Association of State and Territorial Health Officials

Testimony before the House of Representatives Committee on Oversight and Government Reform

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Good afternoon, Chairman Towns, Ranking Member Issa and members of the Committee. Thank you for inviting me to testify before your Committee to update you on the state and territorial response to the novel H1N1 influenza A epidemic and the readiness of health agencies for a potential future influenza pandemic.

I am Dr. Paul Jarris, Executive Director of the Association of State and Territorial Health Officials (ASTHO). ASTHO is the national nonprofit organization representing the state and territorial public health agencies of the United States, the U.S. Territories, and the District of Columbia. ASTHO Members, the chief health officials of these jurisdictions, are dedicated to formulating and influencing sound public health policy and to assuring excellence in state-based public health practice.

A Strong Governmental Public Health System at Work

The Governmental public health system (federal, state, territorial, and local) is front and center as we prepare for, respond to, and recover from disease outbreaks including pandemics. States and territories have made significant progress in pandemic planning as evidenced by our effective response to the ongoing H1N1 epidemic. A recent Harvard School of Public Health survey showed that more than 80 percent of Americans are satisfied with the way public health officials have managed the response to the H1N1 outbreak. Eighty-eight percent of Americans are satisfied with the information public health officials provided to them.

Despite the challenges of the current economy, federal, state, territorial, and local governments have come together to serve the American people as a unified enterprise. During the last three weeks, the Centers for Disease Control and Prevention (CDC), ASTHO, state, territorial, and local public health departments have stood up their emergency operations centers. ASTHO detailed our preparedness specialists to the CDC's Emergency Operations Center in Atlanta to serve as liaison officers at their State and Local Desk. CDC, ASTHO and the National Association of County and City Health Officials moderated daily conference calls with state and local public health leadership to maintain real time situational awareness. ASTHO also facilitated regular regional conference calls between the states and their federal regional representatives to tackle and coordinate vexing planning and response issues. On a daily basis we shared best practices among states for the benefit and use of every agency. ASTHO

provided a critical interface between state and territorial response and federal planning and coordination.

State and Territorial Public Health Preparedness

In FY 2006, Congress invested $600 million in state and local pandemic influenza supplemental funding to support three years of preparedness activities. This funding was fully expended in August 2008. The federal investment enabled state and territorial health departments to lead the development of comprehensive pandemic influenza operational plans. Health agencies have partnered with agriculture, homeland security and emergency management, education, justice, labor, transportation, treasury and commerce, and other state and federal agencies to drill, revise, and refine plans to meet the goal of continuous state operations during a pandemic or other disaster.

Since December 2005, when the first emergency pandemic influenza supplemental was appropriated, state and territorial public health agencies have developed and tested antiviral drug distribution plans; purchased medical and other response supplies including antivirals, ventilators, respirators, laboratory equipment, and personal protective equipment; and exercised their plans for mass vaccination. At this moment, states and territories are carefully considering, and carrying out community mitigation strategies such as closing schools as recommended by federal guidance.

Prior to the current outbreak, all states and territories had their pandemic influenza operational plans assessed by a team of U.S. Government experts and their findings were reported to the Homeland Security Council. The comprehensive, effective, and integrated response with the CDC to H1N1 is a result of the investment Congress made in state and territorial public health preparedness.

State and Territorial H1N1 Response

State and territorial health agencies are on the front line of our nation’s response to this novel influenza epidemic. Disease investigators are on the ground 24 hours a day, 7 days a week to detect infectious disease outbreaks and our state laboratories stand ready to test specimens to identify new and seasonal

influenza strains. Our top priority is to protect the public's health, no matter what the situation. State and territorial public health officials prepare for and respond to all health threats including infectious disease outbreaks, natural or man-made disasters, and food borne illnesses. Public health agencies also understand the complex and devastating effects of pandemics.

However, the current epidemic is occurring during a period of economic hardship. State, territorial, and local health departments are suffering the same effects of the current recession as other sectors of the economy. State, county and municipal budget shortfalls have resulted in the loss of over 11,000 public health workers in the past year, and additional job losses are expected during the remainder of this year. As more public health professionals are laid off to balance state and local budgets, health departments will become even more strained in the fall, should H1N1 turn out to be more lethal. There is no dedicated public health emergency reserve fund states can draw from to pay for the response.

We need to build our workforce now so that we can sustain the current response and prepare for the future. Health departments are stretched to the limit working long and extra shifts, while remaining ever vigilant to handle other emergencies as they occur. State, territorial and local health departments do not have the personnel and financial capital to continue this level of response over a long period. Right now these health departments must also be prepared to respond to other public health threats arising from flooding, hurricanes, tornadoes, and wildfires. Sustained investment is needed. But, federal public health emergency preparedness funding for states and localities declined approximately 25 percent since 2005 and state budget cuts prevent us from absorbing these losses.

Further, state and territorial health departments are committed to carrying out mandated essential functions such as conducting restaurant inspections, maintaining a safe water supply, providing maternal and child health services, screening newborns, giving immunizations, and numerous other activities critical to the public's health. Even before the outbreak, over 60 percent of health departments had reduced public health services, and 30 percent had eliminated entire programs. Additional reductions may be required to balance state budgets. These cuts cannot continue while more and more people in the U.S. are relying on our health departments to provide critical, front line services to protect their health.

It is essential that the state and local public health workforce and infrastructure be reinforced to enable enhanced influenza surveillance, case detection, epidemiological investigation, laboratory testing, medical surge capacity, fatality management, and disease control measures in the event that this novel virus returns with increased deadliness in the fall of 2009, as occurred in 1918. The federal government can purchase enormous quantities of new H1N1 vaccine, but without the public health workforce to distribute and administer it, the vaccine will do no good.

Previous federal investments made possible the effective federal, state, territorial, and local response to H1N1 virus over the last several weeks. Nevertheless, gaps remain and existing resources dedicated to preparedness are insufficient to carry on our response to this novel virus. The current epidemic is stressing our diminished public health workforce after only three weeks of response. A severe epidemic or pandemic will require a three to six month mobilization. Sustaining a response of this magnitude is not possible given the current human and financial resources available to state, territorial, and local public health agencies. Moreover, during the fall, public health will need enhanced surveillance to detect influenza outbreaks and sort out illness caused by seasonal influenza versus illness caused by a return of the novel H1N1 virus.

We must be prepared to sustain a public health response should we face a pandemic with the severity and duration that would require rapid dispensing of antivirals to millions of sick or exposed individuals, launching a national vaccine campaign for hundreds of millions of Americans, and providing professional medical attention in the face of an overwhelmed health care system.

Allow me to mention three key areas where we can improve our readiness:

Disease Surveillance – We need more epidemiologists on the ground to identify outbreaks, monitor the spread of a disease, and inform our response as the outbreak continues. We recommend investing in standardized electronic reporting systems and centralized databases to analyze and respond to geographically widespread outbreaks. It is essential that we have real time capabilities to monitor the prevalence of diseases and identify which populations are most susceptible to certain illnesses whether it is pregnant mothers, children, young adults, or the elderly.

Laboratory Capacity – During our response, public health laboratories quickly exceeded testing capacity. Not only were there not enough laboratorians to maintain three shifts seven days a week, but states also needed additional reagents and other equipment to run the large number of tests required throughout this outbreak. Going forward state health laboratories would benefit from increased investment in electronic health information infrastructure. We recommend increasing our nation's investment in bi-directional data exchange of laboratory test orders and results with CDC. Our country would also benefit from interoperable regional electronic laboratory information sharing networks among state laboratories and health departments. Stronger laboratory capacity will speed our detection of potential cases and enhance our understanding of the characteristics of novel viruses.

Public Health Nursing – State and territorial public health nurses make up 25 percent of a health department's workforce. They are a critical component of our public health infrastructure providing expert advice and guidance to the public and health professionals. Public health nurses frequently oversee crucial emergency response activities such as the mobilization of mass immunization clinics. They are instrumental in overseeing and training volunteer nurses on the safe administration of antivirals and vaccines which includes properly screening individuals for contraindications to medicines or vaccines. During emergencies, we rely on our public health nurses to ensure that vaccines are distributed efficiently, administered correctly, and are properly handled (i.e. refrigerated). We applaud Congress for including funding for nursing workforce development programs in the American Recovery and Reinvestment Act of 2009; however, additional investments are needed to reduce the serious public health nursing shortage in our state, territorial, and local health departments.

We cannot be complacent. We cannot let our guard down. We must redouble our investment in the nation's public health system. Protecting America's health and effectively responding to emergencies, whether pandemics or terrorist attacks, requires sustained commitment and financial support.