



# **BUILDING RESILIENT, EQUITABLE, AND HEALTHY COMMUNITIES POST PANDEMIC AND ALWAYS**

Recommendations for the Next Administration and 117th Congress





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 member jurisdictions directly impact nearly 62 million people, or one in five Americans.

We thank our members, partners, and alumni who took the time to review this document.

We are also grateful to the de Beaumont Foundation for their ongoing programmatic support of the Big Cities Health Coalition.

*Opinions in this report are the Coalition's and do necessarily reflect the views of any one member or funder.*

For more information, visit  
**<http://www.bigcitieshealth.org>**.

OCTOBER 19, 2020



# INTRODUCTION

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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 the nearly 62 million people they serve. The mission of the Coalition is to advance equity and health for present and future generations. Our vision is healthy, more equitable communities through big city innovation and leadership.

Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases.<sup>1</sup> Overall, our field is concerned with protecting the health of entire populations.

Having a public health system that works well matters now more than ever.

“Governmental public health” includes the health departments that work to promote the health and safety of their communities at the state, county, and city level. These departments have primary responsibility for protecting local/state jurisdictions under our federalist system. There are close to 3,000 local health departments that work in tandem with the 59 state and territorial health departments.<sup>2</sup> There are also Tribal health departments, and all collaborate with federal health leadership, particularly the U.S. Centers

for Disease Control and Prevention (CDC) to get their work done.

Our members are on the front lines of public health in urban America, working every day to make it easier for people to be healthy and stay safe. In ‘normal’ times, big city health departments address a wide range of everyday threats, including chronic and infectious disease, environmental hazards, and substance misuse. They focus on prevention, lay the groundwork for healthy choices that keep people from getting sick or injured, put policies in place to create healthier communities, and convene key stakeholders who are both supporters and skeptics of their work. Finally, big city health leaders help build strong resilient communities, respond when public health emergencies occur, and lend support throughout the recovery process.

But as 2020 has shown us, we are not living in ‘normal’ times. COVID-19

has laid bare all of the inequities the field of public health and others have worked to address for decades—systemic racism, income inequality, a lack of paid sick leave, and enormous health disparities that all of these challenges exacerbate. This virus has exploited those with pre-existing conditions, like diabetes or asthma, and others who needed to work during outbreaks to provide for their families. Systemic inequities and the very nature of the virus have a disproportionate impact on people of color and lower-income Americans.

Regardless of the speed and effectiveness of the initial federal response, we all have a responsibility to work to build more equitable, resilient communities post-pandemic. BCHC members and staff, and the field at large, will and must work tirelessly to ensure that a tragedy the scope and scale of this size does not happen again.

Chrissie Juliano, MPP  
Executive Director, BCHC

# THE ROLE OF LOCAL PUBLIC HEALTH IN AMERICA'S CITIES

The nation's urban local health departments are critical to building a healthier, safer, and more secure nation. Metropolitan areas are now home to almost 84% of Americans, and BCHC member health departments serve nearly 62 million or 1 in 5 Americans.<sup>3,4</sup> At their best, these health departments positively impact entire populations and create an environment in which the healthy, safe option is the default option.

Policy innovation at the local level does not just change the trajectory of health for the population city health leaders directly serve—it also drives national change. This is more important than ever. In the last decade, the significance of local governance has only grown as federal level policymaking has stagnated and policy decisions at both the state and federal levels have become increasingly politicized.<sup>5</sup>

In the past year, however, the COVID response has increased politicization and polarization in local and state communities.

Health officials are being harassed and threatened for simply working to keep the public as healthy and safe as possible.<sup>6</sup> Our country must support our local public health workforce and protect it from undo political influence. If we do not, the community's trust in local health departments will erode, and all

## Local, State, Tribal and Territorial Health Departments



<https://www.naccho.org/uploads/downloadable-resources/Workforce-COALITION-August-2020.pdf>

Americans will all be more vulnerable to unnecessary disease and death.

ALMOST **84%**  
OF AMERICANS NOW LIVE  
IN METROPOLITAN AREAS



BCHC MEMBER HEALTH  
DEPARTMENTS SERVE

**1-in-5** AMERICANS

Source: UN World Urbanization Prospects. See endnotes 3 & 4.

# PUBLIC HEALTH PRINCIPLES FOR THE NEXT ADMINISTRATION AND CONGRESS

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While all the recommendations in this piece have been vetted with our members, they feel most strongly about these five high-level principles that undergird the more detailed recommendations below. As such, the 24 undersigned BCHC members recommend the new Administration and Congress base future policy decisions on the following.

**1. Lead with equity and address structural racism.** The mission of BCHC is *"advancing equity and health for present and future generations."* Our country is broken, and it will take all of us to fix it. To do so, we must give voice to the fact that structural racism is at the root of many of our systems and institutions that have never really worked equitably for all. Achieving equity and health for future generations will not be easy. Declaring racism as a public health emergency may help to reframe the conversation and illustrate that we are all only as healthy as the least healthy among us. Moving forward, we must all work harder to diminish discrimination and trauma that is too often experienced among people of color. Doing so will mean rebuilding our communities, and in some cases, the systems within which we operate, so that each and every person, no matter where they live, the color of their skin or where they were born, has the opportunity to live a healthy, full, and productive life.

**2. Address the social determinants to improve health and build more equitable communities.** The social determinants of health are the conditions and environments in which people live, learn, work, and play.<sup>7</sup> These include education, income, and access to healthy food, safe housing, and appropriate clinical care, among other things. Policies that address these determinants and improve quality of life in our communities include, guaranteed minimum income, paid sick/family leave, access to universal pre-k and universal health care, and inclusionary zoning and rental inspection.

**3. Strengthen the infrastructure of the public health system to sufficiently promote and protect the health and safety of all.** In this country, we spend far too much on medical care and not enough on preventing unnecessary disease and death. Public health is the science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention, and detection and control of infectious diseases.<sup>8</sup> Overall, our field is concerned with protecting the health of entire populations, including ensuring access to affordable, appropriate clinical health care. The health of the nation depends on robust investments in prevention and public health, including direct funding for many of the activities that our nation's largest jurisdictions take on in the absence of such support.



**4. Build an appropriately skilled, well-qualified, and well-resourced public health workforce on which our communities can rely.**

Governmental public health is constantly being asked to do more with less. The 2019 local governmental public health workforce was about 136,000 FTEs, having lost approximately 30,000 FTEs since 2008.<sup>9</sup> Those who remain in the workforce are often underpaid and undervalued compared to their colleagues in the private sector. As we respond to and recover from the COVID-19 pandemic, it is imperative that we value the governmental public health workforce for what they are: one of many of the nation's first responders in times of crisis and an invisible ally working to keep communities healthy and safe while facing daily routine challenges.

**5. Recognize the importance of local autonomy, while providing federal resources and leadership in times of crisis.**

Traditionally, local public health departments have always emphasized the importance of autonomy to make policy decisions about the health of local communities. In addition to autonomy, local public health departments also need direct funding to support those decisions and build healthier communities. There has also always been a need for balance, and this remains true today.

In the COVID-19 response, too many decisions have been pushed down to local jurisdictions. A single city or county, no matter how well-resourced or well-led, cannot mount a sufficient response to an emergency of this magnitude on its own. An infectious disease does not respect city limits or state lines, so

guidance must be unified across the country, even as specific strategies, enforcement, and focus will vary by jurisdiction. When the federal and local guidance and messaging diverge, it promotes skepticism among the public, hindering response efforts. It takes a comprehensive, unified strategy, with federal, state, and local officials working in coordination to mount an effective response to a worldwide pandemic. Federal guidance should not be a surprise to local health officials, nor should it force local health officials to disagree with federal entities. Federal officials should not blame local government for specific outbreaks.

**Big city health departments stand ready to collaborate with state and federal partners with transparency and mutual respect as central tenets to the work we must do together for the health of our nation.**

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# LEADING WITH SCIENCE AND DATA IN A TRANSPARENT MANNER

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In the midst of a worldwide pandemic, it has never been more important to make public health decisions based on science and data. Elected leaders need to be transparent and refrain from undermining or politicizing science and data. Inconsistent messaging and a top-down approach have been harmful to the COVID-19 response. All levels of government must work together to present a unified front to the American people.

Elected officials at all levels of government need to rely on experts that have spent their entire careers planning for and responding to public health emergencies. These experts should not only be in charge of managing the response, but also be the face of it. Trusted messengers who have been trained in risk communication should be a clear, consistent voice in challenging times. They know how to balance truth-based messages without panicking the public, know how to explain when the science has changed or mistakes were made, and then move on.

Finally, data and science must be balanced with the reality of what is occurring on the ground. While we must lead with science, it must be validated by what is being seen in the field by practitioners.



## HHS POLITICAL APPOINTEES AND THE PUBLIC'S HEALTH

There are 19 Senate confirmed positions across agencies at the Department of Health and Human Services (HHS), who are formal political appointees.<sup>10</sup> In addition to the Secretary, the heads of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Administration for Children, Youth and Families (ACYF), as well as deputy secretaries, watch dog roles, and the Surgeon General (though on a purposefully different timeline) are all political appointees that change with a new Administration. The director of the CDC is not one such position as it is not in statute, and, particularly in years past, he or she was meant to be a public health professional insulated from politics. That said, in

the past two decades at least, new administrations install their own CDC Director upon taking office.<sup>11</sup>

It is worth considering what additional steps are necessary to protect science from politics particularly as it relates to the CDC. One option is to have the agency's director formally become a political appointee confirmed by the Senate.<sup>12</sup> Another option is to have a "governing board" with that would have oversight responsibilities.<sup>13</sup>

There is no one right answer to address increasing reports of political interference at the CDC and with science more generally. Policymakers should consider a host of options to add additional accountability and a thorough vetting of the leadership of the nation's leading public health agency.



# (RE-)BUILDING THE PUBLIC HEALTH SYSTEM

The U.S. has a disjointed health system—one that focuses on individual, clinical care, rather than one that focuses on promoting and protecting the health of the population, which could be defined as a neighborhood, city, county, state, or region. As a country we spend nearly \$3.5 trillion on health expenditures, which is 18 percent of our GDP.<sup>14</sup> Further, 93 percent of mandatory funding goes to support clinical care, while only 2.5 percent of that health expenditure funding, or less than half a percent of the total GDP, supports prevention and protecting the health of the public.<sup>15</sup>

Access to health care is a human right. But it's important to consider its collective impact. Even if everyone living in this country had been fully insured and able to visit a doctor of their choice, the COVID-19 pandemic would not have been prevented. While a healthier country would have mitigated deaths, medical/clinical care is only one factor that determines an individual's health.

Our public health system is a patchwork quilt of first responders, practitioners, and local, state, and federal experts who work to keep our communities healthy and safe. All levels of government have an critical role to play in this system.

## THE FEDERAL ROLE

In our diffuse and complex government public health system, the federal government's role is to provide command and control in times of crisis, provide guidance and research,

facilitate data collection, and provide funding for the system. The federal government also is meant to support state and local governmental public health activities across the board.

**First and foremost, federal policymakers must sufficiently fund all levels of the public health system.** With rare exceptions, public health funding flows from the federal government to states and then, eventually, to local communities. Public health activities are funded in part by each of those levels of government. Even with that combination of funding streams, this incomplete and disjointed funding process underfunds the local public health system.<sup>16,17</sup>

A well-resourced, well-funded public health system is needed to prevent and respond to public health emergencies, as well as to address every day health issues. When a house is burning, you can't go out and buy a fire truck—

**We need a strong, well-resourced public health system to address social determinants of health and to build and support a healthy and resilient population.**

2018 HEALTH EXPENDITURES

**\$3.5**  
TRILLION A YEAR



**93%**  
IS SPENT ON  
**CLINICAL CARE**

IS SPENT ON  
**PREVENTION  
& PROTECTION**  
OF THE PUBLIC'S  
HEALTH  
**2.5%**

<https://www.cdc.gov/nchs/data/hsr/2018/042.pdf>

it's already too late. Funding the public health system is no different. However, while other emergency response agencies are recognized as critical, governmental public health is chronically underfunded and is *always* forced to do more with less.

Further, the way in which we fund public health is all too often siloed by program or disease, so that little funding goes to support the underlying infrastructure, such as epidemiology and surveillance systems, workforce, and education and communication about the health of the community. Funding must be flexible as health threats are continually changing. Public health needs to take an “all hazards” approach and be nimble in addressing health challenges, which is often

hindered by restrictive funding streams. CDC has in recent years worked to address this by encouraging innovation and leveraging of dollars as is permissible with appropriated dollars. Congress should continue to enable the Agency to do this, and CDC should push the envelope—and their partners who receive the money—to do so.

At the same time, because dollars are passed from one level of government to another, accountability is difficult and the process is incredibly time consuming and often inefficient. Dollars must be sufficient and flexible to ensure that they are used as effectively and efficiently as possible, and in some cases, that means sending dollars directly to the level local.

## HEALTH DEFENSE OPERATIONS BUDGET

To protect funding for public health, Resolve to Save Lives and other advocates have put forth a concept suggesting that some core public health programs be part of a “Health Defense Operations” budget.<sup>18</sup> This action would protect some public health funding from sequestration or budget caps Congress has used in the past.<sup>19</sup> Further, nine leaders in the field sent a letter to congressional leadership proposing this change.<sup>20</sup>

## PREVENTION AND PUBLIC HEALTH FUND (PPHF)

The Prevention and Public Health Fund (PPHF) was created as part of the Affordable Care Act (ACA) and is one of the few mandatory funding streams literally meant to support prevention and public health activities; those activities that happen outside of a doctor's office that affect the health of the whole community. It was meant to complement insurance coverage recognizing that access to clinical care is necessary but not sufficient to getting and keeping our communities healthy.

The PPHF has been under threat practically since it was first enacted,

and with an upcoming ACA challenge in the U.S. Supreme Court, it may again be at risk. Accounting for 12 percent of the CDC's budget,<sup>21</sup> these federal dollars are essential to local and state health departments to carry out their missions. Over the years it has supported a number of programs aimed at addressing the leading causes of death—chronic disease like diabetes, stroke, and asthma—and the immunization program, which plays a critical role in ensuring that lifesaving vaccines get to those most in need. It has also supported the response to disease outbreaks, like Zika,

through the epidemiology and lab capacity program, that sends federal dollars to states and some localities to support disease investigation in their jurisdictions. Finally, the PPHF also funds lead poisoning prevention activities. Loss of the dollars and the intention of the dollars would be devastating to governmental public health departments across the country and to the public's health. Now is not the time to cut this funding. The PPHF must be protected and fully funded.

## THE STATE AND LOCAL ROLE

States are constitutionally responsible for the health of their residents through the 10<sup>th</sup> Amendment of the Constitution.<sup>22</sup> The states and health agency roles and responsibilities vary across the 50 states. Of the nearly 2,500 local health departments who responded to the National Association of County and City Health Officials' (NACCHO) 2019 Profile Survey, about 1,800 were locally controlled.<sup>23</sup> All but one of the BCHC member health departments are locally controlled. Regardless, almost all local health departments, including those in the Big Cities Health Coalition, depend on the state for varying degrees of funding. Others depend on states for access to state public health labs. By and large, however, many BCHC health departments are as sophisticated and resourced as their state counterparts.

Importantly, local health leaders are trusted leaders in their community. They have relationships with both elected and community leaders and are seen as fairly non-partisan. In most cases, localities are able to be more nimble in policy and practice than their state or federal counterparts. Some of this has changed given COVID-19.

The current political environment has damaged some local and state health departments. Members of the public now question science-based

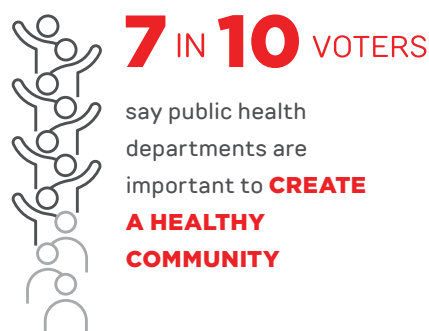
guidance—such as face coverings—that is a key part of the on-the-ground response. Federal level rhetoric has led to a mistrust of science, data, and public health guidance put forth at the local level, even leading to threats against local and state health officials. An unintended consequence of this will be a further “brain drain” of public health expertise at the local and state level as public health experts leave jobs for their own safety. We’ve seen a number of public health officials recently leave their posts in Orange

County, CA, Ohio, and North Dakota, which now has its third state health official during the pandemic.<sup>24,25</sup> All of this makes the country less safe no matter how prepared we are going into an event. **The next Congress and Administration must work closely with local and state health and elected officials to address this.**

## WORKFORCE

At the core of the governmental public health is its workforce, which has been shrinking for years and is constantly being asked to do more with less. The 2019 local governmental public health workforce was about 136,000 FTEs, having lost approximately 30,000 FTEs since 2008.<sup>26</sup> The overall size of this workforce remains largely unchanged since 2013.<sup>27</sup> New data on the state workforce from the Association of State and Territorial Health Officials (ASTHO) finds a decrease of about 10,000 FTEs from 2012 to 2019.<sup>28</sup>

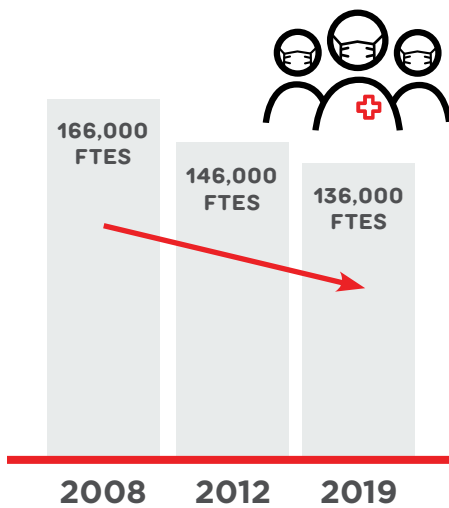
The Public Health Workforce Interests and Needs Survey (PHWINS) has repeatedly found challenges with recruitment and retention and an impending brain drain, due to an aging workforce.<sup>29</sup> Undoubtedly, the pandemic may exacerbate these retirements as burnout becomes more severe. Retention issues in BCHC members’ departments suggest professional development and opportunities for advancement



<https://www.debeaumont.org/news/2020/poll-more-voters-recognize-value-of-local-health-departments/>



### A SHRINKING LOCAL PUBLIC HEALTH WORKFORCE



<https://www.naccho.org/resources/lhd-research/national-profile-of-local-health-departments>

affect this, as well as challenges with hiring the “right” staff into the right positions.<sup>30</sup>

The National Association of County and City Health Officials (NACCHO) together with a Public Health Workforce Coalition they lead has called on Congress to enact and implement a loan repayment program for public health professionals as a first step toward working on the pipeline.<sup>31</sup>

### DATA

It is well documented that the governmental public health system’s data infrastructure is lacking in most jurisdictions. **An immediate, large, and sustained tranche of federal funding must be given to both local**

**and state jurisdictions, to enable a 21st century data infrastructure.**

Our health data systems are antiquated and siloed. While the ACA provided dollars for health care IT, it did little for the public health side. As such, our systems that were behind in normal times have struggled to keep up with COVID-19 information. Surveillance systems, which are meant to serve as early warning signs of flu outbreaks, for example, must also be modernized.

The Data is Elemental Campaign, led by the Council of State and Territorial Epidemiologists (CSTE), the Association of Public Health Laboratories (APHL), and others, has suggested an investment of \$1 billion is needed over the next 10 years to fully implement a 21<sup>st</sup> century data infrastructure.<sup>32</sup> To date, Congress has provided about \$550 million in funds to support such upgrades and will continue to need to do so in the future.

### POLICY RECOMMENDATIONS

- ▶ Congress should enact a mandatory \$4.5 billion per year to support public health at the state, local, territorial and tribal levels.
  - Allocate a significant portion of these funds to local communities in the form of direct federal funding to health departments serving the nation’s largest jurisdictions.

- Flexibility should be encouraged by federal funders. Local health departments should have the opportunity to braid funding across program areas to better coordinate and leverage funds and activities.

- ▶ Create and sufficiently fund a Health Defense Operations budget designation (See text box on page 8).<sup>33</sup>
- ▶ Increase accountability and transparency of federal public health dollars by creating and publicly releasing a more robust accounting of them, which includes to whom they flow and how long it takes to do so.
- ▶ Fund and provide resources necessary to build a 21st century public health data infrastructure along with an appropriately trained workforce that can collect and analyze cross sector data.
- ▶ Invest in the public health workforce, including CDC’s fellowship and training programs, like the Public Health Associate Program, which places CDC-trained staff in the field in a number of big city health departments, as well as a loan repayment program for those who agree to serve two years in a local, state, or tribal health department.
- ▶ Leave the science to the scientists and fund practice-based public health research.

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## COVID-19 PANDEMIC RESPONSE

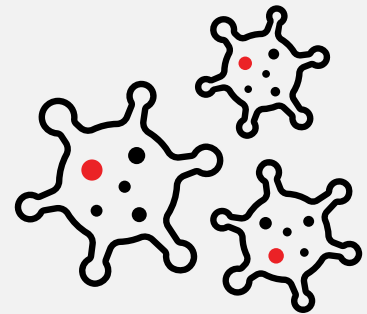
The field of public health has anticipated and prepared for a worldwide pandemic for nearly two decades. Though lives were lost, the H1N1 outbreak in 2009 and the Ebola response in 2014, served to test our country's response mechanisms and provided lessons learned for the eventual SARS-CoV-2 (COVID-19) pandemic. While local and state health departments, as well as the federal agencies, have planned for a pandemic response, no agency could have prepared for the current environment in which they are doing their work. From mixed messages to the public and an all-too-diffuse federal response to underlying health disparities and chronic disease, the United States' response has lagged behind other nations. As of October 10, 2020, the United States had 21 percent of the world's cases and 20 percent of the world's deaths, with just four percent of the world's population.<sup>34,35</sup>

The fact that our governmental public health system has been critically underfunded and understaffed for years cannot be ignored. Despite a lack of resources, local health departments have done all they could to first prevent, and then contain, the effects of COVID-19, rather than just mitigate its impact. Prevention is **only** possible when a robust, well-resourced governmental public health system comprised of career professionals is in place and empowered to do their jobs.

Below we highlight some key policy considerations in light of the COVID-19 response for both the remainder of this pandemic and the next.

### THE FEDERAL AGENCIES AND THE CONGRESS

While local health officials routinely advocate for local autonomy, the Federal government's delegation of the COVID response to the state and local level has become an impediment in many places. **In a national, large scale event, like a pandemic, the federal government must direct the response.** Infectious diseases do not recognize borders. The federal government needs to act to protect the entire populace, rather than jurisdiction-by-jurisdiction.



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**“The best action we can take to confront a public health emergency is to build essential infrastructure before it strikes. If the federal government invests sufficiently in both emergency preparedness programs and the everyday programs that combat chronic disease, address underlying health inequities, and promote community health, we will be more than ready to tackle the next crisis that comes along”**

**— The Fight Against COVID-19, It's Not Too Late to Fix America's Public Health System, Health Affairs Blog, May 12, 2020, May 12, 2020**

<https://www.healthaffairs.org/doi/10.1377/hblog20200510.485086/full/>

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As state and local health departments provide situational awareness of what is needed on-the-ground, such information should be centralized and feed into a government-wide approach. When a nationwide response is led by local jurisdictions, states are left to compete for resources, while inconsistent messages and confusing guidance are issued to the public.

**One of the most important things the federal government can do in an emergency is exhibit command and control of the situation.** Successful examples include leadership from the CDC Director during H1N1 and Ebola.<sup>36</sup> The CDC has not been allowed to lead publicly, casting doubt on their expertise and guidance, and putting them publicly on the sidelines.

**The U.S. Congress must be willing to stand up to insulate science from politics.** Congress’s role is to demonstrate leadership, conduct oversight on the Executive Branch, and provide much needed dollars and resources to local communities across the country managing response and recovery efforts. This system of checks and balances serves to protect federal agencies from politicization and allow the government to operate at maximum efficiency.

**Finally, the federal government also must ensure access to durable goods, using all their power to do so, such as by federalizing the supply chain and actively used the Defense Production Act (DPA).** The fact that

states and locals were tasked with procuring their own PPE or testing supplies early on created chaos in the limited supply chain. This process led to testing bottlenecks, additional costs and logistical challenges.

**“I worry, are we testing enough people? And how do we get the tests to the right people and make sure that we don’t have something brewing that we failed to pay enough attention to and it becomes a huge fire.”**

— Mysheika Roberts, Commissioner of Columbus Public Health

<https://www.nytimes.com/2020/04/25/us/politics/virus-testing-shortages-states-trump.html>

While large sums of dollars have gone through various funding mechanisms to state health departments or local governments, much less has reached local health departments. In fact, in many local jurisdictions, health department staff are being furloughed

and some positions may not return.<sup>37</sup> The work of public health is often *most* needed in times of economic downturn, even as governments at the state and local level see shrinking revenue.

Large local jurisdictions should be able to access federal resources directly, but only a few can. The country’s largest metro areas often have the majority of a state’s population. Requiring a jurisdiction that serves millions of people to work through the state for critical resources is inefficient. In addition to dedicated funding streams, there should be distribution plans in place for these jurisdictions, as well as dedicated funding streams. This includes access to vaccines, testing material, PPE, and other durable goods.

As was pointed out by former Senate Majority Leader Bill Frist and former HHS Secretary Mike Leavitt in their June 2020 testimony to the Senate HELP committee, additional funds are needed for the system to sufficiently prepare and respond to

**Some Big Cities and Counties Receive Federal Funding Directly from the CDC**  
**MOST LOCAL HEALTH DEPARTMENTS DON’T**

Public Health Emergency Preparedness (PHEP)	Immunization Program	Federal Epidemiology and Lab Capacity Program
<ul style="list-style-type: none"><li>• Chicago</li><li>• Los Angeles County</li><li>• New York City</li><li>• Philadelphia</li><li>• Washington, DC</li></ul>	<ul style="list-style-type: none"><li>• Chicago</li><li>• Houston</li><li>• New York City</li><li>• Philadelphia</li><li>• San Antonio</li><li>• Washington, DC</li></ul>	<ul style="list-style-type: none"><li>• Chicago</li><li>• Houston</li><li>• Los Angeles County</li><li>• New York City</li><li>• Philadelphia</li><li>• Washington, DC</li></ul>

<https://www.cdc.gov/cpr/epf/index.htm>.  
<https://www.cdc.gov/vaccines/imz-managers/awardee-imz-websites.html>.



emergencies.<sup>38</sup> The Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) have been underinvested for years.

PHEP and HPP are meant to prepare state and local health departments and health systems to be ready every day for any emergent event. These dollars are not meant for response and, the extent to which funds get passed down to the local level, varies immensely. **Congress should require CDC to provide an annual state-by-state report showing how much federal emergency preparedness funding, including COVID-19 emergency funding, is reaching the local level via state health departments.**

**The Public Health Emergency fund and the Infectious Disease Rapid Response Reserve Fund (IDRRRF) need to be well resourced, and**

**replenished, with no-year funds to ensure the relevant agencies have access to dollars without waiting for Congressional appropriation.**

Emergency dollars to support robust response in the intervening time it takes Congress to act are critical. Big cities are often first to respond to crises ranging from hurricanes to outbreaks to floods using whatever dollars are available at that moment with the expectation that the federal government will contribute to the response. In the 2016 Zika outbreak, it took Congress 233 days to respond to an emergency request from the Obama Administration.<sup>39</sup> In the first days of the COVID-19 response, HHS tapped IDRRRF dollars and exhausted them quickly.<sup>40</sup>

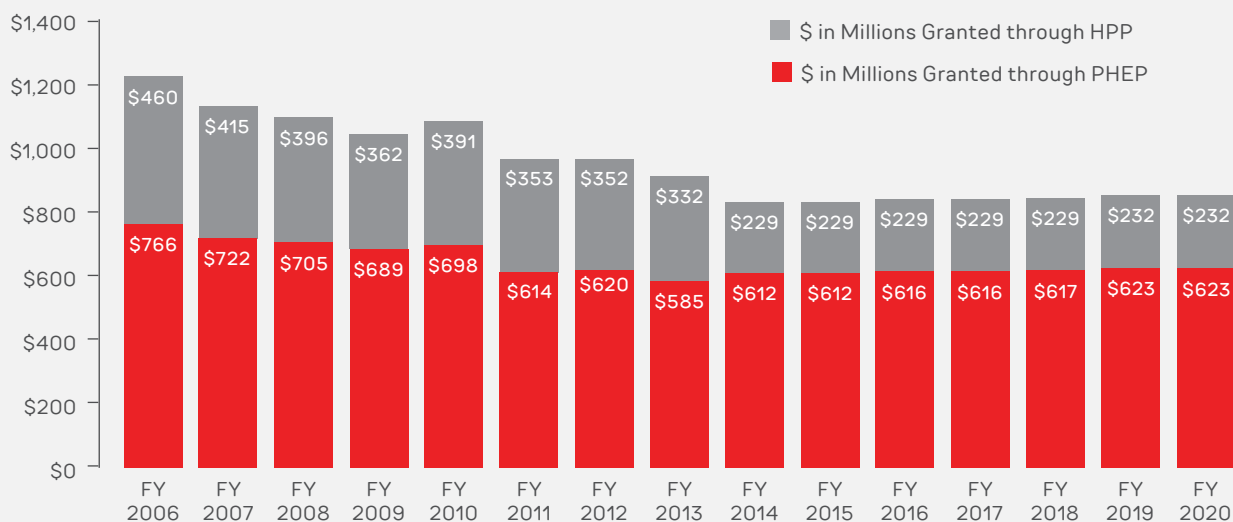
## THE STRATEGIC NATIONAL STOCKPILE

The Strategic National Stockpile (SNS) is meant to be used in a national

emergency, such as a pandemic, to support the on-the-ground response across the country. The SNS is in place because the Congress and previous Administrations realized that local and state jurisdictions do not have the means to procure enough supplies when a national or local emergency occurs.<sup>41</sup>

That said, there are things that the federal government and Congress can do to ensure that states have some level of cache when the next emergency arrives. **The federal government, i.e. CDC and/or ASPR, could offer guidance to health departments and health systems about what materials should be procured. There should also be a federal matching program to ensure that jurisdictions spend dollars appropriately on preparedness.** All too often, “wealthier” states spend dollars to prepare and “poorer” states

## CDC Public Health Emergency Preparedness (PHEP) and ASPR Hospital Preparedness Program (HPP) Funding (30% Cut FY2006–FY2020)



<https://www.phe.gov/Preparedness/planning/hpp/Pages/funding.aspx>.

<https://www.cdc.gov/cpr/readiness/phep.htm>.

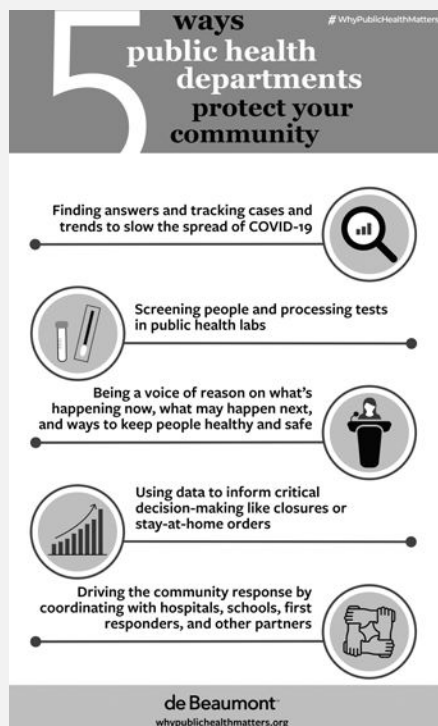
<https://www.hhs.gov/sites/default/files/fy-2021-phssec-cj.pdf>.

[https://www.cdc.gov/cpr/readiness/00\\_docs/PHEP\\_Budget\\_Period\\_2\\_Fiscal\\_Year\\_2020\\_Funding\\_Table.pdf](https://www.cdc.gov/cpr/readiness/00_docs/PHEP_Budget_Period_2_Fiscal_Year_2020_Funding_Table.pdf).

do not. In the event of an emergency, the federal resources often go first to those who failed to prepare.

Resources should be allocated by a formula based on population and need, with a federal and state/local jurisdiction share. Similarly, such a formula could be used to determine if local jurisdictions meet a threshold for directly funding and/or receipt of durable goods from the federal government directly. For example, those local jurisdictions with a population of 500,000 people or more, the threshold for funding in the CARES Act, could be deemed eligible rather than going through their state to procure such material.

**Congress should provide sufficient funding for the upkeep of the SNS and increase transparency.**



Recognizing that there is a need to exercise some level of caution to publicly state what is in the SNS, there is still opportunity to share information with state/local partners and the Congress. Congress should also require additional reporting on status of the SNS, including expenditures and expiration dates of the cache.

### WHO'S IN CHARGE?

In times of emergency, clear lines of authority and responsibility are critical. As several Congressional leaders have pointed out in a host of hearings, there needs to be clarity in departmental and agency roles and coordination to ensure the federal government is leveraging its existing expertise, programs, and infrastructure, while including CDC public health leadership and existing federal advisory committees.<sup>42</sup>

The staffing and funding for the Assistant Secretary for Preparedness (ASPR) at HHS should match its statutory authority to coordinate the response. There also should be standing health security expertise on both the Domestic Policy Council and the National Security Council so that leadership is in place prior to a health emergency.

### POLICY RECOMMENDATIONS

- ▶ Public health emergencies must be managed by experts and driven by data and facts.
- ▶ A response the scale of COVID-19 demands a robust response from the federal government, including clear messaging and guidance, as well as

resources. Operational decisions should be pushed down to state and local authorities as appropriate and when dictated by on-the-ground realities.

- ▶ The federal government has both the responsibility and resources to ensure access to a host of durable goods and should use the DPA as extensively as possible to meet the needs of a response.
- ▶ Emergency preparedness and response dollars must reach the local level, in as direct a manner as possible, and Congress must provide oversight on Administration spending and timelines.
- ▶ Congress should routinely replenish with no-year dollars both the Public Health Emergency Fund and the IDRRRF.
- ▶ The federal government should both fully fund and provide additional transparency on what is in the SNS, as well as issue guidance to states, localities, and health systems around what they should be stockpiling on their own with funding as an incentive.
- ▶ Clear lines of authority must be followed, with appropriate oversight, during a large scale response.
- ▶ Ensure both the White House Domestic Policy Council and National Security Council have standing health security expertise.
- ▶ The Administration must reengage with and learn from the rest of the world, including active participation in the World Health Organization.

## PRIORITY ISSUE AREAS

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### ► Building More Equitable Communities and Addressing Structural Racism

CDC defines health equity as “when everyone has the opportunity to be as healthy as possible.”<sup>43</sup> That equity can only be achieved by identifying and reducing health disparities, which are present across all health issues, and removing a host of structural barriers, which contribute to inequitable outcomes.

All across the United States, cities, elected bodies, and administrative agencies are changing how they make public policy.<sup>44</sup> They are integrating processes and tools to examine how racial inequities might unintentionally result from their decisions — and importantly, they’re adjusting those decisions to prevent those inequitable impacts. This movement to “apply an equity lens in decision making” has yielded concrete changes in local budgets, policies, plans, and programs in ways that protect and improve the health, social, economic, and environmental conditions of communities historically experiencing inequities.<sup>45</sup>

Further, COVID-19 has forced health departments into unprecedented territory with respect to the scale and scope of decisions made to protect the health of the public. According to some BCHC health departments, the urgency and difficulty of rapid decision-making in the pandemic

is requiring them to double-down on their focus on equity, working to ensure that equity considerations remain prioritized and consistently addressed.<sup>46</sup> It is now well known that COVID-19 disproportionately exposes, sickens, and kills people of color, and those who are lower-income, at rates far higher than White, non-immigrant, and higher-income people.<sup>47</sup> A history of systematically racist employment, housing, health, and social policy has patterned these inequitable exposures and outcomes.

Policies related to healthcare access, Medicaid expansion, paid sick leave, universal basic income, affordable childcare, housing affordability and stability, and other issues would go a long way to creating the conditions for health and equity more widely. The federal government can implement these policies at a national level or support state and local versions of these policies. Local health departments actively advocate

for and are ready to operationalize these upstream, population-level interventions to improve health and decrease inequities. The federal government can also support local policy levers by making recommendations and using purse strings to promote implementation. Ideally, all public health agencies from local to the CDC would report on health disparities publicly, and the CDC and HHS would explicitly research the best ways to increase health equity and reduce health disparities and fund those programs across the country. A key part of doing so is to disaggregate public health data by race, ethnicity, gender, and socioeconomic status; all too often it is these factors that should play an outsized role in health status or outcomes.

An equity lens must be also applied to all federal policy and funding decisions. Adequately and appropriately ensuring health equity requires broadly addressing social determinants



of health for whole communities, removing structural obstacles to health such as poverty, racism, and discrimination, and addressing underlying root causes present across communities and society as a whole.

It is also important to give voice to the fact that structural racism is at the root of many of our systems and institutions; we must begin to treat racism as a public health crisis. Declaring racism as such, as at least half of BCHC jurisdictions have done, will help to reframe the conversation and illustrate that we are all only as healthy as the least healthy among us. These declarations recognize the central role that historical and current racism plays in harming the health and well-being of communities of color. The explicit acknowledgement that communities of color suffer higher rates of nearly every adverse health outcome due to systemic racism and issues including inadequate education, discrimination in employment and housing, poverty, mass incarceration,

residential segregation, and racial trauma is a necessary first step in working towards equity.

Moving forward, we must dedicate resources and prioritize work to diminish discrimination and trauma that is all too often experienced throughout communities of color. A measurable step many cities are taking is including more people of color and members of impacted communities in decision-making processes. This, and other strategies to address structural racism and health equity will mean rebuilding our communities, and in some cases, the systems within which we operate, so that each and every person, no matter where they live, the color of their skin, or where they were born, has the opportunity to live a healthy, full, and productive life.

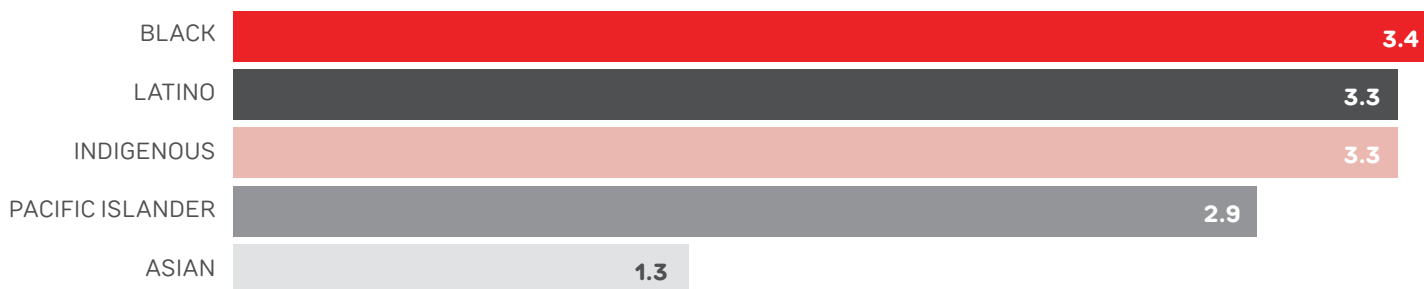
#### POLICY RECOMMENDATIONS

- ▶ Advancing health equity and addressing structural racism must be a national priority in policy, funding, and programmatic decision making.

- ▶ Support antiracist and antibias training for federal employees and contractors, with the understanding that structural racism exists in the US and must be actively confronted.
- ▶ Congress should fund CDC to create a program to coordinate the agency's social determinants of health activities and improve capacity of local and state public health agencies and community organizations to do so.
- ▶ Congress and the Administration should consider equity in every policy decision that is made, specifically funding of programs, including targeting additional dollars to those communities most in need.
- ▶ Data should be more easily available to the public, clearly presented, and disaggregated by race, ethnicity, and socioeconomic status to assist in evaluating impact of funding and policies on those most in need.

### Adjusted for Age, Other Racial Groups Are This Many Times More Likely to Have Died of Covid-19 Than White Americans

*Reflects mortality rates calculated through sept. 15.*



*Indirect age-adjustment has been used.*

Source: APM Research Lab

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## ► Building Safer, More Resilient Communities by Preventing Violence

Violence occurs in several different, yet interconnected, forms.

Community gun violence, domestic violence, bullying and childhood violence have profound negative impacts on individuals, families and communities. These negative impacts can include high levels of trauma, increased levels of mental illness and substance use, as well as reduced levels of health, well-being and economic opportunity across impacted communities.

Violence, like many public health challenges, is preventable. Yet historically, most investments are directed to addressing its aftermath. Communities can be safer by investing in a comprehensive approach to prevent violence, one that supports individuals and families, and by extension, the community at large. A comprehensive approach allows individuals to beat the odds of being impacted by violence, while also going upstream to lower the odds that violence will occur (See illustration on page 18). This is a public health approach to community resilience.<sup>48</sup>

A public health approach to preventing violence and building safer, more resilient communities acknowledges structural racism and other forms of discrimination. Crucially important to this approach is an acknowledgement that the current situation—in which communities of color face concentrated policing, fewer opportunities and deteriorated community conditions—isn't just happenstance. Nor was it the fault

of community members themselves. These conditions were created by policies and practices that have marginalized people of color and poor people into neighborhoods of concentrated disadvantage.<sup>49</sup>

A public health approach to violence prevention, among other things:

- **Puts community members in the lead**—Those impacted by violence have some of the best and most creative ideas about how to prevent it. For a comprehensive violence prevention plan to succeed, community members must set priorities for what can be done to improve conditions to prevent violence and create safety.
- **Is data driven**—Policy makers must look at the specific profile of violence in the community, and determine who is most affected, what's contributing, and what's helping to create safety. And, when strategies are being developed, they must be designed specifically

to influence the conditions that are increasing the risk of violence, according to the data.

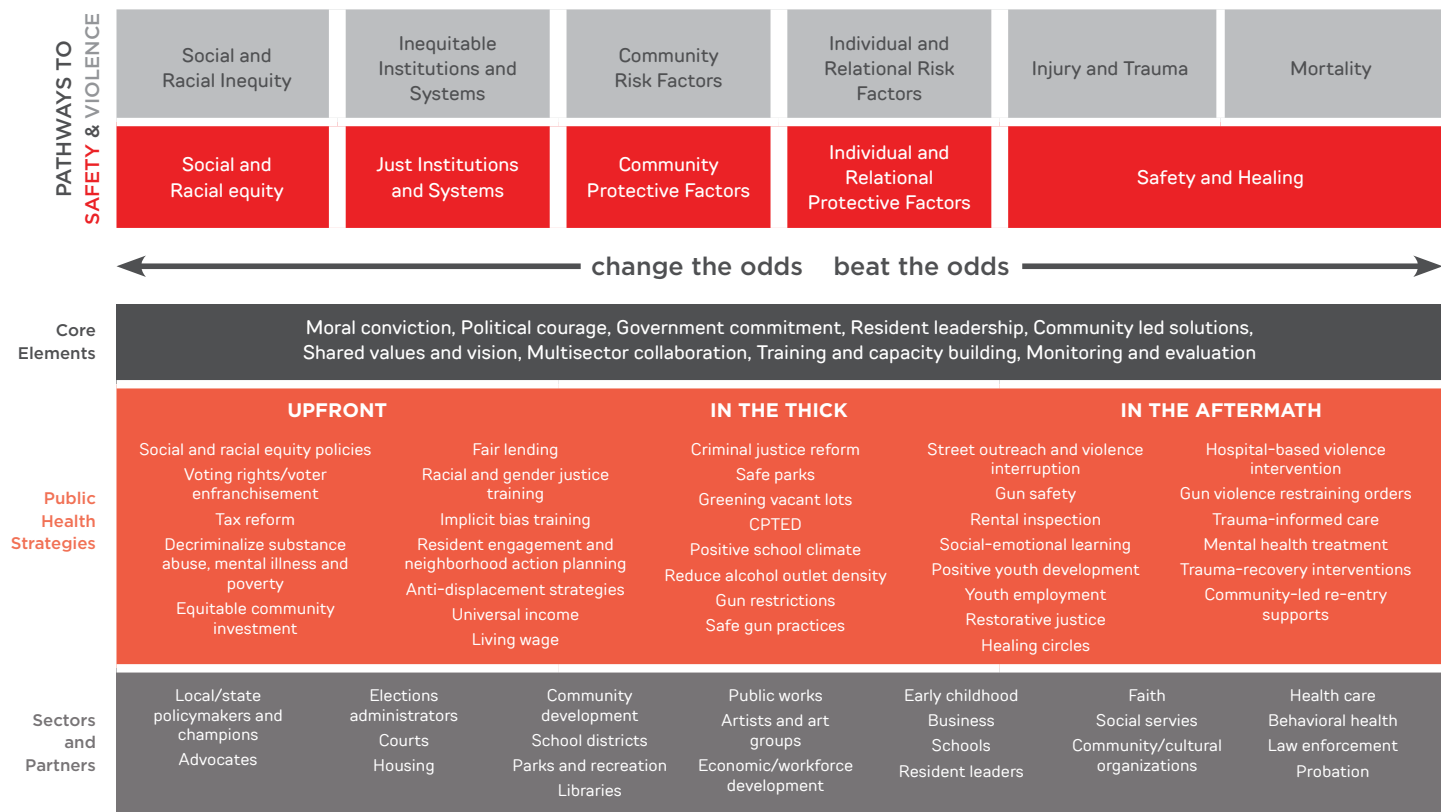
- **Considers community conditions**—As our surroundings shape our experiences and behaviors, successful prevention plans cultivate safety in streets, parks, jobs, schools, places of worship, and elsewhere.

### POLICY RECOMMENDATIONS

- Enact common sense gun laws that reduce access, particularly among youth and those most at risk of harming themselves or others, such as:
  - Comprehensive background checks, including those sold at gun shows;
  - Enhanced prosecution for those found with guns purchased illegally;
  - Access to safe and secure firearm storage among;

- Ban the sale, transfer, importation, and manufacture of assault weapons and large capacity ammunition magazines; and
- Adopt “red flag laws” that permit law enforcement, friends or family members to petition a court to issue an “extreme risk protection” or “gun violence restraining” order if they consider a person to pose a significant threat to themselves or others.
- ▶ Strengthen funding and other policy mechanisms that support community prevention, as well as implementation of violence interruption and trauma informed approaches that are proven to work.
- ▶ Create a CDC-led comprehensive, multisector response to violence that addresses social, emotional, and mental health in addition to physical health in partnership with local public health agencies.
- ▶ Provide increased funds to the CDC for firearm prevention research.
- ▶ Implement and fully fund a nationwide infrastructure to collect a key set of indicators regarding violence in their communities, and identify those indicators that measure community resilience.

### Violence Prevention Framework



Framework developed in partnership with Prevention Institute; Report forthcoming.



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## ► Addressing Substance Use Disorders (SUD)

Big city and county health departments are often among the first to detect emerging drug trends, identify inequities in overdoses, deaths, hospitalizations, and drug treatment, and recognize hyperlocal hotspots. They are then also the first to respond to them, working to mitigate the impact of overdose and other harmful effects of substance use, such as disease transmission. They pilot, implement, test, and study innovative strategies that are often expanded to the state, regional, and national level.

The work of local health departments in preventing and responding to overdoses is inclusive, but not limited to:

- Providing mortality data;
- Compiling, where possible, nonfatal overdose surveillance;
- Managing emergency medical services;
- Responding to those with substance-use disorders who are incarcerated through jail health services;
- Convening local task forces;
- Coordinating with health care systems;
- Distributing Naloxone and similar harm reduction activities; and
- Community-wide public education.

Most drug-related deaths represent preventable ones. In 2019, approximately 72,000 people died due to a drug overdose in the US, an 8 percent increase from 2018's 67,000 drug overdose deaths.<sup>50</sup> In both 2019 and 2018, opioids were involved in approximately 70 percent<sup>51</sup> of those

deaths. While 2018 represented a decrease from 2017 in total overdose deaths, there was an increase in deaths due to synthetic opioids.<sup>52</sup> 2019's overdose deaths represented an increase in overall deaths.<sup>53</sup> In 2019, the decrease in overdose death involving heroin continued, and the increase in overdose deaths involving synthetic opioids continued, indicating the escalating role that illicit fentanyl and similar analogs play in overdose deaths.<sup>54</sup> Provisional data shows a 10% increase in drug overdose deaths in the first 3 months of 2020 compared to those months in 2019.<sup>55</sup>

Increasingly, cities are seeing more drug overdose fatalities that involve cocaine and psychostimulants, indicating the increasing roles of polysubstance use and drugs tainted with potent synthetic opioids.<sup>56</sup> While recent federal SUD programming has largely focused on the fatal impact of prescription opioids, and what is described as the “first wave” of overdose deaths, this completely disregards non-prescription drug use that has been a significant challenge

and source of premature death occurring in the nation's cities for decades. In fact, rates of overdose mortality involving prescriptions are lower in large metropolitan areas than the U.S. average, while rates of overdose mortality involving heroin and synthetic opioids are higher in metropolitan areas.<sup>57</sup> The challenge of fentanyl and other illicit synthetic opioids shows no signs of abating, and the risk of overdose may continue to increase as economic, mental health, and social supports are impacted due to COVID-19.

Local health departments are on the front lines of responding to this epidemic, and yet receive little-to-no dedicated or direct funding to address and prevent the impact that substance use is having on our communities. Instead, local health departments compete for small amounts of grant funds that are insufficient to address the scale of the problem. CDC, at the direction of Congress, took an important first step to get overdose funding local with the Overdose Data to Action project, a 3-year cooperative

agreement that began in September 2019.<sup>58</sup> However, from the start there were challenges related to eligibility including questions of burden and geographic definitions. Future efforts should learn from this work and ensure that funding reaches those local health departments most in need by using accurate data and appropriate geographic definitions to determine eligibility. Overdose Data to Action also funded states and required them to send a certain percentage of funding to communities. A full accounting of how states did so should be reported publicly, which has been a long-standing challenge.

## POLICY RECOMMENDATIONS

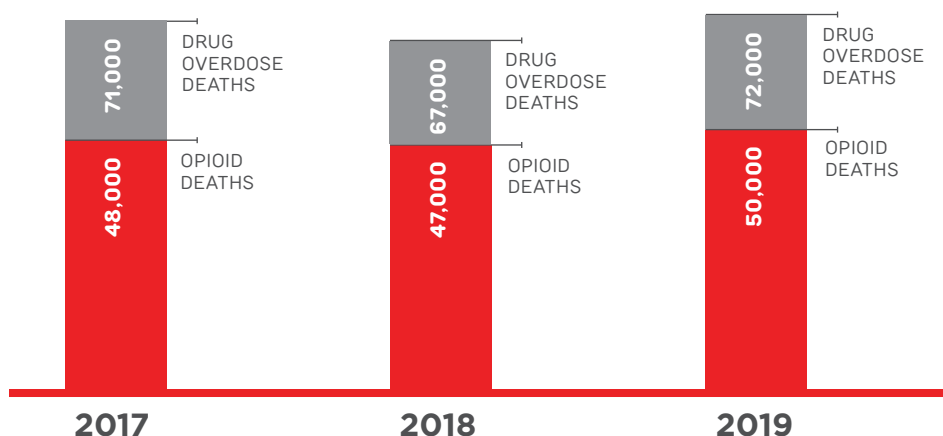
- ▶ Ensure that federal dollars reach the local level, ideally through direct funding, for both responding to the current epidemic and preventing future SUD by addressing its root causes.
- ▶ Eliminate waiver and training requirements related to certain

medication-assisted treatments, such as those around prescribing Buprenorphine that have effectively become barriers to treatment and are restricting access.

- ▶ Incentivize states and localities to include evidence-based social and emotional drug and alcohol prevention into K-12 educational curricula as an addiction prevention intervention.
- ▶ Increase availability of Naloxone and similar overdose reversal drugs by: exploring options for the federal government to bulk-purchase naloxone for distribution to local health departments; and allowing over-the-counter access and/or expanding use of “standing orders,” where a doctor issues a written order that can be dispensed by a pharmacist or other designee(s), without the prescribing doctor being present.

- ▶ Increase availability of fentanyl testing strips to the general public by exempting them from drug paraphernalia laws.
- ▶ Shield localities exploring implementation of evidence-based and practice-informed harm reduction services (such as “safer” consumption or injection sites/facilities) from federal prosecution.<sup>59</sup>
- ▶ Require states, as part of federal funding agreements, to provide local health departments with real-time access to Prescription Drug Monitoring Program data.
- ▶ Increase federal resources to expand current overdose surveillance systems to improve information on full scope of burden of SUDs, associated infectious disease outbreaks, and also to include nonfatal overdose events and reversals.
- ▶ Increase access to syringe services programs through federal dollars and leadership to support comprehensive Syringe Service Programs (SSPs).

## Drug Overdose Deaths



<https://www.cdc.gov/mmwr/volumes/69/wr/mm6911a4.htm>.  
<https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

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## ► Regulating Tobacco Products

Over the years, cigarettes have been the leading cause of preventable death in the United States, accounting for one in five fatalities—more than alcohol, AIDS, car accidents, illegal drugs, murders, and suicides combined.<sup>60</sup> More than 16 million Americans are also living with a disease caused by smoking, including stroke, heart disease, cancer, and emphysema.<sup>61</sup> While traditional cigarettes still pose a significant health in the U.S., the market has rapidly changed in the past several years, with a focus on products that appeal to youth and minorities.

In 2009, Congress passed the Family Smoking Prevention and Tobacco Control Act (TCA), which gave the U.S. Food and Drug Administration (FDA) authority to regulate tobacco products using a public health standard.<sup>62</sup> The TCA prohibited certain characterizing flavors, but notably left menthol in the marketplace. Despite this, the market for flavored tobacco products has been growing, particularly as vaping expands. Even with the Administration's recent enforcement policy to reduce youth access to flavored e-cigarettes, thousands of flavored products will remain available at over 100,000 locations across the country.<sup>63</sup> In the rapidly evolving tobacco market, menthol cigarettes and other tobacco products (smokeless tobacco, cigarillos, and vaping products) are aggressively marketed to appeal to new customers, targeting youth in particular with flavors that play a key role in enticing new users to a lifetime of addiction.<sup>64</sup>

In December 2016, a report by the Surgeon General concluded that

e-cigarette use by young people is a public health concern, noting use of e-cigarettes has surpassed that of regular cigarettes among those under 18 years old.<sup>65</sup> Two years later, the Surgeon General followed that up with an advisory on e-cigarette use among youth, officially declaring e-cigarette use among youth in the U.S. “an epidemic.”<sup>66</sup> This report noted the nicotine salts that comprise certain popular e-cigarettes allow users to inhale more easily and with less irritation. Certain e-cigarettes available in the U.S. have a nicotine level so high that, in some countries, they are illegal for consumers of any age.<sup>67</sup> In 2019, 5.3 million youth, 28% of high school students and 11% of middle school

students, were current e-cigarette users—an increase of over 3 million students since 2017.<sup>68</sup> One out of nine high school seniors (12%) reported that they vaped nicotine nearly daily and the majority of current youth e-cigarette users use flavored products (69%).<sup>69,70</sup>

The impetus to reduce tobacco use and vaping is even greater now than ever. The CDC, FDA, and NIH have indicated that tobacco smoking and vaping can suppress the immune system and increase the risk for developing lung and heart disease and infections, putting smokers at increased risk of contracting COVID-19 and associated complications.<sup>71</sup>



ONE OUT OF NINE HIGH SCHOOL SENIORS REPORTED THAT THEY VAPED NICOTINE NEARLY DAILY.

Additionally, over the past year, there has been an outbreak of e-cigarette, or vaping, product use-associated lung injuries (EVALI). As of February 18, 2020, a total of 2,807 hospitalized EVALI cases or deaths have been reported to CDC from all 50 states, the District of Columbia, and two U.S. territories (Puerto Rico and U.S. Virgin Islands), including sixty-eight confirmed deaths in 29 states and the District of Columbia.<sup>72</sup> This outbreak started in spring of 2019 and peaked in September 2019. Laboratory sample analyses have showed that vitamin E acetate, an additive in some THC-containing e-cigarette, or vaping, products, is strongly linked to the EVALI outbreak.<sup>73</sup>

Even as the federal government ramps up its age restrictions, e-cigarette regulations, and flavor enforcement, loopholes remain.<sup>74,75,76</sup> Big city health departments across the country have led in this space for years, filling

gaps in federal regulations, using innovative and comprehensive policy levers to reduce tobacco use and save countless lives.

#### **POLICY RECOMMENDATIONS**

- ▶ The FDA should use its authority to remove all non-tobacco flavored e-cigarettes, including mint and menthol flavors, from the marketplace both in retail stores and online.
- ▶ The FDA should fully implement proposed graphic warnings for cigarette packages and advertisements that will more sufficiently educate the public about the dangers of tobacco use.
- ▶ Congress should do everything in its power to ensure that FDA uses its full authorities under the TCA to regulate all tobacco products and support the Agency in fully implementing comprehensive tobacco flavor restrictions.

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**Even as the federal government ramps up its age restrictions, e-cigarette regulations, and flavor enforcement, loopholes remain. Big city health departments across the country have led in this space for years, filling gaps in federal regulations, using innovative and comprehensive policy levers to reduce tobacco use and save countless lives.**

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