March 20, 2023

The Honorable Bernie Sanders
Chair
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

The Honorable Bill Cassidy, MD
Ranking Member
Senate Committee on Health, Education, Labor and Pensions
Washington, DC 20510

Re: HELP Heath Workforce Shortages Request For Information
HealthWorkforceComments@help.senate.gov

Dear Chairman Sanders and Ranking Member Cassidy:

I write to you on behalf of the Big Cities Health Coalition (BCHC), to provide comment on the Health Workforce Shortages Request For Information (RFI). We appreciate your leadership in seeking solutions to this ongoing challenge that affects not just individual health, but also the health of communities.

BCHC is a comprised of health officials leading 35 of the nation's largest metropolitan health departments, who together serve more than 61 million – or about one in five – Americans. BCHC seeks to advance a shared, actionable vision to transform urban health. In this vision, all government agencies, healthcare providers and systems and community-based organizations work together to promote and produce health, safety and equity.

Our members and their colleagues in governmental public health across the country have experienced firsthand a host of workforce challenges for years. It is clear that long-term and dependable investments will be needed to help both the health care sector and governmental public health departments recover from COVID's toll on the workforce. Capacity to provide the essential public health services, a host of necessary clinical care services, and especially, to respond to public health emergencies including COVID-19, mpox, and the impacts of systemic racism, has been eroding for some time.

A strong emphasis on strengthening local health capacity is necessary to meet our nation's health and prosperity goals, and while a focus on the clinical care sector is necessary, it is not sufficient. To do so we must invest broadly in the health of communities, which means a focus not just on health care but on prevention and policies and systems that can help or harm a community's health.

As you well know, our governmental public health workforce was in a crisis before the pandemic, with local health departments (LHDs) losing over 20 percent of their workforce compared to before the 2008 recession.[i] Over the same period, the nation's population increased by 8 percent.[ii] In 2019, the number of fulltime equivalent governmental public health staff dropped from 5.2 per 10,000 people to 4.1 per 10,000 people.[iii]

Over time, our nation's health challenges have increased, overwhelming our governmental public health and health care delivery capacity. Impending retirements, a mismatch of skills needed and possessed, too few staff who reflect community makeup, and positions tied only to specific disease states/funding streams have led to both a shortage in people power and a lack of innovation to meet new challenges. Further, we have become a nation of sick-care rather than health care, and now is the time to reorient.

In 2021, the *Staffing Up: Determining Public Health Workforce Levels Needed to Serve the Nation* report[iv] found that the governmental public health enterprise needs to add a minimum of 80,000 FTEs, while local health departments in particular need more than 50,000 additional FTEs to provide adequate infrastructure and public health services. This requires a 73% increase over current staffing levels.[v]

It is also important to note that the LHD response to the pandemic has had wide reaching implications for its attention to, and provision of, services beyond the pandemic. Findings from the National Association of City and County Health Official's 2020 Forces of Change survey[vi] show that 82 percent of local health departments reassigned existing staff from their regular duties to COVID-19 response. This tracks with data from the Public Health Workforce Interest and Needs Survey (PHWINS) which found that nearly three quarters of staff at large health departments were detailed to various COVID response roles.[vii] As these data illustrate, the importance of strong staffing levels is not just to respond during public health emergencies but also to sustain response and services to a number of health priorities.

We need a modern, well-resourced, and sustainable health workforce that has the right mix of skills, and one that is made to last. We need to use what we have learned over the past three years about the vulnerability of the health workforce across the board to create a truly robust all-hazards health infrastructure that is able to rapidly and effectively address health issues that may arise, no matter what the epidemic or situation, as well as work day in and day out, to prevent death and disease and build healthier, more resilient communities.

Below are additional health workforce recommendations.

- *Federal Funds to Support the Workforce Must be Sustained and Predictable*
  The "boom and bust" cycle on which we fund, in particular, the public health system is not conducive to sustaining a high level of preparedness or health services and will not build or support lasting capacity needed to fully protect and promote the public's health. Funds must be predictable and sustained so that staffing can be planned for and hired on a "permanent" basis, not always based on the lifetime of a grant.

  The significant one-time investment Congress provided through CDC 's U.S. Public Health Infrastructure, Workforce, and Data Systems Grant,[viii] meant to strengthen public health infrastructure and workforce, is important, and will help. While the one-time $3 billion dollar investment is significant and much appreciated, it alone is not enough to fully close the gap on ongoing basis. Health departments are worried about the significant funding cliff that is to come. Sustainability and flexibility in the use of workforce funds is critical to build long-term capacity in governmental public health, and programs such as this, are a much-needed example of efforts to provide and sustain a trained, ready, and sufficient health workforce. In FY24, we are asking for a $1 billion investment in public health infrastructure 24, which would allow CDC to support governmental health departments to strengthen their foundational public health capacity.

Additionally, an ongoing investment is critical to ensuring that our governmental public health system is prepared for the next pandemic as well as to strengthen the health of our communities every day. We there request enacting a mandatory, annual $4.5 billion Public Health Infrastructure Fund, such as the one proposed in the Public Health Infrastructure Saves Lives Act, to support health departments and to ensure an adequate workforce to effectively implement public health programs. Because public health funding tends to be siloed and disease-specific, there has been little room to invest in the underlying workforce that supports overall gaps and services. Health departments face shortages of cross-cutting staff, such as experts in public health communications, community outreach, and health equity. We also urge members of the Committee to support CDC's public health infrastructure program in annual appropriations.

- *Enumerate the Public Health Workforce to Better Plan for and Address Shortages*
  While the Bureau of Labor Statistics (BLS) provides critical workforce data in other industries, non-clinical public health workforce data is not available at levels to allow for workforce planning, identification of workforce shortages, and other issues ultimately threatening national security and the health of communities. The COVID-19 pandemic highlighted the importance of understanding the size, composition, and compensation of the public health workforce. It is essential to better define, characterize, and count the public health workforce to improve and maintain workforce competency and effectiveness. BCHC joins our public health partners in requesting that Congress appropriate the funds necessary to support a true enumeration of the public health workforce as is provided by other industries. We urge you to direct BLS and CDC to partner to move this forward. National public health workforce experts are ready to start such a project immediately.

- *Efforts Should Build, Support, and Maintain the Existing Workforce*
  We need to invest in a long term, well-funded, well-trained, and diverse health workforce that is reflective of the community and employed by, or detailed long term to, local health departments. This will take sustained and predictable federal funding to create and support jobs that can support core public health functions, work across health department programs (as opposed to being tied exclusively to siloed disease-specific programs), and support the foundational capabilities of health departments,[ix] including assessment and surveillance and access and linkage to health care, so that all Americans can benefit from these efforts no matter where they live.

  Key workforce vacancies among local health departments include informaticians, molecular lab specialists, public health nurses, and epidemiologists, as well as policy, outreach, communications, and administrative support. The latter, which includes legal, human resource, and finance and contract management positions are often excluded from federal grant mechanisms and are an integral part of ensuring that the work can be done in communities across the country.

  A modern, well-resourced, and sustainable health workforce also requires efforts to recruit and retain top talent, whose skillsets are in even higher demand today by those who can pay more than a local government. Employee benefits, competitive salary, and sufficient training, as well as student loan forgiveness, are all critical to achieving this goal. Programs such as the Centers for Disease Control and Prevention's (CDC) Epidemic Intelligence Service (EIS), the Laboratory Leadership Service, the Public Health Informatics Scholarship, and the Public Health Associate Program (PHAP) – as well as a number of HRSA training programs that support a host of health professions – are all critical for building and retaining a talented and skilled health workforce. These programs must be expanded in concert with a broader federal initiative to recruit, train, and retain the next generation of public health and health care professionals.

- *Incentive Students to Enter the Public Health Field*
  We are grateful to Congress for authorizing the Public Health Workforce Loan Repayment Program in the Consolidated Appropriations Act, 2023, but note that it now must be funded to entice people to enter the field and help retain the current workforce. Additionally, we urge the inclusion of language to treat loan repayment akin to that HRSA uses for the National Health Service Corps program whereby they are exempt from federal income and unemployment taxes.

  Further, to enhance CDC's ability to attract talent BCHC urges providing CDC approval for a Tax Code exclusion from gross income for payments made under the CDC Education Loan Repayment Program for Health Professionals (ELRPHP). The exception will relieve CDC of the tax burden on program funds that provide student loan repayment to new employees enabling CDC to use more of its program funds to provide this benefit to more individuals.

- *Leverage Existing Infrastructure at Health Departments and Across Workforce Programs*
  While not a substitute for permanent workforce members employed at the local level, workforce programs based at the CDC, such as the Public Health Associate Program (PHAP) and the Epidemic Intelligence Service (EIS), as well as other detailed federal employees, have been used to extend the capacity of health departments and key partners at all levels of government. This should continue, and the PHAP and EIS programs should be expanded. They provide critical capacity and public health know-how to supplement the current workforce, and many "graduates" of these programs continue their careers in governmental public health. This is true across the health landscape, not just in public health, as HRSA has a number of similar programs. Unfortunately, low pay scales and earning potential often make it difficult for these trainees to stay in communities into which they are placed, and additional effort should be made to help those individuals continue their careers in the communities in which they served.

- *Diversify the Workforce to Reflect the Community*
  The diversity and representativeness of the health workforce is important to create public trust and to achieve optimal effectiveness. In addition, diversity and representativeness support recruitment and retention. All health workforce programs should consider how to best support efforts to increase diversity and open doors of opportunity for all. The growth and retention of the health workforce requires an intentional focus on racial and ethnic, cultural, and experiential diversity to foster trust and confidence, and to improve representation of the diversity found in communities across the country.

We again thank you for this Committee's dedication to these critical issues. We appreciate the opportunity to comment and welcome the opportunity to discuss these issues moving forward. Please do not hesitate to contact me (juliano@bigcitieshealth.org or 202-557-6507) if I can be of further assistance.

Sincerely,

Chrissie Juliano, MPP
Executive Director

[i] NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. https://www.naccho.org/uploads/downloadable-resources/2019-ProfileWorkforceand-Finance-Capacity_final-May-2020.pdf

[ii] Population Reference Bureau, The U.S. Population Is Growing at the Slowest Rate Since the 1930s. https://www.prb.org/the-u-s-population-is-growing-at-the-slowest-rate-since-the-1930s

[iii] NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008. https://www.naccho.org/uploads/downloadable-resources/2019-ProfileWorkforceand-Finance-Capacity_final-May-2020.pdf

[iv] Staffing Up: Determining Public Health Workforce Levels Needed to Serve the Nation, 2021. Bethesda, MD; Alexandria, VA: de Beaumont Foundation; The Public Health Accreditation Board; The Public Health National Center for Innovations.

[v] Ibid.

[vi] Forces of Change Survey, 2020. Washington, DC: The National Association of County and City Health Officials (NACCHO). https://www.naccho.org/resources/lhd-research/forces-of-change

[vii] https://www.cdc.gov/mmwr/volumes/71/wr/mm7129a3.htm

[viii] https://www.cdc.gov/infrastructure/Funded-Jurisdictions.html

[ix] Transforming Public Health through the FPHS, 2022. Alexandria, VA: Public Health National Center for Innovations (PHNCI), a division of the Public Health Accreditation Board. https://phnci.org/transformation/fphs