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THE WELLNEST WATCH — PUBLIC HEALTH WORKFORCE

Running on empty: America's public health workforce crisis and what it will cost us next time

Even if every prevention dollar were restored tomorrow, would enough trained people be left to do the work?

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There is a crisis unfolding across the United States that does not make the front page or trend on social media. It is not a new pathogen or a natural disaster. It is a staffing crisis: a slow, grinding depletion of the people who are supposed to protect the public's health. Epidemiologists, public health nurses, environmental health specialists, behavioral health counselors and community health workers; the positions are open. The desks are empty. And the remaining staff are burning out at rates that threaten the entire system's ability to function.

This is not a question of whether the United States funds enough prevention programs. That matters, but it is a different conversation. This is about capacity: whether, even if every prevention dollar were restored tomorrow, enough trained people would be left to do the work.

The scale of the gap is difficult to overstate. Recent Public Health Workforce Interests and Needs surveys conducted with the de Beaumont Foundation show a younger, shorter-tenured state and local public health workforce, reflecting substantial post-pandemic turnover. Across recent PH WINS survey waves, roughly one-

third of state and local public health workers report considering leaving their jobs, citing burnout, pay concerns and political hostility. In

specialty areas like epidemiology and laboratory science, vacancy rates in many jurisdictions exceed 20%.

— A WORKFORCE RUNNING ON EMPTY

1 in 3

public-health workers are considering leaving

20%+

vacancy in epidemiology & lab science

Each avoidable emergency-room visit costs **hundreds to thousands** more than the outpatient care it replaces.

The crisis did not emerge overnight. Public health has long operated on a boom-and-bust funding cycle: money flows in during emergencies and recedes once the threat fades. Each bust leaves the workforce thinner and less prepared. COVID-19 was the most devastating blow in a generation. A 2025 report from the Trust for America's Health documented how pandemic-era exhaustion, combined with recent federal hiring freezes and clawbacks of infrastructure funding, has dismantled capacity that took years to build. Many experienced professionals left for the private sector, where salaries are higher and hours are more predictable.

The consequences are predictable and already visible. Outbreak detection depends on trained epidemiologists who can spot unusual patterns and investigate quickly. When those positions sit vacant, clusters of illness go undetected longer, growing into costly regional emergencies.

Extreme weather events require public health teams to coordinate evacuations, ensure clean water and address mental health fallout. Every one of those functions requires people. When the workforce is depleted, communities are left exposed, not because no plan exists but because there are not enough hands to execute it.

The economics are straightforward analyses summarized by the National Institute for Health Care Management show that workforce shortages in primary care and behavioral health are a major contributor to avoidable emergency department use, with each avoidable visit costing hundreds to thousands of dollars more than the outpatient alternative. When a local health department cannot staff its chronic disease program, more people develop uncontrolled conditions and present to emergency rooms in crisis. The costs compound: overworked staff burn out faster and leave, further depleting the workforce in a vicious cycle.

The cost of maintaining standing capacity is a fraction of the cost of responding to the next crisis without it.

In Ypsilanti, this is not abstract. Washtenaw County's health department serves a diverse population of students, families and long-term residents. When positions go unfilled, it means fewer home visits for new mothers, slower follow-up on foodborne illness reports and longer waits for mental health referrals. Eastern Michigan University students in public health see the gap firsthand during field placements: agencies that want to mentor the next generation but barely have staff to keep current services running.

An overlooked consequence is the effect on communication. Effective health messaging requires staff with time to build community relationships and counter misinformation. When

teams are stretched to the breaking point, communication suffers first. Messages become generic or absent, deepening the public trust deficit that already undermines health outcomes.

Reversing this crisis requires treating public health staffing as infrastructure, as essential as roads and clean water. Compensation must be competitive. Training pipelines must expand. And the boom-and-bust funding model must end. The cost of maintaining standing capacity is a fraction of the cost of responding to the next crisis without it. The question is not whether we can afford to rebuild. It is what happens when the next emergency arrives and the workforce is not there.



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