Although there is scant research on how public health workforce shortages and reduced services have affected health outcomes, fewer services and service providers are likely to have, or already have had, negative effects on the health of communities. Research indicates that local health departments with larger staffs and higher per capita funding tend to be higher-performing than departments with fewer staff and financial resources.[29,30] In turn, the performance of local health departments, through public health services such as laboratory analyses and hazard prevention and response, has a substantial influence on community health outcomes, including premature death rates[31] and various measures of mortality.[32] Increases in the number of full-time-equivalents (FTEs) at local health departments per capita are associated with decreases in cardiovascular disease deaths.[33] One recent news article in Nebraska detailed the impact that budget cuts have had on access to prenatal care and screenings; since prenatal care for more than 1,600 low-income women was cut, women are traveling more than 150 miles for prenatal care, and at least five babies have died.[34] A March 2011 *Washington Post* article described how health departments across the country have reduced staff and services as a result of decreased property tax revenues. Reduced funding in El Paso County, CO, stopped the monitoring of air and water quality; in Vermilion County, IL, the public health department cut 35 public health nurses, reducing immunizations and STD screenings.[35] The negative effects of decreased funding and staff on public health are expected to worsen in the near future. As one expert noted, "we haven't seen the wave crash yet; the impacts will be more evident in the next 12 to 18 months."

III. The Affordable Care Act's Workforce Provisions

Recognizing the need for a larger and better trained health care and public health workforce, the Affordable Care Act (ACA) included several provisions designed to enhance the supply and training of this workforce. These provisions can be divided into five sections: Health Workforce Training, Public Health Infrastructure, New Public Health Programming, Health Workforce Analysis and Planning, and Funding. This section summarizes the provisions in the ACA that could support and enhance the public health workforce, and analyzes how these provisions may address some of the challenges described in the previous section. A list of the provisions discussed in detail is provided in Table 1. Throughout this section, we distinguish between authorizations of appropriations (ie. discretionary spending), which require appropriation during future yearly congressional budgeting processes for funds to actually be available for the executive branch to spend; and mandatory appropriations, which are funds directly appropriated by the ACA and which do not require any further congressional action to be available to be spent.

A. HEALTH WORKFORCE TRAINING

The ACA expanded existing and created new programs designed to increase the supply and enhance the training of workers

89% of state health agencies reduced services between 2008 and 2010, especially programs related to health promotion, disease-specific intervention, and laboratory services.[2] 55% of local health departments cut at least one public health program from 2008 to 2009.

across the health workforce. This section first describes the provisions that target public health workers, and then describes provisions targeting the clinical health care workforce.

1. Public Health Workforce Training

Five provisions in the ACA are designed to support the training and education of public health workers in a variety of public health disciplines, including the following two new programs. First, the law created the ***Public Health Workforce Loan Repayment Program*** *(Section 5204)*, a new program in the Department of Health and Human Services (DHHS) that provides up to $35,000 in loan repayment to public health and allied health professionals who agree to work for at least three years at a federal, state, local, or tribal public health agency or fellowship after graduation. Students enrolled in their final year of study or who recently completed a public health or health professions degree or certificate, and have accepted a position or are employed by a governmental health agency or training fellowship, are eligible. Several interviewed experts cited the importance of funding for the loan repayment program, as it would have substantial effects on the recruitment and retention of governmental public health workers because many new graduates are saddled with student debt, and governmental public health positions traditionally pay lower salaries than do similar jobs in the private sector. To train existing public health workers, the ACA created ***Mid-career Training Grants*** *(Section 5206)* for HRSA to provide grants to support scholarships for mid-career professionals in public health or allied health working in federal, state, tribal, or local public health agencies or clinical health care settings to further their education in health. Neither of these two new programs has received any funding through FY2011.

The ACA also reauthorized the existing ***Preventive Medicine and Public Health Training Grants*** *(Section 10501(m)(1))*, which includes both physician residency programs in preventive medicine, and Public Health Training Centers for public health professionals. Administered by HRSA, the program provides grants to support residency training for physicians in preventive medicine, and grants for Public Health Training Centers, which offer opportunities to integrate public health into medical training, as recommended by the IOM.[3] The ACA expanded the eligibility of preventive medicine residencies to allow accredited schools of public health and medicine to partner with hospitals and state, local, and tribal health departments for grants, which can provide residents with opportunities to expand their expertise across settings. During the 2009–2010 academic year, five residency programs supported a total of 39 graduates, of which 36% were from minority backgrounds. Public Health Training Centers focus on continuing education for public health professionals in the core competencies identified by the Council on Linkages between Academia and Public Health Practice for current public health workers. During the 2009-2010 academic year, 181,688 existing public health workers received training at the Public Health Training Centers. The preventive medicine residencies and the Public Health Training Centers together were authorized at $43 million for FY2011. In FY2010, $9 million from the Prevention and Public Health Fund (see section IV) funded nine new awards for an estimated 17 resident physicians during the 2010–2011 academic year. In FY2010, $16.8 million was awarded to support a total of 33 Public Health Training Centers at schools of public health and other public and nonprofit institutions.[36] According to estimates, the President's 2012 proposed budget request of $25 million for the preventive medicine residencies and Public Health Training Centers would train 44 residents and 389,331 existing public health workers.[37]

To alleviate state and local health department shortages of professionals in public health epidemiology, public health lab science, and public health informatics, the law expanded the authorization for the existing ***Fellowship Training in Public Health*** *(Section 5314)* program at the CDC that provides fellowships in epidemiology, laboratory science, and informatics, the Epidemic Intelligence Service (EIS), and other public health science training programs. The stature authorized $24.5 million per year for FY2010 through 2013 for EIS fellowships and $5 million per year each for epidemiology, labo-

Several interviewed experts cited the importance of funding for the loan repayment program, as it would have substantial effects on the recruitment and retention of governmental public health workers because many new graduates are saddled with student debt, and governmental public health positions traditionally pay lower salaries than do similar jobs in the private sector.

ratory, and informatics fellowships. However, in FY2010, only $8 million was appropriated for the fellowships (from the Prevention and Public Health Fund). In FY2011, $250 million from the Prevention and Public Health Fund was appropriated to the fellowships.

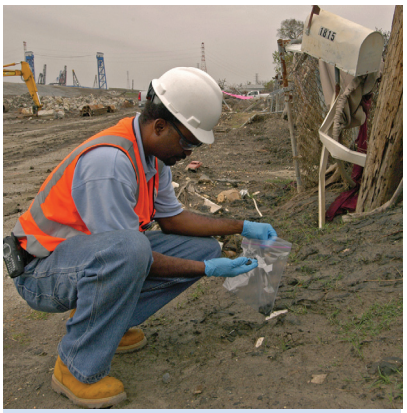
In addition, the ACA created the ***U.S. Public Health Sciences Track*** *(Section 5315)*, a new training track at selected schools of medicine, dentistry, nursing, public health, behavioral and mental health, physician assistance, and pharmacy to award degrees that emphasize team-based service, public health, epidemiology, and emergency preparedness and response. The Surgeon General would administer the track, and participation entails a requirement to serve in the Commissioned Corps of the Public Health Service (see section III, B). The track would be funded through transfers from the Public Health and Social Services Emergency Fund, which provides supplemental funding for health hazard preparedness and emergency response activities, including funds for the Office of the Assistant Secretary for Preparedness and Response (ASPR) and pandemic influenza. In his 2012 budget proposal, President Obama proposed funding the Emergency Fund at $1.3 billion. Virtually all of the funds are allocated to DHHS agencies for award and use in disaster areas, but some funds may be used to support the Track.

2. Clinical Health Care Provider Training

In addition to provisions aimed specifically at the public health workforce, the ACA includes several provisions designed to increase the supply of and enhance training for clinical health care providers—particularly primary care providers—to meet the anticipated higher demand for health care services for millions of newly-insured individuals after 2014. In addition to providing training for health care providers who may work in public health settings, many of these provisions infuse public health concepts into training and educational programs for new and existing clinical health providers.

The ACA expanded and improved the existing ***National Health Service Corps (NHSC)*** *(Sections 5207, 5508(b), 10501(n), 10503)* program, which provides scholarships and loan repayments to primary, dental, and mental and behavioral health care providers who practice in medically underserved areas. The ACA increased the loan repayment amount from $35,000 to $50,000, allowed for part-time service, and allowed recipients' teaching to be counted toward their two-year service requirement. This provision differs from many of the other prevention and workforce initiatives in the ACA in that it includes mandatory funding that is not subject to the annual appropriations process. The NHSC will receive a total of $1.5 billion in mandatory funds from FY2011 through FY2015. For FY2011, the ACA appropriated $290 million, allowing NHSC clinicians to serve an estimated 9.9 million individuals, up from 5.9 million in FY2009. The President's FY2012 budget requests $124 million in discretionary funds for the NHSC in addition to the $295 million in mandatory funds appropriated by the ACA. For FY2012, the administration's target goal is to have 10,683 primary care clinicians in health professional shortage areas compared to 7,530 in FY2010.

To support collaboration between existing primary care providers and public health providers, the law also created the ***Primary Care Extension Program*** *(Section 5405)*, a new program modeled from of the Cooperative Extension Service at the U.S. Department of Agriculture. The program will support and educate existing primary care providers about preventive medicine, health promotion, chronic disease management, evidence-based therapies, and other health care related issues. Local, community-based health workers would serve as health extension agents, providing assistance in implementation of quality improvement strategies or culturally appropriate practices, and link primary care practices to health system resources, including governmental health departments. The University of New Mexico Health Sciences Center's Health Extension Rural Offices (HEROs) is one example of how this program might work in other locales. HEROs link community health needs to university resources to improve population health. HEROs are involved in youth recruitment and community-based workforce training initiatives, and collect data on public health needs and community health status.[38] The ACA authorized $120



Public Health Training Centers focus on continuing education for public health professionals in the core competencies identified by the Council on Linkages between Academia and Public Health Practice for current public health workers. During the 2009–2010 academic year, 181,688 existing public health workers received training at the Public Health Training Centers.

TABLE 1: Public health workforce provisions summary and funding status

TYPE	CATEGORY	PROVISION	SUMMARY	FY10-FY14 ACA AUTHORIZATIONS AND APPROPRIATIONS[1]	FY10-FY14 FUNDING STATUS, FY12 PRESIDENT'S BUDGET REQUEST[2]
HEALTH WORKFORCE TRAINING	Public Health Workforce Training	**Public Health Workforce Loan Repayment Program (Section 5204)**	Creates a new program that provides up to $35,000 in loan repayment for public health professionals who work for a minimum of three years at a federal, state, local, or tribal public health agency.	FY10: $195 m FY11-14: SSAN	
		Mid-Career Training Grants (Section 5206)	Creates a new grants program to support scholarships for mid-career public health and allied health professionals working in public health agencies for advanced education.	FY10: $60 m FY11-14: SSAN	
		Preventive Medicine and Public Health Training Grants (Section 10501(m)(1))	Expands the existing preventive medicine residency program at HRSA to support training to preventive medicine physicians at schools of public health, medicine, hospitals, and state, local, or tribal health departments. The law also expands the Public Health Training Center program at HRSA to support continuing education in core competencies for current public health workers.	FY11: $43 m FY12-14: SSAN	FY10: Prev Med Res: $9 m from PPHF; 27 Public Health Training Centers: $16.8 m ($15 m from PPHF) FY11: $29.6 m ($20 m from PPHF) *FY12 PBR: $25.1 m ($15 m from PPHF)*
		Fellowship Training in Public Health (Section 5314)	Expands the existing health fellowships program to train public health professionals in epidemiology, laboratory science, and informatics, the Epidemic Intelligence Service (EIS), and other training programs that meet public health science workforce needs.	FY10-13: $39.5 m ($24.5 m for EIS, $5 m for each of the other programs)	FY10: $8 m FY11: $20 m from PPHF *FY12 PBR: $25 m from PPHF*
		U.S. Public Health Sciences Track (Section 5315)	Creates a new public health sciences track at selected schools of medicine, dentistry, nursing, public health, behavioral and mental health, physician assistance, and pharmacy to train health professionals in team-based service, public health, epidemiology, and emergency preparedness and response.	FY10 and onwards: SSAN from Public Health and Social Services Emergency Fund	
HEALTH WORKFORCE TRAINING	Clinical Health Care Provider Training	**National Health Service Corps (Sections 5207, 5508(b), 10501(n), 10503)**	Expands the existing National Health Service Corps program, which provides scholarships and loan repayments to primary, dental, and mental and behavioral health care providers who practice in medically underserved areas for a minimum of two years. The law also increased the loan repayment amount from $35,000 to $50,000, allowed for part-time service, and allowed for teaching to be counted toward recipients' service requirement.	FY10: $320 m disc FY11: $290 m mand/$414 m FY12: $295 m mand/$535 m FY13: $300 m mand/$691 m FY14: $305m mand/$893 m FY15: $310 m mand/$1,154 m	FY10: $141 m (discretionary) FY11: $290 m (mandatory) + $141m (discretionary) FY12: $295 m (mandatory); *PBR: $124 m (discretionary)*
		Title VII Health Professions (Sections 5301, 5303, 5307, 5401, 5402, 5403)	Expands the Title VII programs that support training in primary care, dentistry, physician's assistants, and mental and behavioral health providers (Sections 5301 and 5303) and enhances the Title VII workforce diversity provisions, including Centers of Excellence (Section 5401), Area Health Education Centers (AHECs) (Section 5403), and loan repayment and scholarship initiatives (Section 5402), and improves a program to train providers in cultural competency, prevention, public health, and working with individuals with disabilities (Section 5307).	FY10: $390 m total	FY10: $241 m discretionary total for all Title VII Health Professions + $200 m from PPHF for primary care training FY11: $241 m *FY12 PBR: $404 m*
		Title VIII Nursing Education Programs (Sections 5202, 5208, 5308, 5309, 5310, 5311, 5404 10501(e))	Expands the Title VIII programs that support training and diversity in nursing, including student loan programs (Section 5202), grants and scholarships for undergraduate and graduate nursing education and retention (Sections 5308, 5309), loan repayment for nurse faculty (Section 5310, 5311), a new nurse-managed health clinic program (Section 5208), and a new demonstration program for family nurse practitioner training (Section 10501(e)), and grants to help minority individuals complete associate or advanced degrees in nursing (Section 5404).	$338 m total	FY10: $244 m discretionary total for all Title VIII programs + $30 m from PPHF for nursing education FY11: $244 m *FY12 PBR: $313 m*
		Primary Care Extension Program (Section 5405)	Creates a new program, modeled from the Agricultural Cooperative Extension Service, to provide support and information about preventive medicine, health promotion, chronic disease management, evidence-based therapies, and other health care-related issues to practicing primary care providers.	FY11-12: $120 m FY13-14: SSAN	

TYPE	CATEGORY	PROVISION	SUMMARY	FY10-FY14 ACA AUTHORIZATIONS AND APPROPRIATIONS[1]	FY10-FY14 FUNDING STATUS, FY12 PRESIDENT'S BUDGET REQUEST
Public Health Infra-Structure		**Elimination of Cap on Commissioned Corps (Section 5209)**	Eliminates the previous cap of 2,800 for active Regular members of Commissioned Corps members in the U.S. Public Health Service.		
		Establishing a Ready Reserve Corps (Section 5210)	Transfers all of the current members of the U.S. Public Health Service Corps to the Regular Commissioned Corps, and creates a new Ready Reserve Corps consisting of personnel who can assist Regular Corps members in times of emergencies.	FY10-14: $17.5 m	
		Epidemiology and Laboratory Capacity Grants (Section 4304)	Expands the National All-Hazards Preparedness for Public Health Emergencies program by adding a grant program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.	FY10-13: $190 m	FY10: $20 m from PPHF FY11: $40 m from PPHF *FY12 PBR: $40 m from the PPHF*
		Grants to Promote the Community Health Workforce (Section 5313, 10501(c))	Creates a new program for the CDC to award grants to states, local health departments, health clinics, hospitals, or community health centers promote positive health behaviors in underserved communities through the use of community health workers.	FY10-14: SSAN	
		Grants for the construction and operation of School-Based Health Centers (Section 4101)	Creates new grant programs to fund construction and operations of School-Based Health Centers.	Construction: FY10-13: $50 m mandatory each year Operation: SSAN	FY11: $50 m *FY12 PBR: $50 m*
New Public Health Programming		**Maternal, Infant, and Early Childhood Home Visiting Program (Section 2951)**	Creates a new grant program to support states, tribes, and certain nonprofit agencies in funding early childhood home visiting programs, focused on reducing infant and maternal mortality by enhancing prenatal, maternal, and newborn health; child health and development, parenting skills, school readiness, and family economic self-sufficiency.	All mandatory: FY10: $100 m FY11: $250 m FY12: $350 m FY13: $400 m FY14: $400 m	$88 m in mandatory funding released in July 2010
		Community Transformation Grants (Section 4201)	Creates a new program modeled on the Communities Putting Prevention to Work (CPPW) program included in the American Recovery and Reinvestment Act (ARRA) that provides support for evidence-based, community-based activities to promote health and prevent chronic diseases, such as smoking cessation or prevention programs, or enhanced access to nutrition or physical activity.	FY10-14: SSAN	FY11: $145 m from PPHF ($100m in grants released May 2011) *FY12 PBR: $221 m from PPHF*
Health Care Workforce Analyis		**National Health Care Workforce Commission (Sections 5101, 10501(a))**	Creates an independent, 15-member Commission tasked to review health care workforce supply and demand, and make recommendations on national priorities and policies regarding the recruitment, retention, and training of the health care workforce.	SSAN	*FY12 PBR: $3 m*
		National Center for Workforce Analysis (Section 5103)	Codifies and expands the existing National Center for Health Care Workforce Analysis at HRSA and establishes State and Regional Centers for Health Workforce Analysis to research and identify workforce gaps and needs. The Center oversees the State Health Care Workforce Development Grants.	FY10-14: $7.5 m for National Center, $4.5 m for State and Regional Centers	FY10: $2.8 m FY11: $2.8 m *FY12 PBR: $20 m*
		State Health Care Workforce Grants (Section 5102)	Establishes a new competitive grants program to fund workforce planning, development, and implementation activities.	FY10: $158 m, SSAN for subsequent years	FY10: $5.75 m from PPHF *FY12 PBR: $51 m*

1 Funding is discretionary unless otherwise indicated. m=million, SSAN=such sums as necessary, PPHF=Prevention and Public Health Fund. For more information about the Prevention and Public Health Fund, visit: *http://www.healthcare.gov/news/factsheets/prevention02092011b.html*.

2 FY12 PBR= President's Budget Request for Fiscal Year 2012. Note that the President's Budget Request does not guarantee those funds will be appropriated, as final appropriations are made by Congress. For more information about the President's 2012 budget proposal regarding the health workforce, visit: *http://www.hhs.gov/about/hhsbudget.html*.

Most of the ACA workforce programs that have mandatory funding or have received discretionary funds target the clinical health care workforce; only two of the five programs aimed at training public health workers have received funds, and one of these, the preventive medicine residency program, trains physicians.

million for the program for each of FY2011 and FY2012 and such sums as necessary through FY2014. To date, the program has not received funding.

The law reauthorized the ***Title VII Health Professions*** program, which supports the training and diversity of primary care providers, dental health providers, physician's assistants, and mental and behavioral health providers. This includes the primary care cluster—the ***Title VII Family Medicine, General Internal Medicine, General Pediatrics, and Physician Assistantship*** *(Section 5301)* program, which provides grants to develop and operate training programs for primary care physician and physician's assistant training at health professions schools. Because of the ACA, funds can be used to plan, develop, and operate joint degree programs to provide interdisciplinary graduate training in public health, including disease prevention and health promotion, epidemiology, and injury control. The law authorized $125 million for primary care training in FY2010, and such sums as necessary through FY2014. Oral health care provider training had previously been included in the primary care cluster; the law created a separate ***Title VII Training in General, Pediatric, and Public Health Dentistry*** *(Section 5303)* program that provides training, financial assistance, and grants for dental students, residents, hygienists, practicing dentists, or dental faculty in the fields of general, pediatric, and public health dentistry. Grants may be made to support partnerships between schools of dentistry and public health so that dental residents or hygiene students may receive master's-level training in public health. In 2009, the 35 active grantee dentistry programs trained more than 500 residents; the ACA allowed for an expansion of the program to 70 active grantees in 2010. In the ACA, $30 million was authorized for training in dentistry for FY2010, and such sums as necessary through FY2015. These clusters consistently have received funding, in varying amounts. In FY2010, the primary care and oral health care programs together received $54.4 million. Primary care workforce initiatives received additional funding from the ACA's Prevention and Public Health Fund in FY2010: $168 million was awarded to create additional primary care residency slots, and $32 million was awarded to support physician's assistant training. There is evidence that these programs are successful in encouraging providers to practice in underserved areas. The President's FY2012 budget justification reports that in FY2011, 43% of health professionals supported by Title VII entered practice in underserved areas, up from 35% in 2009. President Obama's proposed FY2012 budget requests $139.9 million for primary care training, which would train an estimated 4,000 additional primary care providers over five years, and $49.9 million for oral health care training.

Title VII Health Professions also includes programs that enhance the diversity of the health care workforce. The ***Centers of Excellence*** *(Section 5401)* program, designed to enhance the recruitment, training, and academic performance of minority individuals interested in health careers, was reauthorized, and the authorization was increased to $50 million per year. The President's FY2012 budget requests a continuation of FY2010 and FY2011 funding levels of $24.6 million for the Centers of Excellence. The ***Interdisciplinary, Community-based Linkages*** *(Section 5403)* provision reauthorized Area Health Education Centers (AHECs), which target individuals in urban and rural underserved communities seeking careers in health care or public health. The provision now also includes an option to operate a Youth Health Service Corps. The program was authorized at $125 million per year from FY2010 through FY2014. AHECs were funded at $33.3 million in FY2010, with a slight increase to $34.8 million in the President's FY2012 proposed budget. The ***Health Professions Training for Diversity*** *(Section 5402)* program provides scholarships for disadvantaged students who commit to working in underserved areas as primary care providers, and loan repayment to individuals serving as faculty at health professions schools. The scholarships program was authorized at $60 million for FY2010, but actually received $49.2 million. The President's FY2012 budget requests $60 million. The faculty loan repayment program was authorized at $5 million per year, but only received $1.3 million in FY10, and the President's budget requests

the same $1.3 million level for FY2012. The ACA reauthorized ***Cultural Competency, Prevention, and Public Health and Individuals with Disabilities Training*** *(Section 5307)*, a program to develop and disseminate curricula to support health care provider training to meet the needs of an increasingly diverse patient population, and expanded the program to emphasize training in public health. The program was authorized at such sums as necessary, and has yet to receive funding.

To support and enhance the nursing workforce, the ACA reauthorized and expanded the ***Title VIII Nursing Workforce Development*** programs that support the training and diversity of nurses across the educational spectrum. Title VIII includes: student loan programs *(Section 5202)*, grants and scholarships to undergraduate and graduate nursing education and retention *(Sections 5308, 5309)*, loan repayment for nurse faculty *(Section 5210, 5211)*, a new nurse-managed health clinic program *(Section 5208)*, and a new demonstration program for family nurse practitioner training *(Section 10501(e))*. Title VIII was authorized at $338 million for FY2010 and such sums as necessary through FY2016 *(Section 5312)*. Title VIII also supports ***Workforce Diversity Grants*** *(Section 5404)*, which were expanded to be used to help minority individuals complete associate or advanced degrees in nursing. In FY2010, nursing education programs received $227.7 million and nursing workforce diversity grants received $16.1 million. Also in FY2010, an additional $30 million was allocated from the Prevention and Public Health Fund to support nurse education.[39] The President's FY2012 budget requests a total of $293.1 million in funds for nursing education, and an additional $20 million for Title VIII nursing workforce diversity.

B. PUBLIC HEALTH INFRASTRUCTURE

Several provisions in the ACA focus on increasing the size of the public health workforce. One of these was ***Elimination of Cap on Commissioned Corps*** *(Section 5209)*, which removed the cap on the Commissioned Corps and transferred all Reservists to the active Commissioned Corps. The Commissioned Corps of the U.S. Public Health Service is one of the nation's seven uniformed services. It consists of 11 categories of health professionals, such as physicians, pharmacists, environmental health experts, nurses, veterinarians, and mental health professionals, who work across federal agencies, including the National Institutes of Health (NIH) and the Indian Health Service (IHS). Commissioned Corps members are tasked to respond to public health crises and national emergencies, such as natural disasters, disease outbreaks, or terrorist attacks. Previously, there was a Congressionally mandated cap of 2,800 active members of the Regular Corps. There were an additional 3,200 members of the U.S. Public Health Service Reserve Corps, and another 3,000 inactive or retired members who were not part of the "active" Corps. Reservists were less likely to receive promotions and had less job protection during force reductions than Regular Corps members.[16] The elimination of the Commissioned Corps cap is expected to dramatically increase the number of Commissioned Corps members, although Corps members must now be confirmed by the Senate, and no additional funding was authorized or appropriated to fund an increase in the size of the Corps. To provide support for the ongoing functions of Commissioned Corps members when active Corps members are called away to respond to emergencies, the ACA established a new ***Ready Reserve Corps*** *(Section 5210)*, consisting of personnel who can assist the Regular Corps on short notice for both routine public health and emergency response missions. For each year from FY2010 through FY2014, $17.5 million was authorized for recruitment and training, and to support the Ready Reserve Corps, although no funds have been appropriated to date.

Many public health departments struggle to maintain a sufficient and adequately trained laboratory and epidemiological workforce, and functional, up-to-date equipment. The law expanded the National All-Hazards Preparedness for Public Health Emergencies program by adding the ***Epidemiology and Laboratory Capacity Grants*** *(Section 4304)* program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.

The law expanded the National All-Hazards Preparedness for Public Health Emergencies program by adding the *Epidemiology and Laboratory Capacity Grants* (Section 4304) program to strengthen national epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers.

tional epidemiology, laboratory, and information management capacity to respond to infectious and chronic diseases and other conditions at state, local, or tribal health departments or academic centers. The ACA authorized $190 million per year for FY2010 through FY2013. In FY2010 and FY2011, $20 million and $40 million, respectively, from the Prevention and Public Health Fund supported state, local, and tribal epidemiology and laboratory capacity grants.[40,41] The President's FY2012 budget requests $40 million for the program.

The ACA also created new grant programs to support community health workers and school-based health centers. The ***Grants to Promote the Community Health Workforce*** *(Sections 5313, 10501(c))* is a new CDC program that would award grants to states, health departments, health clinics, hospitals, or community health centers to promote positive health behaviors in underserved communities through the use of community health workers, defined as local individuals who promote health or nutrition in culturally and linguistically appropriate ways, and serve as liaisons between communities and health care agencies. Such sums as necessary were authorized for FY2010 through FY2014, however no funds have been appropriated to date. To increase access to clinical preventive services for children, grants for the construction and operation of ***School-Based Health Centers*** were authorized (Section 4101). The construction grants were appropriated mandatory funds ($50 million each year from FY2010 through 2013). However, the operation grants rely on discretionary funding. They were authorized as such sums as necessary and have not yet received funding.

C. NEW PUBLIC HEALTH PROGRAMMING

The ACA created several new programs to promote local community health and prevent chronic disease which will require a trained workforce. The two main community prevention activities, in terms of funding, are the ***Maternal, Infant, and Early Childhood Home Visiting*** *(Section 2951)* program and the Community Transformation Grants. The ACA created the Maternal, Infant, and Early Childhood Home Visiting program to reduce infant and maternal mortality by enhancing prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, and family economic self-sufficiency. The program is based on previous research on home visiting, which demonstrates positive social and health benefits for expectant and new parents.[42] Like the provision governing the National Health Service Corps, this provision differs from many of the other prevention provisions in the ACA in that it includes mandatory funding. Mandatory funding for the Home Visiting program will total $1.5 billion over the next five years; the first $88 million in grants were released in July 2010.[43] The President's FY2012 budget would provide $329 million to award 56 state and territorial grants and funding for technical assistance, $10.5 million for 18 awards to American Indian tribes, and $10.5 million for research, evaluation, and corrective action technical assistance for states not meeting the benchmarks established by the legislation.

Community Transformation Grants (Section 4201) (CTGs) support evidence-based, community-based activities to promote health and prevent chronic diseases, for example by promoting smoking cessation and prevention, or enhancing access to healthy food and physical activity. The CTG program is similar to the Communities Putting Prevention to Work (CPPW) grants, which were included in the American Recovery and Reinvestment Act (ARRA) in 2009.44 The CTG is a discretionary program, but it has received funding from the Prevention and Public Health Fund – $145 million in FY2011.41 In May 2011, the program announced $100 million in funding to support 75 Community Transformation Grants. The President's FY2012 budget requests $221 million for the CTG program.

D. HEALTH WORKFORCE ANALYSIS AND PLANNING

Numerous public health organizations and researchers have drawn attention to the need for better data about the

The Community Transformation Grants, along with other public health programs funded by the ACA, will require trained public health workers to be implemented successfully.

size, composition, and needs of the public health workforce, both to assess current and projected supply, and to develop workforce planning and training activities.[3,10,25,45] The lack of information and research regarding workforce capacity, shortages, and effective development strategies is recognized across the health workforce generally, and three provisions in the ACA are designed to gather and assess data to enable the workforce to meet the population's health needs. The law created a ***National Health Care Workforce Commission*** *(Sections 5101, 10501(a))* tasked to review the health workforce supply and demand, and to make recommendations on national priorities and policies regarding the recruitment, retention, and training of the health workforce, including public health. The Commission is composed of 15 experts in the health workforce field, appointed by the Comptroller General of the Government Accountability Office (GAO). Beginning in 2011, reports on national priorities and policies are due to Congress and the Administration on Oct. 1 of each year, and reports on high-priority topics are due April 1 of each year. The members of the National Health Care Workforce Commission were appointed on Sept. 30, 2010; however, the Commission to date has not received funding and therefore has not been able to meet. The President's FY2012 budget requests $3 million in funding for the Commission.

Secondly, through the ***Health Care Workforce Program Assessment*** *(Section 5103)*, the ACA codified the National Center for Health Workforce Analysis at the Health Resources and Services Administration (HRSA) and established State and Regional Centers for Health Workforce Analysis. The National Center conducts research on health workforce needs and evaluates federal health care workforce programming, particularly with regard to the Title VII programs described above, and administers the ***State Health Care Workforce Development Grants*** *(Section 5102)*, a new competitive health workforce development grants program. Grants support and enable state partnerships to plan and implement activities leading to comprehensive health workforce development strategies at the state and local levels. In FY2010 and 2011, $5 million of the Prevention and Public Health Fund was awarded to State Workforce Development Grants, which HRSA used to fund 25 states to begin comprehensive planning activities and one state (Virginia) to implement its health care workforce plan.[46] Some of these funds went to support public health workforce research projects at the CDC's two research centers dedicated to the public health workforce: the Center of Excellence in Public Health Workforce Research and Policy at the University of Kentucky's College of Public Health, established in 2008; and the Center of Excellence in Public Health Workforce Studies at the University of Michigan School of Public Health, established in 2009.[47] These efforts will help create a procedure to enumerate the public health workforce that eventually can be scaled to a national level—an important first step in assessing the current public health workforce and identifying gaps and needs. The President's FY2012 budget requests $20 million for the National Center for Health Workforce Analysis and $51 million for State Health Workforce Development Grants in 2012.

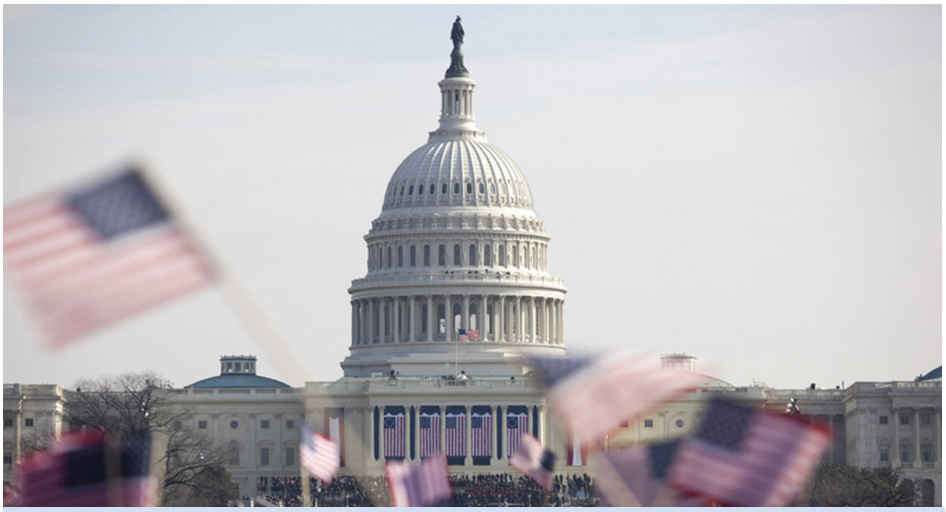
IV. Funding

The health workforce provisions in the ACA have the potential to address the training, recruitment, retention, informational, and worker supply needs facing the public health workforce, particularly at governmental health agencies. The ACA's workforce provisions use a combination of loan repayment, scholarship, fellowship, research, and programming strategies to support existing and new public health and health care workers in a variety of disciplines. However, fulfilling the promise of the ACA's workforce provisions, as with the other parts of the law, depends on whether the law remains intact or is modified, and to what extent its provisions are funded. If fully funded, the ACA's public health and clinical health care workforce provisions would bolster the size and training of the health workforce, and research would produce a better picture of the size, composition, and needs of that workforce. Furthermore, if fully funded, the

Public health workforce research efforts funded by the ACA will help create a procedure to enumerate the public health workforce that eventually can be scaled to a national level—an important first step in assessing the current public health workforce and identifying gaps and needs.

new and expanded public health programming and infrastructure programs would provide an important opportunity to support sustained community-based health promotion and disease prevention activities.

However, prospects for full funding of the ACA's workforce provisions are dim. With the exception of the National Health Service Corps and the Maternal, Infant, and Early Childhood Home Visiting Program, the public health and health care workforce provisions of the ACA are only authorized, meaning they must receive discretionary funds each year through the congressional appropriations process. Unfortunately, the scarcity of resources has prevented the full funding of the workforce and public health programming provisions included in the ACA. To date only 11 of the 19 provisions described in this document have received funding. Of the five public health workforce-specific training programs described above, only two have received funding: the Preventive Medicine and Public Health Training Grant Program and the Public Health Fellowships Program received $33.8 million in FY2010 and $54.6 million in FY2011. Four of these five programs had specific authorization of appropriation lines for FY2010 (vs. "such sums as necessary"). If funded to these authorized levels, these programs would have received a total of $307.5 million; thus, the funds they have received so far are substantially below recommended levels. Seven programs, the Public Health Workforce Loan Repayment Program, the Mid-Career Training Grants, the U.S. Public Health Sciences Track, the Primary Care Extension Program, the Ready Reserve Corps, the Grants to Support Community Health Workers, and the National Health Care Workforce Commission, have not received any funding to date, although funds are requested to support the Commission in the President's FY2012 budget.



Fulfilling the promise of the ACA's workforce provisions, as with the other parts of the law, depends on whether the law remains intact or is modified, and to what extent its provisions are funded.

Most of the funding that has been appropriated for these workforce provisions has come from the ***Prevention and Public Health Fund*** *(Sections 4002, 10401)*, a new mandatory funding stream created by the ACA to expand and sustain investments in prevention and public health programs. The law allocated $500 million to the Fund in FY2010, and gradually increases that amount each year, topping out at $2 billion per year in FY2015 and every year thereafter. Of the $500 million appropriated for the Fund for FY2010, $320 million was used by the Administration to support the health workforce. Controversially, $227 million of the $320 million went to support clinical primary care workforce development, including physician residencies and nurse education,[46,48] despite recommendations by public health groups to focus on public health activities.[49] Nonetheless, $93 million of the $320 was spent on public health workforce training and capacity: $8 million was used to expand the CDC's Public Health Fellowships program, $15 million supported Public Health Training Centers, $20 million went towards the Epidemiology and Laboratory Capacity Grants, and $50 million was used to support performance improvement capacity building in state, local, tribal and territorial health departments through a new CDC initiative entitled the National Public Health Improvement Initiative (NPHII). Of the $750 million allocated to the Fund in FY2011, $125 million is being used to support public health capacity and training, including $40.2 million for CDC's state and local performance improvement capacity efforts, $45 million for public health training initiatives (preventive medi-

The ACA's new Prevention and Public Health Fund has provided key funding for public health and primary care workforce training and support, $320 million in FY10 and $125 million in FY12. However, using the Fund to backfill cuts to public health programs will defeat the purpose of the Fund.

cine fellowships, the Public Health Training Centers, and the Public Health Fellowships program), and $40 million for the Epidemiology and Laboratory Capacity grants. [41] In his FY2012 budget proposal, President Obama requested that $120 million of the $1 billion in mandatory funds from the Prevention and Public Health Fund be allocated to workforce training and capacity: $25 million would support the CDC's public health workforce training programs, $40 million would support Epidemiology and Laboratory Capacity Grants, $40.2 million were requested to support public health infrastructure, and $15 million would support the preventive medicine residency program. The remainder of the Fund monies each year is being used for public health programming and research, which also indirectly supports the public health workforce by sustaining or creating jobs. For example in FY2011 a total of $298 million was allocated to community-based prevention programming, including $145 million for the Community Transformation Grants, and $133 million to research and tracking initiatives.

While the Prevention and Public Health Fund provides a much needed dedicated and stable source of funding for public health, it is a highly controversial element of the Affordable Care Act and vulnerable to political attacks. Starting within months of the passage of the ACA, bills were introduced in Congress proposing to eliminate or defund it, or use it for non-public health purposes. And the Fund continues to be a target for such attacks, either on its own or along with other parts of the ACA. For example, in March 2011, the Health Subcommittee of the House Energy and Commerce Committee held a hearing on changing all mandatory funding in the ACA—including funding for the Prevention and Public Health Fund, NHSC, and home visiting funds—to discretionary funding, which would then be subject to the appropriations process each year.[51] The loss of mandatory funding would be a significant setback to the advances in public health made possible by the ACA.

Even if it is not defunded, the promise of the Fund is also threatened by the need to use it to make up for cuts to CDC and HRSA core funding. Given the current fiscal crisis, most federal agencies, including health agencies, face funding reductions. The final FY2011 Continuing Resolution, approved by Congress on April 14, 2011, cut CDC funding compared with FY2010 levels by more than $740 million, and HRSA by $1.2 billion, including a $600 million reduction in funding for community health centers. Furthermore, the President's FY2012 budget proposed cuts to HRSA and to several CDC programs, including the Public Health Emergency Preparedness Grant Program (-$72 million), and eliminates the Preventive Health and Health Services Block Grant and Built Environment program, with the rationale that these activities will be integrated into programs supported by the Prevention and Public Health Fund. Backfilling these programs using the Fund would defeat the intention of creating an additional funding stream to support new, innovative, community-based prevention and public health programs.

V. Conclusion

The Affordable Care Act reauthorized and created several programs that have the potential to increase the supply and training of the public health workforce, as well as increase our understanding of the capacity and needs of the workforce. Several provisions, including the Public Health Workforce Loan Repayment Program, the Mid-career Training Grants, the Epidemiology and Laboratory Capacity Grants, the Fellowship Training in Public Health, the Preventive Medicine and Public Health Training Grants, and the Commissioned Corps and Ready Reserve Corps, are of particular importance as they help alleviate the longstanding workforce shortages and training needs of governmental public health agencies. However, to date, only some of these

Together, research and advocacy efforts can provide policymakers with evidence that demonstrates the cost-effectiveness of prevention efforts.

provisions have received funding. Most of the health workforce programs that have mandatory funding or have received discretionary funds target the clinical health care workforce; only two of the five programs aimed at training public health workers have received funds, and one of these, the preventive medicine residency program, trains physicians. Although clinicians constitute an important part of the public health workforce, and coordination and cooperation between public health care workers and clinical health care providers is vital in promoting health and preventing disease, there are many other public health professionals who have received less support. With the fiscal situation only worsening, the future funding situation of the ACA's health promotion provisions is very unclear. Public health workers help to create healthier communities —ones with adequate access to preventive health services, healthy food options at school and work, and a well-educated and prepared workforce to respond to emerging population health threats and natural disasters. This is a central part of the vision of the ACA. Sustained, adequate funding is needed to make this vision a reality. Together, research and advocacy efforts can provide policymakers with evidence that demonstrates the cost-effectiveness of prevention efforts, and that funding public health workforce training and capacity is, along with education and transportation infrastructure, a key investment future that will pave the way for our nation's future growth and prosperity.

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