



**TO:** Senator Bill Cassidy, Ranking Member, Senate Committee on Health, Education, Labor, and Pensions

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**RE:** Request for Information on Opportunities to Modernize the U.S. Centers for Disease Control and Prevention

Senator Cassidy:

We are writing in response to your request for input regarding modernizing the U.S. Centers for Disease Control and Prevention (CDC). During the first half of 2022, the Commonwealth Fund supported the [Commonwealth Fund Commission on a National Public Health System](#) (referred to hereafter as the Commission) to offer policy recommendations for how the CDC, along with the federal government more broadly, could modernize the U.S. public health system to better address everyday threats to the health of Americans as well as public health emergencies.

The Commission issued [recommendations](#) applicable to multiple actors across the public and private sectors. The comments offered here focus specifically on Congressional policy options and levers for modernizing the CDC and more broadly, the U.S. public health system. ***The comments provided here reflect the recommendations from the Commission.***

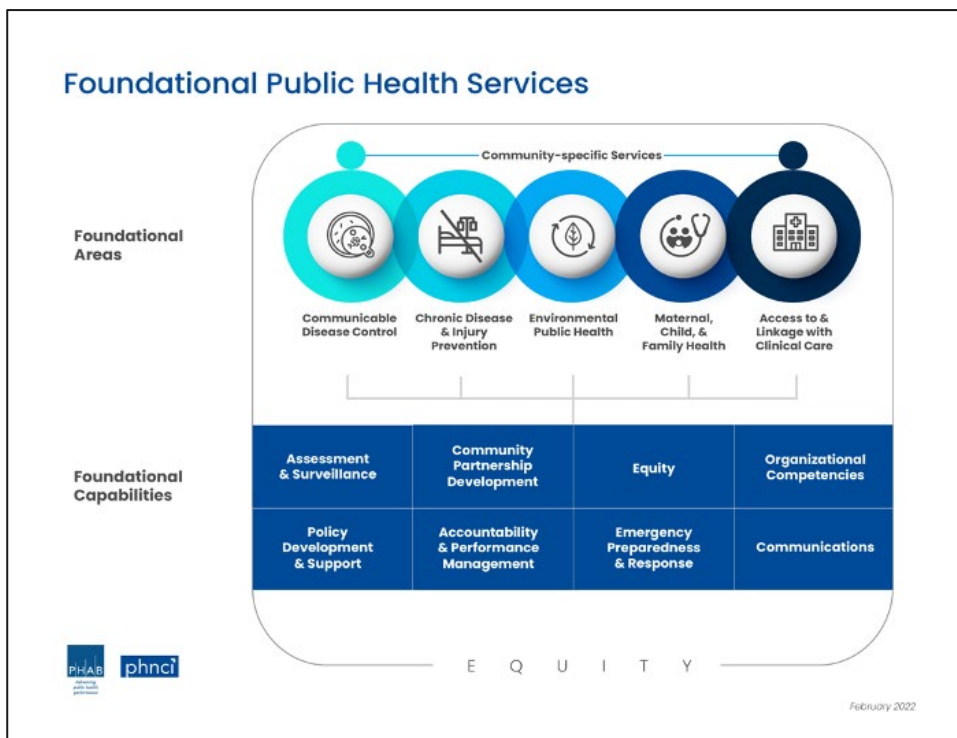
The non-partisan body, chaired by Dr. Margaret Hamburg, was [comprised of leaders](#) with extensive experience at the federal, state, and local levels of public health. They firmly believed that the CDC is a vital part of a national public health system, in particular serving as a lynchpin in providing leadership and resources; and setting standards for state, territorial, local, and tribal (STLT) public health agencies. At the same time, Commissioners recognized that the CDC is just one part of the federal public health enterprise, and for the CDC to succeed, all parts of the federal government must be working well together.

## BACKGROUND

The Commission began its work by recognizing the multiple layers of government that comprise a public health system. Indeed, it deliberately did not refer to a *federal* public health system. Instead, the Commission said:

The ***national public health system*** represents a vision for organizing the efforts of federal, state, local, tribal, and territorial governments to improve public health and achieve health equity. A national public health system should promote and protect the health of every person, regardless of who they are and where they live; implement effective strategies for doing so with others in the public and private sector, including those who can address the drivers of health; respond to day-to-day health priorities and crises with vigor and competence; and, in the process, earn high levels of trust.

As its starting point, the Commission used the consensus that has emerged over the last decade among public health practitioners that focuses on [foundational public health capabilities](#) as the essential building blocks of a national public health system. These are: assessment (including surveillance, epidemiology, and laboratory capacity); community partnership development; equity; organizational competencies; policy development; accountability and performance management; emergency preparedness and response; and communications.



The Commission identified several challenges currently facing public health in the U.S., many of them consistent with those reflected in your request for input, that impede our ability to assure all Americans—regardless of where they live and how their state chooses to organize public health—are served by the foundational capabilities.

With respect to the CDC's role in the federal public health enterprise and the essential roles of other actors for the CDC to succeed, the Commission found that:

- Coordination across the federal government, and especially within the U.S. Department of Health and Human Services (HHS), needs to be strengthened. This is particularly true regarding data modernization but applies more broadly. In a federal system, with shared responsibility between the federal government and STLTs, there must be coordinated leadership and support from the federal government. While the CDC plays an important role, it does not provide the majority of federal funding going to states— even within HHS.
- A true partnership between the federal government and STLTs requires ongoing mechanisms for dialogue and communication, rather than the ad hoc, episodic approaches currently in place.
- Most importantly, inconsistency in federal funding and long-term unpredictability of funding levels for the CDC make it hard for the CDC and STLTs to support the modernization of systems; and to recruit, train, and retain a highly qualified workforce that can deliver the foundational public health capabilities.

### **OPPORTUNITIES FOR CONGRESSIONAL ACTION**

The comments that follow focus on legislative steps that Congress can take to build a truly national public health system—by investing in STLT capacity, improving our data systems at all levels of government and across all health sectors, and strengthening federal leadership.

#### ***Recommendation 1: Congress should support STLTs in building foundational public health capabilities.***

Congress should provide an adequate and reliable source of federal public health funding to states, localities, tribes, and territories to support a modern public health infrastructure. This funding, estimated at an additional \$4.5 billion annually, should be sufficient for every person to be protected by a public health system that delivers on the foundational public health capabilities. Existing funding should be raised to this level over a multiyear period as health departments build their capacity. This funding is in addition to the short-term investment needed to build a true public health data infrastructure discussed below.

This recommendation was premised on three key concepts and lessons learned during the COVID pandemic and during other public health emergencies and challenges. These are:

1. Where you live should not determine how well your health department protects you from public health threats. That is not the case today—both because of state and local level funding decisions as well as inadequate support from the federal government. There is no basic standard that has been set for public health capabilities. Setting minimum standards for public health across the country is essential, as environmental and infectious disease threats do not recognize state borders. Without such basic capacity in place, the financial burden on the federal government is increased dramatically during emergencies as Congress tries to close gaps without a strong framework anchoring its efforts.
2. This federal investment should be tied to building the foundational public health capabilities across state, territorial, local, and tribal health departments. Currently, only a small portion of CDC funding for STLTs is focused on these capabilities.

3. The federal government, through the CDC, should hold states accountable for ensuring that all residents are served by a public health system that meets core standards. There are multiple models for how public health is organized at the STLT level, from highly centralized to very decentralized approaches. No one model has been demonstrated as superior. But states, as the prime grantees of the CDC, should be held accountable for meeting these capabilities, which can be accomplished by tying this new funding (and providing incentives through other HHS programmatic mechanisms) to meeting revised accreditation standards and performance requirements focused on foundational capabilities.

To a large degree, investing in building foundational capabilities is an investment in a public health workforce. The Public Health National Center for Innovation [estimated](#) that there is a shortfall of 80,000 FTEs needed to meet basic community public health functions across the STLTs. The \$4.5 billion recommendation would permit this level of expansion of the workforce, based on salary [surveys](#) of public health workers.

It is important to note that Congress has provided STLTs, through the CDC, with a downpayment on this investment with the funding for public health workforce and infrastructure being distributed, to the tune of \$3.8 billion over the next 5 years, through the newly created [Public Health Infrastructure Grants](#). This is an important start. However, consistent, predictable, long-term funding that is tied to accountability will be essential for states to be willing to hire—and for health departments to be able to recruit—the needed workers for permanent positions. Further, while this funding is an important investment, only a small portion is tied to foundational public health capabilities. As Congress provides more funding for public health infrastructure through the annual appropriations process and through any new mechanism that might be created, focusing STLTs on foundational capabilities and strengthening accountability mechanisms will be critical to assuring this federal investment succeeds.

***Recommendation 2: Congress should provide increased funding and authority to build a national public health data system.***

When it comes to data system infrastructure, while the CDC can play an important part in building state and local capacity and in improving its own data-related efforts, leveraging data across the health system requires engagement across HHS. Thus, the Commission recommended that:

- Congress should grant HHS and its agencies the authority to establish and enforce standards and implementation specifications for data collection, interoperability, and exchange with and among state, local, tribal, and territorial health authorities and private health care entities. With this authority, for example, the CDC should be able to access and analyze important, consistent, and timely data on the evolving pandemic from across the country, as well as data to monitor key health issues outside of emergencies. For more background, see this [Perspectives article](#) in the New England Journal of Medicine.
- Congress should provide the necessary funding to support a modern public health IT system. The Healthcare Information Management Systems Society has estimated that \$36.7 billion over 10 years is needed to support digitizing core public health data functions; creating interoperability among health

care systems and public health systems; and transforming the data capacities of state, local, tribal, and territorial health departments.

- As part of its work on public health data, HHS should tap the expertise of the CDC, the Office of the National Coordinator for Health Information Technology (ONC), the Centers for Medicare and Medicaid Services (CMS), other agencies, and the private sector. Consistent with the recommendations of a recent Government Accountability Office (GAO) report, HHS should develop clear and transparent metrics and timelines for creating a modern public health data infrastructure. In addition, for all programs supported by the department, HHS should require the collection of data on race, ethnicity, and geography, including from states, localities, tribes, and territories.

Accurate information is the lifeblood of a public health system, facilitating everything from the timely recognition of key health threats to the accurate assessment of whether efforts to address them are working. HHS should develop a comprehensive approach to public health data, joining traditional and novel data sources. The Commission specified that this effort should encompass:

- Modernizing traditional public health surveillance led by the CDC
- Including data from federal payers, beginning with CMS and the Health Resources and Services Administration (HRSA)
- Improving state, local, tribal, and territorial health data systems
- Integrating data from the health care system and other nongovernmental private entities
- Including innovative data sources, such as wastewater monitoring
- Using advanced analytic and modeling approaches, drawing from best practices in artificial intelligence and machine learning
- Implementing a dedicated effort to visualize data to increase their accessibility to the public
- Establishing an open data effort that makes datasets accessible to researchers and the public, with appropriate safeguards for privacy.

One critical element of this effort must be to ensure that the CDC has the new authorities it needs to access critical health data, contingent on privacy safeguards and bidirectional sharing of anonymized data with STLTs, local health systems and hospitals, and other health entities. As one example of the need, it is worth recalling that during the COVID-19 pandemic, Congress had to pass special legislation (The CARES Act) so that the CDC could receive accurate reports of positive COVID-19 tests. Unfortunately, this happened quite late, and the CDC and STLTs were operating with incomplete and inconsistent information about the status of the pandemic until then. That act only applied to COVID-19 and has now expired. When the MPox epidemic began, HHS lacked the authority to require the reporting of tests. Only because the CDC had the only available diagnostic test in the US was the agency able to require reporting as a condition of use. However, if a goal is to be able to leverage both public and private sector assets, a model dependent solely on CDC data use agreements is antiquated and unworkable.

***Recommendation 3: Congress should establish a position, such as an undersecretary for public health at the Department of Health and Human Services to oversee and coordinate the development of the national public health system.***

Congress should create a new position, such as an undersecretary of public health, with the authority to give direction to the operating divisions with regard to cross-cutting public health needs and to have budgetary review authority that pertains to the coordination of federal foundational public health capabilities and public health priorities. The interconnectedness of various HHS agencies in support of public health functions requires strong leadership across the agencies, not just at the CDC.

Unlike the Departments of State and Homeland Security (among other federal departments), HHS lacks undersecretaries that oversee complementary aspects of its mission. There is also no organizational home that is currently structured and resourced to provide leadership on a wide range of public health issues. Instead, this job is left to the HHS Secretary and Deputy Secretary, both of whom are stretched thin across many different policy and operational responsibilities within HHS and among other federal entities. Administrations have tried to fill this gap by charging senior officials or offices with coordinating public health efforts. However, these attempts have not created a sustainable, functioning capability to fulfill the federal government's public health responsibilities.

Absent an official or office to lead public health efforts, HHS has had difficulty coordinating the work of the large and powerful agencies that are essential to public health, both within the department and elsewhere in the federal government, and with non-federal partners. The responsibilities of HHS agencies, defined by statute and historical practice, intersect and overlap. For example, the CDC, HRSA, and the Food and Drug Administration (FDA) are all engaged in supporting state and local public health workforce efforts, but there is no plan to coordinate their work. Mechanisms for coordination are often ad hoc, either pursued through new committees or working groups that are created to address specific health topics or through emergency response structures for crisis management. The Office of the Assistant Secretary for Health convenes many of these groups around topical issues and serves in an advisory role for the department's annual budget planning process, but it lacks the authority to direct implementation or funding.

Complementing this coordination within HHS and recognizing the role of many federal departments and offices in addressing the drivers of health, there is also an important role for the White House Policy Councils and White House Office of Management and Budget in supporting HHS by ensuring there is consistent, rather than episodic, federal coordination of a national public health system.

## **SUMMARY**

Congressional action in these three areas—supporting STLTs in developing foundational public health capabilities, building a true public health data system, and empowering HHS public health leadership—would go a long way in assuring our nation is healthier throughout the life course and better able to respond to emergencies. The [Commission's report](#) delved into more detail in each of these areas of recommendations. We would be happy to meet with you or your staff to discuss them in more depth.