# TESTIMONY

## Statement of Thomas L. Milne
**Executive Director**

on behalf of the
NATIONAL ASSOCIATION OF COUNTY AND CITY HEALTH OFFICIALS

before the
Committee on Governmental Affairs
United States Senate

**Hearing on Public Health Preparedness for Terrorism**

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Good morning, Mr. Chairman and Members of the Committee. I am Thomas L. Milne. I am honored to appear before you representing the National Association of County and City Health Officials (NACCHO). I have been the Executive Director of NACCHO since 1998 and prior to that spent 15 years as a local public health director for a tri-county agency in Washington State. NACCHO is the organization representing the almost 3,000 local public health departments in the country. Our organization has been deeply involved in national efforts to upgrade state and local public health preparedness for bioterrorism and other public health emergencies. I am here today to share with you some of the lessons we have learned and how much farther we need to go.

Are we prepared for bioterrorism as a nation? Not nearly enough. Local public health departments have long experience in responding to infectious disease outbreaks and other local emergencies with public health implications. We have made progress and learned important lessons about the challenges of bioterrorism preparedness in the last few years. But we have a long way to go to achieve nationally the capacities necessary to detect and respond to an act of bioterrorism quickly and efficiently in order to contain it, prevent the spread of disease and save as many lives as possible.

Local Interagency Planning for Terrorism

The challenge, and potentially the great strength, of bioterrorism preparedness is that it requires a combination of the resources and skills of public health with those of other public safety and emergency preparedness disciplines. Each of these disciplines must have a robust system in place. As our experience with anthrax last autumn has demonstrated, public health leadership, expertise and resources are essential when an act of bioterrorism is suspected or threatened.

Bioterrorism preparedness planning, just as all local emergency planning, is not adequately addressed by taking a plan or set of guidelines off the shelf. The act of planning itself brings together people from public health, emergency response, law enforcement, local hospitals, physicians, and others to develop a plan that suits their own community's circumstances and needs. The act of planning itself, when done correctly, establishes the lines of communication, responsibilities, and authorities that we have seen are so critical following September 11th and it identifies what capacities and resources remain to be developed and put into place.

Across the nation, local public health departments and their communities are learning that partnerships between public health agencies, health care providers and the traditional first responder entities, such as fire, police and emergency services, can be built and are essential for further progress. In order for the diverse public and private agencies in a city or county to work effectively together to respond to an emergency, they must know each other and must have planned together well in advance. They should not be exchanging business cards during a real crisis!

Growing awareness of the unique requirements for bioterrorism preparedness has brought local public health agencies to the table with other first responders, including law enforcement, in many places. It is important to remember that bioterrorism has two dimensions – the biological, where public health expertise is necessary to detect and respond - and terrorism, which is a criminal act requiring law enforcement prevention and response. In many communities, public health agencies are learning about such issues as incident command and preservation of evidence, while law enforcement agencies are becoming aware of the requirements for information and data exchange in epidemiologic investigations. We expect that these collaborations will continue to grow as more and more localities digest the lessons they learned during the anthrax outbreak and engage in bioterrorism preparedness planning.

It is important to know that such collaboration at the local level is not new. Many local public health departments have good working relationships with their local police, fire, and emergency response agencies. Successful local collaboration has taken place on a large scale in such places as Atlanta, Georgia, Salt Lake City, Utah, and Seattle, Washington in preparation for large international events, such as Olympic Games and a World Trade Organization meeting. On a smaller scale, many health departments, including the one I directed, have worked with police and fire departments for many years for basic emergency preparedness, and to address issues of common concern related to traffic safety, violence prevention, substance abuse prevention, and a host of other issues.

The challenge of bioterrorism preparedness has increased local public health and law enforcement collaboration. For instance, in DeKalb County, Georgia, the Center for Public Health Preparedness of the DeKalb County Board of Health meets monthly with representatives of the police department. The public health department developed a database for the police department to track suspicious package episodes, including the laboratory findings. The police department shares this information electronically with the public health agency to ensure public health analysis and follow-up where necessary. The public health agency has trained the police command staff in the basics of bioterrorism, including likely agents, symptoms, methods of diagnosis and epidemiologic investigation, and prevention and containment of disease epidemics. The police department is training public health agency staff in proper methods of handling potential criminal evidence. DeKalb County and many other localities are planning for joint information centers in which public health, police, fire and other emergency management personnel will cooperate to ensure consistent, effective communication with the public.

These types of collaboration can take place only when the local leadership of law enforcement and public health have a clear understanding of their respective responsibilities and communicate clearly with each other in regular, timely fashion. This communication should be part of an institutionalized joint emergency planning process and preparedness plans should be jointly exercised on a regular basis. We were reminded during the anthrax outbreaks that there are substantial differences in

organizational culture and approach between law enforcement and public health agencies. These can be overcome; indeed, they have been overcome in communities where public health and law enforcement leaders are working together.

At the national level, we see an acute need for coordination of public health preparedness activities undertaken by the Department of Health and Human Services and its state and local partners with other federal emergency preparedness programs, such as those administered by the Department of Justice and FEMA. It is essential that the differing missions of these agencies be well understood by all parties at the state and local levels. Their respective funding streams for terrorism preparedness must enhance each other and must be coordinated at all levels of government in a way that assures maximal appropriate use of the different funding streams. We have a particular concern about the potential expenditure by states or localities of public health preparedness funds on other emergency needs, such as field detection equipment or personal protective equipment, that have been and should be covered by other programs. We would discourage expenditure of the more limited public health funds for such purposes, unless other funds are clearly not available.

Federal Funding for Local Bioterrorism Preparedness

The federal government and states can and must provide coordination, technical assistance, funds and specialized expertise in bioterrorism and public health preparedness. In the end, though, early detection and initial response to a public health emergency takes place at the local level. Local authorities are the first responders to bioterrorism. Congress provided significant new FY2002 funding for upgrading state and local public health capacities. This will enable the Department of Health and Human Services to send $918 million out to states and localities. However, at this point in time, funds have not yet reached local public health agencies and most do not know yet how much they will receive from the state, and for what purposes. For that reason, they have not yet been able to hire or train new staff for bioterrorism preparedness. *The sooner that new funds reach the local level, the sooner local public health agencies and their community partners can begin making real, measurable progress*.

NACCHO has two overriding concerns about federal bioterrorism preparedness funding. The first is that federal funds be used to develop capacities where they are needed. In some areas of bioterrorism preparedness, localities look to states to provide the facilities and expertise. Public health laboratories are a good example of where technical expertise should be centralized at the state level. In most respects, however, *bioterrorism preparedness is local* and the funding emphasis should be at the local level. NACCHO is monitoring implementation of the FY2002 funding carefully to determine whether states will in fact be allocating adequate portions of these funds to build local public health capacity for responding to public health emergencies.

Thus far, the experience of local public health agencies in the states has been mixed. Many are involved to a greater degree than ever before in collaboration with their states to plan how best to use the funds. In a few states, local public health agencies have been informed that, collectively, they will receive more than 50% of the funds that the state receives. Some others, however, are greatly concerned that their communities may benefit very little because the states have not been including them in a meaningful fashion and do not appear to be planning to pass through a significant proportion of the funding. We believe it is critically important that the federal government monitor carefully the uses of these funds, measure their impact at the state

and local levels over time, and insist that funds be used to enable localities to build local public health capacities.

Our second concern is that bioterrorism preparedness funding must be adequate, lasting and reliable to enable local public health agencies to build and sustain permanent improvements in their ability to protect their communities 24 hours a day, seven days a week. Most communities do not now have this level of protection. This cannot be achieved in a matter of months. It is a complex undertaking that requires building cooperation and communication not just among traditional public agencies that are accustomed to being first responders, such as local fire, police and emergency management, but also with private health care providers. Because of the complexity of the task, it will take several years to develop sophisticated disease surveillance and response systems and then to implement and staff them with well-trained people. The funding that is available for this fiscal year represents a down payment on a process of rebuilding that will take many years.

Continuation in FY2003 of this year's $940 million for upgrading state and local public health capacities is a bare minimum requirement for continuing this large, multi-year task. We have estimated that localities need 10,000 to 15,000 new people to work in public health preparedness. In many places it will take more than one year to locate and train qualified people to achieve those staffing levels. Localities and states need assurances that funding will be both sufficient and sustained, so that state and local public health agencies, some of which are experiencing severe funding constraints and cutbacks, can move forward swiftly. Some are already borrowing from other operating funds or reserves, diverting public health resources from other important ongoing work to prevent disease and protect their communities.

Even when the nation's localities have achieved a satisfactory level of preparedness, continued federal assistance will be essential. Our response plans must be continually refined and exercised, people must be continually trained and re-trained, and sophisticated disease surveillance and information systems and associated hardware will require systematic updating.

A local public health infrastructure of trained people, equipment, facilities and systems is absolutely essential; without it, we simply will not have the necessary capacities for bioterrorism preparedness. However, as we invest in public health infrastructure, we are not just preparing for bioterrorism. We are also strengthening our ability to respond to other public health emergencies. The systems for disease surveillance, for communication, for data management, for interagency planning, for mobilizing the community to respond, are the same for bioterrorism as they are for any other disease outbreaks or emerging infections such as West Nile virus, E. coli, Hepatitis C, or Lyme disease. They are the same systems needed for response to the public health threats associated with floods, hurricanes, and other natural disasters. These systems have multiple uses, extending even to improving our abilities to address other public health problems more effectively. ***Every dollar we spend on bioterrorism preparedness will pay off in countless other ways.***

Mr. Chairman, the local public health department is on the front lines. The local public health system is a necessary component of our national security. NACCHO thanks you for understanding this fact and for your continued support.

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