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# Ready or Not?

## PROTECTING THE PUBLIC'S HEALTH IN THE AGE OF BIOTERRORISM

### EXECUTIVE SUMMARY

## TWO YEARS AND NEARLY \$2 BILLION LATER, IS THE NATION BETTER PREPARED?

**T**HE SEPTEMBER 11, 2001 TRAGEDIES AND SUBSEQUENT ANTHRAX ATTACKS MADE THE NATION AWARE THAT THE PUBLIC HEALTH SYSTEM IS ILL-PREPARED TO MANAGE A LARGE-SCALE EMERGENCY. THE UNITED STATES CONGRESS RESPONDED BY APPROPRIATING \$1.8 BILLION TO HELP REVITALIZE AMERICA'S PUBLIC HEALTH SYSTEM.<sup>1</sup>

THIS REPORT EXAMINES WHETHER OR NOT -- TWO YEARS AND NEARLY \$2 BILLION LATER -- AMERICA'S PUBLIC HEALTH SYSTEM IS BETTER PREPARED TO RESPOND TO PUBLIC HEALTH EMERGENCIES. IT ASSESSES BOTH IMPROVEMENTS AND ONGOING AREAS OF VULNERABILITY IN ADDITION TO OFFERING SPECIFIC RECOMMENDATIONS ON HOW TO BETTER PROTECT THE PUBLIC'S HEALTH.

## PUBLIC HEALTH PREPAREDNESS: AN UNSETTLING PICTURE

The federal investment in public health preparedness has led to a perception that America's long-neglected public health system is undergoing rapid and substantial improvements. Trust for America's Health (TFAH) found a more complicated and, at times, unsettling picture.

The report finds that, **despite the needed surge in federal funds, states are only modestly more prepared to respond to health emergencies than they were prior to 9/11.** TFAH found that states have achieved piecemeal progress, but that a full-scale effort to comprehensively fix the nation's public health system is falling short.

<sup>1</sup> The U.S. Congress provided the Centers for Disease Control and Prevention (CDC) with \$940 million in FY 2002 and \$870 million in FY 2003 to support state and local public health preparedness. This study focuses on the FY 2002 funds distributed to states through CDC cooperative agreements.

## PUBLIC HEALTH POST-9/11

### MAJOR PROGRESS

- **Major improvements have been made in emergency communications**, with 89 percent of the U.S. population now covered by the Centers for Disease Control and Prevention (CDC) emergency communications network.
- **Initial bioterrorism plans are now in place in all 50 states and the District of Columbia (D.C.)** However, these plans often consist only of an initial framework rather than specific action steps for emergency implementation.
- **Preliminary laboratory equipment, facilities and staffing upgrades are occurring**, but much more needs to be done. Only six states report they have sufficient facilities.

### MAJOR CONCERNS

- **State budget cuts in nearly two-thirds of states threaten to undermine bioterrorism and other health-crisis readiness.**
- **Much of the federal bioterrorism aid is wrapped up in red tape, with only half of states having spent 90 percent of FY 2002 funds.** Procurement problems, hiring freezes and shortages of trained workers contribute to the delays.
- **Only one-third of states have passed along half of their federal funds to local health departments.** State, local and city health departments often disagree on how resources should be distributed.
- **The public health workforce is about to face a major shortage.**
- **Only two states are at the highest preparedness level required to receive and distribute pharmaceuticals and other medical supplies needed to provide emergency vaccinations and antidotes.**
- **Readiness for threats from infectious diseases and other health crises is in jeopardy**, with only one-quarter of states having a plan to respond to a pandemic flu outbreak.

According to the study results, with the help of the funds, many state and local agencies have developed preliminary preparedness plans, made some improvements to public health laboratories and improved communications capabilities. However, the overall preparedness effort has been compromised by the impact of state budget crises, the lack of priority placed on addressing systemic weakness and the failure to eliminate bureaucratic obstacles.

The public health system is not a single entity, but rather a loosely affiliated network of federal, state and local agencies. These agencies largely define the quality of the nation's response to a public health crisis. They provide initial front-line defenses and

ongoing management of man-made and naturally occurring health threats.

Since 9/11, the federal government has dramatically increased its spending on the state and local public health infrastructure, increasing the \$67 million spent in FY 2001 to \$940 million in FY 2002.

Numerous evaluations of the nation's overall health defenses have found serious deficiencies in the fundamental and underlying structure, including workforce, communications systems, laboratories and health tracking. There has not been, however, a similar evaluation of individual state preparedness levels. This is particularly important to understand, because state and local agencies are responsible for managing emergency first response activities.

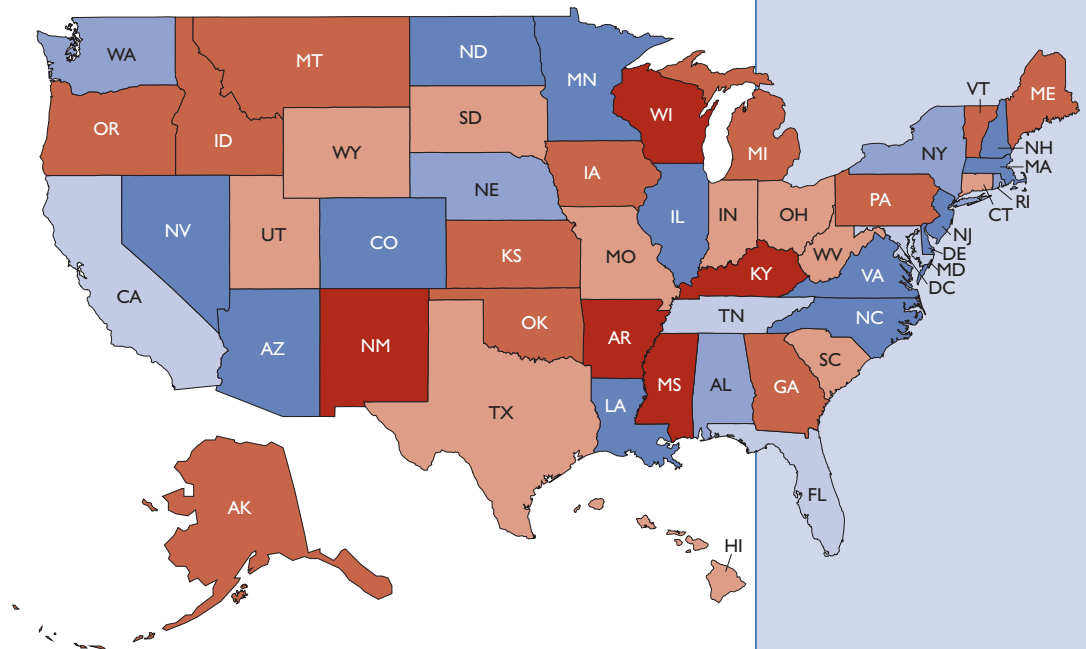
# STATE-BY-STATE PREPAREDNESS INDICATOR SCORES

To assess the states' public health emergency preparedness, TFAH worked with an advisory committee of state and local officials and public health experts to select a series of 10 key indicators that assess fundamental public health capabilities.<sup>2</sup> Collectively, these indicators provide a snapshot of improvements that have been made since 9/11 and areas where the public health system is still vulnerable.

The indicators are divided into three categories: 1) Funding, including a state's efficiency in channeling money to local health agencies; 2) Public health infrastructure, including an examination of workforce, laboratories and communications preparedness; and 3) "Double duty" indicators reflecting how recent public health bioterrorism funding has impacted traditional

public health functions. (See Appendix A for specific indicators and findings.)

California, Florida, Maryland and Tennessee received the highest scores, achieving seven out of the possible 10 indicators. With two out of 10 indicators met, Arkansas, Kentucky, Mississippi, New Mexico and Wisconsin had the lowest scores. More than 70 percent of states received scores of three, four or five.



Number of Indicators	Color
2	Dark Red
3	Light Orange
4	Orange
5	Dark Blue
6	Medium Blue
7	Light Blue

7	6	5	4	3	2
California Florida Maryland Tennessee	Alabama Nebraska New York Rhode Island Washington	Arizona Colorado Delaware Illinois Louisiana Massachusetts Minnesota Nevada New Hampshire New Jersey North Carolina North Dakota Virginia	Connecticut Hawaii Indiana Missouri Ohio Oklahoma South Carolina South Dakota Texas Utah West Virginia Wyoming	Alaska Georgia D.C. Idaho Iowa Kansas Maine Michigan Montana Oklahoma Oregon Pennsylvania Vermont	Arkansas Kentucky Mississippi New Mexico Wisconsin

<sup>2</sup> Of the federal funds devoted to bioterrorism preparedness, this study focuses on the FY 2002 funds distributed through CDC to states for their health departments. This report does not examine the funds distributed by the Health Resources and Services Administration.

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# FORTIFYING THE NATION'S HEALTH DEFENSES: Recommendations from TFAH

To ensure that the nation does not squander this rare opportunity to transform its outdated public health infrastructure into an efficient, accountable, responsive, 21st-Century system that is prepared to respond to all health hazards, TFAH recommends the following actions:

## 1. Public Health Agencies Must be Battle-Ready for All Hazards, Not Just Bioterrorism

TFAH findings indicate progress in rebuilding the public health system, and the nearly \$2 billion in Congressional appropriations has had a noteworthy impact on initial efforts to modernize the nation's public health infrastructure. However, achieving a battle-ready public health defense at the federal, state and local levels will take many years of sustained commitment, funding and oversight, especially because the system has been neglected for decades.

To achieve an adequate level of preparedness for public health emergencies, TFAH recommends the following actions:

- CDC must authorize states to use federal preparedness funds to support an “all-hazards” approach to preparedness that simultaneously addresses the potential for biological, chemical, radiological and natural disease outbreaks.
- CDC, in consultation with state and local health officials and outside experts, must define measurable standards for comprehensive preparedness that all states and major local health departments should meet.
- Congress should provide long-term commitment and oversight toward ensuring the nation achieves adequate and sustainable public health security. As such, Congress should authorize an independent review to assess whether current expenditures -- at the federal, state and local levels -- are sufficient.

## 2. Establish Health Security Requirements: Mandates and Accountability to Ensure All Citizens are Adequately Protected

To date, oversight of how the federal preparedness funding is being used has been insufficient. In fact, CDC does not routinely track annual state and local appropriations for public health programs. To ensure basic preparedness standards are being met, TFAH recommends the following:

- CDC must be required to track state and local funding and expenditures on critical public health functions, particularly those involving federal support.
- CDC should independently verify that health emergency performance standards are being met at the federal, state and local levels.
- CDC should establish rules conditioning ongoing federal funding on the requirement that state or local governments maintain core public health funding levels, thereby ensuring “maintenance of effort” by agencies to meet critical health duties.

## 3. Convene a Summit on the Future of Public Health to Develop a Cohesive, National Approach to Public Health Protection

The President, in consultation with Congress, should convene a summit that will develop a concrete vision for the future of the American public health system and the resources needed to make it a reality. The goal of the summit should be to produce a blueprint for the future; to redesign our public health system to meet this century's current and emerging health threats. At the same time, there should be a national dialogue on the resources required to implement the requisite changes and the need for accountability at every level of the public health system.

THE FULL REPORT IS AVAILABLE ON THE TFAH WEB SITE AT: [www.healthyamericans.org](http://www.healthyamericans.org).

# APPENDIX A:

## TFAH Indicators and Findings

See the full report (available at [www.healthyamericans.org](http://www.healthyamericans.org)) for further explanation of indicator selection and results.

FUNDING INDICATORS	# of States Meeting the Indicator
<p><b>1. Much of the federal bioterrorism aid is wrapped up in red tape, with only half of states having spent 90 percent or more of FY 2002 federal bioterror preparedness funding.</b> (INDICATOR: As of the end of August 2003, states had spent or obligated at least 90 percent of their 2002 federal capacity-building funds.)</p>	24
<p><b>2. State, city and local health departments often disagree about how resources should be distributed. Only one-third of states have passed along at least 50 percent of capacity-building funds to local health departments.</b> (INDICATOR: The state, unless it operates the local health departments, has provided at least 50 percent of its federal money directly to local health departments.)</p>	17 and D.C.
<p><b>3. State budget cuts threaten to undermine bioterrorism and other health-crisis readiness. Nearly two-thirds of states cut funds to public health programs from fiscal year 2002 to 2003.</b> (INDICATOR: State appropriations for public health services have not decreased from state fiscal years 2002 to 2003.)</p>	18
CORE INFRASTRUCTURE PREPAREDNESS INDICATORS	# of States Meeting the Indicator
<p><b>4. The public health workforce is about to face a major crisis. Only two states are at the highest preparedness level required to provide emergency vaccines and antidotes.</b> (INDICATOR: The Department of Homeland Security (DHS) and CDC have determined that the state has assembled the appropriate staffing -- nurses, doctors, and pharmacists -- to receive and distribute an emergency "push package" from the Strategic National Stockpile, which contains 50 tons of pharmaceuticals, antidotes and medical supplies that must be disassembled and distributed throughout the state in the case of an emergency.)</p>	2
<p><b>5. Laboratory upgrading has progressed. Over 80% of states report they have at least one lab able to handle biological agents.</b> (INDICATOR: The state has at least one laboratory equipped to handle critical biological agents and has a Biosafety Level 3 (BSL-3) designation.)</p>	43
<p><b>6. Much more needs to be done to modernize labs. Only six states report that they have sufficient facilities.</b> (INDICATOR: The state reports that it has sufficient BSL-3 laboratory facilities.)</p>	6
<p><b>7. Emergency communications network is greatly improved, now actively covering 89 percent of the U.S. population.</b> (INDICATOR: The state has no more than three counties that have yet to establish continuous high-speed connections to the national Health Alert Network.)</p>	29 and D.C.
<p><b>8. All states have initial bioterrorism plans, but coordination and planning progress is not as far along as it initially appears.</b> (INDICATOR: The state has a CDC-approved plan for developing and initiating a response plan for a bioterrorist attack or other public health emergency.)</p>	50 and D.C.
"DOUBLE DUTY" PREPAREDNESS FUNCTIONS	# of States Meeting the Indicator
<p><b>9. Crucial non-bioterror preparedness is in jeopardy. Only one-quarter of states have a plan to respond to a pandemic flu outbreak.</b> (INDICATOR: The state reports having a completed or draft plan for confronting the emergence of a new, lethal strain of influenza, an outbreak often referred to as "pandemic influenza.")</p>	13
<p><b>10. States are not prepared to communicate with health care providers and the public about emerging health threats. Most states do not have tailored severe acute respiratory syndrome (SARS) information.</b> (INDICATOR: During the SARS epidemic outbreak, the general public and health providers could easily obtain essential, state-specific information about the outbreak.)</p>	11

### PREPAREDNESS ADVISORY GROUP

TFAH selected the Advisory Group members based upon their diverse viewpoints and technical expertise. Most of these individuals also served as peer reviewers on the draft of this report. The opinions expressed in this report are those of the authors and do not necessarily reflect the views of the Advisory Group members.

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