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Understanding the Dynamics of Diversity in the Public Health Workforce

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The US population has become increasingly diverse; during 1965–2015, the proportion of non-Hispanic whites decreased from 84% to 62%, concurrent with a population increase among Hispanics and Asians. According to the US Census Bureau, in 2017, 50% of children younger than 5 years belonged to racial or ethnic minority groups; by 2044, minority groups —that is, African Americans, Asians and Pacific Islanders, Hispanic/Latinos, American Indians, and Alaskan natives, and individuals who are 2 or more races—are estimated to constitute 50% of the US population.[1] Although health indicators, including life expectancy and infant mortality, have improved for most Americans, disparities in health and health care exist, with minority groups being at disproportionate risk of experiencing worse health outcomes from preventable and treatable conditions.[2] A diverse public health workforce is better equipped to address public health disparities than a nondiverse workforce and therefore to implement population-based approaches aimed to improve health in communities.[3] However, the public health workforce is not representative of the population it serves. Overall, only 42% of the governmental public health workforce is people of color.[1,4]

Benefits of Workforce Diversity

One of the pillars in eliminating disparities is increasing diversity in the health professions and in all areas of public health.[3] Parity in workforce composition is one of the 4 overarching goals provided in *Healthy People 2020*. The public health workforce faces several urgent priorities, and developing an ethnically and racially diverse composition to meet the needs of an increasingly diverse nation is among the most challenging.

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Understanding, recognizing, and responding to the challenges associated with limited diversity in the workforce are vital for the organizational success and competitiveness of public health.

Public health agencies that employ a diverse workforce are better positioned to implement targeted approaches in communities where they are needed, create systems to support those needs, and supply a greater variety of effective solutions to help address health disparities.[2,3] Greater diversity of experiences and perspectives yields innovative public health approaches, and stronger evidence and better training related to health equity facilitate improvements in public health outcomes. A diverse workforce is essential for the adequate provision of culturally competent services because it can more easily address cultural and linguistic barriers. For example, health departments with a diverse workforce are more likely to employ strategies to serve culturally and linguistically diverse clients (eg, using interpreter services and having materials translated into languages other than English). However, implementation of such services is not uniformly adopted by all health departments, in part, because of factors affecting workforce diversity and cultural competence.[5]

Challenges in Achieving Workforce Diversity

Data-driven strategies are necessary for enhancing workforce diversity. However, workforce data, and more specifically diversity-related data, are not regularly tracked nationally or readily available. Data from the 2017 Public Health Workforce Interests and Needs Survey (PH WINS)[6–8] and the Federal Employee Viewpoint Survey[9] indicate that minorities only comprise 42% of the governmental public health workforce, with variations across federal (45%), state (36%), and local levels (42%) ranging from 68% in big city health departments to 36% in other local health departments (see Appendix Table 1, available at http://links.lww.com/JPHMP/A614).[1,4] Although the demographic representation of minority groups in public health is generally lower than the US population, a more specific concern emerges when exploring the diversity of certain public health positions. In state and local health departments, the majority of persons of color work in administrative and clerical positions (Table). Conversely, non-Hispanic whites hold the majority of public health science positions in state and big city health departments[4]; this might provide more opportunity to impact policy than administrative or clerical personnel. Furthermore, when looking at career advancement, a greater proportion of non-Hispanic whites held supervisory or managerial positions than do minority groups.[4] Understanding the dynamics of workforce diversity in public health is necessary to guide potential strategies for addressing diversity-associated challenges.

Strategies to Improve Workforce Diversity

Strategies to improve workforce diversity are often focused in 2 main areas: (1) diversifying the educational pipeline; and (2) developing organizational strategies to improve worker recruitment and enhance worksite climate and inclusivity. Diversifying the educational pipeline in public health and other health profession schools requires complex transformations of the education system, from addressing structural barriers in schools and communities that hinder advancement and achievement to ensuring equity in the college

admission process to modifying institutional culture to support students of diverse and disadvantaged backgrounds.[3,10] This entails institutions of higher education prioritizing on the recruitment and graduation of diverse public health students, and offering strong mentoring, advising, and skills development. It is also important for institutions to establish partnerships and collaborations that can contribute to a diverse student body. In addition, organizations seeking to use evidence to direct diversity efforts could encourage the use of evaluation to support best practices. The Association of Schools and Programs of Public Health, the American Association of Colleges of Nursing, the Association of American Medical Colleges, and the National Association of Social Workers have all offered recommendations to increase diversity and inclusion in their respective workforce that include recruiting more diverse students and including cultural competency training within degree programs. Cultural competence can be infused at both the individual level through inclusion in public health degree programs in training programs for the current workforce and on a systems level, where agencies employ specific structures and processes to meet the service needs of diverse populations.[11,12]

Some public health agencies in the United States have increased diversity in recent years. Both the Centers for Disease Control and Prevention and big city health departments are relatively more diverse than state health agencies and other local or regional health departments, although whites often hold more positions at managerial and scientific positions. Public health agencies should build and employ a workforce development strategy to assess and evaluate the diversity within their own workforce as an integral part of their management system, which would require modest time investment and resource allocation. The US Department of Health and Human Services offers tools and guidance to help agency leaders make data-driven decisions and design initiatives to create a culture of engagement, diversity, and inclusion across the federal government. Identifying structural barriers within the organization and public health system that impede diversity and inclusion efforts and utilizing evidence-based decision-making can help agencies develop specific recruitment and retention guidelines, programming, and norms within the organizational culture to support a diverse workforce. These may include, for example, providing mentors and role models to students and employees, eliminating inequity in hiring processes, and addressing retention issues that disproportionately affect people of color working within public health agencies.[11] Furthermore, developing and implementing a workplace diversity plan throughout a public health agency are important because health professionals from minority groups are more likely to serve diverse populations and that can help mitigate some of the access-to-care barriers.[11] Coupling prioritizations to build a more diverse staff with addressing systemic and systematic racism and discrimination in the workforce is one appropriate means of addressing the issue. This may be tracked not only with basic descriptives—for example, the proportion of staff that are people of color— but also through workplace perception and training needs assessment as part of workforce surveillance. PH WINS, for instance, shows a strong correlation between increased skill gaps in cultural competency in terms of training needs and the perceptions of staff of color as to how inclusive their workplace feels.[4]

A comprehensive yet attainable and measurable plan to evaluate changes is necessary, including a champion from the leadership of the agency. Developing and incorporating

diversity and inclusion policies into public health agencies are processes that need to originate at the top and filter through all layers of the organization to be successful. Involving employees from all demographic backgrounds and scopes of occupations in executing diversity initiatives can help foster a sense of equal value. Ensuring diversity in leadership positions can add visibility to the benefits of workforce diversity in public health and help work toward the ultimate goal of racial equity in the workforce. Collectively, these strategies are intended to improve service delivery and targeted interventions for the underserved, foster health promotion in neglected areas of societal need, and enrich the pool of public health managers and decision makers to meet the needs of a diverse populace.[3]

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

Workforce Characteristics by Race/Ethnicity in PH WINS 2017[a]

	SHA-CO[b]		BCHC[b]		Other LHD		National	
	White	**POC**	**White**	**POC**	**White**	**POC**	**White**	**POC**
Supervisory status								
Nonsupervisor	67%	74%	68%	76%	71%	77%	69%	76%
Supervisor	18%	14%	18%	15%	19%	13%	18%	14%
Manager	12%	10%	11%	7%	8%	8%	9%	8%
Executive	3%	2%	3%	2%	3%	1%	3%	2%
	SHA-CO[b]		**BCHC[c]**		**Other LHD[c]**		**National[b]**	
	White	**POC**	**White**	**POC**	**White**	**POC**	**White**	**POC**
Job classification								
Administrative and clerical	41%	51%	28%	42%	34%	45%	36%	46%
Clinical/laboratory	17%	15%	25%	25%	33%	23%	27%	22%
Public health sciences	41%	32%	44%	31%	31%	28%	35%	30%
Social services and all other	1%	2%	3%	3%	2%	4%	2%	3%
	SHA-CO[b]		**BCHC[b]**		**Other LHD[b]**		**National[b]**	
	White	**POC**	**White**	**POC**	**White**	**POC**	**White**	**POC**
Highest degree								
No college degree	14%	16%	8%	19%	19%	24%	16%	21%
Associate's	11%	12%	6%	13%	18%	17%	15%	15%
Bachelor's	36%	32%	39%	35%	39%	34%	38%	34%
Master's	31%	31%	39%	27%	22%	21%	26%	25%
Doctoral	8%	8%	8%	5%	2%	4%	5%	5%
	SHA-CO		**BCHC**		**Other LHD**		**National**	
	White	**POC**	**White**	**POC**	**White**	**POC**	**White**	**POC**
Age in years, mean	48.3[d]	46.1	46	46.0	47.9[d]	45.3	47.8[d]	45.7
Tenure current position, mean	6	5.8	6.5[e]	7.5	7.6	7.4	7	7.0
Tenure current agency, mean	10.3[d]	9.1	9.7[f]	10.6	11.2[d]	9.3	10.8[d]	9.6

Tenure public health practice, mean	13.5[d]	12.1	13.1	13.1	13.4[e]	11.9	13.4[d]	12.3

Abbreviations: BCHC, Big Cities Health Coalition staff; National, national total; Other LHD, other local health department staff; PH WINS; Public Health Workforce Interests and Needs Survey; POC, people of color; SHA-CO, state health agency central office staff.

[a]PH WINS, 2017. From references.[6–9] Results of the Rao-Scott test show differences between white and POC staff at P < .05.

[b]Results of the Rao-Scott test show differences between white and POC staff at P < .001.

[c]Results of the Rao-Scott test show differences between white and POC staff at P < .01.

[d]Results of the design-adjusted Wald test show differences between white and POC staff at P < .001.

[e]Results of the design-adjusted Wald test show differences between white and POC staff at P < .01.

[f]Results of the design-adjusted Wald test show differences between white and POC staff at P < .05.