

Preparing for Potential Health Emergencies and Bioterrorism Attacks

WHY ARE HEALTH EMERGENCIES AND BIOTERRORISM A THREAT TO OUR NATION'S HEALTH?

The Nation Remains Inadequately Prepared:

■ Despite a federal investment of more than \$6 billion to improve public health emergency preparedness after September 11, 2001, analyses find critical areas of the nation's emergency preparedness effort still require attention.²

▲ The federal government has yet to establish clear performance measures and data collection methods to assess the effectiveness of the investments.

■ Only 10 labs in the U.S. are equipped to test for mustard agents, nerve agents, and other toxic chemicals that could be used in a chemical terrorist attack.

■ Ten states do not have adequate plans to distribute emergency vaccines, antidotes, and medical supplies from the Strategic National Stockpile.³

■ Twenty-one states do not have statutes that allow for adequate liability protection for healthcare volunteers during emergencies.⁴

■ Seven states have not purchased any portion of their federally-subsidized or unsubsidized antivirals to use during a pandemic flu.⁵

■ The Homeland Security Presidential Directive 21 identifies mass casualty care as a key priority, however, federal government funding for hospital surge capacity development is only \$100,000 per year per hospital, far from the level needed to adequately prepare.⁶

■ Some \$230 million has been spent on BioSense, the nation's early-event detec-

tion system, however it still "lacks real-time capability and has issued a stream of false alarms that would be comical were the stakes not so high."⁷

The Impact of Health Emergencies Can Take Enormous Human and Financial Tolls:

■ The September 11, 2001 tragedies resulted in the loss of approximately 3,000 lives and an estimated \$80 billion in direct costs.^{8,9}

■ An anthrax attack in New York City could lead to \$90 billion in workers' compensation losses, 3 times more than the entire \$30 billion workers' compensation industry, according to a study by a major financial institution.¹⁰

■ According to a U.S. Centers for Disease Control and Prevention (CDC) study, if public health officials identify an anthrax attack on a city of 100,000 persons, and distribute antibiotics to the exposed persons within 24 hours, the number of lost lives could be roughly 5,000 and economic losses will reach \$128 million. But, if it were to take public health officials 6 days to identify the attack, an estimated 33,000 people could die, and economic losses could reach \$26.2 billion.¹¹

■ In 2003, Severe Acute Respiratory Syndrome (SARS) infected more than 8,000 people and left 774 dead.¹² Its reach demonstrates the tremendous speed in which disease can spread. The economic losses, due to lives lost, quarantines, and lost tourism dollars, are estimated to be \$30 billion to \$50 billion.¹³

"THE ASSUMPTION THAT CONVENTIONAL PUBLIC HEALTH AND MEDICAL SYSTEMS CAN FUNCTION EFFECTIVELY IN CATASTROPHIC HEALTH EVENTS HAS, HOWEVER, PROVED TO BE INCORRECT IN REAL-WORLD SITUATIONS. THEREFORE, IT IS NECESSARY TO TRANSFORM THE NATIONAL APPROACH TO HEALTH CARE IN THE CONTEXT OF A CATASTROPHIC HEALTH EVENT IN ORDER TO ENABLE U.S. PUBLIC HEALTH AND MEDICAL SYSTEMS TO RESPOND EFFECTIVELY TO A BROAD RANGE OF INCIDENTS."¹

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PREVENTING EPIDEMICS.
PROTECTING PEOPLE.

HOW CAN WE IMPROVE READINESS FOR HEALTH EMERGENCIES?

- **Clearly Designate Strong Federal Leadership.** National plans should establish officials in charge of public health preparedness and specify how various departments are to collaborate in the event of a public health emergency.
- **Require Accountability and Conduct Meaningful Oversight.** The federal Pandemic and All-Hazards Preparedness Act, was enacted to improve our emergency preparedness response capabilities. Many deadlines for benchmarks and deliverables, however, have not been met. The Administration must adhere to the deadlines in the legislation, and Congress must conduct ongoing oversight to ensure that progress is being made.
- **Bolster Surge Capacity and the Public Health Workforce.** Public health emergency planning at the federal, state, and local levels must include preparations for mass emergencies, including surge capacity alternative care sites and recruiting

and retaining a robust volunteer health care workforce. Congress should also address the public health workforce shortage crisis through legislation to recruit a new generation of professionals.

- **Modernize Technology and Equipment.** Basic technology and tools of public health must be modernized to adequately protect the American people. This includes research and development of vaccines and new technologies; improved chemical laboratory testing capabilities; and, modernized surveillance systems to detect infectious disease outbreaks or a bioterrorist attack.
- **Partner with the Public.** Preparedness plans need to consider the diverse needs of the U.S. population, in particular, vulnerable and 'special needs' populations. This includes designing culturally competent risk communication campaigns that use respected, trusted messengers to communicate the message.

ENDNOTES

- 1 Homeland Security Council. *Homeland Security Presidential Directive/HSPD 21: Public Health and Medical Preparedness*. Washington, D.C.: The White House, 2007.
- 2 Trust for America's Health. *Ready or Not? Protecting the Public's Health from Diseases, Disasters, and Bioterrorism*. Washington, D.C.: TFAH, 2007.
- 3 Ibid.
- 4 Ibid.
- 5 Ibid.
- 6 E. Toner, et al. "Meeting Report: Hospital Preparedness for Pandemic Influenza." *Biosecurity and Bioterrorism* 4, no 2. (2006): 1-11.
- 7 K. Eban. "Biosense or Biononsense? Years of Development and Hundreds of Millions of Dollars Later, What Has the CDC's Syndromic Surveillance Program Accomplished?" *The Scientist* 21, no. 4 (April 2007): 32, <http://www.the-scientist.com/2007/4/1/32/1> (accessed October 22, 2007).
- 8 Congressional Budget Office. "Cost Estimate: H.R. 4634: Terrorism Insurance Backstop Extension Act of 2004." CBO, <http://www.cbo.gov/ftpdoc.cfm?index=6014&type=0&sequence=0> (accessed January 10, 2008).
- 9 H. Kunreuther and M.K. Erwann. *Dealing with Extreme Events: New Challenges for Terrorism Risk Coverage in the U.S.* Philadelphia, PA: University of Pennsylvania, Wharton School of Business, April 2004, <http://grace.wharton.upenn.edu/risk/downloads/04-09%20Howard%20and%20Erwann.pdf> (accessed January 10, 2008).
- 10 Towers Perrin. *Workers' Compensation Terrorism Reinsurance Pool Feasibility Study*. Stamford, CT: Towers Perrin, March 2004.
- 11 A.F. Kaufmann, et al. "The Economic Impact of a Bioterrorist Attack: Are Prevention and Postattack Intervention Programs Justifiable?" *Journal of Emerging Infectious Diseases* 3, no. 2 (April-June 1997): 83-94.
- 12 World Health Organization. "Summary of Probable SARS Cases with Onset of Illness from 1 November 2002 to 31 July 2003." WHO. http://www.who.int/csr/sars/country/table2004_04_21/en/ (accessed January 9, 2008).
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