Ensuring a Strong Public Health Workforce for the 21st Century: Reflections on PH WINS 2017

Paul K. Halverson, DrPH, FACHE

The success of any organization can be attributed to one thing: its people. This is particularly true for local health departments (LHDs) and state health agencies (SHAs), as the public health workforce is fundamental to achieving organizational goals and improving the health outcomes of populations.

The Public Health Workforce Interests and Needs Survey (PH WINS) is one of the best new tools we have at our disposal to monitor and evaluate the state of the public health workforce www.phwins.org. The insights and research enabled by PH WINS allow us to address training gaps, improve working conditions, and better incentivize qualified workers to enter and stay in governmental public health. I encourage readers to delve into the research to learn more about demographic shifts, workforce training gaps, and drivers of satisfaction.

The replenishment of the workforce is one of the most pressing issues for public health system leaders today. More than a third of SHA respondents indicated that they are considering leaving their organization in the coming year, and a whopping 22% plan to take a job outside of governmental public health. More than one-fifth of LHD survey respondents intend to leave their organizations in the next year for reasons other than retirement. Salary, lack of opportunities for advancement, and workplace environment were cited as the top 3 reasons agency respondents wanted to leave regardless of governmental level or supervisory status.

Author Affiliation: *Richard M. Fairbanks School of Public Health, Indianapolis University–Purdue University Indianapolis, Indianapolis, Indiana.*

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Correspondence: *Paul K. Halverson, DrPH, FACHE, Richard M. Fairbanks School of Public Health, Indianapolis University–Purdue University Indianapolis, Health Sciences Bldg (RG), 1050 Wishard Blvd, Floors 5 and 6, Indianapolis IN 46202 (pkhalver@iu.edu).*

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These data points reveal a workforce cliff that we are quickly approaching. Preemptive steps can be taken to replenish the human capital that is so crucial to governmental public health. Concerted efforts to address the public health workforce's identified dissatisfaction with salaries, job security, career development, training, communication, and workload will improve employee retention and, consequently, agency performance.[1]

Most of us who have been in executive leadership roles within public health are quite used to public health being an underappreciated and underfunded endeavor. Dissatisfaction with low compensation is a direct function of inadequate public health funding. But those of us who lead public health agencies and who do research in public health practice bear a responsibility for this chronic complaint. If we look at most states and counties where public health enjoys strong support and funding, we will discover years of work in demonstrating the value and specific benefits of public health. I am also not convinced that sufficiency of funding should be classified as a partisan issue, but rather as a symptom of dysfunction where inadequate attention to building public health infrastructure is evident. The onus is on everyone in governmental public health to embrace this early warning sign of the impending workforce crisis and redouble our efforts for a fundamental job and compensation system redesign.

Most of our civil service laws and policies were written for governmental public health systems decades ago. I am reminded by our former esteemed leaders that public health was the place to go when you were looking for a stable and secure, low-stress, nine-to-five job. Work has changed dramatically. The demand for highly trained public health workers who are able to handle high pressure, around-the-clock work is fundamentally different from that of many of the bureaucratic positions of years gone by. Not that public health in any generation was boring; we can easily look back on many critical challenges and effective responses that represent the major public health victories of the last century. What I am referring to is the new age of "big data"

and predictive analytics, the mandate for community-engaged research and intervention, and vigilant public health emergency response duties. New threats and greatly enhanced responsibilities along with competition for trained and experienced public health professionals require a new look at both the structure and salary levels of professional positions throughout our agencies.

In addition to increased compensation packages, efforts can be undertaken to improve working conditions. Increasingly, workers today are not planning to retire from the job in which they are currently employed. Many work experts expect the average person will experience 5 to 7 or more jobs in their career. These workers do not conform to a time clock or rigid schedules. They expect collaborative team projects and creative jobs as well as job sharing, remote work, and flexibility in meeting their goals at work.[2] They also expect generous family leave and a high level of sensitivity to work-family balance.

As we move our organizations to address the goals related to health equity, we need to assure our workforce that we are culturally competent and that diversity in the workplace is valued. Historically, bureaucratic organizational structures and personnel management practices need serious modernization. Those of us in senior public health management need to quit rolling our eyes and figure out ways to adapt.

PH WINS data also describe the lack of opportunities for advancement as a motivation for leaving. Budgeting and financing knowledge were cited by 55% of survey respondents. This may be one of the biggest gaps holding back otherwise promising candidates for promotion and speaks to a need to increase the financial literacy of supervisory workers. Public health agencies, accreditation bodies, schools, and programs need to ensure that students are offered and are enrolling in courses that will leave them well-versed in financial analysis methods and funding mechanisms. Moreover, a workforce that is adept in financial concepts will result in system-wide dividends in the form of a more cost-effective delivery of public health services. A large part of the solution lies in continuing education, whether that be on-site or provided via partnership with local colleges and universities.

To adequately address ever-changing training gaps, we need to continue to bridge the gap between health agencies and our increasing number of accredited schools and programs in public health. There is still a significant disconnect between agencies and the institutions that are tasked with educating the public health workforce. Governmental public health is primarily made up of employees with no formal public health training. Despite record numbers of accredited schools and programs, we have not made progress in significantly increasing the number of people working in governmental public health with a public health degree. Given the substantial new capacity of schools and programs granting public health degrees, we must look for system-wide solutions to solve the mismatch between governmental public health positions and new public health graduates.

In light of the impending turnover of the workforce, there is considerable need to pursue programs and policies that incentivize graduates to enter and stay in governmental public health positions. Pipeline programs such as the Centers for Disease Control and Prevention (CDC)–funded and Columbia University–hosted Summer Public Health Scholars Program serve as examples of effective programs that can attract some of our nation's brightest and most promising students to public health.[3] Targeted pipeline programs can increase the demographic diversification of a workforce to better reflect the diversity of the populations they serve.

To offer career opportunities more broadly, I suggest the expansion of the United States Public Health Service (PHS) to state, tribal, local, and territorial (STLT) health agencies. One way to do this is to expand the use of direct assistance mechanisms in federal grants that offer the opportunity to work in a variety of settings and pursue a career with a continuity of retirement benefits and increasing career opportunities. CDC's demonstrably effective Public Health Associates Program is a model that can be adopted and modified for use by others. Aggressively growing the Commissioned Corp to include trained public health professionals routinely assigned to LHDs and SHAs could also build on the successful model of the CDC Epidemic Intelligence Service (EIS) program. In EIS, epidemiologists provide critical expertise under the direction of state or local management with links to CDC. Rather than finding ways to substantially cut the Commissioned Corp, as some would suggest, we should explore radical new ways to expand and modernize its function and make it a primary source of the public health workforce.

The insights provided by PH WINS should empower us to strategically address workforce issues and to ensure a happier, more engaged, and more productive workforce. That public health now has a recurring survey as comprehensive as PH WINS is a testament to the progress made in workforce monitoring, evaluation, and improvement. PH WINS is invaluable to understanding the characteristics, strengths, and weaknesses of the governmental public health workforce.

I also offer a special salute to the de Beaumont Foundation for its insight into funding and designing PH WINS and the partnership with the Association of State and Territorial Health Officials and the

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