



# State of Louisiana

Louisiana Department of Health  
Office of the Secretary

United States House of Representatives Select Subcommittee on the Coronavirus Crisis  
“Upgrading Public Health Infrastructure: The Need to Protect, Rebuild, and Strengthen  
State and Local Public Health Departments.”

September 29, 2021

Testimony of

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Good afternoon Chairman Clyburn, Ranking Member Scalise, and members of the Subcommittee. I serve as the State Health Officer and Medical Director for the Louisiana Department of Health. I am also a member of the Association of State and Territorial Health Officials (ASTHO), an organization which has provided crucial support and coordination throughout the pandemic. On behalf of the Louisiana Department of Health and State of Louisiana, we thank you for your attention and dedication to these pressing issues.

I must note that as I speak to you today many communities in Louisiana continue to struggle in the aftermath of Hurricane Ida. She is tied with Hurricane Laura as the strongest storm by wind speed to hit Louisiana in 150 years and the rebuilding process from both storms will unfortunately continue for quite some time. We are appreciative of the federal government’s continued partnership on this front as many families in affected areas still need our help.

Yet despite these struggles the COVID-19 storm continues to rage, even if it is not as immediately visible. Hurricane Ida has taken the lives of 30 Louisianians. In that same time period—since Ida made landfall—our Department has unfortunately reported out an additional 1,437 new COVID-19 deaths. Since Louisiana’s Delta wave began in early July we have lost 3,060 lives to the virus, and 13,796 lives since our first diagnosed case of COVID-19 in March of 2020.

Our fatality count—as unacceptably high as it is—would undoubtedly be higher if not for the expertise, commitment, and selflessness of our professional public health workforce. Under the leadership of Governor John Bel Edwards and Secretary Courtney Phillips we

have brought a science and compassion-based approach to this crisis. It often falls to our public health workforce to operationalize the response and this workforce—a critical piece of our health infrastructure—is in danger of crumbling. Much like physical infrastructure, routine maintenance and sustained investment are needed to prevent collapse. Let us be frank: stress fractures in our human public health infrastructure have been visible for years. In many departments across the country these fractures have become gaping holes. Retention and recruitment are the reinforced foundation of this infrastructure; state and local health departments need our help shoring up their workforces before they buckle under the weight of a now nineteen-month long pandemic.

I do not intend in any way to discount the heroics of inpatient and outpatient clinical health care workers. As a practicing ER physician, I am one myself and can tell you my colleagues in the clinical sphere have performed with true grit and honor. They are worthy of all accolades and admiration they have received and then some.

But it is public health professionals who provide the bedrock of how we, as a community and as a nation, respond to and ultimately overcome this pandemic. As I speak with you teams within my Department are working to expand testing availability while accounting for multiple supply chain shortages; improve laboratory reporting systems so we learn of results more quickly and with greater precision; improve our data dashboard so the public can better understand the scope of our state's outbreak and more readily assess the current risk to one's own family; conduct contact tracing to inform unknowing individuals of exposure risks and provide counseling on how to stay safe; deploy vaccine and booster shots in a manner that addresses the inequities that have so plagued us to date; and develop effective communication initiatives to counter the mountains of misinformation that are causing immense and irreparable harm to families across our state. These are high-level tasks and require a commensurately high-level workforce.

According to a CDC study published in the Morbidity and Mortality Weekly Report (MMWR) in July, 53% of the 26,174 governmental public health workers responding to a survey fielded in early 2021 reported symptoms or at least one mental health condition in the preceding two weeks, including depression (32%) anxiety (30.3%) PTSD (36.8%), or suicidal ideation (8.4%). Public health workers who reported being unable to take time off from work were more likely to report these symptoms. Employees are dealing with same effects of the pandemic that the public is – for instance, sick family members, kids learning at home, and more than one household member working at home. The burden of COVID-19 on the health care workforce has been well-publicized. Similarly, the governmental public health workforce has worked long hours and weekends under incredibly stressful circumstances. Often this has been without additional compensation, which can be exhausting and demoralizing.

Additionally, some employees are experiencing harassment and/or personal threats because of their jobs. Across the country, health officers have been subject to “doxing” (publishing private information to facilitate harassment), angry and armed protesters at

their personal residences, vandalism, and harassing telephone calls and social media posts—some threatening bodily harm and necessitating private security details. In my own personal experience in Louisiana I found, particularly during our recent Delta surge, increased anger and threats made to me personally, some very ugly and with obvious intent to track down my family's personal identifying information.

I remain deeply concerned about the public health workforce. High rates of turnover and job vacancies—in both COVID-19 response and other traditional program areas—add to the daily work burden of employees. My Department, like other health departments across the nation, is staffed by dedicated and altruistic health advocates who can handle the workload and weight of the moment. Like a clutch ballplayer in the playoffs, this is precisely what they trained for. However, as any well-trained and highly valuable professional, they are sought-after and they have options. We need to be able to provide competitive salaries, opportunities for professional advancement, and the ability to surge resources and expand teams when the need arises. And to do this we need greater flexibility in funding.

The emergency supplemental funding provided by Congress during the pandemic has been instrumental in our ability to mount an appropriate response. During normal times, state and local health departments typically rely on program-based federal grant funding to provide large portions of their operating budgets—often upwards of seventy or eighty percent. While we remain deeply thankful for the resources, and simply would not be able to operate our Department without them, these grants tend to be overly proscriptive and unnecessarily complicated. More importantly, they are too short-lived.

ASTHO officials found that the spending challenges in my own state are not unique and are being felt throughout the country. For example, hiring for government agencies can be complicated and slow. There may be caps on the number of new positions allowed and/or spending limits from the state legislature. Additionally, hiring processes may be lengthy or more cumbersome when compared to private sector employers. Government procurement systems also present hurdles to responding quickly. Once emergency declarations ended, many states reverted to existing processes that were less efficient. The processes take more time, effectively pushing forward the employment dates and the time in which the actual work can occur. Challenges faced with employee recruitment and retention have been exacerbated by COVID and also affect the ability to spend funds. As I mentioned before, public health is experiencing high rates of turnover within existing positions. This creates even more vacancies, and in many cases vacancies are within leadership positions. Positions for which specialized education or skill are needed are in high demand and are especially difficult to fill.

Civil service agencies regulate hires in departments like mine and we simply cannot obtain approval for a new hire or promotion (nor would we in good conscience) if the funding stream will disappear in one or two years. Departments like mine are built on a perpetual stream of short term, high maintenance grants. As a country we must move

away from a boom-and-bust cycle of funding for public health where funding spikes only in response to emergencies like Zika, Ebola, and now COVID-19. Frequently after emergency supplemental funding expires, the normal appropriations process lacks predictability and sustainability resulting in departments having to shutter programs and reallocate staff or furlough staff. It's no way to do business. You can never build for the future if your funding is limited to the priorities of yesterday's appropriations.

ASTHO along with the National Association of County and City Health Officials, Trust for Americas Health, the American Public Health Association, and others are actively advocating that Congress provide long term, sustainable, predictable funding via a public health infrastructure fund. This mandatory source of funding is a step in the right direction to provide disease agnostic funding for public health departments throughout the country so we can modernize the public health system, rebuild the workforce, and promote healthier communities.<sup>1</sup>

To recruit and retain the workforce that is needed to keep America healthy, our health departments need funding mechanisms that allow for strategic investment and longer-term planning. I ask that you consider the following six requests:

- 1) Direct federal agencies to issue public health grants with a minimum of five-year spending durations, and ideally longer.
- 2) Consider providing for health department "capacity building" grants (also known as "core funding"), free of the highly proscriptive deliverables that make it hard to respond to changing priorities and nearly impossible to plan for the future.
- 3) Allocate funding specifically for professional development and career advancement opportunities within health departments.
- 4) Expand educational loan forgiveness programs for public health professionals who become full-time employees of state and local health departments.
- 5) Promote diversity in the public health workforce by funding incentive programs for health departments to recruit public health professionals who come from the communities they intend to serve.
- 6) Create a dedicated public health worker overtime compensation fund to be used by health departments to appropriately and timely compensate their workforce when extended hours or around-the-clock response is needed.

In speaking with colleagues around the country and discussing the need for strong, sustainable public health workforces, the following four requests commonly emerged:

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<sup>1</sup> <https://www.tfah.org/issue-details/public-health-funding>

- Support infrastructure funding for public health modernization and long-term solutions to historically underfunded and overburdened yet essential services.
- Eliminate bureaucratic barriers such as multiple funding streams, spending cycles, and reporting requirements. Blending funding sources, syncing deadlines/timelines, and aligning requirements will reduce the administrative, infrastructure, and personnel burden.
- Expand funding deadlines so that health agencies have longer timeframes in which to work. This would allow thoughtful and strategic planning for longer term and sustainable solutions, as well as permit the time required to work through existing bureaucratic systems which can be quite slow, and appropriately onboard new staff to new roles.
- Allow for flexibility in funding so that states are able to respond to public health gaps that may be unique to them.

In sum, the fragmented disease-specific approach with competitive, short-term grants reduces the impact state and local health departments can have on improving health and responding to emergencies. Beyond funding mechanisms however, we must examine the deficiencies in our public health and health care systems that led to the COVID-19 crisis in the United States. ASTHO recommends requiring a joint congressional inquiry and/or a joint commission to investigate the performance of the entire public health response to COVID-19. This inquiry should be modeled after the one established post 9/11 with a requirement for a robust report so that any recommendations to improve the public health system are informed by data and are devoid of political influence. Our national homeland security apparatus improved substantially as a result of these post-9/11 efforts. We can do the same with our public health infrastructure.

The pandemic has showed us how interconnected and interdependent we all are. When it comes to a robust public health workforce, it is not enough to rely on states alone. Outbreak waves of the virus have spread across the country, bleeding from one state into another. Pandemic response has required close interjurisdictional collaboration as contact tracing, laboratory capability, supply chain management, and acute care capacity frequently cross state lines. As State Health Officer of Louisiana, it matters a great deal to me that Texas, Arkansas, Mississippi, and Alabama have strong health departments. Threats to the health of their constituents will quickly become threats to the health of mine. There is a clear national interest—indeed a national security interest—in bolstering all public health workforces.

Mr. Chairman, I am thankful for the opportunity to address this need, am appreciative of this Committee's important work examining how we can better protect ourselves and I look forward to a continued partnership. Thank you.