

TESTIMONY

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Mr. Chairman and members of the Committee, thank you for the invitation to discuss the state of public health preparedness for terrorism involving weapons of mass destruction. Your leadership and commitment in addressing this challenge comes at a crucial time.

The tragic attacks of September 11, 2001 and the subsequent use of anthrax as a weapon have made us painfully aware of our nation's vulnerability to terrorism, including bioterrorism. We must acknowledge the reality that neither technical barriers nor moral repugnance will protect us from future acts with enormous potential destructive power. We must also recognize that an event does not need to cause mass casualties, in terms of victims or actual deaths, to still be terrorizing and to drastically disrupt life as we know it, undermine public confidence in government and other critical institutions, create panic--possibly disorder--and inflict enormous economic consequences.

We cannot afford to be complacent. Now is the time to define and support a clear action agenda for countering the threat of terrorism involving weapons of mass destruction/disruption. My testimony will focus primarily on public health preparedness and response requirements with respect to bioterrorism, although certain aspects of the public health preparedness needs discussed will apply more broadly to the concerns of a chemical or radiological attack.

Over the past several years, a number of important steps have been taken to improve our preparedness against the threat of bioterrorism. Prior to the events of the fall, significant programs and policies were being developed and implemented to address this complex challenge. In fact, many of those proved to be of value in the face of the attacks, including the pharmaceutical stockpile, the Laboratory Response Network, and upgrades to public health infrastructures for disease surveillance and response. Yet it was long recognized that these programs were not enough: many activities desperately needed to be strengthened and extended; others still needed to be developed and put in place.

Sadly, it often takes a crisis to mobilize the full commitment necessary to address a task, even one as important as terrorism readiness. Today, bioterrorism is no longer a hypothetical event. Our nation has experienced its first documented lethal bioterrorism attack, and another attack could occur again at any time, from many potential sources and using many potential biological agents. Furthermore, the magnitude of such an attack could be far greater than what we have experienced to date.

Realistically, it is not possible to fully prepare for every potential, imaginable threat. Nonetheless, it is possible for our nation to shore up its general Biodefense/public health preparedness to a level at which we can minimize, if not prevent, the potentially catastrophic consequences of a large-scale bioterrorist attack.

Response to Anthrax

Certainly our recent experiences with anthrax disseminated through the mail can teach us many lessons. These anthrax attacks were, in fact, low intensity, low casualty events compared to what could have happened. While tragic, only 5 people died, yet the letter attacks were destabilizing in ways that extended far beyond the body count, and far beyond the sites where anthrax-tainted letters actually traveled. These anthrax-containing letters were enormously costly in both human and economic terms, and we were

inadequately prepared on virtually every level. It is sobering to think how that same anthrax powder introduced into the ventilation system of a major building or two could have produced a horrifyingly worse scenario. Or what might have followed had an attack occurred with a communicable disease agent that spread person-to-person in ever-widening circles of infection and death.

The response to the anthrax events of the fall surfaced many critical issues and concerns. In a fundamental way, it demonstrated significant disconnects between current organizational structures and capabilities and the management needs and operational requirements of an effective bioterrorism response. It underscored the difficulties of understanding and coordinating the complex interactions between different agencies of government, different levels of government, and the private sector – all of which have important roles to play in an effective bioterrorism response. These events also underscored the intertwined legal, ethical, political and logistical difficulties that attend disease control, even when not contagious. In addition, responding to this bioterrorist attack required new levels of partnership between public health and medicine, law enforcement and intelligence. However, these communities did not have enough previous experience working together, and vast differences in their professional cultures, missions and needs clashed. The events of the fall also highlighted the pivotal role of the media, and how an open and constructive partnership with media is paramount in communicating important information to the public and reducing the potential for confusion, fear and panic. Lastly, these events also clearly illustrated that management of such a crisis occurs in the context of a fragmented and vastly under-resourced infrastructure for public health in this nation, and an already strained health care system that faces severe limitations on certain critical resources, including the lack of approved drugs and vaccine, hospital beds, and laboratory testing capacity.

In this time of heightened anxiety and concern, our nation has a real opportunity—and obligation—to make sure that we have in place the right programs and policies necessary to better protect ourselves against this threat, and perhaps to prevent such an attack from occurring in the first place. What is more, there has been a dramatic increase in the resources available to combat this emerging threat. So what needs to be done?

Public Health Preparedness: What is Required?

Even though our nation has experienced its first lethal bioterrorism attack, we cannot assume that the public and key policy makers truly understand the threat that still looms before us. We need to continue to clearly define the threat. The recent anthrax attack was as close to a traditional HAZMAT type of event as a biological event could be in terms of a defined source, and in the sense that teams could arrive at the site, define a perimeter, and identify those who required care. But it must be emphasized that there are many potential biological scenarios that could unfold in very different ways, requiring a different focus, different strategies, and different investments. In this attack, the anthrax was delivered through the mail. But there are many other modalities that would lead to an unfolding disease epidemic with an unknown source. We would not know who had been exposed, nor would we even recognize the attack until cases started to appear in health care centers and hospitals across the country.

There is a continuing need to define and communicate the vital set of roles and responsibilities of our public health system in responding to the bioterrorist threat. Experts agree that there is an urgent need to increase the core capacities of our public health infrastructure to detect, track and contain infectious disease. This means providing resources to strengthen and extend effective infectious disease surveillance systems, including trained personnel, enhanced diagnostic laboratory facilities, and improved communication links across all levels of government and in the private sector. To a large degree, these same systems and activities are crucial to detection and response needs in

the context of naturally occurring infectious disease threats. This is an example of “dual-use” in the most positive sense. It provides the additional benefit of assuring that some of our most fundamental tools for bioterrorism preparedness and response will be utilized as regularly as possible so that we are not testing new systems and approaches for the first time in the midst of a crisis. Response will begin at the local level, thus we must ensure capacity at that level. This capacity must be supported by state and federal assets and capabilities as needed.

As noted, we need to recognize that the bioterrorism threat is embedded in a set of infectious disease concerns for which we should also be better preparing our nation. At the same time, there are some unique preparedness programs that pertain specifically to the bioterrorism threat, for example the national pharmaceutical stockpile. As the nation moves forward with its plan to expand the national pharmaceutical stockpile, our efforts should be linked with the best possible intelligence about what the real and credible threats are. The stockpile must be linked to a real time distribution system. We need to make much more concrete plans with regard to how we are going to distribute the drugs, vaccination, or other interventions that would need to be rapidly mobilized in a mass casualty situation involving very large numbers of individuals.

We also need to consider how to best to prepare the medical care system to surge rapidly in the event of a mass casualty situation. This will require careful advance planning since most hospitals are operating at or near capacity right now. Systematic examination of local capabilities—public and private sector-- and how they can be rapidly augmented by state and federal assets must be part of this effort. There were not enough surviving victims of the New York City September 11 attack to really test the system's ability to respond to a mass-casualty terrorist attack, yet when we read reports in the newspaper of recent studies showing that, on a routine basis, one out of three hospitals in urban settings have their emergency rooms on diversion because of bed and staffing constraints, there is clear cause for concern.

In order to build our knowledge base and better prepare our nation in both the short and long term, we need to define a clear research agenda and invest appropriately to pursue that agenda. This involves R&D for new drugs and vaccines; improved diagnostics for human samples; improved environmental detection capability; and basic research on how these organisms cause disease and how the human immune system responds. Basic research will be essential for developing better drugs and vaccines. We also need the type of systems research that will help us better understand the issues that have been vexing in the anthrax response over the past couple of months, such as environmental decontamination and personal protection.

Finally, we must focus on prevention—a key tenet of public health—and do everything possible to prevent such an attack from occurring in the first place. A key element of prevention is intelligence. Recent events have led to a commitment to improve overall intelligence collection. The public health and scientific community can and should play an important role in this. There is a desperate need for greater biomedical and scientific expertise to be applied to intelligence data collection and analysis. In addition, members of the scientific community may yield new understandings through routine international scientific activities and collaborations, as well as insights into what information is available in the open scientific literature, including what could be potentially misused or misapplied by those who want to do harm. Similarly, public health professionals may have important insights into infectious disease outbreaks or events of potential significance. As such, these scientists may be crucial to building new expertise in this complex area within the intelligence community.

The scientific medical community will also need to engage on the issue of improving

biosecurity in terms of reducing access to dangerous pathogens. Steps have been taken in recent years through the select agent rule at the CDC and some of the new germ bank regulations. But the anthrax situation has demonstrated that we still don't have an adequate handle on whether dangerous pathogens are secured, who is using them, and why. The scientific community needs to mobilize now to help reduce real risks in a way that will not be overly cumbersome to legitimate science and the research enterprise.

We must recognize that while advances in science and technology hold enormous promise for improving health, they also present many opportunities for misapplication or inadvertent harm. The Australian mousepox study is one example of an inadvertent finding that has laid out a road map for others to make an already dangerous pathogen more lethal.

Finally, we need to recognize that there is a great deal that can be done to further secure or destroy dangerous biological materials in the former Soviet Union. We need to expand and accelerate existing Cooperative Threat Reduction (CTR) partnerships (some portion of which is currently on hold), and develop new partnerships with former Soviet scientists who were once part of the bioweapons program but are now under- or unemployed. We have an opportunity through those collaborations to address critical public health and medical issues of mutual concern and reduce the possibility of further development or spread of biological weapons.

Challenges for the Future

In the aftermath of the tragedies this past fall, considerable new attention and financial support is being directed towards combating the threat of bioterrorism, and other possible catastrophic attacks. This is an exciting opportunity, and affords the chance to address many troubling and persistent gaps in public health preparedness. This is a complex challenge and a great deal needs to be done. There will be no quick fixes or simple solutions. Approaches must be comprehensive and investments must be both well directed and sustained, if we are to achieve meaningful and enduring solutions to the problems before us.

The Committee has indicated a serious and appropriate concern as to issues of coordination and communication. In response, I want to raise a set of potential concerns and/or opportunities:

(1) An independent and comprehensive after-action review of the response to the anthrax letters should be undertaken. It is essential to future preparedness and response efforts that a thoughtful, comprehensive and systematic examination of the anthrax episodes/response be undertaken by a qualified, unbiased entity. This must be done in a rigorous fashion, looking within and across the relevant agencies of government, levels of government and at the relationships with private sector organizations. We cannot afford to let these incidents go by without taking formal stock of what happened, what should have happened (but did not), and what needs to be done to improve response in the future. This must be more than a listing of lessons learned. It needs to be a well-researched report, with thoughtful and informed analysis, identification of gaps in preparedness and response, and realistic recommendations for improvement. Such an examination might be something that the Permanent Subcommittee on Investigation might want to consider, or it could be undertaken by an agency such as GAO. The Committee might also seriously consider requesting that such a report be undertaken by a non-governmental entity such as the National Academy of Sciences or an appropriate academic institution. To the best of my knowledge, no such exercise is currently

underway in a crosscutting and systematic manner. Recognizing that the saga of the anthrax letters is still unfolding, there is still a real urgency to undertake such a process, before many events fade from memory and before new events and priorities overwhelm us.

(2) Government coordination and communication. The response to anthrax demonstrated many gaps in the effective coordination of government led response activities and the need to enhance our ability in a crisis to gather information and communicate it efficiently to all relevant parties. For example, among the public health agencies at the local, state, and federal levels, concerted efforts were made to work together as a team. Yet these efforts were clearly hampered by inadequate systems for information sharing, jurisdictional issues and the fact that people and facilities were rapidly overwhelmed by the competing demands of response to the crisis. Similarly, communication and coordination between the public health and law enforcement communities followed along the same path, although these were further exacerbated by the differences in mission, goals and professional cultures between these two different, but important elements of an effective response. In those places where efforts had been undertaken ahead of time to create relationships based on trust before the anthrax events of the fall, operations went more smoothly and information was exchanged with greater regularity and reliability. But the range was enormous.

At the federal level, certainly, attempts were made to increase communication and cooperation during the crisis. For example, the Centers for Disease Control and Prevention sent one of their own up to FBI Headquarters in Washington, DC. But this “foreign exchange” is not ongoing. Processes, systems, funding, and organizational emphasis are not yet in place to support it.

Across many domains, it was evident that effective response requires stronger working relationships across levels of government. While national leadership, guidance and support is essential, it must be recognized that much of the initial crisis response and subsequent consequence management unfolds at the local level. “On-the-ground” local providers – public health and medical professionals, emergency response personnel, law enforcement officials and government and community leaders – provide the foundation of the response and deal with the problem from the moment the first cases emerge until the crisis is over.

A recent GAO report identified over 20 federal departments and agencies as having a role in preparing for or responding to a bioterrorist attack. Similar constellations of diverse agencies might be engaged to respond to other forms of public health emergency. Although efforts have been made to better coordinate federal efforts to combat terrorism, significant fragmentation continues to exist. Opportunities do exist to clarify lines of authority, streamline operations and increase accountability.

One small example recently brought to my attention concerns the fact there are three federal department sponsored assessments, planned or underway, asking states to assess their preparedness status and/or develop plans. The departments involved are DOJ/OJP, HHS and FEMA. Each one has a different purpose and a different approach—all justifiable from a certain perspective. Yet on the receiving end, this can create a confusing picture, and can represent potentially overlapping or competing tasks. It can also mean that important data collected from one assessment may not get shared to improve the programs or policies of other sister agencies. While these assessment/planning activities likely should remain discrete activities, there would be great benefit in central coordination to ensure interaction in the development and implementation of such activities to encourage new efficiency, information sharing, and

avoid unnecessary duplication of effort or confusion.

As a nation, we need comprehensive, integrated planning for how we will address the threat of bioterrorism, focusing both on prevention and response. We need to define the relative roles and responsibilities of the different agencies involved, and identify the mechanisms by which the various levels of government will interact and work together. The new Office of Homeland Security is well situated to take on this task, but it remains to be seen whether they have the tools and ability to achieve this important goal. I certainly hope they can. However, it is difficult to imagine how Governor Ridge can successfully bring together and coordinate all the myriad agencies responsible for different aspects of homeland security without budgetary authority—at a minimum, budget-review and sign-off authority—and Cabinet level status making him at least co-equal to the other members of the homeland security “team.”

In addition to the Executive Branch, coordination efforts must be taken with respect to the organization and activities of Congress to address the threat of catastrophic terrorism. At present, I am told literally dozens of committees/subcommittees are exercising oversight, as well as authorizing and/or allocating resources. Given the complex and multidisciplinary nature of the problem, it is not surprising that a wide array of committees would have a role to play. Nonetheless, assuring the kind of comprehensive and well-integrated strategies needed for effective prevention, preparedness and response will not occur unless there is equivalent integration, coordination and communication among committees and leadership on the Hill.

(3) Importance of public health. We must assure a strong and well-functioning public health infrastructure, capable of responding to any and all threatening biological events, including, but not limited to, acts of bioterrorism. This infrastructure needs to be characterized by a well-trained cadre of public health professionals for disease surveillance and investigation, educated and alert health care providers, upgraded laboratories to support identification, and improved communications and coordination among all responding entities, and across the public and private sectors. Funding must support efforts at the local, state and federal levels and must be sustained for the longer term. Investments must include manpower training and support, planning/exercises resources and laboratory improvement and new procedures. It should be noted that dozens and dozens of public health professional were taken away from their normal and often quite essential job functions in other areas of importance to health, leaving those activities unattended, during the response to the anthrax attacks. Similarly, public health laboratories throughout the nation are still trying to catch up after having to test thousands of specimens thought to contain or be covered with anthrax powder.

State and local public health departments represent the backbone of our ability to respond effectively to a major outbreak of disease, including a bioterrorist attack. Yet these public health agencies have never been adequately supported or equipped to fulfill this mission. In fact, many hesitate to call the array of health structures at the state, county, and local level a public health “system,” because years of relative neglect and underfunding have left them undercapitalized, fragmented, and uncoordinated. If the public health infrastructure in this country is allowed to fall into further disrepair, we will not be able to respond effectively to future incidents.

Unfortunately, if we look at bioterrorism preparedness efforts to date, necessary public health and related medical care activities continue to be underdeveloped and underfunded. Only a very small percentage of funding has supported activities that truly can be considered core elements of an efficient and effective program to address the bioterrorist threat. Clearly, very substantial new monies will now be available. We must ensure that a significant component of those resources are targeted to address these

critical concerns.

We must act on the understanding that public health is an important pillar in our national security framework and public health professionals must be seen as full partners on the American national security team. Public health expertise should be an important and prominent component of the new Office of Homeland Security, and a public health official should become part of the White House national security team.

(4) Increase the capacity of our health care system to provide mass casualty care.

Controlling disease and caring for the sick will deeply engage the public health and medical professions. To a very considerable degree, health care in this country is provided through the private and voluntary sector. There are currently many pressures on health care providers and the hospital community that limit their ability to prepare in some of the critical ways necessary for effective planning in the face of the bioterrorist threat. The enormous downsizing that has occurred, the competitive pressures to cut costs, the just-in-time pharmaceutical supplies and staffing approaches, and the limited capacity for certain specialty services such as respiratory isolation beds and burn units that may become critical in a biological or chemical terrorist attack, all need to be recognized and addressed.

We must be realistic about the potential costs that would be incurred by these institutions and individuals, as well as the enormous up-front investments needed if they are truly to prepare. And in many ways, if you are a health care institution today, making those preparatory investments is a high-risk undertaking. By preparing, you are also almost certainly setting yourself up to incur a series of costs that may not be reimbursed after the crisis is over.

Effective public health preparedness demands new partnerships and improved coordination between government and the non-governmental health care providers. It is evident that we must find better ways to strategically support our health care and public health institutions, because of the implications of a bioterrorist attack and also because of the existing demands on the system, as evidenced this past year when a routine flu season overwhelmed hospital capacity in several cities, and the fact that one in three hospitals already turn away traumas because they are already operating beyond capacity.

There is an urgent need to develop programs that target dollars for health care disaster planning and relief, including training, templates for preparedness, and efforts to develop strategies in collaboration with other critical partners for providing ancillary hospital support in the event of a crisis. This could be done either through the army field hospital model or what was done in the 1918 pandemic flu, when armories, school gymnasiums and the like were taken over to provide medical care. We can take advantage of and build upon decades of disaster planning. In so doing, we need to support local and state planning efforts to assess community assets and capabilities, and we need to take a look at what federal support can realistically be brought to bear locally in a crisis. Federal assets that are mobilized in hours that take even longer to appear on scene are by definition part of a secondary response to an event.

(5) We must build on existing, productive systems. Effective strategies must build on existing systems where possible, but build in flexibility and dispense with old systems that simply are not up to the tasks required. We do not want to develop an entire ancillary system for responding to the bioterrorist threat. Rather, we should strive to integrate our thinking and planning into the continuum of infectious disease threats and potential disasters to which public health agencies are already charged to respond. The last thing

we want is to find ourselves trying out a plan for the very first time in the midst of a crisis. Instead, we want to find the systems that work in routine activities and then identify what we need to do to amplify or modify them to be appropriately responsive for these more acute and catastrophic situations.

(6) Budget coordination/robbing Peter to pay Paul? While I could not be more enthusiastic about increasing funding for biodefense, I do want to raise a note of caution that attention be paid to how resources are being allocated and utilized. First and foremost, we must ensure that these new and very significant resources be distributed in a manner that reflects a carefully considered strategic framework for action, accountability for how the resources are actually spent, and sustainability so that we do not have a single infusion of resources with no follow-through. There is no one-shot activity that can rebuild our faltering public health system, provide the needed surge capacity that our health care system will need to cope with a public health emergency or the demands of mass casualty care, or provide the biomedical breakthroughs that will represent new tools for preparedness in the future. Thus far, my impression is that the administration is very mindful of these concerns in how they are structuring their programs and program oversight.

In addition, however, preparing against the threat of bioterrorism requires a multifaceted approach, and as mentioned earlier, critical components may rest on many broader program and systems. The budget process must reflect this concern, and requires comprehensive attention so that unintentional dislocations in capacity or function do not occur. We certainly do not want to inadvertently undermine the very programs and infrastructures that form the foundation of efforts to prevent or respond to a bioterrorist attack.

For example, concerns have been raised that while large sums of money are being put into the public health components of bioterrorism preparedness at CDC, cuts have been proposed for the CDC Emerging Infections Program and other aspects of public health infrastructure support. These programs are all inter-connected. An effective program of public health preparedness for bioterrorism can only be built on a strong, effective and broad based infrastructure for public health.

In a related arena, meaningful response capability for bioterrorism must rest on a robust and flexible health care system. Already we know that most hospitals are operating in a precarious financial environment, with limited ability to “surge” in response to increased demands for care. While new dollars have been targeted to support planning for how institutions and regions might respond in the event of a mass casualty attack, other components of the budget, such as shifts in Medicare reimbursement to hospitals—quite far afield from bioterrorism budgets--may have more profound effects on the stability of these institutions. For urban areas in particular, we will depend on the network of hospitals to provide a number of critical element of public health preparedness, including: clinical and laboratory detection and response through emergency rooms, trauma centers and health care clinics; ongoing medical assessment and care; and medical education and training to ensure that our medical providers can recognize and respond to a range of unfamiliar and unexpected threats. Particularly for these urban hospitals centers, certain proposed cuts in the Medicare program have the potential to severely limit their effectiveness as part of our overall system for public health preparedness and response in a crisis.

(7) Clarify and coordinate legal authorities. In planning for an effective response, an array of legal concerns needs to be addressed. A very basic and still inadequately addressed issue is that of the declaration of an emergency. What are the existing authorities? Are they public health, or do they rest in other relevant domains? What are the criteria for such a declaration? What are the authorities that still need to be

established?

Other outstanding legal questions concern the ability to isolate, quarantine, or detain groups or individuals; the ability to mandate treatment or mandate work; restrictions on travel and trade; the authority to seize community or private property such as hospitals, utilities, medicines, or vehicles; and the ability to compel production of certain goods. Also, questions involving emergency use of pharmaceuticals or diagnostics that are not yet approved or labeled for certain uses need to be answered now. Related to this are the, as yet, unresolved issues of liability and indemnification which have been especially troubling in the context of vaccine development and delivery, for both routine and possible biodefense needs.

These questions involve many different levels of government and sectors of society, many different laws and authorities, and involve many complex intertwined ethical, political and economic issues. In a systematic and coherent way, we must address these pressing issues and concerns - not just what laws are in place or could be put in place, but also what policies and procedures would be necessary to actually implement them.

(8). Coordination and partnership with the media. The media is key to efforts in a crisis to communicate important information to protect health and control disease, as well as to reduce the potential for panic. We have seen both the press and the public receive a crash course on anthrax. They have been fast learners, and for the most part, the media has done a credible and responsible job in communicating this important information. They have also nobly sought to respond to the need of the public for information when our federal institutions were too slow in response. But there must be a clear plan for providing the news media with timely and accurate information. Furthermore, the credible and consistent voice of well-informed health officials is critical to this effort.

It is clear that the ability of the media to mobilize effectively in a crisis is greatly enhanced by a process of ongoing and continuing mutual communication and education in calmer times. We must strive for the development of a set of working relationships grounded in trust - trust that they will be provided with factual information in a timely and appropriate manner, and in turn, that they will use that information in a responsible, professional way. No doubt there will always be tensions between the desire to get out a good story and an appreciation of the complexities, sensitivities and uncertainties inherent in such a crisis. But stonewalling the press or viewing them as the enemy is virtually guaranteed to make the situation worse. The responsibility the members of the media feel to provide the public with needed information as quickly as possible must not be discounted.

(9) Plan, prepare and practice. Perhaps most fundamentally, the anthrax events of the fall demand that we increasingly engage in planning and preparation—across all the domains mentioned above and more. Planning can make a difference, but we could not begin to prepare in the midst of the anthrax crisis. We still have not adequately prepared top officials to cope with this new type of security crisis; we have not invested adequately in the planning and exercises needed to implement a coordinated response; and we have not adequately educated the American people or developed strategies to constructively engage the media to educate people about what was happening and how to protect themselves.

Prior planning and preparation can greatly mitigate the death and suffering that results from a serious bioweapons attack. As a nation, we need comprehensive, integrated planning for how we will address the threat of bioterrorism, focusing both on prevention

and response. We need to define the relative roles and responsibilities of the different agencies involved, and identify the mechanisms by which the varying levels of government will interact and work together. We need true national leadership to address the bioweapons threat to our homeland. Planning efforts must be backed by the necessary resources and authority to translate planning into action. Moreover, we must practice what we plan. Preparations must be exercised, evaluated and understood by decision-makers if they are to prove useful in a time of crisis.

HHS Consolidation of Communications Offices

In addition to addressing areas of opportunity for improved coordination between federal agencies and other critical partners for public health preparedness and response, the Committee asked the panelists to comment on the proposed consolidation of the communications offices of all the agencies within HHS.

While I do not have first hand knowledge of the exact proposal, I do understand Secretary Thompson's desire to assure that HHS behaves as a unified department composed of a set of agencies, that while extremely varied in their subject matter focus, roles and responsibilities, still works as a team in support of the overall mission of HHS. However, because of the size of the department, the number of discrete agencies, institutes and centers, and the very different objectives and expertise of those component entities, this must be achieved through greater coordination rather than true consolidation. In my view, it would be unrealistic to believe that all of the departmental components could have their communications offices reporting directly to the HHS Secretary's Office. This would neither be logistically feasible or desirable with respect to assuring the communication of often highly technical information in an accurate and efficient manner to others outside the department.

As the management of the anthrax episodes demonstrated, it is generally a mistake to put too much distance between official spokespeople and the subject matter expertise. Most people agree that one of the most glaring deficiencies in the administration's response to anthrax involved the communication strategy. It was ill advised and unhelpful not to have made credible and knowledgeable health officials available early on to explain to both the public and health professional communities, what was happening and why, what they could expect, and to openly discuss what we did and did not know. Instead, inaccurate and sometimes confusing messages were given out. In addition, when official information was not made available in a timely fashion, those voids in information were soon filled with media reports and so-called experts of variable accuracy and quality. In thinking about the restructuring of communications activities within HHS, I caution only that every effort be made to avoid these kinds of disconnects in the future.

Efforts of NTI

Encouraging and supporting our government to deter, prevent, and defend against biological terrorism is a central part of our mission at the Nuclear Threat Initiative (NTI) – an organization founded by Ted Turner and guided by a distinguished board co-chaired by him and former Senator Sam Nunn. We are dedicated to reducing the global threat from biological, nuclear, and chemical weapons by increasing public awareness, encouraging dialogue, catalyzing action, and promoting new thinking about these dangers in this country and abroad.

We fully recognize that only our government can provide the leadership and resources to achieve our security and health priorities. But within that context, NTI is:

- Seeking ways to reduce the threat from biological weapons and their consequences.

- Exploring ways to increase education, awareness and communication among public health experts, medical professionals, and scientists, as well as among policy makers and elected officials – to make sure more and more people understand the nature and scope of the biological weapons threat.
- Considering ways to improve infectious disease surveillance around the globe – including rapid and effective detection, investigation, and response. This is a fundamental defense against any infectious disease threat, whether it occurs naturally or is released deliberately.
- Stimulating and supporting the scientific community in its efforts to limit inappropriate access to dangerous pathogens and to establish standards that will help prevent the development and spread of biological agents as weapons.
- And finally, NTI is searching for ways to help our government and the Russian government to facilitate the conversion of Russian bioweapons facilities and know-how to peaceful purposes, to secure biomaterials for legitimate use or destruction, and to improve security of dangerous pathogens worldwide.

In conclusion, I appreciate all that you are doing to assure the necessary public health preparedness for our nation. To be effective, we will need to define new priorities, forge new partnerships, create new investments to build capacity and expertise, and support new planning. We may never be completely prepared for some of the most catastrophic scenarios, but there is a great deal that can and should be done now.

I look forward to working with you on these important issues and would be happy to answer any questions you may have.

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