ISSUE REPORT

Trust for America's Health
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Public Health Infrastructure in Crisis

HHS workforce cuts, reorganizations, and funding reductions: impacts and solutions

September 2025

Acknowledgments

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Editor's note: Editorial work on this report was completed in late July 2025, with select updates made through mid-August 2025. The content reflects the status of ongoing and proposed federal actions as of that time.

Executive Summary

Trust for America's Health (TFAH) has published reports tracking public health funding for over two decades. These reports examined federal and state funding trends and offered recommendations for making investments that will strengthen public health infrastructure and thereby protect the nation's health and economic security.

This edition of the series represents a departure from TFAH's standard format. The scale and scope of relevant federal policy changes, including reductions to public health funding and to the workforce that have been implemented or proposed in the first half of 2025, warranted a broader analysis of those actions and their potential implications for the nation's public health infrastructure and Americans' health.

The public health system—comprising federal, state, local, tribal, and territorial agencies working in partnership—serves as the foundation for protecting and promoting population health in the United States through disease prevention, emergency preparedness, and health promotion activities. This system is distinct from, yet can collaborate with, publicly funded healthcare programs such as Medicaid. Public health works beyond access to clinical services—and regardless of income—through activities like ensuring safe food and water, monitoring disease outbreaks, conducting newborn screening, improving maternal and infant health outcomes, and maintaining the infrastructure necessary for rapid response to health emergencies.

Federal agencies provide scientific expertise, funding, and technical assistance to state, local, tribal, and territorial health departments, which in turn deliver direct services to communities, conduct disease and injury surveillance, and respond to local health threats. This interconnected system depends on coordination across all levels of government to effectively monitor disease outbreaks, track health trends, respond to emergencies ranging from natural disasters to infectious disease outbreaks, and implement evidence-based prevention strategies that keep communities healthy and generate substantial healthcare cost savings. Every dollar invested in public health prevention programs typically saves multiple dollars in avoided healthcare costs by preventing diseases and injuries before they require expensive medical treatment.[1]

However, public health has been chronically underfunded for decades, with spending on prevention representing only a small fraction of the nation's total health expenditures. The nation faced a shortage of approximately 80,000 state and local public health FTEs prior to the COVID-19 pandemic,[2] and many places still lack modernized data systems and the infrastructure necessary to address 21st-century health challenges.[3] Many state and local health departments operate with outdated technology, insufficient laboratory capacity, and inadequate staffing that limits their ability to respond effectively to health emergencies or implement comprehensive prevention programs. These deficiencies necessitate reliable, adequate and predictable funding to strengthen public health infrastructure and protect the nation's health and economic security

While consequential changes are occurring at numerous federal agencies that impact public health, this year's report focuses primarily on the Centers for Disease Control and Prevention (CDC) and select U.S. Department of Health and Human Services (HHS) agencies. This targeted approach reflects CDC's

central role in national and global public health, as well as its support for state, local, tribal, and territorial public health infrastructure. CDC provides scientific expertise, technical assistance, on-the-ground support during health emergencies, and coordination across public health partners—with about 80 percent of CDC's domestic budget flowing to states, localities, tribes, tribal organizations, territories, healthcare systems, and community partners.[4] Changes to CDC funding and capacity will significantly impact public health services nationwide and jeopardize Americans' health and safety.

This report documents federal actions implemented between January and July 2025, analyzes proposed restructuring and funding changes in the president's fiscal year (FY) 2026 budget request, and provides recommendations for preserving and strengthening public health infrastructure. The analysis aims to support informed decision-making by policymakers and public health officials as they work to ensure Americans' health, safety, and security while maintaining a strong economy and protecting national security interests.

Overview of Federal Policy Actions and Impacts

Throughout 2025, HHS has experienced significant organizational and budgetary changes. These changes have included workforce reductions, the departure of the CDC Director and other senior leaders, funding terminations and clawbacks, delayed funding apportionments, program funding restrictions, and proposed agency reorganizations and funding reductions. This substantial restructuring in federal public health operations and priorities have important implications for state and local health departments, the healthcare system, and communities nationwide. Implications include staffing gaps at health agencies, disruptions to ongoing public health programs, reduced federal support for state and local health departments, loss of public health expertise due to staff reductions, and a weakening of the country's disease surveillance, emergency preparedness, and prevention services.

Critical capabilities could be lost across multiple domains. The proposed elimination of CDC's chronic disease prevention programs—despite the administration's stated goal of reducing chronic diseases[5]—would remove federal support for programs that address conditions that affect six in 10 American adults[6] and that, when combined with mental health conditions, account for 90 percent of the nation's $4.9 trillion in annual healthcare expenditures.[7] Environmental health protections—including programs that address lead poisoning, toxic exposures, water safety, and weather-related health threats—risk being weakened. Emergency preparedness funding faces a proposed 52 percent cut, leaving states and localities more vulnerable to future outbreaks and pandemics, natural disasters, and other health emergencies.

Several actions have been implemented. A federal hiring freeze has prevented agencies from filling vacant positions. Terminations of probationary employees who were recently hired or promoted also occurred, though some were later reinstated. Thousands of HHS employees accepted voluntary separation offers during a period of workforce uncertainty and threatened layoffs, while Reduction-in-Force actions eliminated additional positions across agencies. HHS abruptly terminated more than $12 billion in COVID-era grants to state and local health departments that had been supporting ongoing pandemic-related efforts, as well as broader public health infrastructure improvements—such as modernizing data systems, bolstering laboratory capacity, enhancing electronic case reporting, and strengthening biomedical terrorism preparedness. Additionally, CDC experienced multiple funding disruptions, including delayed apportionment of its FY 2025 appropriation and restrictions on specific program funding.

Some of these actions have faced legal challenges. Federal courts halted certain workforce reductions and the funding terminations for plaintiffs while related litigation continues, though the U.S. Supreme Court permitted some workforce reductions to move forward. The Government Accountability Office (GAO) also found that the National Institutes of Health (NIH) violated the Impoundment Control Act by withholding congressionally appropriated funds without following required procedures, a finding that could have broader implications for similar funding restrictions at other agencies.

The president's FY 2026 budget proposes to formalize and expand this restructuring and funding reduction. The budget requests a 25 percent reduction in HHS discretionary funding and proposes eliminating or consolidating multiple federal agencies. Additionally, the proposal includes a 53 percent budget cut to CDC and the Agency for Toxic Substances and Disease Registry (ATSDR). The Prevention and Public Health Fund (PPHF)—which provides annual support for critical prevention programs in every state and territory, as well as in localities and tribal communities—would be eliminated entirely. The budget would also consolidate HHS's divisions through the creation of new entities, such as the Administration for a Healthy America. It is important to note, however, that Congress can consider these recommendations, but is not required to adopt them.

Perspectives from the Field

TFAH conducted interviews with public health officials who regularly partner with federal agencies to understand how federal funding and workforce changes have affected health services and programs in their communities. The following perspectives illustrate how funding cuts and workforce reductions have affected service delivery and program operations—and how those effects might evolve over time and in communities across the United States.

A shared theme of these interviews is that the speed and scope of the changes have created significant challenges for state and local health departments and other federal health funding grantees in their efforts to maintain essential health services that protect communities from disease outbreaks, prevent chronic conditions, and respond to health emergencies.

"What was really difficult was the quickness of all of this. If I had been given some runway to plan, if I had been told that a grant was ending in six months, I would have had time to figure out some strategies to keep work going. ... I'm going to be having a very tough conversation with our Board of Health about what our public health priorities are in this new environment—what do we keep, what do we let go?"

— Katherine Wells, Dr PH
Director of Public Health
City of Lubbock, Texas

See page 18 for the complete interview with Dr. Wells.

"We will be less prepared. I don't think there's any question about that. Most of what we do in public health is behind the scenes. We are doing things to keep people healthy that the public doesn't know or think about. People go out to eat and don't worry about getting sick or drink tap water and aren't concerned about it being unsafe. The reason for all of these things is public health. When we lose the ability to do these things because our funding goes away, there will be negative consequences."

—Scott Harris, M.D., MPH
State Health Officer, Alabama
2025 President, Association of State and Territorial Health Officials

See page 16 for the complete interview with Dr. Harris.

Strengthening the Public Health System

For decades, the nation's public health system—the constellation of governmental and nongovernmental organizations that contribute to the performance of essential public health services—has promoted and protected both community and individual health. In fact, the largest contributing factors to the increase in Americans' life expectancy over the past century are rooted in public health interventions, including improved sanitation, improved nutrition, tobacco use prevention, stronger infectious disease control, expanded access to vaccinations, and addressing preventable injury (e.g., seatbelt use).[8]

Despite these measurable improvements in the nation's health, the system can and should be strengthened. It has been chronically underfunded and understaffed. Due to being under resourced, the public health system has been unable to sufficiently modernize many core capabilities, such as data infrastructure and disease detection systems, and unable to scale proven solutions to meet population health challenges in every community.

Now is the time to strengthen the public health system as the nation continues to face significant challenges, including rising rates of chronic diseases,[9] outbreaks of vaccine-preventable diseases such as measles,[10] extreme weather events, persistent health disparities, and a mental health and substance use crisis, which, despite recent improvements, resulted in over 200,000 deaths due to alcohol, drugs, and suicide in 2023.[11] Furthermore, despite spending more on healthcare, life expectancy in the United States still lags behind that of other high-income nations.[12]

A strengthened public health system requires the funding, authority, workforce, laboratory and data capacity, and cross-sector collaboration necessary to promote and protect good health across the life span and in all communities. It must also be able to work with other sectors to address structural barriers that are connected to health disparities, such as collaborating with housing agencies on lead poisoning prevention, working with employers and workplace safety agencies on occupational health and safety programs, and partnering with educational institutions on health promotion programs.

The system had room for improvement before the current budget cuts, funding clawbacks, workforce reductions, and proposed agency reorganizations. Now, these actions threaten to worsen the underlying gaps and risk creating a public health system unprepared to meet the health challenges and opportunities of the 21st century.

The public health system is a vital part of a nation's health ecosystem. It is a system driven by comprehensive and real-time data; includes government at all levels; fosters collaboration among public health, healthcare, social services, the business community and other sectors; and is rooted in authentic partnerships with communities. A weakened public health system will negatively impact the nation's entire health ecosystem.

The public health and healthcare sectors are interdependent and are both facing a crisis due to cutbacks. According to the Common Health Coalition, reductions in support for public health infrastructure will ripple across the healthcare sector—impacting patient health and driving up healthcare costs.[13] The consequences of these actions will fall most heavily on populations that already face barriers to care, including low-income communities and rural areas.[14]

A Better Path Forward

The U.S. public health system is at an inflection point, and it is critical that we act. The charge now is to make the decisions and investments necessary to strengthen and improve the system. Doing so is essential to protecting the health improvements Americans have experienced over the last century and to ensuring that progress benefits every community. Cutting programs without thoroughly evaluating their impact is not the answer; finding ways to strengthen them is.

Every system, including public health, has important areas and opportunities for improvement. We must restore the federal programs and funding that are critical to promote and protect the health of all communities. At the same time, we must also reimagine and reinforce what is needed to bolster the system to meet the health threats and opportunities of the 21st century.

The recommendations in this report (see page 28) outline specific actions to help advance the nation toward achieving these goals. Highlighted recommendations include:

- Congress and the administration should restore federal health agencies, funding, and workforces that were cut in 2025.

- The administration and Congress should maintain and strengthen the structure and capabilities of federal health agencies, which have specific, complementary and distinct roles and expertise in protecting the nation's health.

- Congress, in collaboration with federal agencies and outside experts and partners, should lead a bipartisan, deliberative process of reviewing proposals for federal health agency restructuring or development of new agencies.

- Congress and the administration should strengthen CDC as a national, comprehensive public health agency with responsibilities across the detection, prevention, and mitigation of the leading causes of preventable death, illness, and injury.

- Congress and the administration should implement evidence-based processes to identify inefficiencies and enhance the effectiveness of federal public health services, such as improving the efficiency of disbursement of federal funds, program evaluation and data collection, and enabling flexibility when needed.

- Federal agencies must spend all funds appropriated by Congress, as required by law, and the Office of Management and Budget should release full-year funds to agencies after enactment of appropriations legislation.

- Congress should ensure continuous improvement of the nation's public health capabilities and essential services, including workforces, laboratories, and data systems at all levels.

- Congress should restore the Prevention and Public Health Fund and prevent future cuts.

The country needs a public health system that has predictable, adequate, and flexible funding, is rooted in evidence-based policies and programs, and addresses structural barriers to good health in all communities. A strengthened public health system is not optional or a luxury—it is an absolute necessity and a prudent investment to safeguard the nation's health, support a robust economy, and protect national security. These foundational investments in public health are essential to a functioning, thriving, and resilient society.

Federal Public Health Infrastructure Changes in 2025

Between January and July 2025, the U.S. Department of Health and Human Services (HHS) experienced significant organizational and budgetary changes, including workforce reductions; program eliminations; funding delays, cuts, and freezes; and proposed agency reorganizations. Beginning with a hiring freeze on January 20, 2025, these steps have included terminations of probationary employees, voluntary separation programs, Reduction-in-Force (RIF) actions, the termination of over $12 billion in federal health grants to state and local agencies and partners, and various fiscal year (FY) 2025 funding disruptions. These destabilizing actions have created operational challenges for health departments, federal agencies, researchers, healthcare providers, community-based organizations, and ongoing public health programs.

The president's FY 2026 budget proposal would expand these systemic reductions, calling for a broad and substantial 25 percent cut to HHS discretionary funding—including a 53 percent reduction to CDC and the Agency for Toxic Substances and Disease Registry—and proposing the elimination or consolidation of multiple agencies.

The following sections document—as of July 2025—the implementation of these actions, their legal status, and their effects on federal public health operations and federal-state-local partnerships.

Federal Hiring Freeze

On January 20, 2025, President Donald Trump ordered an immediate executive branch hiring freeze for civilian employees via executive memorandum.[15] This freeze applied to all executive branch agencies (including HHS) and barred filling any civilian job vacancies or creating new positions. Limited exemptions were permitted.[16]

On April 17, 2025, the hiring freeze was extended through July 15, 2025,[17] and on July 8, 2025, it was extended again through October 15, 2025.[18] After expiration, agencies are restricted to a one-hire-per-four-departures ratio for new hiring.[19]

As of July 2025, HHS remains under the hiring freeze and is unable to recruit for most vacant positions. Career roles at HHS—from scientists at the National Institutes of Health (NIH) to public health analysts at CDC—cannot be filled except under rare exemptions. The use of contracting to bypass the freeze was explicitly prohibited.[20] The extended freeze has led to declining staffing levels as employees depart without replacement.

Removal of Probationary Employees

In mid-February 2025, HHS notified thousands of recently hired or recently promoted staff that they were being terminated before completing their probationary period (typically the first year of service).[21] These notices affected new civil service hires and many employees who had moved into new roles.

The terminations impacted employees across multiple critical functions, though details were scarce and some removals were later reversed. At CDC, approximately 750 employees received termination notices.[22,23,24] These terminations included fellows from training programs that deploy scientists and public health professionals to work with state and local health departments. According to reports, fellows from such programs had been involved in responding to health emergencies, including tuberculosis outbreaks in Kansas City and infectious disease investigations.[25]

Federal employee unions and several states filed legal challenges, arguing that the terminations improperly bypassed RIF procedures and statutory protections. In late February and March, multiple court orders temporarily halted the removals and required agencies to reinstate about 16,000 probationary employees government-wide (including many at HHS) pending litigation.[26,27] Many affected HHS workers were placed on paid administrative leave.[28]

On April 8, 2025, the U.S. Supreme Court stayed a lower court's reinstatement order,[29,30] and the U.S. Court of Appeals for the Fourth Circuit issued a similar ruling the following day, allowing terminations of probationary employees to resume.[31,32] Subsequently, a federal court required agencies to clarify that dismissals were policy-based rather than performance-related.[33]

On April 24, 2025, President Trump issued an executive order requiring agencies to affirmatively certify new employees as fit for permanent service; otherwise, employees are automatically separated at probation's end.[34]

In May 2025, HHS proceeded with additional probationary removals.[35] As of July 2025, thousands of HHS probationary employees have been terminated,[36] including scientists, analysts, and public health advisors.[37]

Deferred Resignation Programs and Voluntary Departures

In late January 2025, the Office of Personnel Management (OPM) launched a government-wide "deferred resignation" program. Federal employees were given the option to submit a letter of resignation effective September 30, 2025, in exchange for months of pay while being placed on paid administrative leave.[38] The initial window for opting in closed by February 12, 2025.[39]

The response at HHS was significant amid widespread uncertainty about job status and agency restructuring. By the end of February, roughly 10,000 employees—about 12 percent of the department's workforce—had reportedly applied to exit via deferred resignation, voluntary early retirement, or buyout payments.[40]

After the deferred resignation opt-in window closed in February, HHS offered additional voluntary separation incentives,[41] including Voluntary Separation Incentive Payments (VSIP) and Voluntary Early Retirement Authority (VERA). VSIP provided buyout payments based on years of service,[42] while VERA temporarily lowered age and service requirements for immediate retirement eligibility.[43]

Workforce Reductions and Proposed Agency Reorganizations

On March 27, 2025, HHS announced a broad restructuring plan, executed under Executive Order 14210 without congressional notification or approval. This plan included both immediate workforce reductions and longer-term organizational changes.[44, 45, 46]

Reduction-in-Force Actions

On April 1, 2025, HHS began implementing RIF actions that eliminated approximately 10,000 positions.[47] The cuts affected multiple divisions, including about 3,500 positions at the Food and Drug Administration (FDA), 2,400 at CDC, and 1,200 at NIH.[48] For reference, in September 2024, these agencies employed approximately 21,000, 13,000, and 21,000 people, respectively.[49]

The workforce reductions affected disease surveillance, epidemiology, occupational health, and injury prevention programs, as well as others. Among many reductions, CDC's National Institute for Occupational Safety and Health (NIOSH) was particularly affected, with most positions eliminated as part of plans to move the institute to a new entity: the Administration for a Healthy America (AHA).[50,51] NIOSH conducts research on workplace safety and provides guidance to protect workers from occupational hazards,[52] including coal-mining safety programs in states like West Virginia.[53] The National Center for Injury Prevention and Control—which tracks trends, conducts research, and works to prevent injury, overdose, suicide, and violence[54]—lost more than 200 staff members.[55] CDC's lead-poisoning prevention programs, which provide technical assistance and laboratory support to states for childhood lead screening and environmental investigations,[56] were significantly reduced—limiting the agency's ability to provide on-the-ground support during crises such as the 2025 discovery of lead contamination in Milwaukee public schools.[57,58]

The RIFs also shut down specialized laboratories with unique national functions. CDC's sexually transmitted disease (STD) prevention laboratory was closed, halting critical national testing that does not exist anywhere else within HHS.[59] Similarly, CDC's viral hepatitis laboratory—described by the Association of Public Health Laboratories as having "the highest degree of viral hepatitis expertise of any public health laboratory in the world"—was closed, leaving specimens from ongoing outbreaks without testing capacity.[60,61] CDC's Office on Smoking and Health, which supported highly effective state tobacco prevention programs and the *Tips from Former Smokers* campaign, also lost all staff. The Tips campaign alone helped more than 1 million Americans quit smoking, prevented hundreds of thousands of early deaths, and saved billions in smoking-related healthcare costs.[62,63]

In subsequent weeks, HHS reinstated some employees. For example, in June 2025, HHS reinstated more than 450 CDC employees—less than 20 percent of those initially dismissed.[64,65,66] Reinstatements included some workers in HIV/STD prevention, environmental health, and lead-poisoning prevention.

Proposed HHS Reorganization Plan

The administration's proposed restructuring plan aims to consolidate HHS's 28 divisions into 15. (See Figure 1.) The president's FY 2026 budget proposal offers some insight into which programs and functions would be maintained under the consolidated agencies, though many details remain unclear. Key elements include:[67,68,69]

- **Creation of the Administration for a Healthy America (AHA):** This new entity would consolidate elements from the Office of the Assistant Secretary for Health; the Health Resources and Services Administration; the Substance Abuse and Mental Health Services Administration (SAMHSA); the Agency for Toxic Substances and Disease Registry (ATSDR); the National Institute of Environmental Health Sciences; the Office of the Surgeon General; and several CDC centers, including the National Institute for Occupational Safety and Health; the

Figure 1: HHS Reorganization Would Reshape Federal Health Infrastructure

Current HHS (Agencies & Offices)
Administration for Children and Families (ACF)
Administration for Community Living (ACL)
Advanced Research Projects Agency for Health (ARPA-H)
Administration for Strategic Preparedness and Response (ASPR)
Agency for Healthcare Research and Quality (AHRQ)
Assistant Secretary for Technology Policy / Office of the National Coordinator for Health IT (ASTP/ONC)
Agency for Toxic Substances and Disease Registry (ATSDR)
Assistant Secretary for Administration (ASA)
Assistant Secretary for Financial Resources (ASFR)
Assistant Secretary for Health (ASH/OASH)
Assistant Secretary for Legislation (ASL)
Assistant Secretary for Planning and Evaluation (ASPE)
Assistant Secretary for Public Affairs (ASPA)
Center for Faith (Faith Center)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare & Medicaid Services (CMS)
Departmental Appeals Board (DAB)
Food and Drug Administration (FDA)
Health Resources and Services Administration (HRSA)
Immediate Office of the Secretary (IOS)
Indian Health Service (IHS)
National Institutes of Health (NIH)
Office for Civil Rights (OCR)
Office of Global Affairs (OGA)
Office of Inspector General (OIG)
Office of Intergovernmental and External Affairs (IEA)
Office of Medicare Hearings and Appeals (OMHA)
Office of the General Counsel (OGC)
Office of the Secretary (OS)
Substance Abuse and Mental Health Services Administration (SAMHSA)

	Proposed HHS (Reorganization Summary)
new	**Administration for a Healthy America (AHA)** (combines HRSA + SAMHSA + OASH/Surgeon General (OSG) + NIEHS from NIH + NCIPC, NIOSH, NCEH, NCBDDD, Ending HIV Initiative from CDC)
new	**Administration for Children, Families, and Communities (ACFC)** (combines ACF + ACL)
new	**Office of Strategy (OS)** (combines ASPE + AHRQ + NCHS from CDC + Office of Research Integrity from OASH)
new	**Assistant Secretary for a Healthy Future (ASHF)** (combines ARPA-H + BARDA, Project Bio Shield, Pandemic Influenza, and Strategic National Stockpile from ASPR)
new	**Assistant Secretary for Enforcement (ASE)** (combines OCR + OMHA + DAB + OHRP from OASH)
new	**Assistant Secretary for Consumer Product Safety (ASCPS)** (incorporates CPSC within Office of the Secretary)
new	**Office of the Assistant Secretary for External Affairs** (combines OGA + ASL + IEA + ASPA)
modified	**Centers for Disease Control and Prevention (CDC)** (modified: adds Center for Preparedness & Response; transfers NCIPC, NIOSH, NCEH, NCBDDD, NCHS, Ending HIV initiative to AHA)
modified	**National Institutes of Health (NIH)** (modified: transfers NIEHS to AHA)
	Agency for Toxic Substances and Disease Registry (ATSDR)
	Assistant Secretary for Administration (ASA)
	Assistant Secretary for Financial Resources (ASFR)
	Assistant Secretary for Technology Policy / Office of the National Coordinator for Health IT (ASTP/ONC)
	Center for Faith (Faith Center)
	Centers for Medicare & Medicaid Services (CMS)
	Food and Drug Administration (FDA)
	Immediate Office of the Secretary (IOS)
	Indian Health Service (IHS)
	Office of Inspector General (OIG)
	Office of the General Counsel (OGC)
	Office of the Secretary

Notes: This chart reflects the proposed HHS reorganization plan, which has not received congressional authorization.

Sources: HHS Fact Sheet and FY 2026 Budget in Brief[70,71]

National Center for Environmental Health; the National Center for HIV, Viral Hepatitis, STD, and Tuberculosis Prevention; the National Center for Injury Prevention and Control; and the National Center for Chronic Disease Prevention and Health Promotion. According to the Trump Administration, AHA would focus on eight priority areas: prevention, primary care, maternal and child health, mental health, substance use prevention and treatment, environmental health, HIV/AIDS, and workforce development—along with policy, research, and oversight functions.

- **Merging policy and research units:** The Assistant Secretary for Planning and Evaluation would merge with the Agency for Healthcare Research and Quality to form an "Office of Strategy."

- **Consolidating the Administration for Community Living (ACL):** Programs serving older adults and people with disabilities under ACL would be integrated with the Administration for Children and Families (ACF) to form a new Administration for Children, Families, and Communities (ACFC). According to the Trump Administration, this consolidation aims to address social service needs across the lifespan under a unified structure, administering programs for children, families, older adults, people with disabilities, and their caregivers.

- **Shifting components of the Administration for Strategic Preparedness and Response (ASPR):** ASPR leads the nation's medical and public health preparedness for, response to, and recovery from disasters and public health emergencies, and it oversees the nation's medical countermeasures enterprise. The president's FY 2026 budget proposes moving the Biomedical Advanced Research and Development Authority (BARDA), Pandemic Influenza program, and the Strategic National Stockpile into a new "Office of the Assistant Secretary for a Healthy Future" and shifting Healthcare Readiness and Response, Preparedness and Response Innovation, and National Disaster Medical System to CDC.[72] The proposal would eliminate ASPR's Hospital Preparedness Program, Medical Reserve Corps, and the Center for the HHS Coordination Operations and Response Element (H-CORE). The Hospital Preparedness Program provides the primary source of federal funding dedicated to healthcare delivery system preparedness, supporting hospitals and healthcare coalitions in every state and territory in preparing for and responding to emergencies and disasters. The Medical Reserve Corps coordinates volunteer health professionals who provide surge capacity during public health emergencies. H-CORE serves as HHS's operational coordination center for medical countermeasures efforts across the federal government, facilitating interagency response and information-sharing across federal, state, local, and industry partners.

- **Reducing regional offices:** HHS has consolidated its 10 regional offices to five. This consolidation means each remaining regional office must oversee a larger geographic footprint while operating with the same or reduced staffing levels.

The proposed reorganization would create critical operational challenges for state, local, tribal, and territorial partners who must navigate new organizational structures and establish relationships with unfamiliar federal entities. The consolidation disrupts established working relationships and would likely create delays in program implementation and technical assistance delivery.

The plan also creates significant uncertainty about program continuity and effectiveness. Separating interconnected CDC components would undermine collaborative work that is vital for effective public health response. Questions remain about whether transferred programs will maintain adequate resources, specialized expertise, and operational capacity within larger, less specialized organizational frameworks. The success of these consolidations is uncertain given reduced funding levels and the challenges of integrating diverse programs with different statutory authorities and operational requirements.

Legal Challenges and Current Status

As of July 2025, this proposed HHS restructuring has faced significant legal challenges.

On May 5, 2025, the state of New York and 19 other states and the District of Columbia filed a federal lawsuit—***State of New York v. Kennedy***—challenging the workforce reductions set in motion by HHS's March 27, 2025 directive.[73] The lawsuit details impacts on public health programs and federal partnerships with states and localities, including disruptions to disease surveillance, maternal health monitoring, occupational safety research, lead-poisoning prevention, anti-tobacco enforcement, early childhood education support, and poverty-level data collection that underpins state benefits programs.[74]

In a separate case (***American Federation of Government Employees [AFGE], AFL-CIO, et al. v. Donald J. Trump, et al.***), the U.S. District Court for the Northern District of California issued a preliminary injunction on May 22, 2025, halting further implementation.[75] The court found that

reorganizations were likely unlawful, having proceeded without congressional approval and in ways that undermine statutorily mandated agency functions. The court noted that, historically, nine presidents in the past 100 years have sought and obtained congressional authorization for such reorganizations. On May 30, 2025, the U.S. Court of Appeals for the Ninth Circuit denied the government's request to stay the injunction, leaving it in place while the appeal proceeded.[76]

However, on July 8, 2025, the U.S. Supreme Court stayed the preliminary injunction that had been ordered in ***AFGE v. Trump***, allowing the Trump Administration to proceed with RIF planning and reorganization implementation while appeals continue. In an unsigned order, a majority found the administration likely to prevail on the legality of the executive order, though it expressly declined to opine on the legality of any agency reorganization or RIF plans.[77,78]

The Supreme Court's order created a mixed enforcement landscape. On July 1, 2025, the U.S. District Court for the District of Rhode Island had issued a separate preliminary injunction in ***New York v. Kennedy*** targeting four specific HHS components: CDC, FDA's Center for Tobacco Products, the Office of Head Start within the Administration for Children and Families (ACF), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). This injunction prohibited HHS from executing existing RIF notices, issuing new ones, or placing employees on administrative leave within these entities.[79] On July 18, 2025, the Rhode Island court denied HHS's motion to dissolve this injunction, maintaining the restrictions while the case proceeds.[80] However, on August 12, 2025, the court issued a revised preliminary injunction that left the injunction in place but clarified and narrowed its scope. The bar on RIFs and restructuring now applies only to FDA's Center for Tobacco Products; ACF's Office of Head Start (including regional offices); specific CDC units—the National Center for HIV, Viral Hepatitis, STD, and TB Prevention; the Division of Reproductive Health and the Office on Smoking and Health (both within CDC's National Center for Chronic Disease Prevention and Health Promotion); the National Institute for Occupational Safety and Health; the National Center for Environmental Health; and the National Center on Birth Defects and Developmental Disabilities—as well as ASPE's Division of Data and Technical Analysis (the unit that maintains the Federal Poverty Guidelines).[81]

As of mid-August 2025, the resulting legal framework permitted most federal agencies to resume downsizing activities under Executive Order 14210, while the enumerated HHS units listed above remain subject to the Rhode Island court's injunctive relief.

Importantly, Congress has not yet authorized these reorganizations. Historically, the restructuring and elimination of statutorily created agencies has generally not been accomplished through executive action alone. Many HHS agencies operate under specific congressional mandates that define their authorities, responsibilities, and organizational structures, creating legal questions about the scope of executive reorganizational power.

Moreover, the absence of congressional authorization creates substantial operational uncertainty for the federal workforce, state, local, tribal, and territorial partners, and organizations that contract with affected agencies. States, localities, tribes, and territories that have established legal agreements and funding relationships with specific federal agencies face important questions about program continuity and regulatory authority under the proposed reorganization structure.

"Pulling a small handful of examples from the record, we point out that the current executive reorganization facilitates the proliferation of foodborne disease, contributes to hazardous environmental conditions, hinders efforts to prevent and monitor infectious disease, eviscerates disaster loan services for local businesses, and drastically reduces the provision of healthcare and other services to our nation's veterans."[82]

—Judge William A. Fletcher
U.S. Court of Appeals for the Ninth Circuit

Termination and Clawback of COVID-Era Grants

On March 24, 2025, HHS moved to abruptly terminate or clawback over $12 billion in federal health grants that had been awarded to state and local agencies using COVID-era appropriations.[83] CDC was directed to reclaim about $11.4 billion in funds distributed to states and localities for COVID-19 response and recovery, while HHS canceled roughly $1 billion in SAMHSA grants.[84] These grants had been providing vital resources to states and localities in support of pandemic-related efforts as well as broader public health infrastructure improvements.

The terminated funding came from several laws passed between 2020 and 2021, including the CARES Act, American Rescue Plan Act, and other pandemic-related legislation. Some of the

terminated grants were funded until expended or had end dates extending to 2026 and 2027,[85] indicating they were intended to continue beyond the immediate pandemic response. The grants addressed broader public health infrastructure, including infectious disease monitoring, laboratory capacity, emergency preparedness, mental health services, and substance use disorder treatment—areas that have historically faced chronic underfunding and workforce shortages.[86,87,88,89] These investments were designed to strengthen the foundational systems that enable effective public health responses.

After the COVID-19 public health emergency formally ended in May 2023,[90] HHS had approved continued use of these funds and granted extensions to states and localities. Congress reviewed COVID-19 appropriations through the Fiscal Responsibility Act of 2023 and rescinded $27 billion[91,92] in unobligated funds it deemed unnecessary while preserving funding that was already obligated to jurisdictions with approved budgets and workplans—the funding that was later terminated by the Trump Administration.[93]

The bulk of the terminations ($8.9 billion) came from CDC's Epidemiology and Laboratory Capacity (ELC) grants,[94] which serve as the backbone of the nation's disease surveillance system. ELC grants support state and local health departments in detecting outbreaks early, tracking disease patterns, conducting contact-tracing during epidemics, and maintaining laboratory testing capabilities essential to identifying pathogens. These grants fund the epidemiologists and laboratory scientists who monitor everything from foodborne illness clusters to emerging infectious diseases, providing the early warning system that prevents local health threats from becoming national crises.[95]

Another $2.1 billion was terminated from CDC's Immunization and Vaccines for Children programs,[96] which ensure vaccine access for underinsured children and maintain the infrastructure needed to track vaccination coverage, monitor vaccine safety, and respond to vaccine-preventable disease outbreaks.[97]

These programs collectively represent the foundational capacity that enables rapid response to health emergencies and helps maintain population immunity against preventable diseases. State and local health departments reported immediate impacts, including workforce reductions, program disruptions, and service interruptions affecting immunization, disease surveillance, and laboratory operations.[98,99,100]

"...the recent abrupt cancellation of grants totaling as much as $11 billion caught state and territorial health departments by surprise; unfortunately, these actions will significantly impact our public health preparedness and response activities. Although the majority of this funding had already been spent, it was appropriated by Congress and obligated to health departments with work plans, budgets, and timelines approved by federal agencies for ongoing activities. These funds were intended not only for pandemic response, but also for mitigating key health security vulnerabilities that became apparent during the pandemic as well as strengthening our preparedness and response framework for the future. With congressional and executive branch support, these funds were being used to modernize data systems, bolster laboratory capacity, improve electronic case reporting of time-sensitive infectious disease outbreaks, improve H5N1 avian influenza and measles testing, and enhance biomedical terrorism preparedness, to name just a few examples.[101]

—Scott Harris, M.D., MPH
President
Association of State and Territorial Health Officials

The impacts on states and local communities were immediate and broad:[102]

- **Staffing Reductions:** Health departments reported layoffs of specialized public health workers, with some losing critical segments of their workforce in areas such as disease detection, immunization programs, and infection control guidance.
- **Service Disruptions:** The funding terminations affected various essential health services, including mobile crisis response units, mental health and substance use treatment programs, perinatal screening services, and community health worker positions.
- **Infrastructure Impacts:** Health departments lost funding for data system upgrades and public health infrastructure improvements, with some reporting losses on partially completed system implementations.

On April 1, 2025, 23 states and the District of Columbia filed a federal lawsuit challenging the terminations (***Colorado v. HHS***).[103] On May 16, 2025, a District judge issued a preliminary injunction blocking HHS from implementing the grant terminations for plaintiff states.[104] The court's order treats the terminations as "null and void and rescinded" while litigation continues,[105] though the preliminary nature of this relief creates

ongoing uncertainty for states and localities because the injunction could be overturned on appeal, applies only to plaintiff states, and does not guarantee permanent restoration of the terminated funding.

Relatedly, on April 24, 2025, Harris County, Texas; Columbus, Ohio; Nashville, Tennessee; Kansas City, Missouri; the American Federation of State, County and Municipal Employees, and the AFL-CIO filed a separate suit (***Harris County, Texas v. HHS***).[106] On June 17, 2025, the U.S. District Court for the District of Columbia granted a limited preliminary injunction that bars HHS—for now—from terminating, clawing back, or withholding any grant dollars that those four local governments received under statutes whose funding authorizations have expired.[107] The court specifically found plaintiffs likely to succeed on separation-of-powers claims regarding three COVID-era statutes with expired appropriations (the Coronavirus Preparedness & Response Supplemental Appropriations Act, the CARES Act, and the Coronavirus Response and Relief Supplemental Appropriations Act). The order applies only to the four plaintiff jurisdictions and requires HHS to treat the affected grants as fully valid and payable. The court did not find plaintiffs likely to succeed on separation-of-powers claims for grants funded by "until-expended" appropriations, such as the American Rescue Plan Act, though other claims remain pending as the case proceeds.

FY 2025 CDC Funding Disruptions and Legal Implications

Concurrent with the workforce reductions and COVID-era grant terminations and clawbacks, CDC has experienced funding disruptions during FY 2025, including delayed apportionment of appropriated funds and additional restrictions on specific public health programs. These disruptions have created notable operational challenges that extend beyond the agency itself to state and local health departments and nongovernmental organizations nationwide, raising questions about compliance with federal appropriations law.

Delayed Apportionments

Despite Congress passing and President Trump signing a continuing resolution in March 2025 that included $9 billion for CDC, the agency experienced delays in receiving its full appropriation.[108] The normal apportionment process—through which the Office of Management and Budget (OMB) releases funding to the agencies—typically takes 45 to 60 days after a budget is signed. During the latter half of FY 2025, it reportedly stretched for months. Instead of receiving its full appropriation, CDC operated under a series of 30-day funding increments,[109] creating uncertainty about the agency's ability to fulfill its mission and support state and local partners. By early August 2025, nearly five months after the appropriations became law, CDC had received its full apportionment.[110]

The delayed apportionment prevented CDC from issuing notices of award to state and local health departments for critical public health programs, including cardiovascular disease prevention, breast and cervical cancer screening, and emergency preparedness grants.[111] Without these notices, state and local agencies, which receive a significant portion of their public health funding from federal sources—predominantly from CDC— cannot be certain they will be reimbursed for their work, leaving them to either suspend operations and lay off staff, or continue at financial risk.

Additional OMB Funding Restrictions

The White House Office of Management and Budget (OMB) has reportedly implemented additional restrictions on CDC funding through appropriations memos.[112] These restrictions have blocked funding that CDC provides to external partners for specific programs, including youth violence prevention and initiatives addressing diabetes, chronic kidney disease, and tobacco use.

The withheld funding under these restrictions could amount to between $200 million and $300 million. OMB has characterized these actions as programmatic reviews, stating that the office is waiting for CDC's spending plan, though a former CDC official indicated in a news report that the agency had already submitted its spending plan earlier in the year.[113]

Legal Implications: The Impoundment Control Act

The funding delays and restrictions at CDC occur against the backdrop of a significant Government Accountability Office (GAO) determination regarding similar actions at NIH. On August 5, 2025, GAO issued a decision concluding that NIH violated the Impoundment Control Act of 1974 (ICA) by withholding funds from obligation and expenditure without following required procedures.[114]

The GAO decision found that NIH's termination of over 1,800 grants and suspension of grant review processes constituted improper withholding of congressionally appropriated funds. The agency was found to have withheld budget authority without the Trump Administration sending the required special message to Congress and without justification under the limited circumstances permitted by the ICA.

GAO's analysis emphasized that "unless Congress has enacted a law providing otherwise, executive branch officials must take care to ensure that they prudently obligate appropriations during their period of availability." The decision noted that the ICA allows the president to withhold funds from obligation "but only under strictly limited circumstances and only in a manner consistent with that Act."[116]

The legal principles underlying the NIH decision could have implications for CDC's funding situation. The ICA requires that any withholding of budget authority be justified through specific procedures and that agencies demonstrate intent to ultimately obligate appropriated funds within their period of availability.

Observable Impact on Federal Outlays

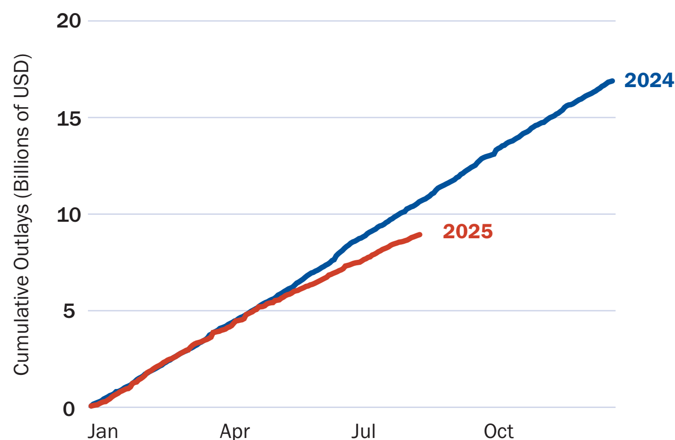
Data from the U.S. Department of the Treasury tracked by The Hamilton Project, an economic policy initiative at the Brookings Institution, shows measurable changes in federal expenditure patterns to CDC during 2025. (See Figure 2.) Through early May, CDC outlays in calendar year 2025 tracked closely with 2024 levels. However, beginning in May, a visible divergence emerged, with 2025 outlays falling below the previous year's trajectory.[117]

This timing aligns with reports of intensified funding restrictions and delayed appropriations affecting the agency. While Treasury outlay data reflects actual fund disbursements rather than obligations, the divergence provides external evidence of disrupted funding flows during the period when state and local health departments reported increasing difficulties accessing expected federal support.

Operational Consequences and Timing Pressures

The combined effect of delayed apportionment and specific program restrictions has created significant operational disruptions as the 2025 fiscal year approaches its September 30 end. CDC staff have expressed concern in news reports that continued delays could prevent the agency from obligating its 2025 funds before they expire.[118]

Figure 2: CDC Outlays Diverged Below Prior-Year Levels Beginning in May 2025



Note: Data reflects actual daily Treasury outlays to CDC as of August 19, 2025, which represent fund disbursements rather than obligations.

Source: The Hamilton Project analysis of U.S. Department of the Treasury data[115]

The funding disruptions have negatively affected CDCs capacity to support state and local health departments during ongoing public health challenges, including outbreaks of vaccine-preventable diseases.[119,120] According to CDC staff who spoke to NPR, the manual processes required to connect appropriated funds to operational accounts mean that extended delays could result in funds returning to Treasury unspent.[121]

The funding situation represents a test of the balance between executive branch budget management and congressional appropriations authority, with direct implications for public health infrastructure and emergency preparedness capabilities nationwide.

Interview with Dr. Scott Harris
State Health Officer, Alabama

TFAH: Let's begin by setting the stage. Would you briefly describe your department and its priorities?

Dr. Harris: We are the governmental public health agency for the state. A lot of what we do is core public health, including immunizations and disease control. We care a lot about population health, they are not our largest programs, and we get federal funding to support those programs, but they are very important to us.

TFAH: What percentage of your department's budget is supported by federal funding?

Dr. Harris: We are about two-thirds federally funded. If you also consider clinical revenue, mostly through Medicaid, we are about 90 percent federally funded. State money accounts for less than 10 percent of our overall budget.

TFAH: How does federal funding and expertise help your state address public health issues? Are you concerned about not being able to call on federal expertise in ways you have been able to in the past?

Dr. Harris: Yes, that's a big concern for us. We have great people working in public health, but we generally don't have subject matter experts on many of the issues that we are called to work on. We work on the front lines to implement policy that gets pushed down from the feds. We rely on them very heavily for guidance and instruction. Whether we are talking about congenital syphilis or avian influenza or any other topic, we certainly need the world's experts who reside at CDC or sometimes at other federal agencies to help us.

TFAH: What program/staffing cuts has your department had to make or anticipate having to make due to federal funding recissions?

Dr. Harris: The cuts that we learned about in April amounted to about a $190 million hit to our agency that happened overnight and without any warning. We came to work on a Tuesday morning and found out that a number of grants had been taken away the day before, which meant that we had about 140 FTEs [full-time equivalents] showing up for work that we no longer had a funding source for their salaries. In many instances we were able to find places for these employees to move to—other grants or other programs—but we did have some reductions-in-force and the work that was being done had to stop because programs were no longer funded.

These were grants that we first received as part of COVID funding, but they weren't just COVID grants. They were grants that applied to epidemiology, laboratory capacity, and infection control. For example, we were working with nursing homes on infection control practices; we worked with hospitals around the state to help train their teams on infection control. These were all appropriate types of work that we were approved to do, and all that work had to stop.

TFAH: Are you worried you will be less prepared for the next public health emergency due to these cuts?

Dr. Harris: We will be less prepared. I don't think there's any question about that. Most of what we do in public health is behind the scenes. We are doing things to keep people healthy that the public doesn't know or think about. People go out to eat and don't worry about getting sick or drink tap water and aren't concerned about it being unsafe. The reason for all of these things is public health. When we lose the ability to do these things because our funding goes away, there will be negative consequences.

We are also worried about emergencies. Human history has shown us that there is going to be something coming down the track. It's inevitable that we will need to have another large-scale response. We can't predict what it will be. Without people working here to plan for these events, we are not going to be as well prepared.

TFAH: In addition to your Alabama duties, you are the current president of the Association of State and Territorial Health Officials (ASTHO). In this role, what concerns or solutions are you hearing from other public health officials?

Dr. Harris: State and territorial health officials understand the importance of using science for population health. That's what we do and although we all work in different states and every jurisdiction has different priorities and different political realities, there's not a lot of disagreement about what works. We believe it's challenging when science isn't the most important criteria in making health recommendations. A lot of people are worried about what will happen with immunization guidance, for example. A lot of us are unsure what to make of a new agency that is going to move programs that were traditionally housed at CDC. You would think that it will need to use the subject matter experts who were once employed at CDC. That's who the subject matter experts are, but it's really unclear.

We don't know if those people are still employed; we don't know what funding is going to be attached to specific programs.

We don't know what the future is going to look like. We wish we had more communication from the feds and more opportunities for our input. We understand frontline public health and how dollars can be spent most efficiently. We understand what programs will and won't work in our own jurisdictions.

TFAH: Going forward, will states need to be more self-reliant in addressing the public's health?

Dr. Harris: We have statutory responsibilities in Alabama that my department has to carry out, so we are always going to do that work. But it's not even possible to think that my state is going to replace the amount of federal funding that seems to be at risk.

Yes, states are going to need to be more self-reliant, but what they are going to be able to do is going to be diminished.

TFAH: What's at stake? What are your concerns regarding how budget cuts and other changes are going to affect health in Alabama?

Dr. Harris: At the most fundamental level, it's the operations of the department. At this point, we're not sure if funding will be available or when it will be available. It's almost impossible for any agency to plan in that kind of an environment.

In terms of our actual public health programs, our population health programs were the ones getting the most federal money, and they are not necessarily statutorily required by the state. This is important work, and I believe we should be doing it, but if we lose two-thirds of our funding, we are going to have to focus on our core county health department functions.

We have wonderful men and women who are public health professionals who are passionate about what they do. They really want to make a difference, they want to help their community, and they do. If we lose those people because we can't afford to pay them, there is going to be less good accomplished than if they were still here.

TFAH: Are you worried that health risks and outcomes will worsen?

Dr. Harris: Well, clearly if we throw less resources at a problem, we are going to get more of that problem. An illustration is tuberculosis programs. Tuberculosis programs are famously on those boom-or-bust funding cycles. You have a tuberculosis outbreak, it gets a lot of attention and funding, you handle that outbreak. Soon afterwards people say, "There isn't any tuberculosis; why are we sending money to that program?" And so, you are back to square one with the next outbreak.

TFAH: What's your message about public health for your state legislators?

Dr. Harris: Public health is for everyone in our state. The public health system needs sustainable, predictable funding for us to be able to keep all Alabamians safe and healthy. Like any large organization, you need some degree of predictability in order to make things function. We need people to understand the importance of what we do and why it's a great investment to fund public health in an appropriate way.

Scott Harris, M.D., MPH
State Health Officer, Alabama
President, Association of State and Territorial Health Officials

TFAH: Any closing thoughts?

Dr. Harris: We fully expect that when there's a transition at the national level there will be changing priorities. That's how our system works. The new administration gets to set the agenda. We respect that and want to work with that. But what we need is something orderly, and what we would love is for someone to consult with us.

This interview was conducted in August 2025. It has been edited for length and clarity.

Interview with Dr. Katherine Wells

Director of Public Health, City of Lubbock, Texas

TFAH: How critical is federal funding to what your department needs to accomplish?

Dr. Wells: It's a large percentage of our budget, about 50 percent of my department budget comes from federal pass-through dollars—25 percent from CDC to the state that then passes through to us and another 25 percent from SAMSHA passed through to us. So, it's the direct funding, but it's also that these federal grants help us set direction locally. That is, the funding helps make the case for leveraging local resources either through matching dollars or in-kind support like IT or facility space. By braiding federal and local funding streams, we can build more sustainable, long-lasting public health programs that meet our community's needs.

I've also had to use my department's reserve funding to respond to the measles outbreak, which left little money to deal with loss of other program funding due to the federal COVID-19 grants clawback and delays in grant funding, including for HIV prevention and emergency preparedness.

TFAH: Beyond funding, in what ways does your department rely on CDC for technical assistance and data? Are you concerned about being able to rely on that assistance going forward?

Dr. Wells: We've definitely felt a loss early in the measles outbreak. One thing that I think most people don't understand is how often a local health department reaches out to CDC for help with various issues. For instance, responding to a rare event that can happen in public health, like an outbreak of a drug-resistant organism. Being able to go to CDC and talk to an expert who has dealt with that organism before is something that CDC can provide that no state can duplicate.

We also rely on the CDC for disease-tracking systems that enable local health departments to detect, monitor, and respond to outbreaks in real-time. Without CDC at the helm, we will not have coordination across states and internationally.

TFAH: Our report summarizes the many funding cuts, clawbacks, and reductions-in-force made to the public health system this year. Has your department had to make cuts?

Dr. Wells: The first thing that affected us was the COVID-19 clawbacks. They required me to lay off two staffers and eliminate three unfilled positions. Beyond that, I moved people around to avoid having to layoff anyone else.

What was really difficult was the quickness of all of this. If I had been given some runway to plan, if I had been told that a grant was ending in six months, I would have had time to figure out strategies to keep the work going or the opportunity to ramp down programs instead of an abrupt stop.

TFAH: Are you concerned that your department now has less capacity to do what is needed to protect public health in Lubbock?

Dr. Wells: Based on the first round of cuts, I still feel like we could respond to an emergency. I'm very concerned about any additional cuts. Any further cuts would impact the department's ability to provide the services that the community is used to seeing.

The problem is that cuts to public health take a while to show themselves—to get to a point where the community understands what's gone. If we become a smaller department, and that happens at the state and local level too, there will be nobody to fill in. And then you'll start seeing things that we are now able to keep under control—like STD rates—start creeping up.

I'm going to be having a very tough conversation with our Board of Health about what our public health priorities are in this new environment—what do we keep, what do we let go? What's more important, congenital syphilis or measles? These are tough conversations. How are we going to keep programs that I think are really benefiting the community, how are we going to keep those funded?

TFAH: Let's talk about the measles outbreak Texas experienced earlier this year. I know your team played a key role in responding.

Dr. Wells: We just declared last week that Lubbock is measles free—meaning the county has gone 42 days without an infection. But some counties are still seeing infections so there's still measles circulating. We are seeing a lot less pressure on our medical system—ERs and urgent care centers—but we need people to understand that the threat of measles is still very real.

Our summer and back-to-school messaging encourages people to not let measles infection rates creep back up. We need people to understand that it's still important to get their children vaccinated.

TFAH: The measles outbreak happened in the midst of budget cuts. How did you manage?

Dr. Wells: One thing that was really hard was that no emergency funding came in to support local health departments. Vaccines came into the community, access to testing came in, but no funding for additional resources we needed on the ground or for staff overtime.

There was a lot of added stress on the department staff, but the resilience of the public health workforce is amazing; they inspire me. Many of us worked 12-hour days, seven days a week. My team was reading about cuts to CDC in the newspaper, but they keep showing up to do what's right for their local community.

TFAH: What's at stake? What are you worried about in terms of public health in Lubbock two, three, five years from now because of these budget cuts?

Dr. Wells: The cuts are going to impact our most vulnerable individuals, people who are helped by the health department, free clinics, and community-based organizations. That safety net isn't very strong, grant stoppages even for a couple of weeks can destroy some of those systems.

You also need an infrastructure to be able to compete for grants, to figure out what funding is available and who in your community can take on the work. If you lose that infrastructure it will take years and years for your community to be able to rebuild those systems.

TFAH: Beyond funding, what has been lost—or do you anticipate losing—in terms of federal public health expertise, experience, data, and on-the-ground help during emergencies?

Dr. Wells: The unknown is the scariest part, and it's going to take the next emergency to figure out exactly what's missing.

It's not just about resource losses at the health department, it's about the impact to a bunch of entities we need to collaborate with—the emergency managers, for example. What's the impact on hospitals, and what happens at the state level? The state provides a lot of in-kind support to us, access to the state laboratory, access to their experts.

CDC has always been there when I had a question and has been able to answer my question. Until I have some need, I don't think I'll be able to figure out what's missing at CDC.

And then there's impact on housing and transportation—these are public health interventions. Their going away will affect the health of the community.

So, I see it as being about what happens within the walls of my department and what happens at all of those other agencies that impact the health of a community. I need a bus system to bring someone to my clinic.

Katherine Wells, DrPH
Director of Public Health
City of Lubbock, Texas

TFAH: Any concluding thoughts?

Dr. Wells: I don't want to say the public health system we have now is perfect. There are definitely places for improvement, and we should have conversations about how to make things better. But we also need to be careful about throwing the baby out with the bath water. I'd love to see a focused conversation about how we can have a better public health system in the United States. That would be a great conversation to have, but it needs to be done strategically.

This interview was conducted in late June 2025. It has been edited for length and clarity.

President's FY 2026 Budget Request

The president's FY 2026 budget includes the Trump Administration's proposal to formally restructure HHS. The budget serves as a funding proposal that would implement the reorganization and workforce reductions initiated through executive actions.

The following analysis is based on the budget request narrative and accompanying documents, though many operational details about program transfers, organizational structures, and implementation remain unclear.

Overview of FY 2026 Proposed HHS Budget

The president's proposed FY 2026 budget requests $94.7 billion in discretionary budget authority[122] for HHS—a marked 25 percent reduction from FY 2025 levels (see Appendix A for a partial list of proposed program eliminations). The budget proposes eliminating several agencies, including: the Health Resources and Services Administration (HRSA), SAMHSA, the Agency for Healthcare Research and Quality (AHRQ), ACL, and ASPR.[123]

The budget creates AHA, which would consolidate components from HRSA, SAMHSA, the Office of the Assistant Secretary for Health, the National Institute for Environmental Health Sciences, and substantial portions of CDC.[124] Within each of these agencies, some programs or offices have already been eliminated, despite being proposed for movement or consolidation. According to the administration, the proposal would reduce HHS's operating divisions from 28 to 15, though Congress has not yet authorized these reorganizations. The administration has already closed five of 10 HHS regional offices.[125]

A central theme throughout the budget is the shifting of responsibility for public health from the federal government to states and localities—or the elimination of services altogether. However, most states and localities lack the capacity to assume these responsibilities. Health departments generally operate on constrained budgets that limit their ability to expand services.[126,127,128,129] Many jurisdictions will be forced to reduce or eliminate public health services rather than maintain them with state resources alone. The combination of reduced federal support and limited state fiscal capacity means that essential public health functions may simply go unfunded in many communities.

At the same time, the budget reduces support for state, local, and territorial public health infrastructure. CDC's Public Health Emergency Preparedness (PHEP) cooperative agreement—the primary source of federal funding for state and local emergency preparedness—faces a 52 percent cut from $735 million in FY 2024 to $350 million.[130] States, territories, and localities use PHEP funding to maintain emergency response teams, conduct drills and exercises, develop response plans, coordinate with healthcare systems, and sustain the workforce and infrastructure needed to respond to outbreaks, natural disasters, and other health emergencies.[131] This reduction threatens to limit jurisdictions' ability to prepare for and respond to health emergencies. About 80 percent of CDC's domestic budget goes directly to states, localities, tribes, tribal organizations, territories, community and faith-based organizations, healthcare systems, and other partners.[132] A cut to CDC funding is a cut to public health funding in every state and community. Similarly, reductions to CDC's workforce eliminate the scientific expertise, technical assistance, and on-the-ground support that state, local, tribal, and territorial health departments rely on during emergencies and for ongoing public health programs.

Furthermore, the elimination of much of CDC's global health work marks a significant retreat from the nation's long-standing commitment to protect and promote health internationally. Because pathogens do not respect borders, reducing the commitment to supporting public health capabilities in other nations weakens U.S. health security as well. Programs for global HIV/AIDS, tuberculosis, and immunization would all end,[133] even as infectious diseases demonstrate the capacity to cross borders rapidly, as seen with Ebola outbreaks and measles cases spreading internationally. The elimination of these programs would not only impact global health outcomes but also weaken America's early warning system for emerging infectious diseases.

The FY 2026 budget proposal also outlines workforce reductions across HHS agencies, with total employment projected to decline from 90,191 positions in FY 2024 to 75,630 in FY 2026—a reduction of 14,561 positions or 16 percent. (See Table 1.)

Table 1: HHS Agency Workforce Levels, FY 2024–2026

Full-time equivalent positions by agency show reductions under proposed reorganization plan

	FY 2024 Actual	FY 2025 Estimate	FY 2026 Estimate	FY 2024 to FY 2026 *% change*
AHA*	190	187	3,115	1539%
FDA	19,698	20,593	16,875	-14%
HRSA**	2,599	2,462	0	-100%
IHS	16,140	15,232	15,232	-6%
CDC + ATSDR	13,242	10,001	7,571	-43%
NIH	19,838	19,803	16,293	-18%
SAMHSA**	816	649	0	-100%
AHRQ**	286	286	0	-100%
CMS	6,608	5,996	5,874	-11%
ACFC	2,053	2,006	1,643	-20%
ACL**	205	206	0	-100%
ASPR**	1,110	1,138	0	-100%
Other	7,406	7,321	9,027	22%
Total	**90,191**	**85,880**	**75,630**	**-16%**

Workforce figures represent full-time equivalent (FTE) positions and military average strength employment.

Totals include: Direct civilian FTE, direct military average strength employment, reimbursable civilian FTE employment, reimbursable military average strength employment, allocation account civilian FTE employment, and allocation account military average strength employment.

**AHA figures for FY 2024 and FY 2025 include personnel associated with: World Trade Center Health Program Fund; Covered Countermeasures Process Fund; Maternal, Infant, and Early Childhood Home Visiting Program; and Vaccine Injury Compensation Program Trust Fund.*

***Zero values for HRSA, SAMHSA, AHRQ, ACL, and ASPR in FY 2026 reflect proposed elimination of these distinct divisions under the reorganization plan.*

"Other" includes HHS divisions not listed separately.

Source: TFAH analysis of agency budget accounts in the Technical Supplement to the president's budget for FY 2026, U.S. Department of Health and Human Services.[134]

The most substantial workforce changes would occur at divisions proposed for elimination or absorption into new entities. Five agencies would see their workforces reduced to zero: HRSA (losing 2,599 positions), SAMHSA (816), AHRQ (286), ACL (205), and ASPR (1,110). Together, these agencies employed up to 5,016 full-time equivalent (FTE) staff. (Comparisons are with FY 2024 levels.)

CDC and ATSDR would experience the largest absolute reduction, with staffing levels declining from 13,242 in FY 2024 to 7,571—a decrease of 5,671 FTEs or 43 percent. This reduction reflects both budget cuts and the transfer of certain functions to other agencies. NIH would see its workforce reduced by 3,545 FTEs (18 percent).

The newly created AHA would grow from 190 positions in FY 2024 (some AHA positions are accounted for in the president's proposal as predating its formal creation) to 3,115 in FY 2026. However, this increase would absorb only about 58 percent of the 5,016 positions eliminated from the consolidated agencies, suggesting an overall reduction in workforce capacity.

Proposed Changes to CDC

The budget would reduce CDC and ATSDR funding by 53 percent, from $9.25 billion in FY 2024[135,136] to $4.32 billion,[137] while transferring selected programs to other entities. Major FY 2024 accounts, including Chronic Disease Prevention ($1.43 billion) and Injury Prevention ($761 million), would be almost entirely eliminated. Some functions are proposed for transfer to the new AHA, including injury prevention programs, lead-poisoning prevention, the Alzheimer's disease program, and NIOSH

operations, though there is uncertainty about which specific components would ultimately transfer and how they would operate within the new structure. Many of these programs have already seen significant workforce reductions. (See Figures 3 and 4.)

The budget would reduce CDC program-level resources by downsizing CDC's appropriation and shifting selected activities out of CDC to AHA and the Office of Strategy. The $1.28 billion total moved offsets about 26 percent of the $4.93 billion cut. After accounting for the transfers, resources supporting activities historically housed at CDC and ATSDR would stand at $5.60 billion—about $3.65 billion (39 percent) below FY 2024.

In short, the proposal cuts CDC and ATSDR appropriations by more than half, then restores about one-quarter of the lost dollars by relocating selected programs to two newly proposed divisions.

Elimination of Chronic Disease Prevention Programs

Despite the administration's stated goal of reducing chronic diseases,[141] the FY 2026 budget proposes the near-total elimination of CDC's National Center for Chronic Disease Prevention and Health Promotion, which addresses the leading causes of illness, disability, and death in the United States.[142] Some functions would transfer to the new AHA. Programs that would be terminated include:

- The Division of Nutrition, Physical Activity, and Obesity, which received $58.4 million in FY 2024,[143] works to address the country's obesity epidemic.[144] The loss of this CDC division would eliminate a federal entity solely focusing on supporting evidence-based strategies to improve nutrition and increase physical activity in communities across the nation.

- The Office on Smoking and Health, funded at $247 million in FY 2024,[145] has been instrumental in reducing smoking rates—including helping to achieve the lowest recorded level of youth tobacco use in 25 years.[146,147] The proposed elimination would end the *Tips from Former Smokers* campaign, which has helped more than 1 million Americans quit smoking, prevented hundreds of thousands of early deaths, and saved billions in smoking-related healthcare costs.[148] It would also terminate support for state tobacco-control programs.

- Heart disease, stroke, diabetes, and cancer prevention and programs—these conditions collectively account for about half of U.S. deaths annually.[149]

- The Racial and Ethnic Approaches to Community Health (REACH) program, which addresses health disparities in communities with the highest burden of chronic disease.[150] REACH has demonstrated significant impact across communities: from 2014–2018, the program provided 2.9 million people with better access to healthy foods, helped 322,000 people benefit from tobacco-free interventions, and increased physical activity opportunities for 1.4 million people. In an earlier cycle, REACH achieved notable reductions in smoking rates among communities of color and improved chronic disease management, including a 44 percent reduction in diabetes-related amputations among African Americans in South Carolina.[151]

- Programs that address upstream drivers of health, which recognize that health outcomes are shaped by factors beyond medical care.[152]

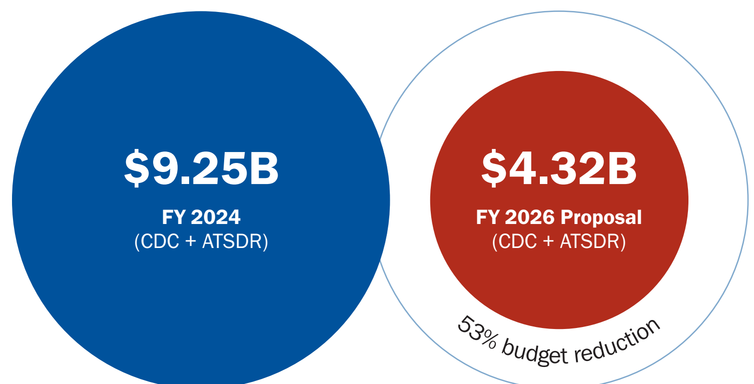
- Healthy Schools, which works with state and tribal education and health agencies to promote the health and well-being of children and adolescents in schools.[153]

Elimination of the Prevention Fund

The FY 2026 budget proposes the complete elimination of the Prevention and Public Health Fund (PPHF or Prevention Fund)—a critical source of sustained funding for disease prevention and health promotion activities in every state and territory, as well as in localities and tribal communities—since its creation in 2010.

Figure 3: CDC Faces $5 Billion Cut Under FY 2026 Budget Plan

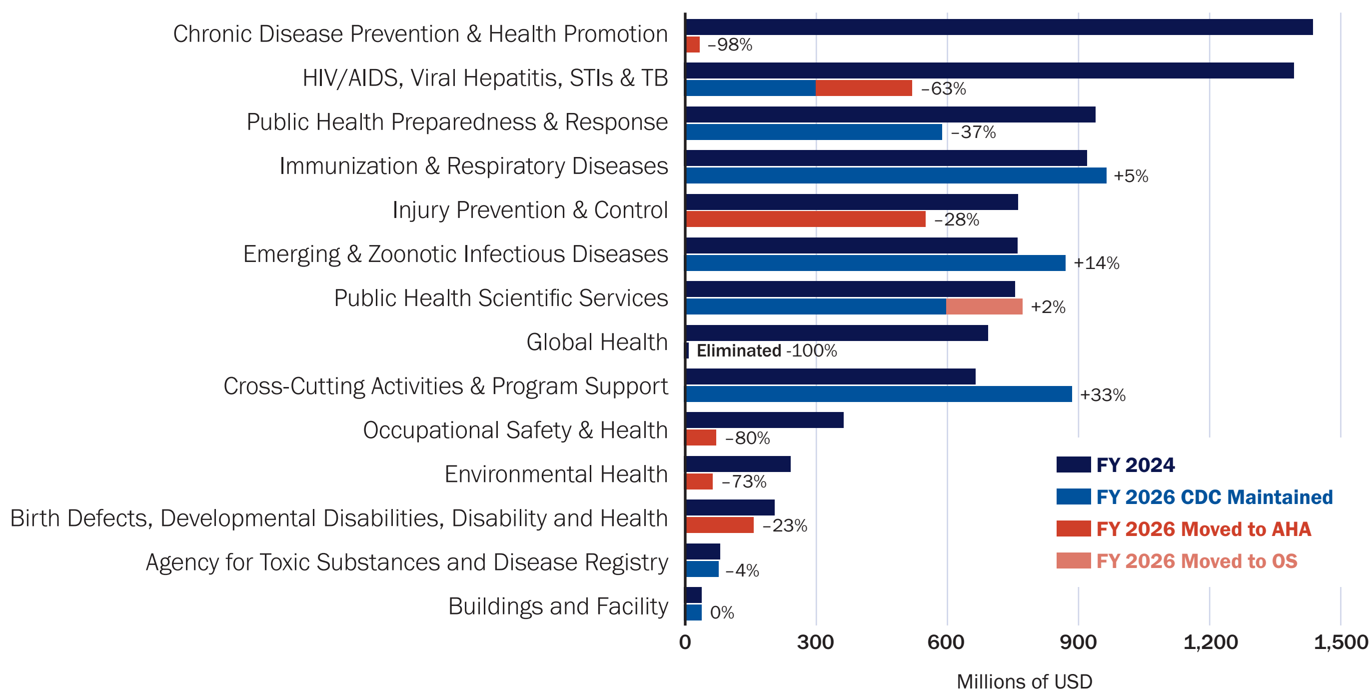
The proposal would eliminate key public health centers



Note: Figures represent program-level funding, which includes budget authority, Prevention and Public Health Fund transfers, and other funding streams. Portions of eliminated CDC funding would be transferred to the proposed AHA.

Sources: FY 2024 CDC and ATSDR Operating Plans[138,139] and FY 2026 HHS Budget in Brief[140]

Figure 4: President's FY 2026 Budget Proposes Deep CDC Cuts, With Few Dollars Shifted Elsewhere



Note: In addition to shifting funding to the proposed Administration for a Healthy America or the Office of Strategy, the FY 2026 budget proposes several realignments of CDC activities. Surveillance for Emerging Threats to Mothers and Babies would move from Birth Defects, Developmental Disabilities, Disability and Health into Emerging and Zoonotic Infectious Diseases, along with Parasitic Diseases and Malaria from Global Health. The combined Ready Response Enterprise Data Integration Platform/Forecasting and Outbreak Analytics line would move from Public Health Preparedness and Response to Cross-Cutting Activities and Program Support. Environmental Health Laboratory and Environmental Health Threats Prevention (referred to as "All Other Environmental Health" in FY 2024) would move from Environmental Health to Cross-Cutting Activities and Program Support, along with Global Public Health Protection from Global Health. Finally, ASPR's Healthcare Readiness and Response, Preparedness and Response Innovation, and the National Disaster Medical System would transfer to CDC's Public Health Preparedness and Response account. The FY 2026 data presented here incorporate these proposed changes.

Sources: FY 2024 CDC and ATSDR Operating Plans,[154,155] as well as FY 2026 CDC Congressional Justification Detail Table and FY 2026 HHS Budget in Brief[156]

The PPHF provides about $1 billion in mandatory funding annually that has supported key public health programs and activities across multiple HHS agencies.[157] From FY 2013-2024, it invested more than $13.5 billion. At CDC, which has received the bulk of fund allocation, it has sustained immunization programs, epidemiology and laboratory capacity, chronic disease prevention efforts, and public health workforce development. These programs represent the front lines of the country's defense against both infectious and chronic diseases—the infrastructure that identifies outbreaks, tracks disease patterns, and implements prevention strategies before health crises emerge.

Prevention Fund investments have saved money and lives, partially or fully supporting cost-effective programs such as the *Tips from Former Smokers* campaign and the Diabetes Prevention Program. Without it, and with CDC's funding reduced by more than half, major prevention programs could face severe reductions or elimination.

Environmental Health Programs Eliminated

The FY 2026 budget proposes significant reductions to environmental health programs, eliminating key initiatives that protect U.S. residents from environmental hazards, such as chemicals, unsafe water, and exposure to toxins following disasters. The Childhood Lead Poisoning Prevention Program would be moved to the new AHA along with the Division of Laboratory Sciences (DLS) and National Biomonitoring Network.

Programs proposed for elimination include the National Environmental Public Health Tracking Network, which provides data on environmental hazards and their health effects,[158] as well as programs that reduce asthma morbidity and mortality.[159] Money to support CDC's funding and technical assistance for state, tribal, local, and territorial health agencies in advance of environmental exposures and during emergencies would also be eliminated. Grant recipients use these resources to reduce the risk of wildfire smoke exposure, detect infectious diseases

circulating in a community through wastewater testing, and identify unusual occurrences of pediatric cancer and potential environmental exposures.

The complete elimination of climate and health programs would reduce federal capacity to address weather-related health threats, including extreme heat, hurricanes, wildfires, and shifting disease patterns. These programs are increasingly critical as extreme weather events grow in frequency and intensity, with climate disasters causing billions of dollars in economic losses and straining healthcare systems nationwide.

Public Health Emergency Preparedness and Health Security Weakened

While maintaining some emergency response capabilities, the budget would significantly reduce the nation's public health emergency preparedness infrastructure. The PHEP cooperative agreement, which provides critical funding to state and local health departments for emergency preparedness and response, would be cut by $385 million, from $735 million in FY 2024 to $350 million.[160] This 52 percent reduction would limit jurisdictions' ability to prepare for and respond to public health emergencies, including disease outbreaks, hurricanes like Helene and Milton, the devastating flooding in Texas during summer 2025, recent California wildfires, and other threats.

The reorganization would shift some ASPR programs to CDC, including Healthcare Readiness and Response and the National Disaster Medical System, while moving BARDA, Pandemic Influenza programs, and the Strategic National Stockpile to a new Office of the Assistant Secretary for a Healthy Future.[161]

The budget also cuts $275 million in funding that helps healthcare systems prepare for emergencies. The Healthcare Readiness and Recovery program would see its funding reduced from $305 million to just $30 million.[162,163] Within that portfolio, the Hospital Preparedness Program cooperative agreement, which is the primary source of federal funding dedicated to healthcare delivery system preparedness, would be eliminated. This program supports hospitals and healthcare coalitions in every state and territory in preparing for and responding to emergencies and disasters, ensuring medical surge capacity and coordinated response during crises.

These changes would weaken the nation's health security infrastructure and emergency response capabilities at a time when emergencies and disasters are increasing in frequency and severity.

Proposed Creation of the Administration for a Healthy America

The Trump Administration's proposed new AHA is being created with the stated goal of "more efficiently coordinat[ing] chronic care and disease prevention programs."[164] The FY 2026 budget would fund AHA at $19 billion and includes program transfers with modified funding levels, such as:

- From CDC's National Center for Injury Prevention and Control, programs addressing suicide, overdose, and violence prevention would be transferred, but with a reduction in funding from $761 million in FY 2024[165] to $550 million.[166] CDC's program addressing Adverse Childhood Experiences, which are potentially traumatic events that can have long-term negative impacts on health, opportunity, and well-being, would be eliminated entirely.
- Certain environmental health programs, including those addressing safe water and lead poisoning.[167]
- Some occupational health programs from CDC's National Institute for Occupational Safety and Health (NIOSH).

For programs slated to move to AHA or another newly created agency, the president's budget request does not clarify if the equivalent programs, experts, capabilities, and public health approaches would be sustained.

The proposed AHA represents an untested organizational structure that would consolidate diverse programs with different statutory authorities, operational requirements, and specialized expertise. The consolidation raises questions about whether a single entity can effectively manage the breadth of functions previously housed across multiple specialized agencies, from occupational safety research to substance use treatment. The success of these consolidations remains uncertain given reduced funding levels and the operational challenges of integrating programs that serve different populations and require distinct technical expertise. Additionally, the disruption of established working relationships between federal agencies and their state, local, tribal, territorial, and community partners would affect program implementation and service delivery during the transition period.

Data and Surveillance Systems at Risk

The budget proposes moving the National Center for Health Statistics from CDC to the Office of Strategy within the Office of the Secretary,[168] placing this critical data-collection agency under

more direct control of the HHS secretary and separating it from CDC's scientific and programmatic expertise. This reorganization is accompanied by a budget reduction from $187 million in FY 2024[169] to $175 million in FY 2026.[170]

Additional surveillance systems could face disruption through the elimination of CDC centers. The National Center for Chronic Disease Prevention and Health Promotion oversees key surveillance systems, including the Youth Risk Behavior Surveillance System (YRBS) and the Behavioral Risk Factor Surveillance System (BRFSS), which track health behaviors and risk factors across populations. The National Center for Injury Prevention and Control operates surveillance systems monitoring violence, suicide, and unintentional injuries.

These surveillance systems provide essential data for public health decision-making at federal, state, and local levels, such as identifying emerging health trends, tracking vaccination coverage, monitoring the effectiveness of prevention programs, detecting disease outbreaks, and informing resource allocation decisions. Their elimination or transfer could affect continuity of data collection and the ability to track health trends over time.

Impact on State and Local Health Departments

Due to executive actions taken in FY 2025 and those proposed for FY 2026, state and local health departments will face substantially reduced federal support for public health functions. These changes represent a fundamental shift in the long-standing interdependent roles of federal, state, and local agencies within the public health system. Approximately 80 percent of CDC's domestic budget flows to external partners such as states, localities, tribes, tribal organizations, territories, healthcare systems, and community partners.[171] Reductions in federal funding, expertise, and systems would directly impact state and local public health spending and capacity.

State and local health departments would face:

Reduced Capacity: With reduced federal support, health departments would need to make difficult choices about which programs to maintain and which to eliminate.

Loss of Technical Assistance: Many eliminated programs provide not just funding but technical assistance for state and local health departments. The loss of CDC's chronic disease prevention infrastructure would leave jurisdictions with less access to evidence-based strategies and best practices for addressing conditions like diabetes, heart disease, and obesity. Similarly, the loss of environmental health expertise was demonstrated during the 2025 lead-poisoning crisis in Milwaukee public schools, when CDC was unable to send experts to the city to provide on-the-ground support, as staff for the lead program had been temporarily terminated.[172]

Loss of Data Visibility: CDC maintains key data systems and laboratories that provide jurisdictions with critical information about the health status of their populations and how they compare nationally. If some of these systems are weakened or eliminated—or as connections between jurisdictions and CDC experts diminish—health departments will lose visibility into population health trends, limiting their ability to target resources effectively and measure program impact.

Risk of Widening Health Disparities: States and localities with limited resources would be less able to maintain programs, exacerbating geographic and population health disparities. Rural and under-resourced communities would be particularly affected.

Current Status of the FY 2026 Budget

As of July 2025, the FY 2026 budget proposal is under congressional review. On July 31, 2025, the Senate Appropriations Committee approved its version of the FY 2026 appropriations bill by a bipartisan vote of 26–3. The Senate bill rejected the Trump Administration's proposal to restructure, eliminate, or consolidate many public health programs, instead providing $9.2 billion for CDC—approximately $70 million below FY 2024 levels but substantially higher than the administration's request for $4.3 billion.[173,174,175]

The Senate bill sustains critical programs across CDC, including chronic disease prevention, the Office on Smoking and Health, injury prevention programs, global health programs, and environmental health programs. It maintains level funding for public health emergency preparedness ($735 million) and public health infrastructure ($350 million). The legislation also includes new oversight provisions requiring the HHS secretary to submit detailed plans before initiating CDC reorganizations and directing HHS to brief the appropriations committees on payment system disruptions affecting states and localities.[176]

In early September 2025, the House Appropriations Committee also advanced its FY 2026 HHS appropriations bill, which includes a $1.7 billion cut to CDC. While the bill rejects the administration's agency restructuring proposals, it eliminates all funding for domestic and global HIV activities, tobacco prevention, the Preventive Health and Health Services Block Grant, and other programs.[177]

Potential Consequences of Proposed and Implemented Restructuring

The fundamental restructuring of federal health infrastructure documented in this report would have significant effects across multiple sectors if fully implemented.

Immediate Operational Effects

The elimination of thousands of federal health positions will reduce specialized expertise. The loss of unique national capabilities would create gaps in essential public health functions that cannot be readily replaced. In some cases, the experts and laboratories impacted by cuts to CDC are the only ones in the nation with these unique capabilities.

State and local health departments would face immediate funding reductions. Most jurisdictions would need to scale back prevention programs, reduce disease detection activities, or eliminate specific services previously supported by federal funds. Rural communities and areas with limited public health infrastructure would face particular challenges.

Emergency Preparedness and Response Capacity

The proposed reduction in CDC's emergency preparedness funding to states and localities would limit the ability of health departments to maintain response capabilities for disease outbreaks, natural disasters, or other health emergencies. This reduction comes as the nation continues to face various health threats requiring coordinated federal-state-local responses. The cuts would lead to workforce losses across the country in laboratories, disease detection, emergency response, and other critical areas.

The reorganization would also significantly affect national security and emergency response capabilities through the elimination of ASPR as a distinct entity and the redistribution of its functions to CDC and a proposed Office of the Assistant Secretary for a Healthy Future. As required by statute, ASPR leads the medical and public health response and coordinates the medical countermeasures (MCM) enterprise for disasters and emergencies. The president's FY 2026 budget proposes moving some healthcare response activities to CDC while eliminating funding support for healthcare preparedness across the country. ASPR has led a successful MCM enterprise that has strengthened the nation's biodefense, including FDA approval of more than 100 BARDA-supported products.[178] The FY 2026 budget also proposes a 36 percent cut to BARDA's budget and a 23 percent cut to the Strategic National Stockpile. These reductions, combined with the logistical challenges of restructuring the nation's MCM enterprise, would disrupt research, development, and deployment of countermeasures for the next public health emergency.

Surveillance and Data Systems

Surveillance systems that monitor disease trends, health behaviors, and environmental hazards could experience disruptions during transitions to new organizational structures. The elimination of CDC centers responsible for chronic disease surveillance (including YRBS and BRFSS systems) and injury surveillance would affect the ability to detect emerging health threats or track progress on public health indicators.

Moving the National Center for Health Statistics from CDC to a policy office could affect how findings are integrated with broader epidemiological research.

Healthcare Access and Prevention Programs

The elimination of HRSA as a distinct operating division would create operational disruptions even if programs transfer to AHA, as consolidation would affect program management, technical assistance, and established relationships with community health centers, other service providers, and workforce development programs. HRSA supports workforce development programs that train healthcare professionals for underserved areas. The disruption could particularly impact Federally Qualified Health Centers, which provide primary care in medically underserved communities. Rural communities and low-income populations that rely on these federally supported healthcare services would experience the most serious impacts during the transition period.

Prevention programs addressing chronic diseases, substance use, and tobacco control currently reach millions of Americans. Changes to program structure and funding levels would affect ongoing efforts to address conditions such as diabetes, heart disease, and addiction, particularly in communities that have benefited from targeted programs addressing health disparities.

Potential Long-term Impacts

The policy changes would have effects that extend beyond immediate budget cycles:

- **Increased Healthcare Costs:** Prevention programs have been shown to reduce healthcare expenditures by addressing conditions before they require expensive treatment interventions.[179] The elimination of these programs and/or people being unable to access preventive care due to lack of health insurance would lead to increased healthcare spending.[180]
- **Economic Impact:** Poor health outcomes and disability reduce workforce productivity.[181] The elimination of programs that keep Americans healthy would have negative economic consequences for businesses, communities, and the nation.
- **Reduced Life Expectancy:** The United States already lags behind other high-income nations in life expectancy.[182] The elimination of programs addressing the leading causes of death could worsen this trend.

Implementation and Transition

The timing and scope of these effects could depend on congressional decisions regarding the FY 2026 budget and subsequent appropriations. Additionally, it remains unclear whether the administration will proceed with restructuring efforts if Congress does not codify the reorganization proposals through legislation. Some changes could occur immediately upon budget implementation, while others might develop over months or years as existing grant periods expire and programs wind down.

These potential consequences represent important considerations for policymakers as they evaluate the changes that have been initiated or proposed.

Recommendations for Congress and the Administration

Every person in America should have the opportunity to live a healthy life regardless of where they live. Achieving this goal requires communities supported by a robust public health system at every level—federal, state, local, tribal, and territorial—as well as policies that promote health and well-being. Whether responding to outbreaks, preventing children from drowning, reducing obesity, or protecting communities from wildfire smoke, the nation's public health system is essential for saving lives and reducing healthcare spending. The public health system—comprising governmental and nongovernmental entities that work together to protect communities from preventable disease and injury—needs a baseline of resources, connectivity, workforce, and structures to function effectively.

To protect the nation's health, economic security, and national security, TFAH recommends that Congress and the administration take the following actions for FY 2026 and beyond. These recommendations address urgent challenges currently facing the public health system.

Recommendation: Congress and the administration should restore federal health agencies, funding, and workforces that were cut in 2025.

The rapid elimination of federal programs and loss of expertise across HHS is having a negative impact on the public's health and public health capabilities across the country. These actions were taken without congressional approval, and thus we also encourage HHS to work with Congress to conduct a comprehensive analysis of the impact of these cuts.

Recommendation: Congress and the administration should maintain and strengthen the structure and capabilities of federal health agencies, which have specific, complementary, and distinct roles and expertise in protecting the nation's health.

Proposals to fundamentally alter CDC, ASPR, SAMHSA, HRSA, ACL, and other federal public health agencies will lead to serious disruptions in the detection and prevention of diseases and delivery of services and other supports in communities.

Recommendation: Congress, in collaboration with federal agencies and outside experts and partners, should lead a bipartisan, deliberative process of reviewing proposals for federal health agency restructuring or development of new agencies.

The administration should provide a comprehensive plan to Congress on its proposals to restructure federal agencies prior to moving forward, including plans to ensure essential public health services to all communities. To inform the process, relevant congressional committees should hold listening-sessions and hearings with governmental and nongovernmental components of the public health, healthcare, patient, and scientific ecosystem to ensure federal agencies can support the health protection needs of all communities.

Recommendation: Congress and the administration should strengthen CDC as a national, comprehensive public health agency with responsibilities across the detection, prevention, and mitigation of the leading causes of preventable death, illness, and injury.

In order to fulfill its role in protecting the health of the American people and in supporting state and local efforts to do the same, Congress should provide at least $11.58 billion for CDC in FY 2026, with increases to follow. The boom-and-bust cycle of public health appropriations, unpredictability of funding, and lack of federal funding flexibility create instability for the public health system.

Recommendation: Federal agencies must spend all funds appropriated by Congress, as required by law, and OMB should release full-year funds to agencies after enactment of appropriations legislation.

Impounding, delaying, freezing, or terminating public health funding that has been passed into law leaves every community at risk, weakens the economy, and disrupts research. Even funding delays cause health departments and nonprofit organizations to end programming and lose staff. Congress should conduct oversight and ensure that federal agencies expend all money as directed by Congress.

Recommendation: Congress should enact full-year appropriations bills for HHS and its agencies and operating divisions.

Continuing resolutions, short-term funding, government shutdowns, and across-the-board cuts are all deeply harmful to public health and scientific research. They prevent the efficient and effective use of taxpayer dollars and hinder the hiring and retention of skilled workers.

Recommendation: Congress and the administration should implement evidence-based processes to identify inefficiencies and enhance the effectiveness of federal public health services, such as improving the efficiency of disbursement of federal funds, program evaluation and data collection, and enabling flexibility when needed.

For example, federal agencies should streamline grant application and reporting processes to reduce administrative burden on state and local health departments while maintaining accountability. These improvements would allow public health dollars to reach communities more quickly and enable better assessment of which interventions are most effective in protecting population health.

Recommendation: Congress should restore the Prevention and Public Health Fund and prevent future cuts.

PPHF has made critical investments in every state and territory, such as expanding vaccine access through CDC's Immunization Program, building laboratory capacity, and preventing chronic disease. In its first 15 years (FY 2010–2024), the Prevention Fund has invested more than $13.5 billion in resources to states, localities, territories, and tribal and community organizations in support of critical prevention and public health programs.[183] Despite its impact, PPHF has already been cut by $12.95 billion from FY 2013 through FY 2029. Congress should restore this funding and not use it as an offset in future legislation.[184]

Recommendation: Congress should reject new discretionary budgetary caps.

Inadequate overall health funding with arbitrary caps fails to account for inflation, new public health threats, and population growth.

Recommendation: Congress should ensure continuous improvement of the nation's public health infrastructure, capabilities, and essential services, including workforce, laboratories, and data systems at all levels.

Congress should enact legislation such as the Public Health Infrastructure Saves Lives Act, which would provide sustained funding for the Public Health Infrastructure Program, which in turn is strengthening the nation's public health system to address 21st-century health threats and opportunities. This investment is vital to ensuring health departments have more effective emergency responses, faster disease detection, and continuous progress toward preventing chronic diseases. In the interim, Congress should provide robust annual appropriations for public health infrastructure, data modernization, and epidemiology and laboratory capacity, the majority of which supports foundational capabilities across the country.

Recommendation: Congress should create a Health Defense Operations budget designation to exempt biodefense programs central to health security from the annual discretionary budget allocations and to ensure these critical activities receive the sustainable resources necessary to secure Americans' health, economic, and national security.

Budget caps and competing priorities in the nondefense discretionary budget category continue to constrain annual discretionary appropriations, making it nearly impossible to invest in medium- to long-term health defense.

Appendix A: Programs and Funding Lines Proposed for Elimination in the President's FY 2026 Budget Request

The following programs and funding lines at CDC, SAMHSA, and ASPR would be eliminated under the president's FY 2026 budget proposal. This list is based on analysis of FY 2026 budget documents.[185,186,187,188]

Centers for Disease Control and Prevention

- Acute Flaccid Myelitis (AFM)
- Domestic HIV/AIDS Prevention and Research, including School Health
- Prion Disease
- Chronic Fatigue Syndrome
- Harmful Algal Blooms
- Healthcare-Associated Infections
- Amyotrophic Lateral Sclerosis Registry
- Climate and Health
- Trevor's Law
- Environmental and Health Outcome Tracking Network
- Asthma
- Adverse Childhood Experiences
- Youth Violence Prevention
- Unintentional Injury, including Traumatic Brain Injury, Drowning, Elderly Falls
- Injury Prevention Activities
- Injury Control Research Centers
- Firearm Injury and Mortality Prevention Research
- National Occupational Research Agenda
- NIOSH Education and Research Centers
- Personal Protective Technology
- Other Occupational Safety and Health Research, including Total Worker Health
- Global HIV/AIDS Program
- Global Tuberculosis
- Global Immunization Program, including Polio Eradication and Measles and Other Vaccine Preventable Diseases
- Academic Centers for Public Health Preparedness
- Preventive Health and Health Services Block Grant
- Tobacco
- Nutrition, Physical Activity, and Obesity
- School Health
- Health Promotion
- Vision and Eye Health
- Inflammatory Bowel Disease
- Interstitial Cystitis
- Excessive Alcohol Use
- Chronic Kidney Disease
- Chronic Disease Education and Awareness
- Prevention Research Centers
- Heart Disease and Stroke
- Diabetes
- National Diabetes Prevention Program
- Cancer Prevention and Control
- Breast and Cervical Cancer
- Breast Cancer Awareness for Young Women
- National Program of Cancer Registries
- Colorectal Cancer
- National Comprehensive Cancer Control Program
- Johanna's Law
- Ovarian Cancer
- Prostate Cancer
- Skin Cancer
- Cancer Survivorship Resource Center
- Oral Health
- Safe Motherhood/Infant Health
- Arthritis
- Epilepsy
- National Lupus Patient Registry
- Racial and Ethnic Approach to Community Health and Healthy Tribes
- Social Determinants of Health
- Million Hearts
- National Early Child Care Collaboratives
- Hospitals Promoting Breastfeeding

Substance Abuse and Mental Health Services Administration

- Mental Health Awareness Training
- Healthy Transitions
- Children and Family Programs
- Consumer and Family Network Grants
- Mental Health System Transformation and Health Reform
- Project LAUNCH
- Primary and Behavioral Health Care Integration and Primary and Behavioral Health Care Integration Training and Technical Assistance
- Mental Health Crisis Response Partnership Pilot Program
- Homelessness Prevention Programs
- Criminal and Juvenile Justice Program
- Assertive Community Treatment for Individuals with SMI
- Minority AIDS Initiative (Mental Health)
- Minority Fellowship Program (Mental Health)
- Seclusion and Restraint
- Tribal Behavioral Health Grants (Mental Health)
- Infant and Early Childhood Mental Health
- Interagency Task Force on Trauma-Informed Care
- Strategic Prevention Framework
- Sober Truth on Preventing Underage Drinking (STOP Act)
- Tribal Behavioral Health Grants (Prevention)
- Minority AIDS Initiative (Prevention)
- Minority Fellowship Program (Prevention)
- Screening, Brief Intervention and Referral to Treatment
- Targeted Capacity Expansion
- Pregnant and Postpartum Women
- Improving Access to Overdose Treatment
- Building Communities of Recovery
- Recovery Communities Service Program
- Children and Families (Youth and Family TREE)
- Treatment Systems for Homelessness
- Criminal Justice Activities
- Minority AIDS Initiative (Treatment)
- Minority Fellowship Program (Treatment)
- Grants to Prevent Prescription Drug/Opioid Overdose-Related Death
- Peer Support Technical Assistance Center
- Treatment, Recovery and Workforce Support
- Emergency Department Alternatives to Opioids
- Comprehensive Opioid Recovery Centers
- First Responder Training (FR-CARA)
- Youth Prevention and Recovery Initiative

Administration for Strategic Preparedness and Response

- Medical Reserve Corps
- ASPR Center for the HHS Coordination Operations and Response Element (H-CORE)
- Hospital Preparedness Program cooperative agreement (According to the budget, there would be a Health Care Readiness & Recovery line in CDC, but it would only sustain the National Special Pathogen System and Cybersecurity and Infrastructure Protection.)

Endnotes

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