



Public Health Emergency Preparedness

**FY 2012 Labor HHS Appropriations Bill
Department of Health and Human Services**

Agency	Program	2010	2012 President	2012 TFAH
CDC	State & Local Preparedness & Response Capability	\$761,100,000	\$651,000,000	\$761,100,000
ASPR	Hospital Preparedness Program	\$417,000,000	\$375,000,000	\$417,000,000

State and Local Preparedness: The 2009 H1N1 influenza pandemic and 2010 Gulf Oil Spill demonstrated the importance of continued preparedness by building capabilities that can be applied universally to all hazards. Through the Public Health Emergency Preparedness (PHEP) Cooperative Agreement, the Centers for Disease Control and Prevention (CDC) distributes grants to 50 states, four metropolitan areas (New York City, Chicago, Los Angeles and Washington, DC) and eight U.S. territories for public health infrastructure upgrades to prepare for and respond to acts of terrorism, natural disasters, or infectious disease outbreaks. A large portion of this funding provides state and local health departments with the ability to create and sustain the public health workforce crucial to emergency preparedness and response. Preparing for future outbreaks will require predictable and ample long-term funding for infrastructure, staffing, enhanced laboratory capacity, and training.

With these preparedness funds, health departments have enhanced their disease surveillance systems and trained staff in emergency response. In 2010, Trust for America’s Health found that states had made significant progress in the past decade in their ability to respond to disasters. All states have developed public health emergency response plans, pandemic influenza plans, and plans for the receipt, distribution and dispensing of materiel from the Strategic National Stockpile; nearly every state maintained their Laboratory Response Network chemical capability; 44 states had activated their emergency operations center in the previous year; and only 2 states were unable to acknowledge notification of emergency exercises within 60 minutes; and nearly all states have 24/7 communications systems linking hospitals, health officials and law enforcement. All state and local health departments can receive and investigate urgent disease reports 24/7.

Despite these accomplishments, challenges remain. Public health officials have noted that health departments are encountering the loss of experienced staff, including specialists such as epidemiologists. In fact, a 2009 assessment by the Council of State and Territorial Epidemiologists (CSTE) found that the number of epidemiologists working in state health departments decreased 12% from 2004 to 2009. The National Association of County and City Health Officials (NACCHO) also found that 23,000 local health department jobs – 15 percent of the local public health workforce – were lost since January 2008. Meanwhile, federal support for public health preparedness has already been cut by 27 percent since FY2005.

In a 2008 progress report, CDC noted that 31 state public laboratories reported difficulty recruiting qualified laboratory scientists, and no state public health laboratory can rapidly identify priority radioactive materials in clinical samples. According to another survey conducted by the Association of State and Territorial Health Officials, the Association of Public Health Laboratories, CSTE and the National Association of County and City Health Officials, many local health departments lack plans for mass patient care and fatality management, and 43 percent of small local health departments have no staff dedicated to preparedness. To address these challenges, sustainable funding is necessary. Supplemental funds help support the equipment and systems needed for response, but cannot provide the sustained support needed for a ready public health workforce.

Recommendation: Provide \$761.1 million for State and Local Preparedness and Response Capability. Funds enable CDC to help public health departments continue to develop the capabilities necessary to detect and respond to a public health emergency, as well as for technical assistance, research, measurement, and evaluation. Funds will also be distributed to state, local, and territorial public health agencies to support continued training and exercises, enhance capabilities to conduct public health surveillance and investigation, improve state and local capabilities for the distribution and dispensing of supplies from the SNS, and bolster public health laboratory capabilities for surge capacity following an event. Given the budget crises at the state and local level, such a drastic decrease in funding would be devastating to the nation's security. Preparedness is dependent on maintaining a well-trained public health workforce, and inconsistent funding results in serious gaps in our ability to respond to new health threats. The FY12 cuts would eliminate the Chemical 1 Laboratory Program (10 states), the Career Epidemiology Field Officer Program (23 states), and all Preparedness and Emergency Response Learning Centers and Preparedness and Emergency Response Research Centers (17 states).

Hospital Preparedness: In the event of a major disease outbreak or bioterror attack, the public health and health care systems would be severely overstretched. Policymakers must address the ability of the health care system to quickly expand beyond normal services during a mass casualty event. The Hospital Preparedness Program (HPP), administered by the Assistant Secretary for Preparedness and Response (ASPR), aims to develop health system preparedness capacity through the following priority areas: interoperable communication systems, bed tracking, personnel management, fatality management planning and hospital evacuation planning.¹ During the past five years HPP funds have also been used to build surge capacity, decontamination capabilities, and to conduct training, education, drills and exercises. HPP includes a particular focus on meeting the needs of at-risk populations. In recent years, the program has used funds to develop regional healthcare coalitions, which build a communitywide, coordinated approach to preparedness and develop relationships between hospitals, public health, and emergency response agencies.

All 50 states, D.C., major cities and territories receive funds through HPP. In its evaluation of the program, the Center for Biosecurity found that health system preparedness for medical disasters has improved significantly since the inception of the program.² However, the assessment also found that planning for catastrophic events remains in the early stages. Funding for HPP must be maintained to retain and build on the progress made in hospitals' ability to respond to a disaster.

Recommendation: Provide \$417 million for the Hospital Preparedness Program. Funds will enable the program to maintain recent momentum in building regional healthcare coalitions, developing capacity to respond to a mass casualty event, extend interoperable communications, and prepare the healthcare workforce to meet the public's needs in a disaster.

¹ HHS, Hospital Preparedness Program. <http://www.phe.gov/preparedness/planning/hpp/Pages/default.aspx>.

² Center for Biosecurity at UPMC, March 2009. <http://www.upmc-biosecurity.org/website/resources/publications/2009/2009-04-16-hppreport.html>