Riding the Emergency Funding Rollercoaster

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Emergency state and federal funds are a critical tool for addressing specific threats and a lifeline for many communities during and after a disaster. Local Public Health Agencies (LPHAs) either lead or coordinate disaster response in most communities, but governments have not invested in public health at a level commensurate with this responsibility. Preparedness funding that is intended to provide readiness and ensure response capacities, such as the Public Health Emergency Preparedness (PHEP) cooperative program, has followed a boom-bust cycle with the cadence national emergencies. Since its inception after the 9/11 attacks, PHEP allocations have oscillated but overall decreased by 31%.[1] Much emergency funding, including most FEMA supports, are also reimbursement based, which erroneously assumes that states and localities have sufficient cash or rainy-day funds to meet emergency needs and the spending authority to use them for a public health emergency.

Even if preparedness and response investments were adequate and consistent, local public health recipients are often too atrophied to fully apply those resources. Worse, when injected into a system with chronic underinvestment, these resources can do significant harm. Taking on functions required by emergency funding can quickly lead to staff burnout as they attempt to cover those functions in addition to roles required by regular programmatic funding. During a disaster, staff in chronically under-resourced agencies will experience excessive hours, a frightened and demanding public, and multiple forms of trauma. While such hardships can never be entirely prevented, a well-resourced and prepared agency can mitigate this harm through staff redundancies, local volunteer corps, cross-trained teams, and cross-jurisdictional agreements with other local public health agencies.

In prolonged emergencies, mandated response activities will cannibalize non-emergent services, halting or reducing their provision for months. The 2021 Public Health Workforce Interest and Needs Survey (PH WINS) revealed the extent of staff diversions to COVID-19 response: [2]

- 68% of environmental health staff, normally responsible for retail food safety, childcare facility inspections, and other key protections
- 55% of maternal and child health staff, normally conducting newborn screenings, well-child visits, and responsible for infant mortality prevention
- Over 90% of communicable disease staff, normally responsible for investigation and control of disease like hepatitis A (HAV), influenza, and norovirus

Emergency public health response activities, as mandated in funding SOWs and contracts, assume a level of staffing, information technology, and other infrastructure that no longer exists in many localities and states, if it ever did. These agreements are also inflexible, requiring activities that may become ineffective or even counter-productive when circumstances change. As authorized by federal pandemic response legislation, the CDC greatly expanded the main communicable disease funding stream (Epidemiology and Laboratory Capacity), but could not allow recipients to shore up infrastructural capacities that would greatly improve their ability to use the funding effectively (or use it at all). This is partly why a significant amount of federal pandemic response funding remains unspent.[3]

[1] Boddie C, Watson M, Sell TK. Federal funding for health security in FY2017. Health Secur. 2016;14(5):284–304.
[2] McCullough, J. Mac PhD, MPH; Robins, Moriah MPH. The Opportunity Cost of COVID for Public Health Practice: COVID-19 Pandemic Response Work and Lost Foundational Areas of Public Health Work. Journal of Public Health Management and Practice 29(Supplement 1):p S64-S72, January/February 2023. | DOI: 10.1097/PHH.0000000000001656
[3] https://www.nytimes.com/2023/02/13/us/politics/covid-public-health-departments.html