

Leadership Day, May 17-18, 2022

Public Health and Pandemic Preparedness

With the onset of the coronavirus came the rude awakening that the United States was ill-prepared for a pandemic that is now in its third year. As a result, this nation has faced unprecedented challenges to its public health infrastructure, its ability to develop and manufacturer critical health care supplies and vaccines, and its frontline workforce that has had to adapt to providing continuous care and services at near-crisis levels. Now more than ever, Congress should support funding for federal agencies and initiatives that invest in public health research and pandemic preparedness, such as the U.S. Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), gun violence research, and ensure that telehealth flexibilities put in place during the public health emergency (PHE) are extended and expanded in the most appropriate manner beyond the pandemic.

Public health in this country has largely been neglected and remains chronically underfunded. In a recent [report](#) by Trust for America's Health, it was revealed that the U.S. spends an estimated \$3.6 trillion annually on health, with less than 3.0 percent of that spending directed toward public health and prevention. Furthermore, public health spending as a proportion of total health spending has been decreasing since 2000 and falling in inflation-adjusted terms since the Great Recession. This must change in order for us to emerge from this pandemic and be ready for the next, should it come.

Sustained and adequate funding is essential for the federal government and public health agencies to support the country's ongoing efforts to prevent and mitigate the harmful effects of COVID-19 on patients. Yet, without additional federal resources these critical efforts are in jeopardy of not continuing. New funding is necessary to purchase enough booster vaccines for all patients. Resources are also needed for the development and supply of variant-specific vaccines if needed in the future. The federal government will also not be able to obtain enough supplies of monoclonal antibody treatments, which could be depleted as soon as this month. In addition, the robust COVID testing capacity built up over the preceding months could start declining in June and some COVID surveillance programs may have to be discontinued if a new and sustained infusion of funding is not provided. This is where public health agencies, the CDC, the NIH, and all flexibilities put in place during the PHE and beyond become so vital.

The ability to provide critical and ongoing care through telehealth services has become one such vital flexibility put in place since the onset of the PHE but, unfortunately, those flexibilities will expire at the end of the PHE or soon after. Studies have shown the benefits of the use of telehealth, which has risen sharply since the start of the pandemic. According to the Department of Health and Human Services' (HHS) December 2021 [report](#) on telehealth use, the number of Medicare fee-for-service beneficiary telehealth visits increased 63-fold in 2020, from approximately 840,000 in 2019 to nearly 52.7 million in 2020. ACP [supports](#) the expanded role of telehealth as a method of health care delivery that may enhance the patient-physician relationship, improve health outcomes, increase access to care from physicians and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care.

Another important public health issue that is too often neglected is the lack of federal research and funding dedicated to firearms-related injury and death. In 2020, 45,222 Americans lost their lives due to firearms, according to the [CDC](#). On average, 124 individuals [died from gun violence](#) every day in 2020, an additional 15 more gun deaths per day than in 2019. This should serve as a wakeup call for Congress to act to improve the safety of all Americans, including funding for firearms violence prevention research by both the CDC and NIH and how to best develop intervention and prevention strategies to reduce injuries caused by firearms.

Overview of Congressional Action

Funding for Public Health: While bills have been enacted into law to fund the federal agencies and programs noted above up until Oct. 1, 2022, Congress is now faced with the task of working in a bipartisan fashion to fund those same programs beyond that point into the new fiscal year, 2023, which begins on Oct. 1, 2022, or the government shuts down.

- In FY2022, the CDC received about \$8.5 billion, about \$500 more than the FY2021 funding level. View [joint letter](#) in support of \$11 billion for the CDC in FY2023.
- In FY2022, the NIH received \$45 billion, about \$2 billion more than the FY2021 enacted level. ACP supports \$49 billion for the NIH in FY2023.
- In FY2022, firearms violence prevention research received \$25 million for -- \$12.5 million for the CDC's research and \$12.5 for the NIH's research, the same as in FY2021. View [joint letter](#) in support of \$60 million for CDC and NIH firearms violence prevention research in FY2023.

ACP is encouraged by the bipartisan PREVENT Pandemics Act, S. 3799, legislation reported favorably by the Senate Health, Education, Labor and Pensions (HELP) Committee to the Senate floor that addresses the need for improved pandemic readiness. ACP [supports](#) several provisions in that legislation, including a 12-member "National Task Force on the Response of the United States to the COVID-19 Pandemic" that would review the United States' response to the COVID-19 pandemic. Unfortunately, Congress remains stalled on a pathway forward for supplemental funding for COVID-19 mitigation efforts and assistance, even as ACP continues to urge lawmakers to reach an agreement for such funding.

The *Consolidated Appropriations Act, 2022* (H.R. 2471), which funds the federal government through the end of the 2022 fiscal year, included a welcome extension of telehealth flexibilities for physicians to provide services to patients who are enrolled in Medicare. ACP has strongly advocated for extending those flexibilities, which were granted due to the COVID-19 pandemic, further beyond the end of the PHE. H.R. 2471 extended the lifting of geographic site restrictions so telehealth services can continue to be provided to those in both rural and urban areas and allows for audio-only telehealth services for five months **past** the end of the declared PHE.

Request of Congress

- ✓ **Support funding in FY2023 appropriations** - \$11 billion total for the CDC, \$35 million for the CDC's Injury Prevention and Control, Firearm Injury and Mortality Prevention Research; \$49 billion in total for the NIH, \$25 million for the Office of the Director, Firearm Injury and Mortality Prevention Research.
- ✓ **Cosponsor and pass in the House *the COVID Supplemental Appropriations Act, 2022, H.R. 7007***, or a similar supplemental funding package, which would provide 15.6 billion in additional funding for COVID relief.
- ✓ **Cosponsor and pass in both chambers *the CONNECT for Health Act (H.R. 2903/S. 1512)* and *the Telehealth Extension Act of 2021 (H.R. 6202/S. 3593)***, which would remove arbitrary restrictions on where a patient must be located to utilize telehealth services; enable patients to continue to receive telehealth services in their homes; ensure federally qualified health centers and rural health centers can furnish telehealth services and improve data collection and analysis for at least two years.

Additional policy priorities can be found at: [Policy Priority Issues | ACP Services](#)