

Statement of James (Jerry) Gibson, MD MPH, Director of Disease Control, South Carolina Department of Health and Environmental Control, and immediate past president of the Council of State and Territorial Epidemiologists, to the Institute of Medicine meeting on Biological Threats and Terrorism – November 27-29, 2001

I will speak on my perceptions of the preparedness of state and local public health departments to detect, investigate and respond to potential bioterrorist attacks and threats of such attacks. I am making one fundamental assumption that I believe most of us share here: that a major long-term goal in building an effective response to bioterrorist attacks is to re-build the American public health infectious disease control capacity which suffers currently from at least thirty years of deferred maintenance. This disease control capacity is congruent with the acute infectious disease control infrastructure, which consists of trained organized people, communication systems and laboratories. The state of disarray of these systems is summarized well in the Institute of Medicine's 1988 report on The Future of Public Health. I have seven points to make, and then six recommendations.

First, public health organization and capability are highly varied across the 51 state and 3000 local health departments of the United States. Some are strong, but many are very weak, some of those large population centers. However, the need to respond well to a bioterrorist threat is present in all jurisdictions. Therefore, there exist critical disparities in needed capability. Our preparedness building cannot ignore the weak departments.

Second, the public health system is very fragmented in many states. Local health departments are separate from the state health department, which has little leverage to improve them. Often they communicate minimally, and working in partnership is difficult.

Third, our task for bioterrorism preparedness is to build complex human systems that must work right the first time they are challenged. That is difficult: people are less consistent than vaccines. It implies to me that the bioterrorism response systems must be integral parts of the regular infectious disease surveillance and control systems if they are to be exercised regularly, and perform when needed.

Four: In the end, public health response capacity is people, trained people. Local health departments in particular are very short of these. Thus capacity building requires recurring funds to hire people, not a one-time capital investment. There is no way around this need.

Five: To plan, organize, hire staff and train them takes time. Even in the private sector it takes time, and the ability of state and local health departments to adapt to urgent circumstances and speed up operations is also highly variable. Thus finding ways to help state bureaucracies develop a sense of urgency, while still maintaining their programs for HIV/AIDS, family planning, diabetes mellitus, vital statistics etc. is essential. The key implication of this fact is that the speed at which health departments can absorb new funds is limited; capacity building does not happen overnight.

Six: “Planning is an unnatural process....” Getting a bioterrorism operational plan, integrated with key partners, in every county and city (not to mention every hospital) is a major challenge. Health departments have limited leverage to assure it happens. Thus this critical process of assuring local bioterrorism preparedness planning will take substantial resources.

Seven - the most important point: Most state health departments are very dependent on federal grant funds to operate their programs. In my state of South Carolina about 38% of the integrated health department’s (state and the 46 counties) budget comes from federal cooperative agreements; another 38% is earned from Medicaid and other sources, and is thus not available for bioterrorism preparedness. Essentially all the discretionary funds are federal. Therefore, I would like to propose six principles under which new federal bioterrorism grants should be allocated to states and locals. These principles come from a new document from the Association of State and Territorial Health Officials (ASTHO) Anti-terrorism Task Force.

1. Such grants should provide for state flexibility of use. Funds should be routed in such a way that their use for public health is assured, but beyond that the state should have the discretion to spend them where they are most needed. Also, states should have the authority in emergencies to redirect federal grant funds and federally funded staff to areas of critical need, without penalties. This process should avoid cumbersome multiple layers of permission seeking from the granting agency.
2. Funding should be based primarily on state need rather than be competitive. Given the wide range of state capabilities, competitive funding will only make the strong stronger and leave the weak as vulnerable as before.
3. Funding budgets must be multi-year, to allow for the time needed for states to absorb funds. Funding will have to continue to some extent long-term, since new staff are an essential part of preparedness.
4. State and local health department should be required to plan and submit funding proposals together, so that planning and implementation can be coordinated. Likewise, the grant process should require coordination and communication between public health and other agencies receiving bioterrorism funds.
5. A mechanism is needed for state and local health departments to share best practices and ideas that work rapidly. Possibly a series of ongoing email-based surveys of innovative ideas could help do this.
6. New information, communication or surveillance systems should be built on or be integrated with existing systems such as NEDSS, HAN and Epi-X.

I was also asked to give my first three priorities for action to build state and local public health response capability to a bioterrorist attack. These are:

A. Make federal cooperative agreement funds available to all states to be used primarily to build city/county public health capability for disease surveillance and investigation. In many states, what is likely to work best is to hire surveillance and epidemiology mentor/trainers on a regional basis to train, support and work with local-level infectious disease control staff to build active surveillance. These regional bioterrorism epidemiology staff can also promote local liaison between key participants and preparedness planning.

B. Provide good educational materials and methods of dissemination by state health departments for primary care clinician education on detection, reporting, clinical care and infection control of the first-line and also second-line bioterrorist agents. The dissemination should be via grants to states and large city public health departments, because the optimal method of disseminating and reinforcing the messages will vary locally and must be determined locally. A major purpose of such education programs should be to build relationships between state/local health departments and clinicians.

C. Provide sufficient funds to complete the national, state-based system of electronic infectious disease surveillance (NEDSS) which has been begun. This is a very challenging task and will take several years to complete, test, de-bug and optimize. It will also require significant recurrent costs for maintenance.