Written Testimony
House Energy and Commerce Health Subcommittee
Caring for America: Legislation to Support Patients, Caregivers, and Providers
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Statement of Lisa Macon Harrison, MPH
President, National Association of County and City Health Officials

Good morning, Chair Eshoo, Congressman Guthrie, and members of the Subcommittee. My name is Lisa Macon Harrison. I am President of the National Association of County and City Health Officials (NACCHO), the association that represents our nation's nearly 3,000 local health departments. I am also the Director of the Granville-Vance Public Health Department in North Carolina, serving a population of approximately 100,000 residents in two rural counties. Thank you for the opportunity to speak to you today about the critical importance of our nation's local public health workforce and legislative opportunities to support us

I have led our local health department for nearly a decade where each day I see firsthand the incredible contributions of the public health workforce. This was true before the pandemic, whether it be serving new families in our newborn home-visiting program, addressing opioid use, inspecting water sources to ensure they are safe to drink, or improving nutrition through the WIC program.

And it certainly is true now, 20 months into the largest public health challenge of any of our lifetimes. In my district alone, our 12 public health nurses have delivered 35,000 vaccines, which is 50% of the COVID-19 vaccines in our counties. We are contact tracing and testing. We are consulting with local schools and businesses on how to be open and safe. Across the country, staff do this work despite great challenges, increased hours at low pay, severe burnout, harassment from some members of the community, and our public health authority challenged.

The pandemic has also stretched thin our already lean workforce, diverting resources from addressing the community's health priorities such as regular immunizations, sexually transmitted infections, maternal health, and vector control, to work on COVID-19 response. Preliminary findings from NACCHO's 2020 Forces of Change survey show that over 80% of local health departments reassigned existing staff from their regular duties to the agency's COVID-19 response. This highlights the importance of strong staffing levels not just to respond to the pandemic, but also to rebuild the many other health department priorities that have been impacted by the response.

Our workforce is our most critical asset. However, a decade of disinvestment leading up to the pandemic meant that health departments were understaffed and overworked long before the crisis hit.

Across the board, governmental public health was hit hard by the Great Recession, and whereas much of the rest of the public sector workforce recovered or grew, local and state health departments did not. NACCHO's Profile of Local Health Departments, a census of the field, found that between 2008 and 2019, local health departments lost over 20% of their workforce capacity, when accounting for

population growth.[1] State health departments also saw their job rolls shrink, losing nearly 10% of their workforce from 2012-2019.[2] These job losses are compounded by the state of the governmental public health workforce. Before the pandemic, a survey of health department staff found that nearly half were projected to leave the field in the next five years due to retirement or to pursue opportunities in the private sector.[3] These challenges have only increased during the pandemic, as staff are burnt out and tired after serving on the front lines of the pandemic response for 20 months with much more work to do. The effort required to date takes a toll: A Center for Disease Control and Prevention study found that over a two week time period this spring, 53.0% of public health department worker respondents reported symptoms of at least one adverse mental health condition, including symptoms of depression, anxiety, PTSD, and suicidal ideation.[4] The incredible work has also gained notice in other sectors, and their skill sets are more valued than ever. Many health departments have seen their staff recruited out of the field for more lucrative positions in local hospitals or the private sector. We expect this migration out of governmental public health to be more acute when the pandemic ends, as many of my colleagues have stated that they are committed to stay the course during the crisis but leave when the threat is abated.

We have also seen the politicization of the response take a toll, both on the broader workforce and on health department leaders. In fact, a NY Times report published just last week found that over 500 local health department leaders have been fired, retired, or resigned since the beginning of the pandemic, leaving holes in health department leadership across the country.[5] While it is more difficult to track broader staff departures across the country, we know that turnover is up across communities and some health department staffs have shrunk during the pandemic.

This is playing out in communities across the country. In Atlanta, Georgia, a colleague lost at least 20% of her nursing workforce to state contract options that were more financially competitive. In other states across the country, private consulting firms are being engaged at more than twice the short term investment than local health departments. I have seen firsthand the turnover rate increase at my local health department Granville-Vance Public Health. My staff have been with me for years, some more than 20 years. Our annual turnover before the pandemic was 2 – 5% per year. In the last two years I have seen that turnover rate increase to 10 – 12%. In rural areas like the district I serve, recruitment for

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[1] National Association of County and City Health Officials, "NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008." Research brief, May 2020. https://www.naccho.org/uploads/ downloadable-resources/2019-Profile-Workforce-and-Finance-Capacity.pdf

[2] Association of State and Territorial Health Officials, "New Data on State Health Agencies Shows Shrinking Workforce and Decreased Funding Leading up to the COVID-19 Pandemic." Press release: September 24, 2020. https://astho.org/ Press-Room/ New-Data-on-State-HealthAgenciesShows-Shrinking-WorkforceandDecreased-Funding-Leading-up-totheCOVID-19-Pandemic/09-24-20/

[3] Robin N, Castrucci BC, McGinty M, Edmiston A, Bogaert K. Local Public Health Workforce Interests and Needs in 2017: A Nationally Representative Benchmark of the Local Governmental Public Health Workforce. JPHMP. 2019; 25:S16-S25. https://phnci.org/uploads/resource-files/Staffing-Up-Research-Brief.pdf

[4] 3 Bryant-Genevier J, Rao CY, Lopes-Cardozo B, et al. Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID19 Pandemic — United States, March–April 2021. MMWR Morb Mortal Wkly Rep 2021;70:947–952. DOI: http://dx.doi.org/10.15585/mmwr.mm7026e1

[5] Baker, Mike, Ivory, Danielle. Threats, Resignations and 100 New Laws: Why Public Health Is in Crisis. (2021) Retrieved from https://www.nytimes.com/2021/10/18/us/coronavirus-public-health.html

positions like nutritionists, nurses, and environmental health specialists is extremely challenging and filling vacant positions takes months.

The public health workforce crisis needs your attention – not only to get us through the pandemic and recovery, but also to do the many other critical tasks needed to keep communities healthy and safe across the board. In order to build a public health workforce for the 21st Century, we must focus on three key factors: retaining trained staff, recruiting top talent, and expanding the workforce with predictable, sustainable funding.

That is why we are so appreciative that you are considering a bipartisan piece of legislation that would make a meaningful impact in these efforts: H.R. 3297, the Public Health Loan Repayment Act. This bill, led by Representatives Crow, Dr. Burgess, Guthrie, and Chair Eshoo, would create a loan repayment program for public health professionals who work at a local, state, or Tribal health department for at least three years. The program would cover a wide range of disciplines and background, helping to ensure that it meets the skillsets needed by the hiring health department. It is modelled after the successful National Health Service Corps, which helps support the clinical health care workforce, and would be the first dedicated program to help recruit and retain top talent into health departments, where they are so desperately needed.

We have heard from health departments large and small about the important role such a mechanism could have in recruiting and retaining new staff to the health department. Moreover, it has support from over 100 stakeholder groups, including public health organizations, medical associations, academic organizations, labor, and consumer groups.[6] We hope to have your support as well.

While this legislation is a critical component to recruit and retain new talent into local, state, and Tribal health departments, I must also highlight two additional issues that need your attention and assistance.

First, we need to invest more in health departments to expand the employee base. While the public health loan repayment bill will help recruit new staff, local, state, and tribal health departments need predictable, sustained, and disease-agnostic funding to bring back the positions we have lost and support optimal staffing levels. According to a new analysis by the de Beaumont Foundation and the Public Health National Center for Innovations, the nation needs 80,000 more sustained full-time-equivalent positions in local and state health departments to provide basic community services. This does not include the staff needed to fulfil disease-specific programmatic needs. Further, based on existing shortages, approximately 54,000 of these additional full-time-equivalents should be deployed to local health departments, and the most acute needs are in local health departments, specifically those that serve fewer than 100,000 people.[7] Federal COVID-19 pandemic emergency funding has been critical to get to this point of the pandemic, but it is temporary and narrowly targeted to the response. As we have seen before, crisis funding comes during the emergency, but quickly fades, leaving us in the same position or worse. Sustained federal resources to invest in the public health infrastructure are critical to ensure we have the workforce in place that is needed not just during the pandemic, but into the future.

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[6] National Association of County and City Health Officials, "Keep Communities Healthy by Investing in the Public Health Workforce." https://www.naccho.org/uploads/downloadable-resources/Workforce-COALITION-2021.pdf

[7] deBeaumont Foundation, Public Health National Center for Innovations, "Workforce Levels Needed to Provide Basic Public Health Services for All Americans," Research Brief: October 2021. https://phnci.org/uploads/resource-files/Staffing-Up-Research-Brief.pdf

Second, we must do better to increase salaries and benefits for public health department staff and offer those already in the pipeline a career ladder to stay in the field. Federal policy plays a role here as well, as jobs tied to specific federal programs often pay less than a living wage. For example, my staff in the Women, Infant and Children Nutrition Program (WIC) have just been moved up to $15 per hour by making local adjustments. Local public health workforce positions are important to fill - and we have to AT LEAST be able to pay a living wage in areas across the rural-urban continuum.

The challenges facing the public health workforce are incredible, but with your help we can make a meaningful impact to support them, while they support the communities in which we all live. On behalf of the entire public health department workforce, thank you for your attention to these issues and for your consideration of the Public Health Loan Repayment Act today. I am happy to answer any questions.