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TO: **Senator Bernie Sanders**, Chair of Senate HELP Committee
Senator Bill Cassidy, M.D., Ranking Member of Senate HELP Committee
Senator Bob Casey, Member of Senate HELP Committee
Senator Mitt Romney, Member of Senate HELP Committee

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DATE: **July 10, 2023**

SUBJECT: **Comments on Pandemic and All Hazards Prevention Act Discussion Draft**

Thank you for the opportunity to provide feedback on your bipartisan discussion draft for the Pandemic and All Hazards Prevention Act (PAHPA) reauthorization, released on July 3, 2023. Thank you also for your continued leadership on these critical issues that sit squarely at the intersection of public health, pandemic preparedness, health care delivery, health care access and racial equity.

The COVID-19 pandemic brought to light the longstanding weaknesses in our public health infrastructure. While there were many successes in the US response, there are a number of areas that need to be examined and strengthened in order to mitigate future pandemic threats.[1]

The Commonwealth Fund is a nonpartisan foundation with over 100 years of experience in funding and carrying out research and analysis on some of society's most pressing health challenges. In 2020, at the height of the COVID-19 pandemic, we launched a special focus area in public health – looking specifically at the areas where federal and state policies could help to ensure the U.S. was better prepared for future pandemics. As such, we formed the nonpartisan *Commonwealth Fund Commission on a National Public Health System* to set forth a vision and concrete recommendations for a robust and sustainable public health system built on organizing agencies, increasing funding, formalizing processes, and improving public trust.

[1] Meagan C. Fitzpatrick, Rachel Nuzum, and Alison P. Galvani, "Lessons from COVID-19 Can Help the U.S. Prepare for the Next Pandemic," *To the Point* (blog), Commonwealth Fund, July 5, 2023. https://doi.org/10.26099/hw2y-nb73

The comments presented here today for consideration draw from the Commission recommendations and from the work of our many grantees and partners actively working in this area. Please find our comments below on select sections of the draft.[2]

Title I—State and Local Readiness and Response

Sec. 101. Public Health Emergency Preparedness program

Sec. 101 amends and reauthorizes the Public Health Emergency Preparedness (PHEP) program.

The Committee should consider requiring the Centers for Disease Control and Prevention (CDC) to measure and report on the foundational capabilities of health departments receiving public health infrastructure funding and authorize CDC to tie the receipt of federal funding to progress in achieving foundational capabilities. CDC can direct key funding to these foundational capabilities through its grants, contracts, and cooperative agreements, including but not limited to the Public Health Emergency Preparedness program.

Emergency preparedness rests on a foundation of effective day-to-day public health functioning. Where you live should not determine how well your health department protects you from public health threats. Setting minimum standards for public health across the country is essential, as environmental and infectious threats do not recognize state borders. The foundational capabilities framework has broad bipartisan support and has been adopted by Indiana, Ohio, Kentucky, Washington, and other states to measure improvement in core public health protections.

Title II—Federal Planning and Coordination

Maintaining a strong public health infrastructure that's poised to respond in emergency situations requires a designated leader within HHS who can serve as a focal point for responsibility and accountability.[3] Unlike other federal departments, HHS lacks undersecretaries that oversee complementary aspects of its mission. There is currently no organizational home that is structured and resourced to provide leadership on a wide range of public health issues. The recently established White House Office of Pandemic Preparedness and Response Policy is limited to just infectious disease threats.

The Committee should consider establishing a new position, such as an undersecretary for public health, that would lead public health efforts at HHS. This role would focus on supporting local and state public health departments in areas such as data, workforce, laboratories, and procurement—as well as ensuring responsibility and accountability within HHS for other priority public health issues such as the maternal health crisis or overdose/addiction epidemic. Such a position would address a concern we

[2] The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

[3] Commonwealth Fund Commission on a National Public Health System, *Meeting America's Public Health Challenge: Recommendations for Building a National Public Health System That Addresses Ongoing and Future Health Crises, Advances Equity, and Earns Trust* (Commonwealth Fund, June 2022). https://doi.org/10.26099/snjc-bb40

heard from state and local officials working both in Democratic and Republican administrations across the country relating to inadequate coordination within HHS.

Sec. 202. Strategic National Stockpile and Material Threats

Sec. 202 amends the Strategic National Stockpile program, including by directing the Secretary, in managing the stockpile, to “utilize tools to enable the timely and accurate tracking, including the location and geographic distribution, of the contents of the stockpile throughout the deployment of such contents.”

The Committee should consider establishing a supply chain inventory and management program at the Department of Health and Human Services (HHS). This program should permit reporting on key supplies in an emergency and provide authority to HHS for redistribution when essential for clinical care. This program should be able to operate during drug shortages of essential medications at the Secretary's direction, in addition to declared emergencies. This program should also be required to address equity concerns by monitoring and reporting in real time on the racial, ethnic and social vulnerability of the communities or institutional population mix that are the recipients of such supplies.

Additionally, if a pilot program for state stockpiles is to be launched (Sec. 104), Congress could consider requiring the collection and reporting of racial and ethnic data along with measures of the social vulnerability (SOVI) of the community when material is deployed from a state stockpile.

Public health emergencies do not affect every location the same way at the same time. As a result, demand-driven shortages—as we saw during COVID-19—can be addressed by redistribution of key resources. Although the enabling statute for the Strategic National Stockpile (SNS) authorizes the Secretary of HHS to “devise plans for effective and timely supply-chain management” of the SNS specifically (42 U.S.C. § 247d- 6b(a)(3)(E)), additional statutory authority would be required for HHS to establish a generally applicable supply chain program.

Sec. 205. Pilot Program for Public Health Data Availability.

Sec. 205 establishes a pilot program to support public availability of public health data and enable bidirectional data sharing between federal and state offices.

As written, this policy is a move in the right direction, but without a requirement to report health care or laboratory data, the policy will likely not achieve the stated goals. To strengthen this component, one could consider requiring the reporting of critical health care data to HHS by both public and private health care actors.[4] Enhanced investments will be necessary for state, local, and tribal entities (SLTs) to upgrade both their data collection and reporting systems. Congress could also authorize funding to upgrade the public health data infrastructure to ensure its interoperability and enhance privacy protections. Data shared with the federal government could be de-identified to alleviate concerns about privacy. In return, Congress could require that HHS share aggregated, anonymized data with the public and with public and private health care organizations.

For example, the language around wastewater surveillance (Sec. 105) requires that grant recipients be able to share data with other grant recipients but misses an opportunity to link agencies conducting

[4] David Blumenthal and Nicole Lurie, "A Critical Opportunity to Improve Public Health Data," The New England Journal of Medicine (2023). https://www.nejm.org/doi/10.1056/NEJMp2306226

surveillance directly with state and local communities that may need to take action on the surveillance findings.

It is not a question of if, but when, the next public health threat will occur. Public health emergencies like COVID-19 do not discriminate by party affiliation. A bipartisan effort to preparedness and response is essential to maximize our nation's resiliency and the health of the American public.[5]

[5] Rachel Nuzum and Anand Parekh, “Health Emergencies Don't Discriminate by Political Party—Pandemic preparedness requires a bipartisan approach,” Medpage Today, July 5, 2023. https://www.medpagetoday.com/opinion/second-opinions/105335