PAHPA: KEY TO PUBLIC HEALTH EMERGENCY PREPAREDNESS

THE BIG PICTURE

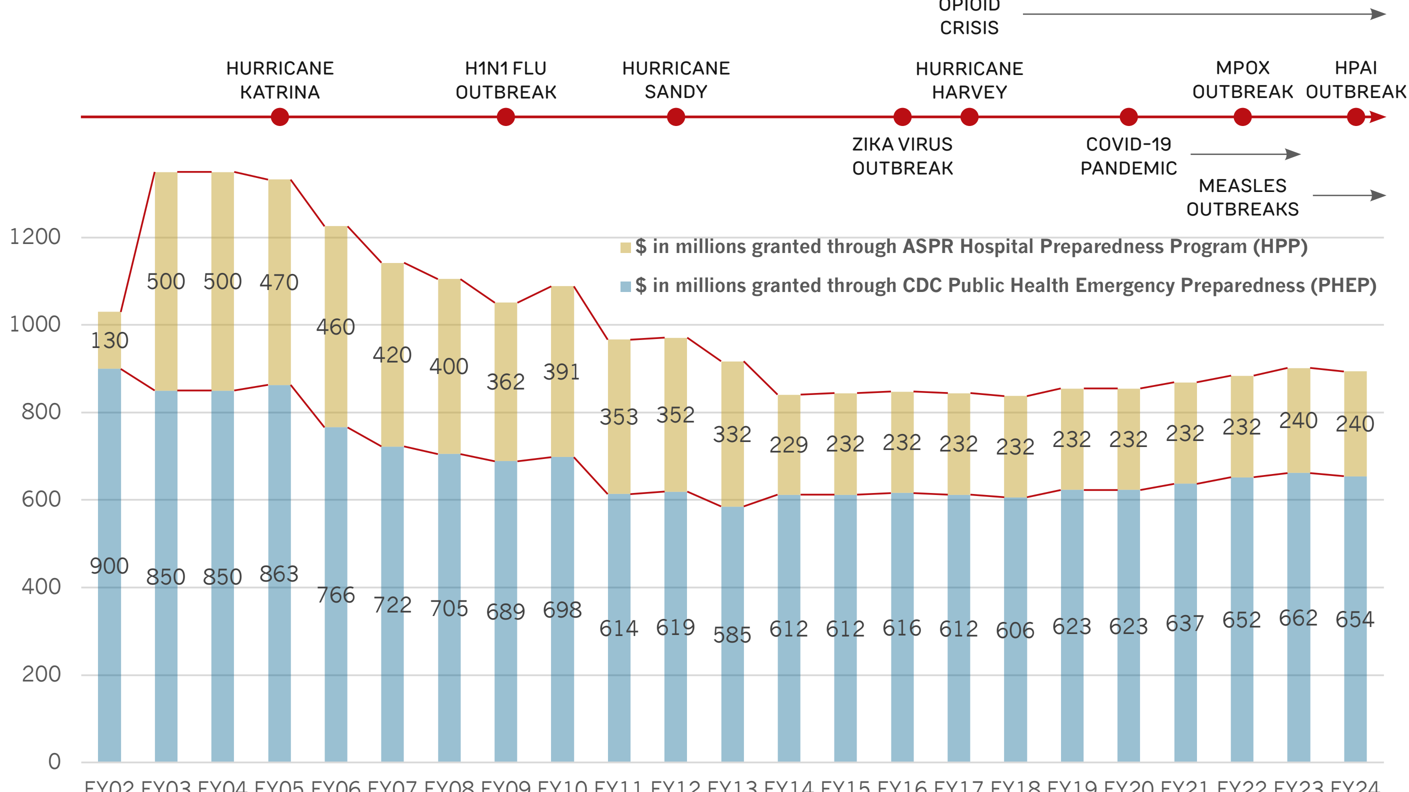
Reauthorize PAHPA to enable health departments to prepare for future public health emergencies.

Big city health departments (including county departments that serve big cities) are on the front lines preventing and responding to public health emergencies, including natural disasters such as fires, floods, earthquakes, terrorist attacks, and pandemics.

Public health preparedness at the state and local level is funded through federal cooperative agreements authorized in the **Pandemic All-Hazards Preparedness Act (PAHPA)**. Specifically, the Centers for Disease Control and Prevention (CDC) and Administration for Strategic Preparedness and Response (ASPR) provide funding to 50 states, four localities (Chicago, Los Angeles Co., New York City, Washington, D.C.), and eight territories and freely associated states. Most local health departments receive funding through their states rather than directly from the federal government.

Local health departments help build resilient communities by preparing for these emergencies and supporting residents recovering from them. Funding authorized through PAHPA is critical to that lifesaving work.

CHART (below): Despite a sharp increase in severe public health emergencies, preparedness funding has plummeted 34% since FY 2003.*



** Numbers based on amounts awarded not appropriated. Sources: [PHEP Cooperative Agreement Archive (CDC)](); [Infectious Disease Threats (GAO)](); [ASPR Health Care Readiness Programs Funding](); [Public Health Preparedness (GAO)]()*

PAHPA: A BRIEF HISTORY

Congress signed the Pandemic and All-Hazards Preparedness Act (PAHPA) into law in 2006 and since then has reauthorized it twice.

PAHPA built upon previous law to address pandemic preparedness and biodefense following the 9-11 and anthrax attacks, Hurricane Katrina, and global spread of H1N1 influenza. It expanded the focus from bioterrorism to all hazards: natural disasters, chemical, nuclear, or radiological incidents, and emerging infectious diseases (EIDs).

PAHPA sought to improve public health and health care emergency preparedness and response by reauthorizing expiring programs in the Public Health Service Act, including those that fund state and local health departments. It authorized a new **Assistant Secretary for Preparedness and Response (ASPR)** and established new authorities, including the **Biomedical Advanced Research and Development Authority (BARDA)**.

The **Pandemic and All-Hazards Preparedness Reauthorization Act (PAHPRA)** in 2013 and **Pandemic and All Hazards Preparedness and Advancing Innovation Act (PAHPAIA)** in 2019 built on PAHPA to refine programs and responsibilities at the federal, state, and local level; incentivize the development and purchase of medical countermeasures; and establish advisory committees and the **Public Health Emergency Medical Countermeasure Enterprise (PHEMCE)**.

Timeline of
Public Health Emergency Preparedness Legislation

2000

PUBLIC HEALTH THREATS AND EMERGENCIES ACT (PL 106-505)

Authorizes grants to states to build public health preparedness at $50M; reestablishes Public Health Emergency Fund (PHEF) authorized in 1983

2002

PUBLIC HEALTH SECURITY AND BIOTERRORISM PREPAREDNESS AND RESPONSE ACT (PL 107-188)

Establishes Assistant Secretary for Public Health Emergency Preparedness position; expands CDC activities and Strategic National Stockpile; authorizes state grants for hospital preparedness ($1.08B) and National Disaster Medical System (NDMS, $520M)

2004

PROJECT BIOSHIELD ACT (PL 108-276)

Authorizes market incentives for development of chemical, biological, radiological, and nuclear (CBRN) medical countermeasures (MCMs)

2005

PUBLIC READINESS AND EMERGENCY PREPAREDNESS (PREP) ACT (PL 109-148)

Allows HHS Secretary to issue a declaration during a PHE, providing immunity from liability related to MCMs

2006

PANDEMIC AND ALL-HAZARDS PREPAREDNESS ACT (PL 109-417)

Creates ASPR and BARDA, authorizes PHEP at $824M and HPP at $474M, transfers NDMS to ASPR from DHS; authorizes Medical Reserve Corps

2013

PANDEMIC AND ALL-HAZARDS PREPAREDNESS REAUTHORIZATION ACT (PL 113-5)

Reauthorizes PHEP at $642M and HPP at $374M; temporary reassignment of state and local personnel during a PHE; ASPR given lead responsibility for emergency preparedness and response, required to develop PHEMCE strategy and implementation plan, and manage and execute BioShield contracts

2019

PANDEMIC AND ALL HAZARDS PREPAREDNESS AND ADVANCING INNOVATION ACT (PAHPAIA) (PL 116-22)

Reauthorizes PHEP ($685M) & HPP ($385M); authorizes uses for Public Health Emergency Fund; authorizes advance funding to buy MCMs and support R&D of MCMs; allows strategic initiatives for antimicrobial resistance, pan flu, EIDs

2022

PREVENT PANDEMICS ACT (PL-117-328)

Establishes White House Office of Pandemic Preparedness and Response Policy; Senate confirmation of CDC director in 2025; provisions to enhance public health data collection at the state and local level; reauthorization of the public health loan repayment program

"One of my biggest worries is that we lose the capabilities we've built. We didn't know what we didn't have, and then we discovered we didn't have it, and then we quickly built it with a significant amount of COVID supplemental funds with the support of Congress. Now that we have these things, how do we keep them and preserve them so we could use them next time? I think the PAHPA conversation's going to be really important in that."

—DAWN O'CONNELL, ASSISTANT SECRETARY FOR PREPAREDNESS & RESPONSE

BCHC PRIORITIES FOR REAUTHORIZATION

Public Health Emergency Preparedness (PHEP) Cooperative Agreements

The PHEP grant program (42 U.S.C. 247d-3a(h)(1)), administered by CDC, was created after September 11, 2001, to provide core funding to strengthen local and state health departments' ability to respond to public health emergencies, including terrorist threats, infectious disease outbreaks, natural disasters, and CBRN emergencies. PHEP funding to grantees has been cut by nearly 30% over the last two decades, despite the increase in emerging and re-emerging infectious diseases, and weather-related, environmental, and other emergencies and disasters. The continuous barrage of wide-scale public health emergencies, such as the COVID-19 pandemic and mpox and HPAI outbreaks demonstrates the need to reauthorize and reinvest in these programs to rebuild and bolster our country's public health preparedness and response capabilities. The U.S. needs stronger local, state, federal, and territorial public health agencies capable of protecting the health of all Americans in the face of 21st-century threats.

BCHC recommends:

- PHEP be reauthorized at $1 billion, which would account for inflation since the program began and align it with its original, intended buying power of $1.08 billion.
- Congress request a GAO report examining how states determine the appropriate portion of PHEP awards for local health departments and make recommendations on how these funds can be more efficiently used to support system-wide preparedness.

Hospital Preparedness Program (HPP) Cooperative Agreements

HPP (42 U.S.C. 247d-3b), administered by ASPR, prepares the nation's health care system to save lives during emergencies and disasters. HPP supports regional health care coalitions to incentivize readiness, assess risks and needs, train the workforce, and maintain preparedness among organizations that might otherwise see each other as competitors. ASPR data show that about 96% of participating hospitals say HPP support has improved their ability to decrease morbidity and mortality during disasters. Despite this, HPP has been cut by more than 50% over the last 20 years.

BCHC recommends:

- HPP be reauthorized at $500 million – the amount grantees received 20 years ago in FY 2003.

Public Health Emergency Fund (PHEF)

Emergency dollars are critical to support a robust response in the intervening time it takes Congress to act. Big cities are often first to respond to crises and must use whatever dollars are available at that moment, with the expectation that the federal government will contribute later to the response. For example, in the 2016 Zika outbreak it took Congress more than 200 days to respond to an emergency request from the Obama Administration. A mechanism to get dollars out quickly to local, state, and federal public health agencies is critical for standing up an emergency response in a timely manner.

BCHC recommends:

- Reauthorizing the PHEF, thus reinstating a method to quickly provide money to the HHS Secretary as well as to state and local partners. Such funds should be additive, not require jurisdictions to use existing preparedness funds, and should also not rely on CDC to use their own response fund, which is primarily used to support internal activities.
- Creating a trigger mechanism whereby the PHEF receives an immediate infusion of resources once a public health emergency is declared.

Adult Vaccine Infrastructure

The COVID-19 pandemic taught us that we need a comprehensive vaccine infrastructure to immunize all Americans against infectious disease threats. Such a program is essential for maintaining the infrastructure needed for future pandemic response, while also ensuring access to routine vaccines in non-emergencies. The National Vaccine Program or 317 is essential, but it is not sufficiently funded to support vaccination for all uninsured adults. Even with improvements in access to adult vaccines in Medicare Part D, Medicaid, and CHIP, significant gaps in coverage and infrastructure for adults still exist.

BCHC recommends:

- Authorizing a Vaccines for Adults program, or provide sufficient resources to expand

the 317 program to support un- and under-insured adults' access to Advisory Committee on Immunization practices (ACIP)-recommended routine and outbreak vaccines at no cost.

Minimize Burden and Increase Flexibility of Grants for STLT Governmental Public Health Agencies

Effective public health response depends on coordinated action between the federal, state, tribal, local, and territorial (STLT) levels of government. As CDC supports STLT readiness and response, it needs explicit authority to direct funding to agencies at all levels of government. Any such authority should also include an analysis of the efficiency and efficacy of dollars getting local through grants to states.

BCHC recommends:

- Whenever possible, CDC should broaden its grantmaking pool to include, at minimum, the 107 jurisdictions funded under the Public Health Infrastructure and Grant Program. These grantees include 50 states and Washington, D.C., eight territories/freely associated states, and 48 local health departments that serve either cities with a population of at least 400,000 or counties with a population of at least 2,000,000 (based on the most recent U.S. Census).
- Multi-year funding awards with 24-month budget periods and the ability to redirect funds during the budget period. This would reduce the administrative burden of processing carryover and no-cost extension requests.

Public Health Data

BCHC also supports giving CDC the authority to collect and coordinate the public health data necessary to serve its mission and address known blind spots. The current framework for collecting and sharing public health data has resulted in fragmented and inconsistent reporting to CDC, and to state and local public health partners. Expanded data authority for CDC would allow for more complete and timely data sharing, while reducing burden on providers. Every effort must be made to strengthen public health data systems as an essential component of emergency preparedness.

BCHC recommends:

- Congress provide CDC with the authority to require reporting of minimum necessary data to serve a range of public health and other mission-critical use cases.
- Including the *Improving Data Accessibility Through Advancements in Public Health Act or Improving DATA in Public Health Act* (H.R. 3791/S. 3545) that promotes coordination between federal agencies to share critical public health data used to prepare for and respond to public health emergencies. The bill also creates standards to improve and secure the transfer of electronic health information and establishes an Advisory Committee to ensure that public health data reporting processes are carried out effectively.

Temporary Reassignment of Federally Funded Staff

Currently, only governors and tribal leaders are authorized to submit temporary reassignment requests to support a public health emergency. BCHC supports reauthorizing temporary reassignment of federally funded staff in the event of an emergency and urges modification to the provision to provide flexibility so local health departments and federal agencies may also issue and receive temporary reassignments. Expanding that mechanism would enable increased continuity of operations that are vital for a response.

BCHC recommends:

- That Congress direct HHS to work with its agencies to establish a "one-stop shop" for STLT health agencies to submit emergency reassignment requests. STLT health agencies should not need to repeat the entire process each time the public health agency renews an employee.
- Changing the language to allow PHEP directors to submit the request on behalf of the jurisdictions directly to ASPR, not via an elected official.

The Big Cities Health Coalition (BCHC) is a forum for the leaders of America's largest metropolitan health departments to exchange strategies and jointly address issues to promote and protect the health and safety of their residents. Collectively, BCHC's 35 member jurisdictions directly impact more than 61 million people, or one in five Americans. **bigcitieshealth.org**

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