



STATEMENT OF

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**LOCAL PREPAREDNESS: INFLUENZA AND MAJOR PUBLIC HEALTH THREATS
BEFORE THE HOUSE GOVERNMENT REFORM COMMITTEE**

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Mr. Chairman, my name is Karen Miller, County Commissioner from Boone County, Missouri. Boone County is a small county in largely rural Central Missouri which is home to the University of Missouri, located in the county seat of Columbia. I am here today, not only as a County Commissioner, but also as President of the National Association of Counties (NACO)*. I am honored to testify before you and the Committee on this important issue as I am well aware of your distinguished career in county government. I am also pleased to share the panel with others who recognize the importance of our nation's public health preparedness.

Additionally, I would especially like to thank the National Association of County and City Health Officials for their expertise in county public health issues and their assistance with my testimony today.

America's 3,066 counties vary in geographic shape, size, population, and in the services we provide, but one common thread is that we all play an integral role in protecting our communities. Counties are the nation's "first responders" who respond to virtually every emergency situation, whether it is a flood, an act of terrorism, or the outbreak of disease. This includes small rural counties, such as Boone County, which make up 2/3 (over 2100) of our nations counties.

Mr. Chairman, I have one overall message for you today: *We have made much progress in public health preparedness, but we have a long way to go.* At the local level, the people who work diligently on influenza immunization are the same people who are working every day to improve public health preparedness for any type of emergency. As the public health threats to which they must respond increase, we are asking the same people to do much, much more with resources that still are very limited. Today, on behalf of the nation's counties, I urge two actions: 1) Sustained and increased federal funding for public health preparedness; and 2) Greater, systematic attention by federal policy makers to the realities of local public health emergency planning and response.

*NACO is the only national organization representing county government in the United States. Through its membership, urban, suburban and rural counties join together to build effective, responsive county government. The goals of the organization are to: improve county government; serve as the national spokesman for county government; serve as a liaison between the nation's counties and other levels of government; achieve public understanding of the role of counties in the federal system.

As this Committee has recognized, our communities must be prepared for any disease outbreak, whether it results from an act of nature or an attack of terror. We have all been concerned about the potential for widespread influenza, because we have seen how it can take the lives of our children. We remember the scares caused by the anthrax attacks of 2001, and we want to be sure we know what our communities will do if the unthinkable occurs.

The good news is that the nation's counties are better prepared now than they were two years ago. The infusion of federal funds for building state and local public health capacities has helped a great deal. The plans that are in place will serve us well, whether we face an outbreak of influenza or smallpox.

We have already benefited from improved public health preparedness, even though there has been no truly catastrophic event. For instance, although we hope we will never see a case of smallpox, we have made great progress in planning for mass vaccination. Public health agencies know what they would have to do to mobilize and carry out vaccination of large numbers of people in a short time. Those same plans can be used, and have been used, in events where localities have had to address other public health emergencies. When we are prepared to mount a mass smallpox vaccination effort, we can also do the same for influenza.

In my own county, the work we did last year on developing a local health alert network, which was aided in part by public health preparedness grant funding, improved our response to influenza this year. It enabled us to share current local data about flu cases and state and CDC recommendations with our local medical providers. Our new grant-funded regional epidemiologist created weekly influenza summaries that we sent out to the medical community via the local health alert network. This has improved physician reporting of influenza, which is essential to help us identify any large outbreak. A regional public health information officer, also hired with public health preparedness grant funds, serves us and 16 other counties. This has enabled us to be more proactive in educating the general public about flu vaccination and how to prevent the spread of flu.

However, when my health department, or any local health department, needs to respond to influenza, or to a requirement to vaccinate medical personnel against smallpox, as we did last year, we are still using the same staff that carries out routine public health activities. The number of hours required to plan and carry out vaccination clinics pulls many people away from routine duties and those come to a halt. We just don't have the resources or staff to compensate for these demands. Of the approximately 3,000 public health departments in the country, nearly all are understaffed and underfunded. Estimates suggest that more than 15,000 public health workers are needed nationwide. In Arlington County, Virginia for instance, it takes 90 people to set up one clinic for mass vaccination or mass distribution of medication.

What we want you to understand is that we have drawn upon far more local resources than federal funds to move forward in public health preparedness. The federal funding has brought important assistance to local health departments, such as more state laboratory capacity to identify disease agents quickly, and more support from epidemiologists. That is critical and we are grateful. However, the real work of preparing for and responding to public health emergencies locally takes place with the same people and facilities that we have always had. We are asking our public health nurses, educators, technicians and administrators to do a great deal more with less.

We still have a long way to go. We know that large-scale influenza or SARS might resurface in any community at any time. However, we have never had to implement large-scale isolation and quarantine. The logistical problems of doing this, and making sure that large populations remain safe and healthy, are quite overwhelming. Plans for these extreme, complex measures are not fully developed in many places. We are plowing new ground.

In addition, many communities are concerned that they lack adequate arrangements for what we call "surge capacity," that is, extra doctors, nurses, epidemiologic investigators, and others who are not needed all the time, but would need to be called into service to contain an outbreak and care for patients in an emergency. Also, electronic information systems that are so necessary for communication and gathering data about the occurrence of diseases are improving, but there is still a very long way to go to achieve the seamless communication and interoperability that we need.

It is essential that the federal government remember that public health preparedness is not a destination that some day we will reach and then be able to stop. Rather, it is a journey during which we will improve little by little, day by day and year by year. We must always be using exercises to test our abilities and we must always be training new people, adapting to new technologies, and preparing to address new threats.

The influenza season is not quite over, but it is clear that, despite many tragic deaths, this was not the pandemic that we all fear. However, local public health departments were intensely occupied in addressing a pressing need to immunize as many people as possible and dealing with the sudden unavailability of vaccine. We have long experience in promoting and providing immunization and have dealt with vaccine shortages before. We think we did a good job under adverse circumstances.

Most local public health departments had plans for identifying stocks of available vaccine and reallocating vaccine among providers in their community. Many localities also tapped into their own funds to purchase vaccine for children and high-risk adults, when it was still available. State-based electronic reporting systems, such as the Health Alert Network funded with federal bioterrorism dollars, were used to report surpluses and shortages and help redistribute vaccine within states. To help prevent the spread of influenza, many localities launched public education campaigns with whatever resources they had available, using the mass media, posters, web sites, outreach to physicians and schools, to teach good hand hygiene and cough etiquette and the difference between a cold and the flu. The documents that CDC made available helped localities craft their own messages, but there is still a need for CDC to help us by crafting short, simple messages that we can use as they are, rather than having to boil down longer, more technical information ourselves.

The unexpected demand for flu vaccine and its subsequent unavailability concerned us because it required us to change our strategies and our public messages midstream. In prior years, local public health departments have promoted flu vaccination vigorously, particularly for high-risk groups such as the elderly. We know that it can save many lives. It pained us greatly when we found ourselves unable to offer vaccination to all who asked, particularly because the Flumist vaccine that remained available is unsuitable for children and the high-risk groups on whom we focus our service. There were approximately 70 counties in my state alone, who experienced a flu vaccine shortage this year and it is much too costly to overstock.

Public health requires good collaboration between federal, state and local governments, because each has an important, unique role to play. The fact remains, though, that disease outbreaks don't occur in states. They occur in communities and it is our counties and cities that bear the greatest burden for response. Local jurisdictions know better than the state what they need to be prepared. They know what their staffing needs are, what their training needs are, and how they could make the most efficient use of limited funding.

There are states in which many localities believe that they could be benefiting far more from federal bioterrorism preparedness dollars if the state were responsive to their needs and priorities. Moreover, we are deeply concerned that the Administration has proposed to cut the funding to CDC for upgrading state and local public health capacity by 11 percent. The local needs are compelling and they grow every day, as new health threats arise.

In addition, it is essential to understand that public health preparedness at the local level does not involve only public health departments. It is part of our overall emergency management system, with all its public and private partners. Across the nation, public health personnel are working closely with other local emergency management, fire and law enforcement personnel. Although public health professionals at the local, state and federal levels will provide leadership and expertise in a public health emergency, any community's success will depend on good communication and cooperation among all of our public safety agencies. There are a number of different federal funding streams for emergency readiness, but they all come together at the local level.

In closing, I'd like to re-emphasize the need for sustained and increased federal funding for public health preparedness and greater, systematic attention by federal policy makers to the realities of local public health emergency planning and response.

Again, Mr. Chairman, I thank you for the opportunity to testify before you today. I would be pleased to answer any questions you may have.