Commentary

Building Preparedness by Improving Fiscal Accountability

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Prior to the terrorist attacks of 2001, federal spending related to bioterrorism preparedness was quite limited; and prior to 1996, it was nonexistent. Reacting to the emerging possibilities of biological attacks, the federal government enacted the Nunn-Lugar-Domenici Domestic Preparedness Program of 1996, which was the first piece of legislation to address bioterrorism. Several years later, Congress passed the Public Health Threats and Emergencies Act of 2000, which spent approximately $300 million on biodefense in 2001 and allocated $50 million in particular to build capacity in state and local health departments.[1] Following the 2001 anthrax attacks, the threat and potential destructive effects of biological attacks and pervasive limits to state and local public health infrastructure became clearly apparent. Congress responded to this new menace by passing the Public Health Security and Bioterrorism Preparedness Act of 2002, increasing funding for state and local biodefense to nearly 4 billion dollars over 4 years.[1] The intent of these new funds was to enhance public health's future capability and capacity to launch a successful response to a biological attack or other catastrophic health event. There remains, however, serious problems accounting for the use of these federal funds and assuring their maximal effectiveness.[2]

Since 2001, the federal government has spent nearly $13 billion on biodefense. Specifically, roughly $1 billion per year has been allocated to local and state jurisdictions to improve public health capabilities and bioterrorism preparedness. However, the means to account for this spending is severely limited because of a variety of issues that highlight the variability of public health practice and organization across the country. The methods with which state governments allocate—and account for—these funds to public health departments and local jurisdictions differ widely. The mission and responsibilities associated with serving the public's health are organized in a different manner. Some states have several agencies that fulfill a spectrum of public health functions, while others merely have one central agency handling all of these responsibilities. Similarly, the duties of different public health departments can vary substantially from one state or locality to another.[3] Moreover, there is no one set of guidelines or definition for what type of expenditures actually classify as spending on public health. These factors make it very problematic to account for the money being spent on bioterrorism preparedness as well as compare any of the public health outcomes related to these expenditures.

This new investment in bioterrorism preparedness unfolded during a particularly harsh period of decline in state and local spending on public health. Beginning in 2000–2001, state budgets deteriorated substantially, a result of revenue reversals that continued through 2002 and 2003. According to the 2000–2001 State Health Care Expenditure Report, during 2002, 37 states had to cut their enacted budgets by an aggregate $13 billion. These reductions in state expenditures particularly affected some of the traditional duties of the public health system such as tobacco control programs, water quality, and communicable disease control programs. As a result, many localities appeared to replace or supplant these cuts to state public health funding with new federal biodefense funds. In

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addition, many states were unable to identify sufficient numbers of qualified and specialized personnel to enter these new, federally funded biodefense positions. Consequently, many states moved staff from other departments into these positions, relying on short-course and on-the-job training.[1] Such circumstances further highlight the need for greater accountability in expending public health dollars.

A clean impediment to the future allocation of federal funds is the lack of effective means to gauge where and how that money is being spent. Research is needed to assess and classify the areas in public health readiness that are lacking and to identify the system requirements for linking this spending to effective and corresponding public health programs.[4,5]

To properly assess the impact of spending on public health and bioterrorism preparedness, there is a critical need to develop a financial taxonomy. This will assist Congress in providing oversight and evaluation of public health preparedness expenditures across state and local health departments. This will allow public health decision makers to determine where funding is most effective and will facilitate the implementation of more evidence-based approaches to bioterrorism readiness.

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