



March 20, 2023

The Honorable Bernard Sanders  
Chair  
Committee on Health, Education, Labor  
and Pensions  
United States Senate

The Honorable Bill Cassidy, M.D.  
Ranking Member  
Committee on Health, Education, Labor  
and Pensions  
United States Senate

Dear Chair Sanders and Ranking Member Cassidy,

Thank you for the opportunity to respond to your [Request for Information](#) on the drivers of health care workforce shortages and potential solutions.

The Commonwealth Fund supports independent research on health care issues and makes grants to promote better access, improved quality, and greater efficiency in health care, particularly for society's most vulnerable, including people of color, people with low income, and those who are uninsured.

Below we offer a range of legislative opportunities informed by Fund-supported research that would strengthen the workforces for public health, behavioral health, and primary care.

### **Public Health**

Public health is "[what we as a society do collectively to assure the conditions in which people can be healthy](#)." The fallout from the COVID-19 pandemic underscores the need to improve the conditions necessary for health and well-being in our communities—starting with a well-staffed and well-resourced public health system.

Building a diverse, well-trained public health workforce is crucial to make progress on pressing issues facing our communities every day, including addiction, overdose, and maternal mortality. The [Public Health National Center for Innovations Staffing Up project](#) estimates 80,000 new state and local positions are needed nationwide to meet foundational public health services.

Chronic underfunding of public health, which has persisted since long before COVID-19, has left our health departments understaffed and overworked. Historically, public health has experienced a "boom and bust" cycle of budgeting, with surges in federal funding in response to emergencies followed by budget retrenchments. This cycle makes it hard for state and local public health agencies to invest in long-term capacity building.

The [most detailed estimate of the funding needed](#) for state and local health departments to provide [basic services](#) suggests that the United States should spend at least \$32 per capita for these services. However, average per capita spending is currently \$19, producing an overall shortfall of \$4.5 billion annually. These figures are an underestimate, as they are based primarily on personnel and do not include other aspects of core infrastructure such as material, equipment, or training.

Making these investments now will better prepare us to effectively respond to public health emergencies of the future. To that end, the [Commonwealth Fund Commission on a National Public Health System](#) presents a vision for a robust and sustainable public health system built on organizing agencies, increasing funding, formalizing processes, and improving public trust. The [Commission's report](#) includes the following federal policy recommendations to build a stronger public health workforce.

To enable a strong and capable national public health system, the Department of Health and Human Services (HHS) should carry out a comprehensive workforce strategy consisting of investments in the state, local, tribal, and territorial (SLTT) public health workforce and several fundamental workforce initiatives. As part of such a strategy, the Committee should consider the following:

1. Authorize sustainable funding for core public health infrastructure and public health IT modernization around the country, based on best estimates of needs. As explained in the Commonwealth Fund Commission report, these are approximately \$4 billion for core public health activities and \$3.5 billion for IT modernization annually. If possible, these funds should be mandatory appropriations.
2. Require the Centers for Disease Control and Prevention (CDC) to measure and report on the [foundational capabilities](#) of health departments receiving public health infrastructure funding and authorize CDC to tie the receipt of federal funding to progress in achieving foundational capabilities. This includes the \$3.9 billion workforce and public health infrastructure investment now being managed by CDC.
  - Emergency preparedness rests on a foundation of effective day-to-day public health functioning. The foundational capabilities framework has been adopted by Indiana, Ohio, Kentucky, Washington, and other states to measure improvement in core public health protections. CDC can accelerate this progress by directing key funding to these foundational capabilities through its grants, contracts, and cooperative agreements including but not limited to the Public Health Emergency Preparedness (PHEP) cooperative agreement.
3. Direct HHS to expand and modernize its workforce programs to make it possible to detail more federal staff to SLTT agencies.
  - This effort should include the Epidemic Intelligence Service and the U.S. Public Health Service Commissioned Corps. Its dual goals should be to expand the workforce and expertise available to health departments while improving the

development, coordination, and implementation of federal programs as these staff rotate back to their HHS agencies. HHS should promote diversity in this effort, alongside training on effective community engagement strategies. A companion program should bring SLTT personnel to the federal government.

4. Direct HHS to establish a national continuing education and training system for public health, in coordination with schools and programs of public health and together with SLTT health partners.
  - To promote multisector collaborations, this system should also address education of personnel in agencies outside the traditional boundaries of public health such as education, housing, and criminal justice. Over time, health departments could use this system to credential individuals for particular roles.

## **Behavioral Health**

There is a mismatch between the demand among people seeking behavioral health care and the supply of behavioral health providers in the U.S., with [160 million people living in one of the 6,602 mental health professional shortage areas](#). The workforce shortage stems from a [variety of issues](#), including low pay relative to the costs of education, administrative burden, high caseloads, lack of quality supervision, and poor organizational culture.

Meeting people’s behavioral health needs along the full continuum of care—from prevention to recovery—requires a more diverse workforce that includes those with shared lived experience. Recruiting, integrating, and retaining the paraprofessional workforce—including certified peer support specialists and community health workers—is an important part of providing culturally appropriate care and supporting long-term recovery. [Evidence indicates improved outcomes and cost savings](#) from engaging paraprofessionals in care teams. Building career ladders for paraprofessionals in addition to traditional ways of supporting the behavioral health workforce (e.g., loan forgiveness) are key to cultivating a high-quality behavioral health system that meets the full continuum of patients’ needs.

To expand and diversify the workforce, the Committee should consider the following:

1. [Provide support and technical assistance](#) to states, commercial payers, and health care providers on integrating peer support specialists and other behavioral health paraprofessionals into behavioral health payment and delivery systems.
2. Provide funding and technical assistance to help states, payers, and providers integrate behavioral health care into different settings that meet people where they are—particularly [primary care](#), schools, and [rural settings](#). For instance, Congress could offer grants to support primary care providers’ upfront implementation costs as they set up integrated models of care.

- [Research suggests](#) primary care physicians can treat patients with mild to moderate depression just as well as psychiatrists. Training and supporting primary care providers to offer some behavioral health services could help address the nationwide shortage of specialist providers. Models like the [collaborative care model](#) enable primary care providers and behavioral health care managers to meet the needs of patients with mild to moderate conditions, while allowing the limited specialty care workforce to focus on those with more severe and complex needs.
3. Expand training grants and loan forgiveness programs that strengthen and diversify the behavioral health workforce, as well as encourage providers to work in underserved communities.
- [Forgiving student loans for individuals working in nonprofit organizations](#) encourages behavioral health professionals to work in organizations serving the nation’s at-risk youth and families.
  - Congress could provide funding for centers like Nebraska’s [Behavioral Health Education Center](#) (BHECN), which established behavioral health career pathways and mentoring programs to [engage rural high school students in behavioral health careers](#) and provide funding for graduate school and residency. The BHECN projects include funding clinical supervision, licensure application reimbursement, workforce recruitment and retention projects for students and behavioral health professionals, telehealth support in rural areas (including funding for equipment), and training opportunities.

## **Primary Care**

Accessible, quality primary care is the foundation of a high-performing health care system. [Decades of evidence](#) shows that primary care is associated with [decreased hospitalization](#), higher patient satisfaction, and [greater equity](#) in health outcomes.

However, gaps in compensation and the undervaluing of primary care services over time has created a shortage of primary care providers, with more physicians choosing to enter higher-paying specialties. These trends necessitate a major shift in not only *how much*, but also *how* we pay for primary care.

These payment reforms should also be coupled with stronger investments in training programs that ensure culturally competent and accessible care for all communities.

The [Commonwealth Fund Task Force on Payment and Delivery System Reform](#) included the following workforce-related recommendations in its [report](#) on ways to improve quality, advance equity, and increase affordability of health care in the U.S. The Committee should consider these steps to expand and diversify the workforce, particularly in medically underserved and high poverty areas:

1. Substantially expanding the number of slots, generosity of scholarships, and loan forgiveness in the National Health Service Corps (NHSC) and Indian Health Service (IHS) scholarship and loan repayment programs.
2. Establishing goals for NHSC and IHS to recruit clinicians of color.
3. Increasing funding for programs authorized under Title VII of the Public Health Service Act that aim to diversify the health care workforce.
4. Substantially expanding the Teaching Health Center Graduate Medical Education Program and the Advanced Nursing Education Workforce program in medically underserved areas.
5. Convening a national technical expert panel tasked with identifying strategies beyond the NHSC and IHS to recruit primary care clinicians to serve in rural and frontier areas and retain them.

Thank you again for the opportunity to submit these comments. We are happy to discuss these policy proposals in further detail at your convenience.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Nuzum', with a long, sweeping horizontal line extending to the right.

Rachel Nuzum  
Senior Vice President, Policy  
The Commonwealth Fund