Public Health Preparedness for Disaster: Perspective from Washington, DC

Janet Firshein

A lot of eyebrows were raised last year when, in the wake of the September 11 attacks, Health and Human Services Secretary Tommy Thompson proclaimed at a press conference that the United States was well prepared to handle “any contingency, any consequence that develops for any kind of bioterrorism attack.” Few groups were more surprised at this assurance of US readiness than the public health community. The Rodney Dangerfield of American health care, the public health system has rarely gotten the respect it deserves. After September 11, 2001, that attitude shifted. Regardless of the motivation, public health leaders are hoping the newfound respect will translate into meaningful fiscal support for an infrastructure that has been neglected far too long.

Policymakers may have little choice. As Americans quickly learned after September 11, local public health departments are the first line of defense when the United States is faced with a bioterrorist attack. Nevertheless, two thirds of local public health agencies say their communities are not fully prepared for a bioterrorist attack. Nearly a quarter of these agencies told the National Association of County and City Health Officials that they have no response plan for bioterrorism, and only 20% have a comprehensive plan in place.

The National Association of County and City Health Officials findings make clear that the gap in public health readiness is wide and varied, says Fitzhugh Mullan, MD, a professor of public health and pediatrics at George Washington University in Washington, DC (oral communication, 2001). Mullan, a former US Assistant Surgeon General who once was New Mexico’s Secretary of Health, says it is important to keep in mind that many of the nation’s 3,000 public health departments do not even have round-the-clock on-line capabilities. Some 10% do not have Internet/e-mail access. Mohammad Akhter, MD, executive director of the American Public Health Association (APHA), says it was fortunate that the bioterrorist attacks initially occurred in larger cities with strong public health systems (oral communication, 2001). New York City and Washington, DC, have dealt with deadly threats such as acquired immunodeficiency syndrome (AIDS) and the West Nile virus. They have round-the-clock staff, top-notch communication abilities, and well-trained medical personnel. Those conditions are not comparable in smaller communities and rural areas, which Akhter says typically have anemic health departments that are poorly staffed and equipped (oral communication, 2001).

With the nation’s attention focused on public health, APHA and other public health groups are urging the Bush administration and Congress to cement gaps exposed by the anthrax incidents. In late October, APHA asked federal policymakers to provide \$10 billion over the next 5 years to help public health departments prepare for and respond to bioterrorism. Akhter points out that, in the month

following the September 11 attacks, state health departments spent \$250 million just responding to anthrax threats and exposures (oral communication, 2001).

In December Congress funnelled \$2.9 billion in federal money to support public health preparedness against bioterrorism. President Bush, in his fiscal 2003 budget, has proposed channeling \$1.6 billion to state and local governments to help hospitals and others cope with bioterrorism attack. Public health leaders are working to ensure that this kind of infrastructure and capacity support will be continued over the long term.

If the money and momentum is only directed at stockpiling drugs and vaccines without equal attention to public health structural issues, Professor Mullan fears an opportunity would be lost. For now, he remains cautiously optimistic. “We’re now in a state of crisis. Whether it will result in long-term changes in how we invest in, recruit for, and sustain public health personnel remains to be seen” (oral communication, 2001).