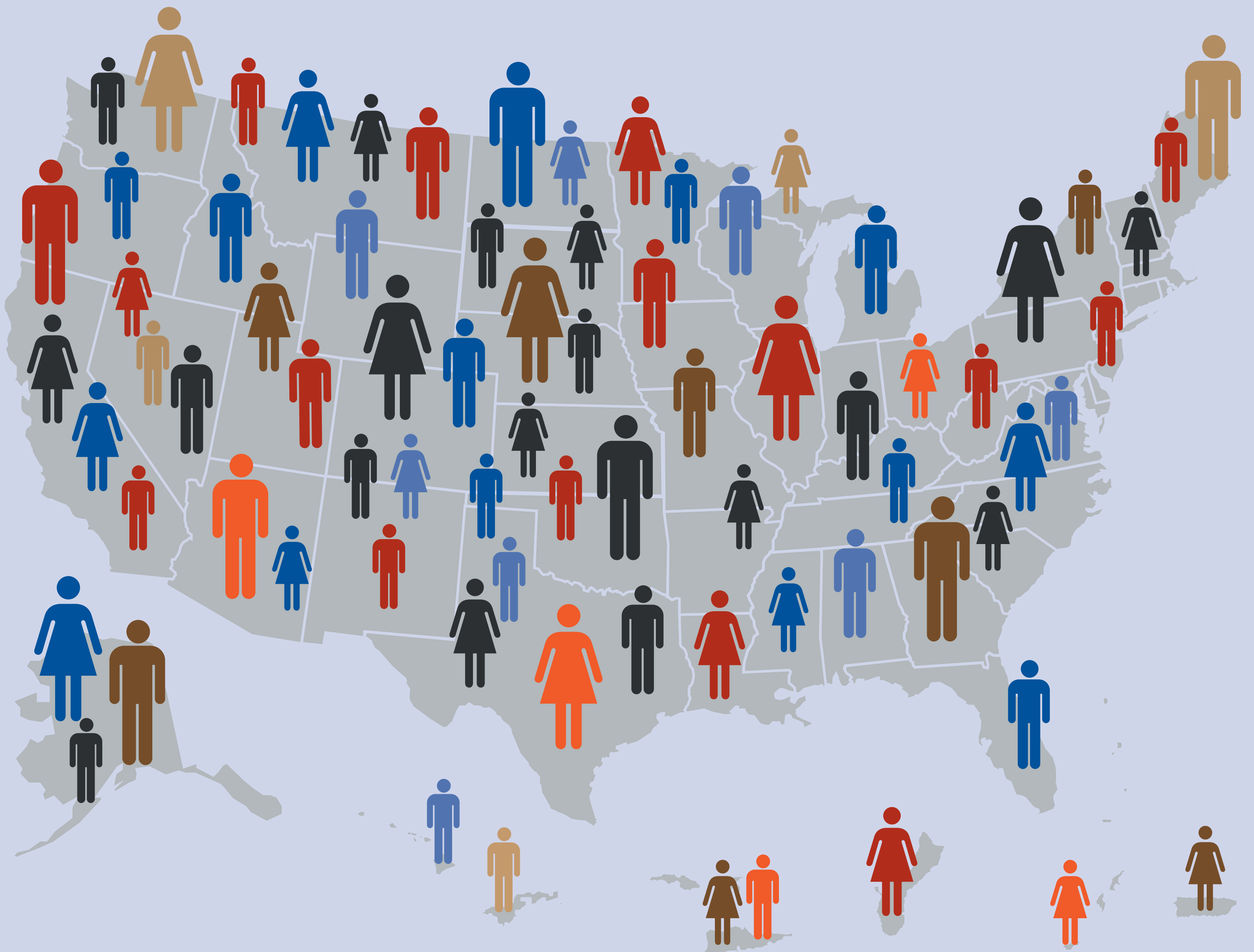
PATHWAY TO A HEALTHIER AMERICA:

A Blueprint for Strengthening Public Health for the Next Administration and Congress



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April 2024 National Convening

In April 2024, TFAH hosted a convening of organizations and leaders from across the country to identify and discuss critical issues and opportunities facing the nation's public health ecosystem. That discussion helped establish the framework for this report.

The following people participated in the convening. While their participation does not necessarily constitute agreement with all of the report's content, the report benefited from their input and expertise. TFAH wishes to express its sincere appreciation to all the convening participants.

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EXECUTIVE SUMMARY

Our Public Health System is at an Inflection Point. It is Critical That We Act.

Every person in America should have the opportunity to live a healthy life regardless of who they are or where they live. Achieving this goal requires communities supported by a robust public health system at every level — national, state, local, tribal, and territorial — as well as policies that promote health and well-being. This transition document provides a policy blueprint for the next Administration and Congress that, if adopted, will safeguard the health, economic, and national security of our nation.

Throughout our history, the nation's public health system has protected and promoted individual and population health by preventing illness and injuries. Public health professionals assess and monitor health. They detect, track, and respond to infectious disease outbreaks, ensure that the water we drink and the food we eat are safe, promote healthy behaviors, and respond to public health emergencies such as natural disasters.

Examples of successful public health initiatives include programs to ensure that all children are vaccinated against vaccine-preventable diseases. Among children born between 1994 and 2023, routine childhood vaccinations made available through the Vaccines for Children program will have prevented approximately 508 million illnesses.[1] A second example is public education campaigns encouraging smokers to quit. The Centers for Disease Control and Prevention's (CDC) Tips from Former Smokers campaign has helped approximately 1 million people stop smoking, preventing an estimated 129,000 early deaths and saving approximately $7.3 billion in smoking related healthcare costs.[2]

The largest contributing factors to the increase in life expectancy are rooted in public health interventions.

In addition, when food-borne illnesses or measles cases are detected in a community, public health swings into action to stop the outbreak from spreading and protect the local population and economy. During the COVID-19 pandemic, the nation's public health ecosystem was foundational to ensuring that the COVID-19 vaccine reached the public, including communities that faced barriers to vaccine access and acceptance. It is estimated that vaccinations against COVID-19 prevented more than 18.5 million U.S. hospitalizations and 3.2 million deaths, saving at least $1 trillion in healthcare spending.[3] This success depended in part on public health's efforts to communicate the vaccine's safety and effectiveness and to enable vaccine access in every community.

Americans are living longer thanks in part to public health.

Improved life expectancy is one of the most significant public health accomplishments in the United States. Life expectancy for a person born in 1900 was 47.3 years. Based on 2022 data, U.S. life expectancy has now reached 77.5 years of age,[4] but this can vary, in some cases widely, based on where a person lives or their race.[5] The largest contributing factors to the increase in life expectancy are rooted in public health interventions and efforts, including improved sanitation, improved nutrition, tobacco use prevention, stronger infectious disease control (including vaccinations), and addressing preventable injury (e.g., seat belts).[6] Even within these advancements, disparities persist, with some groups experiencing fewer or slower improvements in health outcomes.

WHAT ARE THE CORE ATTRIBUTES OF A ROBUST PUBLIC HEALTH SYSTEM?

A strong public health system ensures its entire community is safe and healthy by preventing and containing health hazards. With appropriate capabilities in place, a robust public health system can save lives and reduce public spending. Providing high-quality, data-driven public health protections in every community requires a strong foundation of public health infrastructure and essential services.

Foundational public health capabilities are the cross-cutting skills and capacities needed to support basic public health protections, as well as other key programs and activities for promoting community health and achieving equitable health outcomes. When public health professionals talk about infrastructure, they are referring to these foundational capabilities. These include:

1. Assessment and surveillance;

2. Community partnership development;

3. Equity;

4. Organizational competencies;

5. Policy development and support;

6. Accountability and performance management;

7. Emergency preparedness and response; and

8. Communications.[7]

These foundational capabilities are necessary to protect health across the lifespan and across key public health areas: communicable disease control; chronic disease and injury prevention; environmental public health; maternal, child, and family health; and access to and linkage with clinical care.[8]

This strong foundation also enables health departments to provide essential services tailored to the health needs of the communities they serve. Experts have agreed that every health department should have the resources, workforce, and systems in place to deliver 10 Essential Public Health Services:[9]

1. Assess and monitor population health status, factors that influence health, and community needs and assets;

2. Investigate, diagnose, and address health problems and hazards affecting the population;

3. Communicate effectively to inform and educate people about health, factors that influence it, and how to improve it;

4. Strengthen, support, and mobilize communities and partnerships to improve health;.

5. Create, champion, and implement policies, plans, and laws that impact health;

6. Utilize legal and regulatory actions designed to improve and protect the public's health;

7. Assure an effective system that enables equitable access to the individual services and care needed to be healthy;

8. Build and support a diverse and skilled public health workforce;

9. Improve and innovate public health functions through ongoing evaluation, research, and continuous quality improvement; and

10. Build and maintain a strong organizational infrastructure for public health.

Successful public health systems promote community conditions that support optimal health for all and work to remove systemic barriers that have resulted in poor health and health disparities. In addition, a strong public health system comprises federal, state, tribal, territorial, and local health agencies working within an ecosystem that also includes coordination and partnerships with the healthcare system, public safety and emergency response agencies, human service and charity organizations, education and youth development organizations, recreation and arts-related organizations, faith-based organizations, community-based organizations, economic and philanthropic organizations, and environmental agencies and organizations.

Too many Americans are still suffering from preventable health problems.

While people are living longer in the United States, the nation still ranks lowest for life expectancy among all other high-income countries and has the highest rates of avoidable deaths.[12] Five of the 10 leading causes of death in the U.S. are or are strongly associated with preventable and treatable chronic conditions.[13] Ninety percent of the country's $4.5 trillion in healthcare spending are expenditures related to chronic or mental health conditions.[14]

TERMS USED IN THIS REPORT

Public health — "What we as a society do collectively to assure the conditions in which people can be healthy" (Institute of Medicine, 1988). The term encompasses a broad range of activities from the neighborhood to the national level that protect the health of individuals, families, and communities.

Health equity — Health equity means that everyone has a fair and just opportunity to be as healthy as possible.[10]

Public health system — The public health system is the constellation of governmental and nongovernmental organizations that contribute to the performance of essential public health services for a defined community or population.[11]

On aggregate, people are living longer than in past decades, but many are living with preventable chronic conditions and diseases, such as obesity, diabetes, coronary heart disease, hypertension, and substance use disorder. In fact, an estimated 129 million Americans have at least one chronic condition, and 42 percent have two or more.[15] Many of these conditions are linked to social, economic, and environmental challenges such as economic instability, lack of access to affordable housing and reliable transportation, and lack of access to affordable nutritious foods.[16] The nation is also facing other growing health threats, such as mental health and substance misuse crises,[17] high rates of maternal mortality,[18] emerging and reemerging infectious diseases,[19] and more frequent and severe natural disasters.[20]

Compounding the nation's public health crisis are avoidable population health differences rooted in structural factors such as race-based or gender-based discrimination, economic inequality, and geographic inequality along rural versus urban/suburban lines. Historic and contemporary policy choices around housing, community development and investment, public health, and healthcare have led to communities that produce inequitable health and well-being outcomes. Addressing these challenges at the individual level does not change or alter the community or environmental context that contributes to poor health. Lasting change therefore requires a population-level, public health approach through a strong public health system.

Funding cuts and challenges to public health authorities threaten Americans' health.

Despite its critical role in the health of the nation, the public health system is at an inflection point. One reason is the lack of sustained investment in its infrastructure,

Data infrastructure and interoperability are critical to an effective public health system.

capabilities, and workforce.[21] Due to being under resourced, the public health system has been unable to sufficiently modernize many core capabilities, such as data infrastructure and disease detection systems and to scale proven solutions to meet our population health challenges.[22] Congress has already rescinded dollars appropriated in recent years to shore up disease detection and workforce programs. The nation is thus in the austerity phase of the familiar "boom-and-bust" cycle of public health funding, which will lead to a loss of expertise and cutting of successful programs.

Furthermore, public health's ability to protect communities is at risk as policymakers and courts have proposed or enacted policies that undermine the role of public health or preventive healthcare. Recently, some state legislatures have proposed or acted to restrict the authority of public health officials to respond to an emergency.[23][24] Some states have also made it easier for parents to opt children out of school vaccination requirements without medical or religious exemptions.[25] These shifts have serious consequences for the health and safety of communities.[26]

Another area of concern relates to calls to limit the mission and scope of the work of the Centers for Disease Control and Prevention (CDC). CDC is the nation's health promotion and protection agency. Its role, scope, and expertise are unique across the federal government, and its most important contribution is its ability to create and safeguard good health rather than treat disease. The CDC workforce has a unique and comprehensive skill set with expertise in epidemiology and across the spectrum of the public health endeavor, from disease detection and tracking to emergency response planning and activation, to educating the public about and enabling health promoting behaviors. Changing the CDC scope and mission to one that is less comprehensive would undermine its mission to save lives and protect people from health threats.

Finally, the public health system and its practitioners are being undermined by surging health misinformation and disinformation, contributing to both distrust in public health officials and burnout among the public health workforce. The consistent and intentional spread of misinformation and disinformation around public health issues inclusive of and beyond COVID-19 and vaccinations, is widespread and is spurring distrust in and hampering the effectiveness of public health professionals. Modern technology and communication tools make it ever more challenging to prevent the spread of false information. Agencies are further hampered by the lack of resources dedicated to the public health communications workforce and related strategies and efforts.

Despite these challenges, we have seen significant recent progress in improving population health. Congress has invested in the first cross-cutting public health infrastructure grant program, launched in 2022, to ensure health departments meet their community's most pressing needs. The launch of the 988 Suicide and Crisis Lifeline in July 2022 has provided a lifesaving resource for millions of Americans in crisis.[27] And expanded Supplemental Nutrition Assistance Program (SNAP) benefits, in addition to updated nutrition standards in school meals and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, have ensured more families get the healthy meals they need to thrive.

This *Blueprint Report* provides a roadmap for the Administration and Congress taking office in January 2025 to improve the health and well-being of the nation. It additionally highlights recent progress in public health policy demonstrating that when Congress and the Administration act in support of public health, the return is improved preparedness and strengthened individual and community health and safety. The report pairs notes on public health progress with stories of public health's impact in communities across the nation, demonstrating the value of our public health ecosystem.

Because our health is not solely the domain of public health departments, this report also includes policy recommendations to address structural drivers of diseases and health disparities. Protecting Americans from today's crises – chronic disease, mental health challenges including the overdose epidemic, and infectious disease outbreaks – as well as tomorrow's unknown threats requires this kind of comprehensive approach.

The report's recommendations are a result of convenings with experts, practitioners, and community members as well as research to determine key evidence-based policies to support six priority areas. These action steps will improve the nation's preparedness for future threats, improve overall health for all Americans, decrease preventable healthcare spending, and reduce health disparities—making the United States a more resilient, healthy, and secure nation.

2024 Blueprint Priority Areas and Highlighted Recommendations

This report includes recommendations across six priority areas to protect and strengthen public health, prevention, and our nation's health security. The following are highlighted recommendations. A full list and explanation of the recommendations is included in each of the report's chapters.

Priority 1: Invest in Infrastructure and Workforce to Ensure Our Public Health System Can Meet the Challenges and Opportunities of the 21st Century.

- Congress should protect and increase overall funding for CDC to strengthen public health and save lives nationwide.
- Congress should ensure continuous improvement of public health infrastructure.
- Congress should invest in public health data modernization and enact the Improving DATA in Public Health Act to better detect and contain health threats.
- Congress and U.S. Department of Health and Human Services agencies should support efforts to bolster recruitment, retention, and resilience of the public health workforce.

Priority 2: Strengthen Prevention, Readiness, and Response to Health Security Threats.

- The White House should maintain coordination and leadership around public health emergencies and biodefense.
- Congress should expand public health emergency preparedness funding for state, tribal, local, and territorial jurisdictions.
- Congress and the Administration for Strategic Preparedness and Response (ASPR) should strengthen the emergency readiness of the healthcare delivery system.
- Congress should enact legislation to ensure access to vaccines for uninsured and underinsured adults.
- The White House and Congress should renew the nation's global health security commitment.
- Congress should support nationwide efforts to protect against environmental and climate-related health threats through the National Center for Environmental Health (NCEH) and the Agency for Toxic Substances and Disease Registry (ATSDR).
- Congress and the Administration should support interagency efforts to address the impact of extreme heat on health.

Priority 3: Promote the Health and Well-being of Individuals, Families, and Communities Across the Lifespan.

- Congress should increase funding to CDC's National Center for Chronic Disease Prevention and Health Promotion.
- Congress should enhance benefits in and protect access to the Supplemental Nutrition Assistance Program (SNAP).
- Congress should make healthy school meals for all permanent.
- Congress should create a national standard requiring employers to provide job-protected paid sick, family, and medical leave for all employees.
- Congress and HHS should address Adverse Childhood Experiences (ACEs) by passing the Preventing Adverse Childhood Experiences Act and increasing the investment in the CDC ACEs program.
- Congress should fund the nationwide implementation of CDC's Comprehensive Suicide Prevention Program and support SAMHSA's efforts to bolster the continuum of crisis care.

- Congress and the Administration should fund CDC's internal capacity for healthy aging efforts and its support to build and sustain age-friendly public health systems in state, local, tribal, and territorial public health departments.
- Congress and the Administration should support a national strategy for increasing social connectedness to reduce the effects of social isolation and loneliness across the lifespan.

Priority 4: Advance Health Equity by Addressing Structural Discrimination.

- Federal agencies should regularly update and report progress on agency equity plans, ensuring metrics are inclusive of and extend beyond tracking disparities.
- Congress and the Administration should ensure accurate and complete data collection to report health-related information by race/ethnicity, age, sex, disability, language, sexual orientation, gender identity, and geography.
- Federal health agencies should focus funding on populations at elevated risk for chronic disease and poor health outcomes due to the impact of structural discrimination and disinvestment.
- The Administration and Congress should respect and honor the sovereignty of Tribal Nations by rectifying the funding shortfalls to support programs identified as a result of Executive Order 14112 - Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination.

Priority 5: Address the Non-Medical Drivers of Health to Improve the Nation's Health Outcomes.

- Congress should increase funding to $150 million for the Social Determinants of Health program at CDC and pass the Improving Social Determinants of Health Act.
- The Administration should continue to build on the Centers for Medicare & Medicaid Services' (CMS) efforts to support Medicaid, Medicare, and CHIP program coverage of patients' health-related social needs.
- CMS and Congress should explore opportunities to expand the capacity of healthcare providers and payers to screen and refer individuals to social services.
- Congress should amend tax laws to increase economic opportunity for families by expanding access to the Child Tax Credit and Earned Income Tax Credit.

Priority 6: Enhance and Protect the Scientific Integrity, Effectiveness, and Accountability of the Agencies Charged with Protecting the Health of all Americans.

- The Administration and Congress should maintain the existing structure of federal health agencies, which have specific roles and expertise in protecting the nation's health.
- The Administration should protect the scientific integrity of public health agencies and leaders.
- Congress and HHS should invest in and prioritize effective public health communications and reducing the spread of misinformation and disinformation.
- HHS programs and grantmaking agencies should encourage meaningful community partnerships in jurisdictions.
- Lawmakers and courts should reject laws that weaken or preempt public health authorities, which could threaten basic public health protections, such as outbreak detection, vaccination, and response.

PRIORITY 1: Invest in Infrastructure and Workforce to Ensure Our Public Health System Can Meet the Challenges and Opportunities of the 21st Century.

For decades, the increasing life expectancy in the United States could be tied to advances in public health – such as vaccination, clean air and water, and recognition of tobacco as a health threat.[28] However, the U.S. is currently struggling to recover from the alarming recent declines in life expectancy due to the addiction and overdose epidemic, rising chronic disease rates, and the COVID-19 pandemic. Despite spending far more on healthcare than any other high-income nation, the U.S. has substantially worse health outcomes.[29] Many of these premature deaths and excessive healthcare costs could be averted through a strategic and sustained focus on effective prevention and public health. In fact, the median return on investment for public health programs in high-income countries like the U.S. is a staggering $14.3 to every $1 spent.[30] The health and safety of every community and our national and economic security depend on a stronger public health system that is equipped to address a wide range of 21st century challenges and opportunities.

Public health laboratories and epidemiologists are foundational to disease detection and control.

THE PROBLEM:

Insufficient, inconsistent, and siloed funding and chronic underinvestment in public health have limited the public health system's ability to modernize basic public health infrastructure, provide essential services, and adapt to new or evolving health risks — putting the nation's health and economy at risk.

THE SOLUTION:

Policymakers must provide consistent, cross-cutting funding to support the foundations of a strong, 21st century public health system, including infrastructure, a larger, more diverse and better equipped workforce, and modernized data systems.

The public health infrastructure — the people, services, and systems that promote and protect health, is dangerously underfunded, threatening the lives and livelihoods of all Americans. In addition, because so much public health funding is tied to specific health conditions or disease outbreaks, there has been little sustained investment in cross-cutting public health infrastructure — including workforce and data systems.

WHAT ARE PUBLIC HEALTH'S FOUNDATIONAL CAPABILITIES?

Public health's foundational capabilities are the cross-cutting skills and capacities needed to support basic public health protections, as well as other programs and activities that are key to ensuring a community's health and achieving equitable health outcomes.[31] A strong public health infrastructure has the following foundational capabilities:

- **Assessment:** The ability to track the health of a community through data, case finding, and laboratory tests with particular attention to those most at risk.
- **Community partnership development:** The capacity to harness and align community resources and actors to advance a community's health.
- **Equity:** The ability to strategically address social and structural determinants of health through policy, programs, and services as a necessary pathway to achieve equity; and to systematically integrate equity into each foundational capability.
- **Organizational competencies:** The ability to lead internal and external stakeholders to consensus and action.
- **Policy development and support:** The ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based and legally sound.
- **Accountability and performance management:** The ability to apply business practices that ensure efficient use of resources and foster a continuous learning environment.
- **Emergency preparedness and response:** The capacity to respond to emergencies of all kinds, from natural disasters to bioterrorist attacks.
- **Communications:** The ability to reach the public effectively with timely, science-based information. [32,33]

Before the pandemic, public health departments were working from a resources deficit, and we are returning to a boom-and-bust cycle of public health funding. TFAH's *Chronic Underfunding of America's Public Health System* report has demonstrated the impact of the stagnation in funding, with effective programs failing to reach all states. In addition, *Staffing Up*, a joint project of the de Beaumont Foundation and the Public Health National Center for Innovations, found that state and local health departments need to add the equivalent of 80,000 full-time positions in order to provide a minimum set of public health services in their communities.[36] Since the COVID-19 pandemic, many public health workers have also reported symptoms of post-traumatic stress disorder, harassment and threats, and poor mental health.[37] This burden is contributing to employees leaving or considering leaving their organization, which threatens the resilience of the entire public health system. A March 2023 study estimated that almost half of all state and local public health employees who were over 35 years of age left their jobs between 2017 and 2021. Younger employees or those with shorter tenures left their jobs at an even higher rate. The authors warn that if these separation rates continue, about 100,000 public health workers will leave their jobs by 2025.[38] Given the need to be prepared for future public health emergencies, investing in public health workforce recruitment and retention must be a priority.

Congress made important investments in foundational public health capabilities, e.g., population health assessment, data systems, and workforce development, since the onset of the COVID-19 pandemic. These investments have contributed to stronger partnerships between healthcare and public health and social services and public health, more effective disease detection, and a new pathway into careers in public health. However, public health infrastructure funding is returning to a phase of austerity. The impending funding cliffs for programs that received short-term pandemic response dollars, such as for data modernization and support of the public health workforce — funding that has since been spent or in some cases rescinded — will significantly weaken the public health infrastructure at a time when sustained investment is greatly needed to improve the nation's health and be better prepared for the next health emergency.

Congress has already rescinded dollars intended to shore up public health, including for workforce and disease detection.[39] The Fiscal Responsibility Act (FRA), enacted in July 2023, rescinded pandemic response appropriations

and funding from the American Rescue Plan Act (ARPA) that had been allocated to the Centers for Disease Control and Prevention (CDC), the Administration for Strategic Preparedness and Response (ASPR), the Health Resources and Services Administration (HRSA), the Defense Production Act Medical Supplies Enhancement, the National Institutes of Health, and the Food and Drug Administration (FDA). In total, the FRA rescinded approximately $13.2 billion in emergency response funding, according to estimates from the Congressional Budget Office.[40] Beyond curtailing the pandemic response, these cuts harm the underlying public health system. If future investments are not made, the result of rescissions and funding cliffs will be the end of many critical programs including disease tracking through wastewater testing, the Public Health AmeriCorps and other workforce programs, and vaccine access for uninsured adults. Cuts would also significantly hinder progress for public health infrastructure, disease forecasting, and data modernization.

These rescissions and funding cliffs underscore how challenging it is for public health agencies to recruit, hire, and retain the needed workforce, to respond to routine and emergency public health needs, and to plan for the future. Public health agencies must be equipped to adapt to unanticipated threats, such as emerging diseases, more frequent and severe weather events, and the impact of misinformation.

WHAT WOULD A NATIONAL PUBLIC HEALTH SYSTEM LOOK LIKE?

In June 2022, The Commonwealth Fund Commission on a National Public Health System issued a report outlining steps to strengthen the public health infrastructure at all levels of government and build a national public health system.[34] The Commission report defined a national public health system as "the organized 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."[35]

TFAH calls for building a strong foundation now to enable public health systems to provide essential services and programs to support healthy, thriving communities that are better prepared for the public health challenges that the future will undoubtedly bring.

PROGRESS MILESTONES

- With the launch of the Public Health Infrastructure Grant program and creation of CDC's Public Health Infrastructure Center, CDC is expected to award more than $5 billion over a 5-year period for public health infrastructure, workforce, and data systems. The cross-cutting Public Health Infrastructure Grants enable health department recipients to address their communities' most pressing needs.
- Investments in CDC's Data Modernization Initiative have led to significant advancements in electronic case reporting, electronic laboratory reporting, and reduced time and hours for disease reporting.[52]
- The establishment of the CDC Center for Forecasting and Outbreak Analytics improves response to public health emergencies by advancing outbreak forecasting tools and techniques. The Center has already helped improve disease predictions for COVID-19, measles, Mpox, polio, and acute pediatric hepatitis.[53]
- The creation of the Public Health AmeriCorps helps create pathways to careers in public health with a focus on building public health capacity in the most underserved communities.
- Congress passed the Public Health Loan Repayment Act to support recruitment and retention of workers in governmental public health departments.

IMPACT STORIES

Public Health AmeriCorps Expands Public Health Capacity in Underserved Areas

Public Health AmeriCorps, funded by the American Rescue Plan Act, is a partnership between CDC and AmeriCorps to open new pathways to public health careers and develop the next generation of public health leaders. The program has launched careers for more than 4,700 participants, with a focus on service in rural, urban, and tribal underserved communities.[54,55] For example, the Public Health AmeriCorps project at Appalachian State University is providing on-site training and experience for 25 participants to serve in 25 rural counties of western North Carolina as community health workers. These members are providing psychological first aid, emergency preparedness, and other public health support to health departments, long-term care facilities, and hospitals.[56]

Public Health Data Modernization Reduces Workforce Burden and Response Time

One major priority of CDC's Data Modernization Initiative is significantly increasing rates of electronic case reporting (eCR) – the automatic exchange of data between electronic health records and public health agencies, a key step toward integration between healthcare and public health systems.[57] Thanks to this initiative, from January 2020 to September 2024, the number of healthcare facilities using electronic case reporting to public health agencies increased from 153 to over 41,000 in all 50 states and two territories.[58] In one example, health officials in Tennessee were able to rapidly detect and investigate an outbreak of *Candida auris (C. auris)*, a type of yeast that can cause severe illness and that spreads easily among patients in healthcare facilities, in less than a day.[59] A state epidemiologist used eCR data to detect a cluster of *C. auris* in one county, allowing the officials to work with the healthcare systems to rapidly find additional cases and prevent further spread. In a critical access healthcare system in Virginia, using eCR saved a reported $700,000 and 21,900 provider hours over a one-year period compared with manually reporting of COVID-19 cases.[60] As another example, prior to adoption of eCR, the Minnesota Department of Health used manual data entry to process case reports at 500 per day. The automation of eCRs has allowed the department to process 4,000 eCRs per day, reducing staff entry time from 32 to zero hours.[61]

Public Health Infrastructure Investments Modernize Health Department Management

The landmark Public Health Infrastructure Grant (PHIG) is a cross-cutting investment in public health modernization and foundational capabilities. 107 health departments in all 50 states, D.C., eight territories, and 48 large localities were awarded more than $4 billion from FY 2022-2024.[62] The Alabama Department of Public Health (ADPH) exemplifies a state using PHIG to become more efficient and effective. The department used PHIG funding to implement a workforce recruiting campaign, digitize its human resources platforms and streamline hiring practices to improve recruiting and retention, and modernize its grants management and evaluation initiatives.[63] The department improved its recruiting practices so much it is collaborating with other state agencies on aligning their personnel hiring processes enabling faster hiring, particularly important when a health emergency requires increased staffing.

THE LOOMING PUBLIC HEALTH FUNDING CLIFF: A CRISIS IN THE MAKING

A modern and robust infrastructure, including data and disease surveillance systems and a highly skilled workforce, is the underpinning of an effective public health system. Progress toward that goal has been made, but decades of underfunding have left too many health departments dependent on antiquated systems and insufficient staffing levels. In addition, the combination of expiring COVID-19 emergency response funds and funding recissions mandated by the Fiscal Responsibility Act of 2023,[41] present a significant risk to the public health programs and capacities that were strengthened during the pandemic response.

Public health funding is now in another austere phase of a boom-and-bust funding cycle. COVID-19 response funds were a significant but short-term source of public health investment over the past four years, including funding through the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 and the American Rescue Plan Act (ARPA) of 2021. However, such funding was temporary and has now been largely obligated, or, in some cases, rescinded by Congress.[42] The result is a serious funding cliff for CDC and many health departments, where federal assistance for specific programs or personnel is no longer available and program cuts have been made or are on the horizon. Allowing these funding cliffs to occur without providing long-term funding alternatives risks undoing years of progress toward a healthier and more resilient nation.

The following CDC programs face significant funding cliffs and recissions.

Advanced Molecular Detection (AMD):
The AMD program, crucial for identifying and tracking infectious disease threats, received a one-time supplemental appropriation of over $1.7 billion in 2021. This funding dramatically expanded the nation's capacity for genomic sequencing and analysis. However, this supplemental funding ends in 2024, leaving the program with only its annual base appropriation of $40 million[43]—a staggering reduction. This cliff threatens to reverse critical gains in pathogen detection and surveillance capabilities.

The Public Health Workforce:
CDC awarded $3 billion to health departments nationwide to address chronic workforce shortages exacerbated by the pandemic.[44] This funding supported hundreds of new positions across state and local health departments. However, these are one-time funds, potentially leading to widespread layoffs and a return to the pre-pandemic workforce levels that left the nation unprepared for COVID-19. In addition, $176 million in funding—about half of its original budget—for the Public Health AmeriCorps program was rescinded as a result of the Fiscal Responsibility Act. The program has created pathways to public health careers for more than 4,700 future public health leaders, with a focus on service in underserved communities in rural, urban, and tribal areas.[45, 46]

Public Health Infrastructure:
As of January 2024, CDC had awarded $4.35 billion in grants to strengthen public health infrastructure across 107 state, territorial, and local health departments.[47] Over $3.8 billion of these funds, critical for modernizing public health systems and capabilities, are set to expire in fiscal year (FY) 2027. Without sustained funding, health departments may struggle to maintain the improvements made in data systems, laboratory capacity, and community partnerships.

Center for Forecasting and Outbreak Analytics (CFA):

Established with one-time funding during the pandemic to enhance the nation's ability to use advanced data, models, and analytics to support public health decision-making, CFA is the only federal entity with the primary mission of providing infectious disease forecasts to inform a response. Congress provided base funding of $50 million in FY 2023 and $41 million in FY 2024, with a rescission of $8.8 million.[48] These continued decreases will require CFA to pull back on investments in establishing capabilities at the state and local levels, particularly within Insight Net, a collaborative network of more than 100 partners established to enhance modeling and analytic capabilities across U.S. health departments. Experts estimate $100 million per year would allow CFA to continue operating at its current levels.

National Wastewater Surveillance System:
Over $500 million in supplemental funding has been invested to build a nationwide wastewater surveillance system capable of detecting COVID-19 and other pathogens.[49] While health departments may still have some funding to support activities, there were no funds appropriated in the FY 2024 budget; the $20 million proposed in the FY 2025 budget would maintain a much scaled-down version of the program. This represents a massive reduction in funding, threatening to dismantle much of the surveillance network built during the pandemic.[50]

THE LOOMING PUBLIC HEALTH FUNDING CLIFF: A CRISIS IN THE MAKING, Cont.

Bridge Access Program:
CDC's Bridge Access Program, launched to ensure continued access to COVID-19 vaccines as they transitioned to the commercial market, ended in August 2024.[51] The program provided free COVID-19 vaccines to adults without health insurance and those whose insurance did not fully cover vaccine costs. It utilized a network of local health providers, HRSA-supported health centers, select pharmacies, and community events to distribute vaccines. The program's expiration could leave millions of adults without access to free COVID-19 vaccines, potentially widening health disparities and reducing overall vaccination rates. This comes at a time when COVID-19 continues to circulate, and updated vaccines are necessary to address new variants. The Administration has proposed a broader Vaccines for Adults program to enable uninsured adults to have access to recommended vaccines.

Rescissions from the Fiscal Responsibility Act:

Compounding the problem of expiring funds, the Fiscal Responsibility Act of 2023 mandated significant rescissions of unspent COVID-19 emergency funds, many of which officials had planned to use to shore up underlying public health capacity. Some of these rescissions included:

- **Vaccine Programs:** Over $945 million was cut from programs that help get vaccines to people, build vaccine equity, and encourage vaccination.
- **Disease Tracking:** About $430 million were taken away from efforts to track how diseases emerge and change over time.
- **Global Health:** More than $300 million were removed from CDC's work on health issues around the world.
- **Data and Forecasting:** Nearly $18 million were cut from programs that help predict and understand disease outbreaks.

The combination of expiring supplemental funds and mandated rescissions threatens to recreate the cycle of boom-and-bust crisis funding that left the United States vulnerable to COVID-19. Key consequences include:

Workforce Reductions: Many health departments may be forced to lay off staff hired with emergency funds, losing valuable expertise and capacity.

Technology Setbacks: Investments in data modernization and surveillance systems may be difficult to maintain without sustained funding.

Reduced Preparedness: The ability to quickly detect and respond to new disease threats may be compromised as programs like AMD and wastewater surveillance are scaled back.

Widening Health Disparities: Many of the programs facing cuts were instrumental in addressing health inequities exposed by the pandemic. Their reduction may disproportionately impact communities that are under-resourced and marginalized.

This sidebar was originally published in TFAH's *The Impact of Chronic Underfunding on America's Public Health System 2024: Trends, Risks, and Recommendations* report.

RECOMMENDATIONS

Congress should protect and increase overall funding for CDC to strengthen public health and save lives nationwide. TFAH supports providing sustained, predictable annual appropriations for CDC of at least $11.5 billion in FY 2025, with continued growth in the years that follow. Presently, more than 80 percent of CDC's domestic funding is allocated to state, local, territorial, and tribal health departments, academic partners, and community-based organizations to implement evidence-based public health and prevention programs. Due to underfunding, many proven, evidence-based public health and prevention programs have yet to reach all 50 states, including programs aimed at preventing the leading causes of death and drivers of healthcare costs.

Congress should ensure continuous improvement of public health infrastructure. TFAH supports sustained funding for the people, services, and systems needed to build foundational public health capabilities and provide essential services nationwide. Congress should enact legislation such as the Public Health Infrastructure Saves Lives Act, which would provide ongoing funding for CDC's Public Health Infrastructure Program to ensure health departments have more effective emergency responses, faster disease detection, and continuous progress toward preventing chronic diseases. In the interim, Congress should provide at least $1 billion in annual appropriations for CDC's newly established Public Health Infrastructure Grant program, ramping up to $4.5 billion per year. This program is already yielding important progress in strengthening the foundations of public health across the country.

Congress should modernize public health data systems to better detect and contain health threats. CDC's Public Health Data Modernization is designed to update and sustain the data infrastructure at CDC and at state, local, tribal, and territorial health departments. This initiative enables real-time and actionable data to improve responses to epidemics and the effectiveness of related programs. Investments to date are already yielding benefits, such as faster case reporting, improved interoperability with clinical care systems, and reduced staff hours needed by both healthcare and public health workers. The Data: Elemental to Health campaign estimates that at least $7.84 billion is needed over five years to strengthen public health data systems at the state and local levels.[64] The Assistant Secretary for Technology Policy and Office of National Coordinator for Health Information Technology (ASTP/ONC) should also finalize and implement the Patient Engagement, Information Sharing, and Public Health Interoperability proposed rule as a means to promote seamless reporting between healthcare and public health.[65]

Congress should enact the Improving Data Accessibility Through Advancements (DATA) in Public Health Act to strengthen and streamline public health data reporting. The legislation would establish uniform standards for sharing public health data and allow the U.S. Department of Health and Human Services (HHS) to strengthen data sharing processes between public and private health entities. Such legislation updates archaic health data sharing standards while ensuring confidentiality of data.

Congress should restore the Prevention and Public Health Fund to $2 Billion and reject further cuts. The Prevention and Public Health Fund was created by the Affordable Care Act (ACA) to improve health and restrain the rate of growth in healthcare costs. Thus far it has made more than $12.3 billion in critical, evidence-based investments in every state and territory, such as expanding vaccine access through the CDC Immunization Program, building laboratory capacity, reducing tobacco use, and preventing chronic disease.[66] In addition to representing more than 10 percent of CDC's annual budget, the Prevention Fund supports prevention programs at the Administration for Community Living (ACL) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Despite funding critical work, the Prevention Fund has already been cut by $12.95 billion from FY 2013 through FY 2029.

Congress should support efforts to bolster recruitment and retention of the public health workforce. While emergency supplemental funding can help with short-term staffing needs for discrete emergency response requirements, it cannot be used to recruit and retain the workforce in the long term.

- Congress can build the public health workforce by significantly expanding CDC's **Public Health Workforce** line, which includes programs that embed professionals into state, tribal, local, territorial (STLT) health agencies and it should invest in programs to strengthen the public health workforce through fellowship and scholars programs. Congress should also add $100 million per year for **Public Health AmeriCorps**, which faces a funding cliff that will effectively end the program. The program has successfully recruited and trained future public health leaders to address health needs in rural, urban, and tribal underserved communities. Congress should also amend the tax code to waive the tax burden for student loan repayment of their fellows, which would allow additional recruitment into fellowship programs.
- Congress should support recruitment and retention of a well-trained, diverse, and sufficient public health workforce by funding HRSA's **Public Health Workforce Loan Repayment Program**. The U.S. Department of Education and the U.S. Department of the Treasury should expand student loan repayment and forgiveness programs for public health workers, including current public health workers.
- Congress should support funding for CDC's **John R. Lewis Undergraduate Public Health Scholars Program**. The program introduces undergraduate students to topics in minority health and health equity while supporting career development through a public health practicum.

Congress and HHS agencies should expand efforts to promote a resilient public health workforce. Given the toll of attacks on the public health workforce, stress, and turnover,[67] Congress should provide additional funding for CDC and the National Institute for Occupational Safety and Health to develop and deploy mental health resources for public health workers, authorize and expand funding for HRSA programs that promote resilience and mental health among health professionals, and ensure the public health workforce are eligible for these programs.

PRIORITY 2: Strengthen Prevention, Readiness, and Response to Health Security Threats.

Prevention, detection, and response to health risks are essential to the health and economic security of the nation. In 2023, the United States experienced a record number of billion-dollar weather disasters,[68] while extreme heat remained the deadliest weather threat.[69] The past two decades have seen waves of emerging infectious disease outbreaks, from the 2003 severe acute respiratory syndrome (SARS) outbreak to the over 1.8 million worldwide deaths due to the COVID-19 pandemic, to the recent human cases of avian influenza. In addition, pockets of vaccine hesitance have led to the reemergence of vaccine-preventable diseases like measles in the U.S. and globally. [70,71] Vaccination coverage has declined among children entering kindergarten, dipping below the 95 percent coverage target nationwide and much lower in some communities, fueling the likelihood of preventable outbreaks and suffering.[72] In addition, an estimated 50,000 U.S. adults died each year from vaccine-preventable diseases prior to the COVID-19 pandemic,[73] and the U.S. spends an estimated $26.5 billion annually treating such diseases in adults over 50.[74] Natural and man-made disasters, from train derailments to terrorism, have far-reaching impacts on the physical and mental health and well-being of communities.

Every part of the country and all residents are at risk for health emergencies. Yet, some populations bear a disproportionate risk for poor health outcomes and a more protracted recovery from disasters. Centering equity to ensure overall population health will create more resilient communities.

PROBLEM:

Public health hazards, such as infectious disease outbreaks, disasters, and bioterrorism, are increasing and pose significant threats to the nation's security, well-being and prosperity. Too often, federal responses to health emergencies are hampered by inadequate funding and challenges to public health authorities. The nation's high rates of chronic disease and underlying health and socioeconomic disparities create additional vulnerabilities.

SOLUTION:

The nation needs to redouble its efforts to prepare for and respond to public health emergencies, wherever they originate. We must build on recent progress and heed the lessons of the COVID-19 pandemic in order to protect the health of all Americans.

TFAH's recommendations focus on modernizing the systems and policies needed to ready the nation for 21st century health threats. The recommendations of this section cover three domains: 1) cross-cutting readiness and response, 2) containment of infectious disease outbreaks, and 3) response to health risks from environmental hazards and climate change. TFAH's *Ready or Not: Protecting the Public's Health from Diseases, Disasters, and Bioterrorism* report series has noted significant progress in the nation's health security enterprise since the 2001 September 11th and anthrax attacks, but the country can no longer afford to depend on decades-old systems and policies to protect the population from modern health emergencies. The White House and Congress must act with urgency to equip the health security enterprise with the resources required to protect every community.

PROGRESS MILESTONES

- The White House health security infrastructure has been enhanced through the creation of the Office of Pandemic Preparedness and Response Policy and the appointment of senior advisors to the President on biodefense and global health security.
- HHS began implementing a strategy to develop a more resilient public health supply chain including by creating an Office of Industrial Base Management & Supply Chain and issuing contracts to bolster domestic production of supplies and materials for medical countermeasures.[75]
- Congress invested in innovative disease detection methods, such as CDC's Center for Forecasting and Outbreak Analytics, genomic sequencing, and wastewater surveillance.

PROGRESS MILESTONES

- Congress provided annual and one-time funding for the Infectious Disease Rapid Response Reserve Fund; a reserve of readily available money designated for HHS response actions during the early stages of an infectious disease threat.
- Between December 2020 through November 2022, the U.S. COVID-19 vaccination program is estimated to have prevented more than 18.5 million additional hospitalizations, 3.2 million additional deaths, and saved the U.S. $1.15 trillion in medical expenditures.[76]
- The availability of preventive tools for infectious diseases was expanded through the development and deployment of vaccines and antibodies for Respiratory Syncytial Virus (RSV), Mpox, and other emerging and reemerging threats.
- Vaccines for Children marked its 30th year, increasing routine vaccination for children against 19 different diseases. Routine vaccination for children born during that time period (1994 – 2023) will have prevented about 508 million illnesses, 32 million hospitalizations, and saved over 1.1 million lives.[77]
- Congress passed legislation requiring coverage of vaccines in Medicare Parts B & D without cost sharing.
- Congress passed the Vaccine Awareness Campaign to Champion Immunization Nationally and Enhance Safety (VACCINES) Act to increase research and effective messaging to improve vaccine confidence and counteract misinformation.
- The Administration created the Office of Climate Change and Health Equity at HHS to serve as a department-wide hub for climate and health policy.
- Multiple agencies across the federal government collaborated on the launch of the National Integrated Heat Health Information System and its web portal, heat.gov, including the HeatRisk tool.[78]
- The Bipartisan Infrastructure Investment and Jobs Act was enacted in 2021 and included significant investments in climate resilience and adaptation,[79] safe drinking water, and wastewater infrastructure.[80]
- The Environmental Protection Agency (EPA) finalized stricter air quality standards on fine particulate matter and estimates that these updates will prevent up to 4,500 premature deaths, 290,000 lost workdays, and yield up to $49 billion in health benefits.[81]
- EPA finalized a rule setting standards for per- and polyfluoroalkyl substances (PFAS) in the water supply.[82] The Agency for Toxic Substances and Disease Registry (ATSDR) also released PFAS information for clinicians to guide testing and clinical management.[83] High levels of PFAS have been linked with health issues such as increases in cholesterol, kidney and testicular cancer, and decreases in birth weight.

IMPACT STORIES

Local/Federal Partnership Speeds Response to a Measles Outbreak

Measles is a highly contagious, potentially severe, viral infection that is mostly vaccine preventable. Thanks to an effective measles, mumps, and rubella (MMR) vaccine, measles was considered eliminated from the U.S. in 2000.[84] However, pockets of unvaccinated people put entire communities at risk. U.S. MMR coverage among kindergartners is now below the 95 percent coverage target and is much lower in some communities and increases in global measles levels mean travel-related cases can introduce new outbreaks.[85] One such outbreak occurred in Columbus, Ohio, beginning in November 2022. Columbus Public Health and the state health department were notified of two cases and initiated an investigation and response, with support from a CDC team.[86] Among the 85 cases that were confirmed before the outbreak was declared over, 80 were unvaccinated, including 25 infants too young to receive their first dose. Columbus Public Health and Franklin County Public Health interviewed patients, conducted contact tracing and monitoring, coordinated with healthcare and childcare facilities, and tracked laboratory results, along with educating the public about the importance of vaccination.[87,88] The outbreak was successfully contained and declared over in February 2023.

Leveraging Preparedness Funding to Protect Residents from Wildfire Smoke Exposure

Federal funding is crucial to maintaining state, local, and territorial public health preparedness for a range of threats. Using its CDC Public Health Emergency Preparedness (PHEP) Cooperative Agreement funding, the state of Washington has built a robust emergency medical logistics capability that it leveraged when planning for the 2023 wildfire season. PHEP funding supports the state's planning, training, and exercising of its medical logistics capacity with local and tribal partners. This preparedness planning enabled the state to distribute 850 portable HEPA (high efficiency particulate air) cleaners purchased with state funds to local health jurisdictions, tribes, and community-based organizations within 24 hours of orders being placed. As demand for the cleaners continued the state used PHEP funding to purchase an additional 500 cleaning units. The air cleaners were used during the 2023 wildfire season in areas experiencing wildfire smoke, reducing the number of people with underlying medical conditions and others sensitive to smoke presenting to emergency departments.[89]

Ensuring Hospital Preparedness to Respond to Emergencies

Federal support is also needed to ensure the safety of patients and healthcare personnel during emergencies. In April 2023, Oklahoma's Regional Medical Response System, supported through ASPR's Hospital Preparedness Program, coordinated a successful response to 18 tornadoes that hit central Oklahoma in one day. The healthcare coalition coordinated with hospitals, emergency medical services, public health, and long-term care facilities to respond to the disaster. The coalition identified needs at local healthcare facilities and helped coordinate an immediate evacuation and safe relocation of 79 residents of a nursing home facility that had sustained damage in the storms. Not a single resident of the facility was injured.[90]

Building Local Capacity to Respond to Global Threats

Global health security is the effort to prevent, detect, and respond to infectious disease and other acute public health threats that cross geographical regions and international boundaries.[91,92] Stopping outbreaks at the source also protects Americans' health and economic resilience. Within the U.S., CDC, the U.S. Agency for International Development, the White House, and other agencies have distinct roles in promoting and coordinating global health security. One key strategy is to build local capacity to detect and respond to health threats, which improves the speed and quality of their responses. For example, in 2022-2023, local disease detectives who had been trained through CDC's Field Epidemiology Training Program were instrumental in bringing Uganda's Ebola outbreak under control.[93] By supporting domestic capacity, global partners can reduce the risk and costs of a larger health crisis.

RECOMMENDATIONS

Cross-Cutting Readiness and Response

Congress should reauthorize the Pandemic and All-Hazards Preparedness Act (PAHPA). PAHPA provides the statutory framework for the nation's health emergency enterprise, including public health and healthcare readiness grants, medical countermeasures research and development, and situational awareness. Congress should leverage the opportunity to enact legislation to transform and modernize preparedness efforts through the provisions described below. Congress should avoid using PAHPA as a vehicle for weakening federal health authorities.

The White House should maintain coordination and leadership around public health emergencies and biodefense. The White House should preserve and strengthen the Office of Pandemic Preparedness and Response Policy to ensure permanent public health security leadership in the White House to advise the president and coordinate interagency activities around biodefense.

Congress should expand public health emergency preparedness funding for state, tribal, local, and territorial jurisdictions. CDC's Public Health Emergency Preparedness (PHEP) Cooperative Agreement requires at least $1 billion per year in the near term. PHEP has saved lives by building and maintaining a nationwide public health emergency management system that enables communities to prepare for and rapidly respond to public health threats. PHEP supports nearly 6,000 state, tribal, local, and territorial preparedness staff across the country, including significant investments in laboratory, medical countermeasures distribution, and epidemiological infrastructure.

Congress should increase overall funding for the Administration for Strategic Preparedness and Response (ASPR). Increasing ASPR's base budget would enable ASPR to expand its workforce and enable a more effective preparedness and response infrastructure at the agency. ASPR deploys response teams for a range of emergencies – from wildfires to overrun hospitals – but receives limited funding to both prepare and respond.

Congress and ASPR should strengthen the emergency readiness of the healthcare delivery system. Congress should increase its investment in Health Care Readiness and Response, administered by ASPR, which supports the preparedness of the healthcare delivery system for disasters. Severely eroded funding has created a patchwork of readiness, putting patient care at risk. ASPR should also support the Hospital Preparedness Program (HPP) by shoring up pediatric and surge capacity planning within the program.

Congress should create a Health Defense Operations budget designation to exempt health defense programs central to health security from the annual discretionary budget allocations and to ensure these critical activities receive the sustainable resources necessary to secure Americans' health, economic, and national security. The biodefense exemptions would include programs such as PHEP, HPP, the Strategic National Stockpile, and other critical programs. Budget caps and competing priorities in the nondefense discretionary budget category continue to constrain annual discretionary appropriations, making it nearly impossible to invest in medium- to long-term health defense.

Congress and HHS agencies should ensure efficient responses through crisis funding mechanisms. In addition to stable core funding, Congress should continue a no-year infusion of funds into the Public Health Emergency Rapid Response Fund and the Infectious Diseases Rapid Response Reserve Fund to serve as available funding that may provide a temporary bridge between preparedness and supplemental emergency funds. When supplemental funds are needed, Congress should provide flexibility for jurisdictions to use these funds for their most urgent response needs and for overlapping emergencies. CDC should also refine its mechanisms to distribute funding to states and localities more efficiently.

Congress and ASPR should invest in and coordinate medical countermeasures research, development, stockpiling, and distribution for a range of pathogens. Supporting the entire public health emergency medical countermeasures enterprise – from seed research to distribution – across HHS is needed to neutralize the risk of known and unknown health threats. Congress should provide additional funding for ASPR to address emerging infectious diseases, which remain a serious threat to human health. ASPR also needs additional contracting authorities, similar to those of the U.S. Department of Defense, to enable the agency to quickly procure supplies needed for public health security. ASPR should continue to ensure coordinated, aligned, and transparent medical countermeasures activities across HHS and other relevant agencies and with private sector, public health, and academic partners.

Congress should provide CDC, ASPR, and other HHS agencies additional direct hiring authority. Congress should help CDC and other HHS agencies be nimbler in response to emerging health threats or during public health emergencies by providing additional direct hiring authority during such emergencies. CDC and other relevant HHS agencies are vital to the nation's prevention and response of public health emergencies, yet they are subject to bureaucratic hiring procedures even during times of crisis. Congress should help these agencies become more responsive by providing additional direct hiring authority during emerging threats or public health emergencies. The limited direct hiring authorities included in the Consolidated Appropriations Act of 2023 were a good start, but not nearly sufficient for the level of staffing required for large-scale events like pandemics. In addition, the HHS secretary should issue guidance on how agencies can use existing hiring authorities.

Containment of Infectious Disease Outbreaks

Congress should enact legislation to ensure access to vaccines for uninsured and underinsured adults. Uninsured and underinsured adults still face barriers to vaccination. A recent study found that adult vaccines could return up to 19 times their initial investment in health and economic benefits.[94] Congress should enact legislation authorizing a permanent program to enable all uninsured and underinsured adults to have access to recommended vaccines at no cost.

Congress should support the National Immunization Program and outreach. Congress should provide significant increases for CDC's National Immunization Program to support immunization infrastructure, outbreak response, and vaccine delivery across the country. The Immunization Program supports state, local, and territorial immunization systems to increase vaccination rates among uninsured and underinsured adults and children and respond to outbreaks of vaccine-preventable diseases. However, the growing number of outbreaks and increasing costs of immunizations means states have less money to support these efforts. Increased funding would enable jurisdictions to better respond to outbreaks, educate the public, target populations experiencing worse outcomes, improve vaccine confidence, establish partnerships with trusted messengers, and operate data systems. Congress should also increase annual funding to study and address the causes of vaccine hesitance and improve communications and engagement.

Congress should enable next generation detection and forecasting of pathogens beyond funding cliffs. Thanks to one-time investments, CDC has created the nation's first Center for Forecasting and Outbreak Analytics, expanded wastewater surveillance, and accelerated the national infrastructure for genomic sequencing through the Advanced Molecular Detection Program. However, funding cliffs, which could begin in 2024, puts this progress at risk. Congress should fund these innovative methods for detecting and modeling outbreaks. Congress should also continue to invest in core disease detection capabilities through the Epidemiology and Laboratory Capacity program.

The White House and Congress should renew the nation's global health security commitment. Congress and the Executive Branch should demonstrate a long-term, sustainable commitment to global health security by implementing the goals laid out in the National Biodefense Strategy. The White House should continue to strengthen partnerships with international bodies such as the World Health Organization, including by finalizing the international pandemic treaty, and work with partner countries to strengthen core public health capabilities. Congress should solidify America's role as a global health leader by committing sufficient resources to CDC's Global Public Health Protection program.

Congress should take significant steps to address antimicrobial resistance (AMR). Drug-resistant infections kill at least 35,000 people in the U.S. each year,[95] and the misuse and overuse of antimicrobials in humans, animals, and plants are the primary drivers of this crisis.[96] At the same time, there is insufficient investment in new antimicrobials, as they are typically used for a short time and are not as profitable for developers as treatments for chronic conditions.[97,98] Public-private partnership in both antimicrobial development and stewardship is imperative. Congress should enact the Pioneering Antimicrobial Subscriptions to End Upsurging Resistance (PASTEUR) Act to drive sustainable antimicrobial innovation and provide resources to antimicrobial stewardship programs in hospitals and long-term care facilities. Congress should fund antimicrobial resistance activities across HHS, including CDC's antibiotic resistance initiative to detect and prevent cases.

Congress should pass the Protecting America from Seasonal and Pandemic Influenza Act to strengthen the pipeline of influenza vaccines, diagnostics, and therapeutics. The comprehensive authorizing bill would implement and build on the National Influenza Vaccine Modernization Strategy. The bill would take steps to speed up vaccine development, support immunization information systems, strengthen the supply chain for these products, and authorize sustainable funding for the federal influenza ecosystem.

Response to Health Risks from Environmental Hazards and Climate Change

Congress should support nationwide efforts to protect against environmental and climate-related health threats through CDC's National Center for Environmental Health (NCEH). NCEH safeguards the health of people across the country from environmental hazards such as lead poisoning, chemical exposures, and climate threats, but limited funding prevents lifesaving programs from reaching all states. Congress should provide sufficient funding for NCEH programs to reach all states, including to expand CDC's Climate and Health Program to improve climate readiness in all states and territories. Only nine states and two localities are current grantees of CDC's Climate and Health Program, which gives these communities assistance to implement the CDC Building Resilience Against Climate Effects (BRACE) framework. The BRACE framework can help jurisdictions identify likely climate-related health impacts and create and implement adaptation plans.

Congress should also increase funding to extend CDC's National Environmental Public Health Tracking Program to every state. The network helps states collect key data around environmental health threats and target interventions to save lives. The Tracking Network also partners with the Climate and Health Program and National Oceanic and Atmospheric Administration on the Heat and Health Tracker, a national resource that provides local heat and health information so communities can better prepare for and respond to extreme heat events.

Congress should expand the ability of the Agency for Toxic Substances and Disease Registry (ATSDR) to respond to emergencies. Congress should provide at least $100 million in funding for ATSDR in the near term. ATSDR's expertise and ability to respond around the clock have been critical in dealing with response from incidents like the East Palestine, Ohio train derailment, Canadian wildfire smoke, and contamination from per- and polyfluoroalkyl substances (PFAS). ATSDR expands the environmental health capacity in state health departments, allowing them to do critical work to identify if and how people are exposed to hazardous substances and take steps to prevent and address those exposures.

Congress and the Administration should bolster the Office of Climate Change and Health Equity. Congress and the Administration should provide appropriations for HHS's Office of Climate Change and Health Equity (OCCHE) to support its mission of serving as a government wide hub for climate and health resilience policy in pursuit of equitable health outcomes.

OCCHE coordinates and aligns agency-wide programs to develop climate and health resilience for populations that are disproportionately affected, climate actions to reduce health disparities, and health sector resilience and environmental harm reduction. To date, OCCHE has not received appropriations from Congress, creating challenges such as a lack of staffing stability and difficulty engaging in long-term planning.

Congress and the Administration should support interagency efforts to address the impact of extreme heat on health. The burden of extreme heat is not evenly distributed across populations; older adults, young children, pregnant people, individuals with chronic and mental health conditions, people with disabilities, people with low-incomes, people who work outdoors, people who are unhoused, and some communities of color face the most risk. Extreme heat can also be a significant contributor to severe maternal morbidity and is the leading cause of weather-related death in the U.S.[99] Congress should sustain funding for multiagency efforts to address health impacts of extreme heat, including the National Integrated Heat Health Information System.

The White House, EPA, and federal partners should take steps to improve indoor and outdoor air quality. Poor indoor air quality is a significant environmental health risk, exacerbated during emergencies like wildfires and extreme heat events,[100] and drives the spread of transmission of many infectious diseases.[101] Yet, healthy indoor air quality is not well defined and is largely unregulated.[102] The Environmental Protection Agency (EPA), in collaboration with CDC, National Institute for Occupational Safety and Health (NIOSH) and other relevant federal agencies, should establish guidelines for indoor air quality in public buildings and schools and provide incentives for retrofitting existing buildings. The Administration should also protect, enforce, and strengthen the Clean Air Act, in particular the National Ambient Air Quality Standards (NAAQS) which place national limits on pollutants such as particulate matter (soot) and ozone (smog). EPA should protect particulate matter standards from legal challenges and continue to build on this progress to protect public health.

The Administration and Congress should protect and strengthen the Clean Water Rule to safeguard clean water for all U.S. residents. The rule includes measures to ensure a safe water supply, such as addressing the ongoing problem of lead, per- and polyfluoroalkyl substances, and algal toxins in drinking water; taking steps to reduce the potential for waterborne illnesses; and increasing protection against potential acts of terrorism on America's drinking and agricultural water systems.

PRIORITY 3: Promote the Health and Well-being of Individuals, Families, and Communities Across the Lifespan.

While public health innovations have increased United States life expectancy in recent decades[103] and over the past century, there was an alarming decline in U.S. life expectancy in 2020 and 2021 (primarily due to the COVID-19 pandemic and other drivers, including drug overdose deaths). Life expectancy rebounded slightly in 2022 but still has not reached pre-pandemic levels.[104] The U.S. has the lowest life expectancy at birth and the highest death rates for avoidable or treatable conditions as compared with other high-income nations.[105]

Americans experience the highest maternal and infant mortality rates among all high-income countries.

THE PROBLEM

Life expectancy across the U.S. declined in 2020 and 2021 and varies by race, ethnicity, socioeconomic status, and geography.[121] Yet, while spending in the U.S. treating illness and injury continues to skyrocket, spending on public health and prevention is less than 5 percent of the total $4.5 trillion spent annually on healthcare.[122] On average, the community conditions of where a person lives in the U.S. impacts how healthy they can be and how long they will live.

THE SOLUTION

Promoting good health across the lifespan requires leveraging public health resources and expertise and improving coordination between public health, healthcare, social services, and other sectors. Government at all levels should partner with community-based organizations and community leaders to focus resources and tailor programs on reducing health risk factors across all age groups. Focusing efforts on those populations that disproportionately experience barriers to optimal health is an additional key to improving the nation's health.

Additionally, Americans experience the highest maternal and infant mortality and the highest rates of people with chronic health conditions of any high-income nation.[106] Approximately 90 percent of the $4.5 trillion spent in the U.S. on healthcare are expenditures related to chronic or mental health conditions.[107] There are also persistent disparities in disease and mortality rates by age,[108] race,[109] income,[110] geography,[111] and other factors often caused by structural disadvantages that create health disparities. Even groups previously less affected are at risk of earlier death, such as younger adults facing diet-related cancer diagnoses,[112] overdoses, and suicides.[113]

Americans are facing health struggles across the lifespan. Families, especially those with infants and young children, increasingly struggle to obtain and maintain economic stability and good health due to structural factors.[114] Access to nutritious foods and physical activity remain a hallmark of chronic disease prevention, but food insecurity affects all ages within the lifespan, especially families with children. Lower income areas and areas with more Black residents have fewer grocery stores, less healthy food access, and fewer opportunities for safe physical activity.[115,116] Children and adolescents increasingly face mental health challenges due to such factors as ongoing issues related to their home and school environments,[117] and the impact of social media.[118] Older adults face a lack of services and investments in their health, especially in rural areas.[119]

Collectively, these trends highlight the need for health promoting interventions and policies across the lifespan and within specific populations, particularly for groups at heightened risk due to the intersection of risks. For example, an older adult who lives in an urban heat island or with limited access to transportation faces compounding barriers to health. In addition, substance misuse and mental health challenges are persistent in every community and are complicated by the growing number of Americans experiencing loneliness and social isolation and a sense of hopelessness.[120]

Expanding access to effective preventive and public health services and programs.

Healthcare coverage and access are key components to improving the public's health, improving health outcomes, and preventing health conditions from worsening. However, access is inconsistent across ages, regions, and populations. Many uninsured people are non-elderly adults who have at least one full-time worker in the family, with higher uninsured rates in the South and West.[123] Ten states have not yet expanded Medicaid to individuals earning up to 138 percent of the poverty level.[124] Medicaid expansion is linked to reductions in mortality and improvement in mental and overall self-reported health. In addition, data shows that Medicaid expansion has several economic benefits for states and communities including job creation, particularly in the healthcare sector, which often stimulates growth in other parts of the economy.[125] A third benefit is reduced uncompensated care costs for hospitals and thus strengthened financial stability for those facilities, especially in rural communities.[126] Pandemic-era coverage policies helped drive the number of uninsured Americans to record lows in 2022, but these policies ended in 2023.[127] Millions of children and adults—disproportionately people of color[128] —were disenrolled from Medicaid after becoming eligible for services during the COVID-19 public health emergency.

Access to healthcare is one key to improving U.S. maternal health.

Relatedly, access to preventive healthcare services, such as diabetes, cancer, and depression screenings and vaccines, is an important factor to save lives and improve health. Eliminating cost-sharing for high-quality preventive care, as required by current law, has led to increases in utilization of these critical services, as even modest cost-sharing deters patients from receiving care.[129] Yet, a current legal challenge (*Braidwood Management v. Becerra*) could eliminate for millions of Americans the availability of recommended preventive services at no-cost to patients.[130] Eliminating this requirement would be dangerous, potentially leading to delayed diagnoses and life-saving care for cancer, cardiovascular disease, hepatitis B, and other conditions.[131]

Protecting people against health risks requires expanding effective prevention programs to reach more communities and individuals. Positively, behavioral health initiatives have received substantial federal support for state and local efforts to address infrastructure development for substance use disorder and related individual-level crises.[132] Yet, there are still gaps in coordination and access to other services, including workforce shortages and program participation. For example, the 988 Suicide and Crisis Lifeline, a vital resource to address the nation's mental health and substance use crises, is not permanently funded by all states.[133] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides additional support for nutritious food during pregnancy and early years of development, but only about half of eligible mothers participate.[134] SNAP plays a critical role in reducing food insecurity and poverty, especially among households with children and older adults, but policy proposals being considered in Congress could create additional barriers to the resource.[135] Programs that promote positive school environments and prevent negative mental health outcomes, such as through the CDC Division of Adolescent School Health, need additional support to reach more schools. Preventing and mitigating the effects of adverse childhood experiences (ACEs) (including experiencing and exposure to violence) can drastically improve health, but CDC efforts in this space lack funding to reach students nationwide.[136]

PROGRESS MILESTONES

- The first White House Conference on Hunger, Nutrition, and Health in over 50 years was held, accompanied by a National Strategy aimed at spurring federal and private sector action on reducing diet-related diseases and addressing nutrition insecurity.[137]
- HHS hosted its first-ever Food is Medicine Summit, launched three new public-private partnerships, and released five Food is Medicine principles that will guide the department's work on educating the public, changing public policies, and integrating nutrition in the services it provides as part of a broader effort to reduce diet-related diseases in the U.S.[138]
- In 2021, the U.S. Department of Agriculture (USDA) supported states to provide Healthy School Meals for All in schools nationwide, ensuring millions of children had access to free nutritious meals. After the COVID-19 public health emergency, eight states enacted their own policies: California, Colorado, Maine, Massachusetts, Michigan, Minnesota, New Mexico, and Vermont.[139]
- USDA released an update to school meal nutrition standards to strengthen child nutrition, including new limits on added sugars and sodium.[140]
- USDA released updates to the WIC benefit food packages to further promote positive maternal and child health outcomes. Important updates included codifying higher benefit levels for participants to purchase fruits and vegetables, in addition to offering more culturally appropriate food options in the benefit.[141]
- FDA issued voluntary guidance in 2021 to the food industry on sodium-reduction targets by 2024. The goal is a gradual reduction of sodium in commercial recipes and production. An evaluation of the first two years showed promising decreases in sodium levels, particularly in the combined packaged and restaurant food categories.[142] In August 2024, FDA issued draft guidance on the second phase of voluntary sodium-reduction targets, which builds on the initial targets.[143]
- FDA conducted a study to inform a proposed rule to help consumers more easily identify healthy foods by standardizing a front of package labeling system for food packages.
- In 2022, Congress passed the Bipartisan Safer Communities Act, which included significant funding for mental health and suicide-prevention services, including pediatric mental health, first responder mental health, community-based mental health services, and school-based training and services.[144]
- In 2022, the country transitioned the National Suicide Prevention Lifeline to the 988 Suicide and Crisis Lifeline, with increases in calls and texts from 2022 to 2023 and specialized services for the LGBTQ+ population, people with disabilities, and non-English speakers. Since the launch of 988, counselors have answered more than 10 million calls, texts, and chats.[145]
- With the support and direction of Congress, CDC established a new Behavioral Health Coordinating Unit to align and amplify the agency's mental health, well-being, substance use, and overdose activities.
- In 2022, the White House announced a *Blueprint for Addressing the Maternal Health Crisis* a whole-of-government approach to address maternal mortality and morbidity.[146] After two years of work the Administration announced several progress milestones including the first ever baseline health and safety requirements for maternal emergency and obstetric care in hospitals and the extension of Medicaid coverage for new mothers of infants from 2 to 12 months.[147] In addition, the HHS Office on Women's Health launched a national campaign to raise awareness regarding postpartum depression, highlight reliable resources, and share information on opportunities to access care.
- The U.S. Surgeon General released a new Surgeon General Advisory titled *Our Epidemic of Isolation and Loneliness*, calling attention to the public health crisis of loneliness and lack of social connection as well as the importance of reducing social isolation across the lifespan.[148]
- The Older Americans Act reauthorization of 2020 led to the establishment of the Interagency Coordinating Committee on Healthy Aging and Age-Friendly Communities (ICC), a collaboration of 16 federal agencies and led by the Administration for Community Living. The ICC received its first funding from Congress in FY 2023.[149] In 2024, the ICC released a report to Congress, *Aging in the United States: A Strategic Framework for a National Plan on Aging*.[150]
- Recognizing the growth of the U.S. older adult population, *Healthy People 2030* includes new goals specific to older adults, including those related to physical activity and nutrition, preventable hospitalizations, and dementia diagnoses.[151]
- In 2020, the CDC announced the creation of the new Healthy Aging Branch within the Division of Population Health to better coordinate CDC programs on chronic disease management, mental health, brain health, emergency preparedness for older adults, COVID-19 guidance, and caregiver supports.

IMPACT STORIES

Vaccines for Children Program – 30 Years of Protecting Children from Diseases

The Vaccines for Children program was established by Congress in 1994. The program provides recommended childhood vaccines against 19 diseases at no cost to eligible children. Eligible children include those who are Medicaid-eligible, uninsured, underinsured or of American Indian or Alaska Native descent. The program helped prevent about 508 million illnesses and approximately 32 million hospitalizations in children born between 1994 and 2023. It saved an estimated 1.1 million lives during that time.[152]

Washington State and Tribes Partner to Better Meet the Needs of Tribal Elders

TFAH's Age-Friendly Public Health Systems (AFPHS) initiative includes engagement with the Northwest Washington Indian Health Board (NWWIHB), a consortium of six federally recognized tribes in Washington state. Through a partnership with the Washington State Department of Health, TFAH has worked with the NWWIHB to build resources and supports for tribal elders in the six tribes that are working within the AFPHS 6Cs Framework. The 6Cs Framework provides goals and tactics for ways that public health agencies can understand and support the needs of older adults. For example, the NWWIHB created a website to share information on healthy aging with tribal elders and their families, primarily focused on risk and protective factors for Alzheimer's Disease, which is prevalent among Native American elders. Through this project, the NWWIHB also conducted surveys of three of the tribes to assess and address the needs of tribal elders on education levels, housing (including major and minor repairs that are needed), insurance coverage, social services, and any hardships associated with aging. One tribal survey showed that over 86 percent of homes needed at least minor repairs. The surveys will allow the NWWIHB and the tribes it represents to have a more concrete picture of the challenges facing tribal elders and where additional funds and resources should be targeted.

CDC Grants to States Provide Support for Prevention Programs

CDC's Injury Center provides funding to states for programs to support overdose prevention programs through its Overdose Data to Action (OD2A) cooperative agreement. Arizona and Indiana are two of many states receiving such funding. With this funding, Arizona has increased surveillance activities to grow and strengthen ACEs prevention programs, supported overdose prevention programs, including naloxone distribution and use education, supported the expansion of comprehensive opioid management programs at Critical Access Hospitals, and has invested in tailored, community-led overdose prevention programs.[153] Palm Beach County, Florida, uses OD2A supported data infrastructure to understand where the overdose crisis is happening and how to prevent it in high priority areas. Palm Beach is advancing youth substance use prevention and partnering with public safety and first responders to connect people at risk of overdose to care and treatment.

WIC Gives Children a Healthy Start

2024 marked the 50th anniversary of the WIC program. WIC assures healthy pregnancies, birth outcomes, and child development through nutrition programs, breastfeeding support, education on healthy eating, and referrals to healthcare and social services. Because it is such an important source of prenatal support, it is estimated that every $1 invested in WIC saves about $2.48 in medical, educational, and productivity costs.[154] The 2024 updates to the WIC food packages, including increased fruit and vegetable benefits, will further expand the health advantages of the program. The program's breastfeeding support services have had a significant impact. For example, a 2024 study examining the Minnesota WIC's breastfeeding peer-counselor program found that it was effective in increasing the proportion of WIC participants breastfeeding at three and six months, with the strongest impacts in rural communities.[155] Nationwide, 70 percent of infant WIC participants were breastfed after birth in 2022, up from 57 percent in 2004.[156]

RECOMMENDATIONS

Congress should increase funding to CDC's National Center for Chronic Disease Prevention and Health Promotion to provide adequate resources to all eligible states or communities, including states that already have high rates of chronic disease. Within the Center, Congress should provide at least $130 million in funding in FY 2025 to the Division of Nutrition, Physical Activity, and Obesity to allow effective prevention programs to reach all 50 states, U.S. territories, and tribal communities. Increased funding would also enable additional chronic disease data collection and strategies for specific communities.

Congress should expand access to the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for young children up to age 6 and women up to two years postpartum. Congress should also enhance the nutritional quality in WIC through increased fruit and vegetables benefits and increase the overall value of benefits.

Congress should enhance benefits in and protect access to the Supplemental Nutrition Assistance Program (SNAP). Within the Farm bill, Congress should protect the update to the Thrifty Food Plan, which increased pre-COVID-19 pandemic SNAP benefits by 21 percent, and continuously review the effectiveness of the benefit level. The Administration and Congress should also reject any legislative or regulatory efforts that would effectively limit SNAP eligibility, reduce the value of benefits, or create any other barriers to participating, such as imposing additional work requirements or time limits or eliminating broad-based categorical eligibility.

Congress should make healthy school meals for all permanent as a step to end child hunger and ensure access to healthy foods. Congress should also increase funding for outreach to ensure children and families eligible for school meals and Summer Electronic Benefit Transfer (EBT), referred to as SUN Bucks, are enrolled.

FDA should create a mandatory front-of package label for packaged foods to help consumers make informed choices. The U.S. Food and Drug Administration (FDA) should swiftly move forward in implementing a mandatory front-of-package nutrition label system for packaged foods, a key recommendation from the White House National Strategy on Hunger, Nutrition, and Health. Front-of-package labels have been proven to help consumers make better choices by putting simplified, essential nutrition information on the front of packaged food products.

Congress and the Administration should support community physical activity needs through Complete Streets principles, including by funding active transportation for biking, sidewalks, and recreational trails that are safe and accessible for all age groups and people with disabilities. State adoption of active transportation principles should be a condition for receipt of federal funding for major transportation projects.

Should federal courts overturn part or all of the Affordable Care Act's preventive services requirements, Congress should act quickly to restore coverage of such services without cost sharing. A court ruling could disrupt access to life-saving preventive services, such as vaccines and cancer screenings, to millions of Americans.

Congress, the Administration, and state lawmakers should continue to expand access to and improve the affordability of health insurance. Doing so includes extending marketplace subsidies that are set to expire after 2025 and supporting incentives for the expansion of Medicaid in remaining states, which have disproportionately high numbers of people of color and families with low incomes.

Congress should create a national standard requiring employers to provide job-protected paid sick, family, and medical leave for all employees, including for the birth or adoption of a child, taking care of a sick family member, or staying home when sick themselves. Paid sick leave has public health benefits such as reducing the risk of spreading infections among employees and customers, while paid family leave is proven to improve maternal and child health.[157,158] These policies can also reduce costs for employers and improve productivity and worker retention.[159]

Congress should pass the Black Maternal Health Momnibus Act, comprehensive legislation to address the nation's maternal mortality and morbidity crisis. The bill comprises 13 individual bills that include support for maternal mental health, perinatal services, and research.[160] Congress should also continue to grow investments in programs included in the bill that address safe motherhood and improved birth outcomes.[161]

The Administration should swiftly finalize the FDA's proposed rules to prohibit menthol in cigarettes and flavors in cigars. Smoking remains the leading cause of preventable disease and death in the United States.[162]

Research estimates that prohibiting menthol cigarettes would prevent 654,000 smoking attributable deaths, including 255,000 deaths in the Black/African American population, by the year 2060.[163] In addition, eliminating flavored cigars will likely deter young people overall, especially young Black people, from smoking by diminishing cigars' appeal and palatability, which will reduce the number of new smokers.[164]

Congress and HHS should address Adverse Childhood Experiences (ACEs) by passing the Preventing Adverse Childhood Experiences Act and increasing investment in CDC ACEs program, which disseminates evidence-based strategies to prevent ACEs, promote positive childhood experiences and mitigate the impact of trauma and community violence. The Preventing Adverse Childhood Experiences Act would support critical efforts at CDC through grants for data-driven, evidence-based strategies, as well as new research on the impact of ACEs.

Congress and HHS should increase support for mental health and resiliency programs in schools through the CDC Division of Adolescent and School Health (DASH). The DASH program works to promote schools where youth can gain fundamental health knowledge and skills, connect to health services, and learn in safe and supportive environments. At least $100 million in annual appropriations would extend DASH to roughly 25 percent of all students in all states, the District of Columbia, Puerto Rico, tribal communities, and territories. Additionally, schools need support from SAMHSA for training and programs to promote connection and provide culturally and linguistically appropriate mental health services and screenings, such as those proposed in the Mental Health Services for Students Act.

Congress should fund the nationwide implementation of CDC's Comprehensive Suicide Prevention Program and the continuum of crisis care. An estimated $80 million in funding would enable CDC to expand prevention activities in all 50 states, including tribal communities, the District of Columbia and U.S. territories. Passage of the Kid PROOF Act would also assist parents with tools to limit access to lethal means of suicide, and increased funding for foundational research into lethal means could help identify populations at risk of suicide and evaluate new interventions. Additional investments should bolster the continuum of crisis intervention programs and supports through SAMHSA, including by investing in improvements to the 988 Suicide & Crisis Lifeline, mobile crisis units, and expanded support for post-crisis care.

Congress should increase support for prevention and early intervention services for youth and families by passing legislation such as the Helping Kids Cope Act or the Strengthen Kids' Mental Health Act to expand the pediatric behavioral health workforce and raise Medicaid reimbursement rates for related services. In addition, Congress should set aside funds for upstream prevention approaches in SAMHSA's Community Mental Health Services Block Grant through legislation such as the EARLY Minds Act.

Congress and the Administration should fund CDC to strengthen its internal capacity for healthy aging efforts and its ability to support and sustain age-friendly public health systems in state, local, tribal, and territorial health departments. Enacting and funding the Protecting the Health of America's Older Adults Act would build on existing healthy aging work at CDC. Expanding CDC's healthy aging funding would enable CDC to further develop an age-friendly public health systems approach, focusing on multi-sector collaboration and partnerships with other health and aging services sectors. These efforts are especially needed in rural and frontier settings and areas primarily serving communities of color that have received fewer or disjointed supports due to historic underinvestment.

Congress should bolster programs that support the health of older adults and caregivers, such as by passing the Older Americans Act and funding National Family Caregiver Support programs, CDC falls prevention programs, and healthy brain programs to address dementia.

Congress and the Administration should support a national strategy for increasing social connectedness to reduce the effects of social isolation and loneliness across the lifespan. This effort would involve developing and sufficiently funding a research task force focused on building out evidence-based strategies to address social isolation in key populations. Activities should include collecting quality data from individuals experiencing disadvantage to better understand trends in social isolation and inform potential strategies within and across specific communities.

PRIORITY 4: Advance Health Equity by Addressing Structural Discrimination.

Structural discrimination is a form of discrimination that limits resources, power, and opportunity for individuals and populations based on social or physical characteristics or other statuses, e.g. race/ethnicity, gender, sexual orientation, gender identity, socioeconomic status, disability, immigration status, geography, etc.[165] Health equity is achieved when everyone can reach optimal health without any one person or population having greater advantage or increased burden based on social characteristics or status.

Evidence supports that health inequities are largely driven by structural discrimination, especially structural racism.[166,167] Structural discrimination shapes the social and physical environments in which people are born, live, grow, work, and age. For example, structural racism in housing, such as redlining, created historical and contemporary barriers to accessing capital for homebuying based on the race of the applicant and the racial composition of the neighborhood. The practice of redlining and other real estate practices created segregated communities resulting in reduced community and economic development, as well as underinvestment in quality, affordable, and safe housing, transportation, education, healthcare, and parks and recreation/greenspace, all of which impact health.

THE PROBLEM

Structural discrimination and the resultant systemic inequities have been perpetuated through the policies, norms, and practices in the United States for hundreds of years. Because of these long-standing and ongoing inequities, disparities in health and well-being have been persistent, resulting in increased risk of poor health and higher rates of deaths from illness and injury among populations that have been disadvantaged.[168]

THE SOLUTION

Achieving health equity requires an intentional focus on ending structural discrimination and taking specific actions to drive systemic change. Given the structural drivers — economic, social and systemic factors — a multi-agency, multi-sector, coordinated response is necessary to eradicate health inequity and disparities. Concerted leadership and action from the Administration and Congress to address the allocation of resources and to transform policies to advance health equity is needed.

Another example of structural discrimination is geographic discrimination, whereby access to and support for resources vary based on geographic boundaries. Most notably in the U.S. is the differential access to resources along rural versus urban geographies. Rural communities across the U.S. are characterized as having high land area with low population density. The most recent Census shows that while rural areas comprise 72 percent of the U.S. land area, only 14 percent of the U.S. population live in rural areas.[169] The vast amount of land and fewer residents have resulted in a serious underinvestment in public health and in indicators that drive health outcomes such as access to quality healthcare, transportation infrastructure, education and economic development.

Similarly, underinvestment in tribal areas has contributed both to chronic health disparities in American Indian/Alaska Native populations and in inadequate public health infrastructure in Tribal Nations.[170] Chronic underfunding and unmet needs in Indian Country were highlighted in a 2018 report of the U.S. Commission on Civil Rights, noting the Trust and Treaty obligations the U.S. government has to federally recognized tribes and the special government-to-government relationship between federal and tribal governments. This trust relationship "obligates the federal government to promote tribal self-government, support the general wellbeing of Native American tribes and villages, and to protect their lands and resources."[171]

Ensuring that all communities have the opportunity for optimal health is a central goal of the public health ecosystem.

Structural discrimination results in reduced aggregate life expectancies for population groups who are systemically marginalized when compared with their non-marginalized counterparts (e.g. those who are white, do not have a disability, cis-gendered, live in urban areas). This is exacerbated when examined through an intersectional lens (e.g. persons who are Black, have a disability, and are LGBTQ+)[172]. The regular occurrences of prejudice, violence, and microaggressions, paired with systemic discrimination, result in trauma, chronic stress, poor mental and physical health, and chronic conditions such as high blood pressure and other forms of cardiovascular disease. This is compounded by community and environmental resource deficits such as a lack of access to nutritious foods, sidewalks and bike paths, quality healthcare and behavioral health services, and central air or other cooling systems to contend with extreme heat.

In addition to the community and individual toll, structural discrimination has an economic toll. It is estimated that the overall economic burden of racial and ethnic health inequities was $1.03 trillion in 2018.[173] The economic burden is mostly driven by premature death but is also due to lost labor market productivity and excess medical cost. When examining healthcare spending alone, health inequities result in nearly $320 billion annually and could reach $1 trillion by 2040.[174]

The insidious and historical nature of structural discrimination and health inequities means there is no panacea to instantly cure the problem. It will take the work of governmental and non-governmental entities to address the discriminatory ills of the county. An important place to start is by ensuring that collected health data is specific and comprehensive enough to detect health inequities. Being able to disaggregate data by population groups and geography is vital to attaining an accurate picture of a community's true health status and needs.[175]

While health equity concepts are foundational to all TFAH's policy recommendations, recommendations in this report chapter highlight programs and policies specifically designed to reduce health disparities.

PROGRESS MILESTONES

- The Office of Management and Budget (OMB) revised the federal standards for maintaining, collecting, and presenting data on race and ethnicity to include updated race and ethnicity categories and to require the collection of additional detail beyond the minimum categories to ensure further disaggregation.[176]

- Several Executive Orders (EO) have been issued to advance equity through federal agency action:

  - EO 13985 Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,[177] which directed federal agencies to advance equity and equal opportunity, including assessing federal programs through an equity lens. This was followed by EO 14091, Further Advancing Racial Equity and Support for Underserved Communities Through the Federal Government,[178] which established Agency Equity Teams across the federal government and directed OMB and federal agencies to incorporate equity into policies and practices.

  - EO 14031 Advancing Equity, Justice, and Opportunity for Asian Americans, Native Hawaiians, and Pacific Islanders, which created a President's Advisory Commission within HHS.[179]

  - EO 14112 Reforming Federal Funding and Support for Tribal Nations to Better Embrace Our Trust Responsibilities and Promote the Next Era of Tribal Self-Determination, which seeks to identify and mitigate barriers to federal funding and program support for Tribal Nations.[180]

- All federal agencies have developed Equity Action Plans, which seek to address potential barriers underserved communities may face in accessing agency funding, policies, and programs. For example, the USDA plan included outreach and modernization to increase access to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and to school meals, including in rural school districts.[181]

- CDC launched its first agency-wide health equity strategy in 2021, to make equity foundational to its work and workforce. CDC programs are updating the agency's funding opportunities to embed health equity in every notice.

- In 2023, CDC established the Office of Rural Health with a directive from Congress to work across the agency to coordinate and improve rural public health efforts.[182] CDC released a Rural Public Health Strategic Plan in 2024 to advance rural public health science, infrastructure and workforce, and practices over the next five years.[183]

- The Racial and Ethnic Approaches to Community Health (REACH) program marked its 25th anniversary in 2024, and its community partners have demonstrated success in reducing rates of obesity, increasing fruit and vegetable consumption, and reducing exposure to tobacco.[184]

IMPACT STORIES

Partnering for Vaccine Equity

The early rollout of COVID-19 vaccines was marked by disparities, with some racial and ethnic groups less likely to have access to or have confidence in the vaccine compared with non-Hispanic white people.[185] With emergency funding from Congress, CDC launched the Partnering for Vaccine Equity program, which supported partner networks to improve vaccine access and increase vaccine confidence and uptake in communities experiencing disparities in immunizations.[186] The program helped 325,000 trusted messengers conduct community outreach, engaged 550,000 clinicians, and supported 255 educational campaigns in 45 languages, leading to 2.3 million COVID-19 and flu vaccines administered.[187] Congressional rescission of funds for vaccine equity, however, may threaten the ability of these networks to continue, despite ongoing disparities in accessing routine immunizations.

Ensuring vaccine access and confidence is critical to limiting the spread of infectious diseases.

Local Solutions to Health Disparities through CDC's Racial and Ethnic Approaches to Community Health (REACH) program

Through REACH (2023-2028), CDC funds 50 organizations in 32 states and the District of Columbia to carry out proven strategies to improve health, prevent chronic diseases, and reduce health disparities among racial and ethnic populations with the highest risk, or burden, of chronic disease. Local, culturally appropriate strategies include promoting food service and nutrition guidelines, expanding produce prescription programs, increasing safe and accessible physical activity through community design, and implementing policies that achieve continuity of care for breastfeeding support. For example, the YMCA of Coastal Georgia REACH program, in partnership with Healthy Savannah, supports access to safe physical activity, healthy food, and breastfeeding support in communities experiencing high rates of chronic disease and food insecurity.[188] Activities include mobile farmers' markets to increase healthy food access, coordinating with faith organizations and government partners to develop an urban trail network to boost physical activity, and supporting education and continuity of care for breastfeeding to give infants a healthy start.

RECOMMENDATIONS

Federal agencies should regularly update and report progress on agency equity plans, ensuring metrics are inclusive of and extend beyond tracking disparities. The Administration should continue to update departmental equity action plans and report on their progress toward successful implementation and impact on equity. Reporting should show progress on measurable advances toward equity that are more than reporting data or updates on disparities. Equity based metrics that track process and outcomes, as well as awareness, understanding and reach of program information are essential to demonstrating progress. Tools such as MITRE's Framework for Assessing Equity in Federal Programs and Policies offers the Administration guidance on how to establish multi-level equity goals.[189] In some instances, measures may exist in other agency documents or plans and thus should be incorporated into the agency equity plans. To ensure accountability of federal policies and programs in achieving equity, an evaluation report should be issued annually on the progress to Congress and the public.

Congress and the Administration should ensure accurate and complete data collection to report health-related information by race/ethnicity, age, sex, disability, language, sexual orientation, gender identity, and geography. Congress should provide adequate funding for agencies to implement the updated, revised Statistical Policy Directive No. 15: Standards on Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. The Administration should require universal adoption of the updated standards among all government agencies and any entities that collect data that support or interface with federal programs and/or receive federal funding. Additionally, the Administration should expand on the updated data collection standards to ensure that accurate and detailed demographic data on age, sex, sexual orientation, gender identity, disability, language, and geography are standardized to reflect the broad identities of the nation, which will allow for equity analyses of federal programs.

Congress should enact, fund and build on the Health Equity and Accountability Act (HEAA) and similar legislation to improve healthcare access and to reduce disparities among communities of color and other populations that are disproportionately impacted by health risks. The legislation includes 10 titles that cover a range of provisions aimed at improving health outcomes, boosting health workforce diversity, ensuring culturally and linguistically appropriate care, and advancing disaggregated health data collection and reporting.

Congress should increase funding for existing, effective programs that address health disparities such as CDC's Racial and Ethnic Approaches to Community Health (REACH) program and the Healthy Tribes program. REACH grantees work to decrease rates of smoking, reduce obesity, and improve healthy behaviors within specific racial and ethnic groups in communities with high incidence rates for chronic diseases. The programs within Healthy Tribes provide tribal organizations with resources, technical assistance, and evidence-based policies so that each grantee can then develop its public

health infrastructure and epidemiology capacity and create chronic disease prevention programs that center tribal history, traditions, and beliefs.

Federal health agencies should focus funding on populations at elevated risk for chronic disease and poor health outcomes due to the impact of structural discrimination and disinvestment. Communities disadvantaged by systemic discrimination, including those living with health disparities as part of systemic marginalization, must receive appropriate funding and investment to support their ability to improve health outcomes. Federal health agencies should consider factors such as disease burden when determining grant-making eligibility criteria and enable capacity-building funding so the communities with the greatest need can access and benefit from competitive grants. Congress and federal agencies should ensure funding is reaching communities that are under-resourced, marginalized, and disproportionately impacted.

Congress should appropriately and adequately fund and resource agencies with the expressed role of addressing health disparities and advancing health equity. The HHS Office of Minority Health, the National Institute on Minority Health and Health Disparities, and each agency office of minority health and health equity, (Agency for Healthcare Research and Quality Office of Extramural Research, Education and Priority Populations, CDC Office of Health Equity, Centers for Medicare & Medicaid Services Office of Minority Health, Food and Drug Administration Office of Minority Health and Health Equity, Health Resources and Services Administration Office of Health Equity, and Substance Abuse and Mental Health Services Office of Behavioral Health Equity) must have the authorities, budget, and resources comparable to other offices, institutes, and centers within the respective agency and/or aligned to the statutory mandate of that office or institute.

The Administration and Congress should respect and honor the sovereignty of Tribal Nations by rectifying the funding shortfalls to support programs identified as a result of Executive Order 14112 — Reforming Federal Funding and Support for Tribal Nations to Better Embrace the Country's Trust Responsibilities and Promote the Next Era of Tribal Self-Determination. The executive order starts the process of fully respecting the sovereignty of Tribal Nations and their right to self-determination by removing barriers to federal funding and reporting that currently prevent full, equitable, and adequate support for tribal related programs.

PRIORITY 5: Address the Non-Medical Drivers of Health to Improve the Nation's Health Outcomes.

Whether referred to as social determinants of health (SDOH) or non-medical drivers of health, these terms refer to non-medical factors influencing individuals' health and well-being, including the conditions in the environments where people are born, grow, work, live, and age.[190] For example, economic disadvantage often creates nutrition insecurity, which in turn raises the risk of chronic diseases such as hypertension and diabetes.[191] Unstable housing negatively affects physical and mental health and makes it more difficult to access healthcare.[192] Such adverse conditions contribute to excess healthcare costs[193] and decreased life expectancy and contribute significantly to health disparities.[194] Primary prevention of diseases, injuries, and health inequities requires addressing the upstream drivers that contribute to poor health. For these reasons, *Healthy People 2030* has an increased focus on addressing these conditions as a means to improving population health and eliminating health disparities.[195]

During the COVID-19 public health emergency, elected officials and agency leaders at all levels of government observed the longstanding connections between health outcomes and housing instability,[196] unstable employment and income, and food access.[197,198] The policy responses to the COVID-19 pandemic – intended to bolster economic security during disruptions in employment and education – provide real-world evidence of the positive health impacts of addressing non-medical drivers of health. For example, expansion of the Child Tax Credit in 2021, which temporarily reduced child poverty by a staggering 46 percent,[199] also resulted in improved parental mental health[200] and reduced food insufficiency.[201,202] Leadership of the U.S. Department of Health and Human Services of both political parties have identified social determinants as a driver of the nation's poor health outcomes and high healthcare costs.[203,204]

THE PROBLEM

A growing recognition that non-medical factors are a significant contributor to much of the nation's poor health outcomes has not yet been matched by policy action and sustained program investment. The nation's health and economic security depends on moving further upstream to prevent disease and reduce health disparities.

THE SOLUTION

The public health sector must be intentionally incorporated into the planning and execution of health-related initiatives to better align disparate systems and approaches to improve population health. Additionally, community members and those with lived experiences must be full partners in creating, designing, and implementing initiatives to address pressing health challenges. Policymakers should also extend policies proven to alleviate poverty and other non-medical drivers of poor health.

Public health and healthcare each have important, complementary roles to play in addressing both SDOH and health-related social needs (HRSN). To attend to immediate, individual-level needs, healthcare systems and payers are increasingly screening patients for HRSN, such as housing and food security, referring patients for services, and in some cases, paying for those services.[205] Private and public payers are both recognizing the promise of such interventions, including a return on investment. The Centers for Medicare and Medicaid Services (CMS) is offering mechanisms and guidance for states to pay for health enabling services such as housing and nutrition supports through Medicaid managed care, Section 1115 demonstration waivers, Home and Community Based Services authorities,[206] and Children's Health Insurance Program (CHIP) mechanisms.

SOCIAL DETERMINANTS OF HEALTH AND HEALTH-RELATED SOCIAL NEEDS

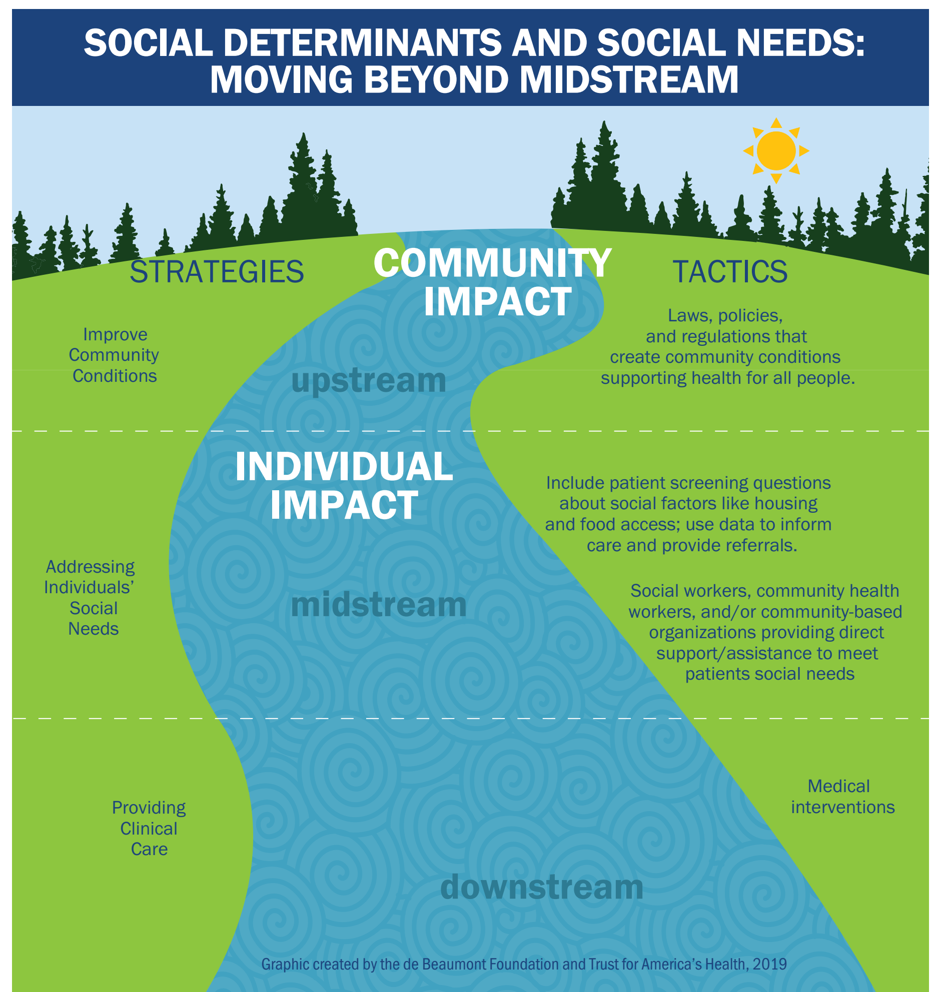
The terms "social determinants of health" and "health-related social needs" are sometimes used interchangeably, but they have different meanings and implications.

Social Determinants of Health (SDOH)/Non-Medical Drivers of Health (NMDOH) refer to the conditions in which people are born, live, learn, work, and age that impact their health and well-being.[207,208] SDOH may impact an entire group, population, or community, such as the built environment, economic stability, education access, and polluted air and water. Addressing SDOH requires systemic, multisector approaches.

Health-Related Social Needs (HRSN) indicates an individual's unmet adverse social, economic, or other non-medical needs that affect that individual's health. These requirements may include food security, housing stability, or access to reliable transportation.[209] Assistance for meeting these individual needs does not address the underlying economic or social conditions that lead to social needs.

However, there are obstacles to addressing HRSN through healthcare alone. First, interoperability limitations hinder coordination between healthcare, public health, and social services data systems, making it more difficult to screen and refer patients for services. Greater interoperability and incorporation of SDOH data in electronic health records could improve patient referrals to social services.[210] Second, a patient may be referred for services that are not available in a community, such as in areas with lack of affordable housing (a social determinant of health). These challenges highlight the need for multisector approaches.

Public health is poised to expand its efforts to move upstream, but siloed, disease-specific funding prevents many health departments from taking further action on SDOH. Already, health departments are successfully engaging across sectors to promote policy, systems, and environmental changes. For example, they are contributing to community changes that promote healthy living, such as tobacco-free policies, community-clinical linkages, and improved food access.[211] CDC envisions four primary roles for governmental public health to address SDOH: 1) as a changemaker, to support and inform policy efforts and lead interventions; 2) as a convener, to bring together multisector partnerships; 3) as an integrator, to provide important data from health and non-health sectors; and 4) as an influencer by using scientific expertise to inform community actions.[212] With appropriate resources, communities across the country could leverage partnerships and resources to focus on upstream drivers of poor health.



PROGRESS MILESTONES

- In 2023, the Administration released the first-ever *U.S. Playbook to Address Social Determinants of Health*, highlighting actions federal agencies are taking to address SDOH.[213] The companion document, HHS's Call to Action to Address Health Related Social Needs serves as a resource to promote cross-sector partnerships to create a more integrated health and social care system.

- *Healthy People 2030*, which sets data-driven national objectives to improve the nation's health and well-being over the next decade, identified SDOH as a priority area, including by creating a HHS work group dedicated to developing and tracking progress toward the objectives related to SDOH.[214]

- Beginning in 2021, Congress funded CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) to build capacity to address non-medical drivers of health.[215] To date, CDC has funded 71 recipients to develop multisector, implementation-ready Accelerator Plans to address SDOH.[216] These planning grants help accelerate action around domains such as food and nutrition security, community-clinical linkages, and the built environment. Through additional support from Congress, CDC is also supporting implementation of these plans through three-year Addressing Conditions to Improve Population Health (ACTion) projects.[217]

- To inform future and ongoing SDOH work, CDC studied successful multisector community partnerships (MCPs) across the country as part of the Improving Social Determinants of Health — Getting Further Faster (GFF) initiative. Researchers found that of the 42 GFF partnerships evaluated, 90 percent of them contributed to community changes that promote healthy living. Of the 29 partnerships that reported health outcomes data, their programs are projected to save $644 million in medical and productivity costs over 20 years.[218]

- The Improving Social Determinants of Health Act was introduced in Congress in 2021[219] and again in 2024[220] to provide a statutory framework and to fiscally support CDC's SDOH work, including authorizing multisector grants to address upstream drivers of health and coordinate activities across CDC.

- CDC's PLACES data provides health data by county, ZIP code tabulation areas, places, and census tract. In 2023, PLACES added nine measures at four geographic locations to help identify the geographic distribution of health inequities and help prioritize investment in areas with the greatest need.[221]

- In 2022, CMS provided guidance on how states can address HRSN through Medicaid Section 1115 demonstration waivers.[222] The number of Medicaid Section 1115 demonstration awards related to addressing HRSN continues to increase. As of July 2024, 21 states had approved waivers for HRSN, and 16 more had pending waivers.[223]

- In 2023, CMS released a detailed framework outlining coverage of HRSN in Medicaid and Children's Health Insurance Program (CHIP).[224] This included guidance for state Medicaid managed care plans to offer services, like housing or nutrition supports, as substitutes for standard Medicaid benefits (i.e. "in lieu of services").[225]

- CMS introduced the HRSN Screening Tool and guidance from the Accountable Health Communities (AHC) Model to promote universal HRSN screening.[226]

- The American Rescue Plan Act (ARPA) expanded the federal Child Tax Credit to families with low- and moderate-incomes, temporarily lifted 2.9 million children out of poverty, reducing child poverty to a record low.[227,228] The expiration of the expanded tax credit resulted in a record rise in poverty in 2022.[229]

- ARPA temporarily extended the Earned Income Tax Credit (EITC) for workers without a qualifying child, resulting in a significant decrease in housing hardship, food insufficiency, and difficulty with expenses.[230]

- Some states and localities used ARPA State and Local Recovery Funds to increase the supply of affordable housing,[231] and Economic Impact Payments provided many individuals with increased food sufficiency and decreased difficulty with expenses.[232]

IMPACT STORIES

Multisectoral Partnerships to Promote Food and Nutrition Security in Rural Illinois

With assistance from CDC SDOH planning (Accelerator) and implementation (ACTion) grants, Illinois's Ogle County Health Department is addressing food and nutrition security for residents in four rural counties across the state. The health department partnered with local organizations and conducted needs assessments to create a cohesive plan.[233] The health department established mini food centers to increase access to healthy food options and is launching a TV and radio media campaign to raise awareness of food insecurity and reduce stigma associated with receiving food assistance. It is also partnering with University of Illinois extension offices to offer a nutrition curriculum for individuals and families. To ensure sustainability, the food centers will be managed by "hosting centers"- partner organizations that will incorporate sponsorships from different businesses and companies within their area to help fund them. Four mini food centers opened between May and June 2024, providing 24/7 access to food for roughly 30,000 community members across Lee, Ogle, Carroll, and Whiteside counties, and three more mini food centers are scheduled to open by October 2024.[234]

Leveraging Public and Private Resources to Reduce Disparities in Muskogee County, Oklahoma

With assistance from a CDC SDOH accelerator grant, Muskogee County Social Determinants of Health Consortium led a multisector partnership to develop and implement an SDOH plan for Muskogee County. The Consortium collected data from 260 county residents and conducted 75 key informant interviews to inform the SDOH Accelerator Plan's focus on social connectedness and community-clinical linkages. The plan addresses a critical need for greater access to care due to poverty, low availability of local primary care physicians, distance to existing providers, and limited access to transportation. To date, Saint Francis Health Systems has committed $100,000 to implement the plan, improving the health of nearly 69,000 rural residents of the county.

Addressing Medicaid Beneficiaries' Non-Medical Health Needs

States are increasingly leveraging Medicaid Section 1115 Demonstration Project Waivers authorizing coverage for services such as housing and nutrition support and case management.[235,236] In Arizona, for example, the state's Medicaid agency worked with CMS to develop a Housing and Health Opportunities (known as "H2O") plan to meet the housing needs of high needs/high-cost patients experiencing housing instability. A collaborative process enables the identification of eligible members, assessment, and referral for housing services such as transitional housing and tenancy services.[237]

RECOMMENDATIONS

Congress should increase funding to $150 million for the Social Determinants of Health program at CDC to expand meaningful multisector partnerships between public health and community partners that address social determinants of health including economic opportunity, housing, transportation, and access to nutritious foods.

Congress should pass the Improving Social Determinants of Health Act to authorize the expansion of CDC's SDOH work to better align initiatives and programs, including existing grants and funding streams for communities. The funding would also support the development of a unified infrastructure to enhance data collection and evaluation, policy analysis, best practices, and communities of practice related to SDOH within state, territorial, tribal, and local governments.

The Administration and relevant federal agencies should implement the *U.S. Playbook to Address Social Determinants of Health*. This implementation should include regularly updating the playbook, public reporting of progress across the domains, and presidential budget requests that support the action items therein.

The Administration should continue to build on the Centers for Medicare & Medicaid Services' (CMS) efforts to support Medicare, Medicaid, and CHIP program coverage of patients' health-related social needs (HRSN). The Administration should support CMS in building capacity to expedite the review and approval of appropriate Section 1115 waivers and state plan amendments that would ensure state Medicaid, CHIP, or Medicaid managed care organizations can reimburse HRSN, including community-based organizations and social service providers. CMS can also provide state Medicaid agencies with targeted technical assistance to further build the capacity of community-based organizations to engage with healthcare entities.

CMS should continue to incorporate screening for and addressing HRSN into CMMI models. CMS announced in 2022 that all Center for Medicare and Medicaid Innovation (CMMI) model participants will be required to have a health equity plan. These plans should include a focus on assessing and addressing social needs as a necessary approach to advance equity. In addition, CMS should ensure that CMMI models facilitate cross-sector partnership and support for the infrastructure (e.g., community care hubs) that help address HRSN.

The Administration, led by the Assistant Secretary for Technology Policy/National Coordinator for Health Information Technology, should continue to promote SDOH data interoperability to improve privacy-protected Health-Related Social Need (HRSN) data collection and sharing between healthcare, public health, and social service agencies. The Administration should facilitate technical assistance to states so they can advance HRSN data interoperability.

CMS and Congress should explore opportunities to expand the capacity of healthcare providers and payers to screen and refer individuals to social services by leveraging existing billing-code options; coordinating

care delivered among healthcare, social service, and safety net programs; sufficiently reimbursing social-services providers, and more fully integrating social needs data into electronic medical record systems.

Congress should amend tax laws to increase economic opportunity for families. Congress should expand the full Child Tax Credit (CTC) with an inflation adjustment for families with low incomes, which is estimated to benefit about 16 million children.[238] Congress should also extend the Earned Income Tax Credit (EITC) to adults without a qualifying child.

Congress should enact federal housing and place-based policies that promote housing stability and economic opportunity. Congress should support housing stability, especially among moderate-to-low-income individuals, through increasing funds to U.S. Department of Housing and Urban Development (HUD) for housing choice vouchers, housing rehabilitation, and rapid re-housing efforts.[239] Congress should also promote neighborhood improvement by increasing funding for existing place-based programs, such as the HUD Choice Neighborhood program, which leverages public and private dollars to enable neighborhood transformation and the U.S. Department of Education's (ED) Promise Neighborhoods program, which supports a continuum of solutions for communities to ensure children and youth in poverty-concentrated communities can succeed in school and beyond.[240] HUD and the Department of Education should collaborate with HHS on implementation of these programs.

Congress should expand access to high-quality early childhood education by increasing funding and reimbursement for Head Start and Early Head Start. High quality early childhood education has been proven to have numerous health and economic benefits, such as increased access to nutritious meals and exercise, improved mental health, greater likelihood of receiving dental care, improved cognitive outcomes, and reduced public spending on Medicaid and social services.[241]

PRIORITY 6: Enhance and Protect the Scientific Integrity, Effectiveness, and Accountability of the Agencies Charged with Protecting the Health of All Americans.

Promoting and protecting the health of individuals, families, and communities is vital to a healthy, thriving, and resilient society. Public health has been defined as "what we as a society do collectively to assure the conditions in which people can be healthy."[242] The United States' approach to public health is an ecosystem of federal, state, local, tribal, and territorial health agencies with specific and varying responsibilities. Government, primarily through public health agencies at every level working in partnership with other agencies, sectors, and communities, has a unique responsibility to promote and protect the public's health.[243]

With this charge and responsibility, public health agencies have driven more than a century of progress in improving the nation's health, from reducing infant mortality and controlling infectious diseases to increasing life expectancy and promoting healthier behaviors.

Despite this important role and impact of public health, the public health agencies are currently facing significant threats.

THE PROBLEM

Chronic underfunding, misinformation and disinformation, workforce shortages, threats to public health structures and authority, and an erosion of trust in the nation's public health agencies are putting decades of progress at risk and jeopardize the health and safety of the nation.

THE SOLUTION

Congress and the Administration must ensure that the federal, state, local, tribal, and territorial agencies that comprise the public health ecosystem have the necessary resources, infrastructure, trust, and authorities to fulfill their mission of protecting and promoting the public's health.

Threats to the authority of public health agencies.

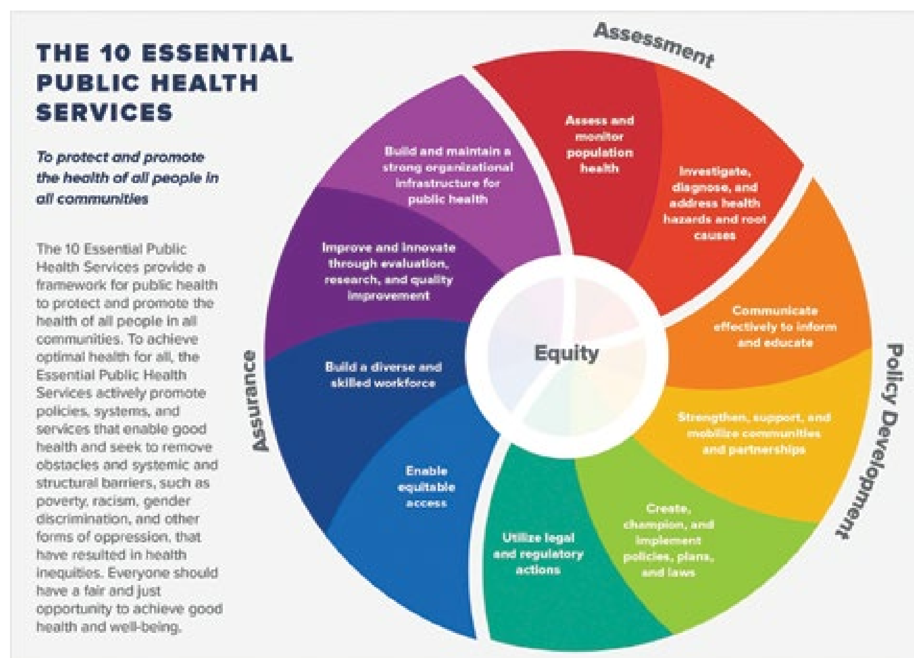
The U.S. Constitution sets a framework for the federal government and states to protect the health of communities and to take actions to stop the spread of infectious diseases into the U.S.[244,245] Recently, some state legislatures have acted to restrict the authority of public health officials to respond to an emergency – limiting, for example, the ability to issue emergency orders (even when they are reviewable by the courts). Such limitations are dangerous and could have serious implications for the state and local response to outbreaks.[246] At this pivotal moment for the health, stability, and prosperity for the nation, it is imperative that governmental public health has the necessary resources, infrastructure, and authorities to carry out its day-to-day functions and to effectively prepare for and respond to emergencies.

At the federal level, judicial decisions may undermine the authority of public agencies. The Supreme Court's recent decision, *Loper Bright Enterprises v. Raimondo*, which overturned the 40-year "Chevron doctrine" precedent of judicial deference to federal agency decisions, could have wide-ranging implications for public health, safety, and the environment.[247] As a result of this ruling, it could be easier to challenge long-established rules around drug approval, food safety regulations, and environmental standards.

Threats to resources for public health agencies.

Chronic underfunding of the public health system at all levels has also contributed to longstanding challenges like workforce shortages, outdated data and communications systems, and limited surge capacity during emergencies.[248]

The 10 Essential Public Health Services describe the activities that public health agencies should undertake in all communities.



Source: de Beaumont Foundation and the Public Health Accreditation Board Center for Innovation.

At the federal level, expiring emergency funds and rescissions have created significant funding cliffs within numerous federal public health programs and among state and local public health agencies. These factors significantly hinder the system's capacity to address the complex and growing health challenges confronting the nation. Because more than 80 percent of CDC's domestic funding is allocated to state, local, territorial, and tribal health departments, academic partners, and community-based organizations,[249] cuts to CDC funding weakens public health at all levels.

Threats to the scope of public health agencies.

In addition to these challenges, recent proposals to restructure or limit the scope of work of CDC to solely focus on infectious disease threats are ill-advised. CDC's core mission is to save lives and protect communities from all health threats – not just infectious diseases. Changes to the CDC scope and mission to one that is less comprehensive would undermine its mission to save lives and protect people from health threats. As eight former CDC directors, who served in both Republican and Democratic Administrations, recently stated, "Limiting our health defense to just some threats would be like allowing our military to protect us from only some types of attack, telling the National Weather Service to warn people about tornadoes but not hurricanes, or allowing doctors to treat only some diseases."[250]

The agency's success in helping save millions of lives and reducing healthcare costs through injury

prevention, tobacco reduction, and maternal and child health promotion demonstrate the need for such an approach. Repeated public health emergencies and outbreaks – from the Zika outbreak to the East Palestine, Ohio train derailment – have shown that responses require expertise and resources that come from across the agency rather than a single program or center. Furthermore, communicable and noncommunicable diseases and emergencies are inextricably linked: people with underlying health conditions are at higher risk of death from COVID-19,[251] influenza,[252] and natural disasters like extreme heat.[253,254]

Additionally, proposals to fundamentally restructure CDC would set back years of work to develop partnerships and programs across the country. CDC serves as the primary source of funding, technical assistance, and accountability for public health and prevention programs. This work requires the unique and trusted relationships the agency has built with state, local, tribal, and territorial partners to carry out its health promotion and disease prevention mission.

Threats to the scientific integrity of public health agencies.

The politicization of public health measures and policies during the COVID-19 pandemic, coupled with the spread of misinformation and disinformation, has led to increased skepticism, hostility toward, and a lack of trust in public health officials and agencies. The Government Accountability Office and other organizations cited multiple allegations of political interference with the scientific integrity and communications of federal health agencies during the pandemic[255] that undermined the credibility and public's trust in these agencies. GAO defines "political interference" as political influences that seek to undermine impartiality, nonpartisanship, and professional judgment.[256] Strengthening and providing greater clarity around the scientific integrity of federal agencies will help restore public trust.

Threats to trust in public health agencies and officials.

Restoring public trust in public health agencies, officials, and communications is a critical step to making the nation healthier and more prepared for the next crisis. Misinformation and disinformation on health issues have proliferated in recent years, with dangerous consequences. Increasing vaccine skepticism is among the most glaring examples of the impact of misinformation and subsequent waning trust in proven public health measures. Harassment of public health officials multiplied after the onset of the COVID-19 pandemic,[257] harming the morale and contributing to the attrition of the public health workforce. Improving public health communications will help the American people make informed choices and better disregard misinformation. Building meaningful partnerships between health agencies and community leaders will help ensure community health needs are met.

TFAH's policy recommendations would bolster the effectiveness of and trust in the nation's public health agencies.

PROGRESS MILESTONES

- HHS issued a proposed updated HHS Scientific Integrity Policy in 2023 to establish clear policies and procedures to ensure the integrity of all aspects of HHS scientific activities. The draft included policies to prohibit scientific interference, to facilitate the free flow of scientific information, and forbidding censorship or alteration of scientific findings.[258]
- CDC conducted an agency-wide review of how the agency develops and deploys its science and of CDC's processes, systems, and structure. This review led to the launch of CDC Moving Forward in 2022. Major priorities included: share science and data faster; translate science into practical policy; prioritize health communications, with a focus on the American public; develop a CDC workforce ready to respond to future threats; and promote partnerships.[259]
- CDC reduced the scientific review clearance time for CDC publications by 50 percent.[260]
- In 2024, CDC overhauled and streamlined the CDC.gov website to make the site easier to navigate and provide relevant information to various audiences, including the American public.
- CDC reorganized the Director's Office of Communications to prioritize communication with the public and improve integration across the agency.
- FDA is implementing efforts to improve its approach to scientific communication to the public. The agency commissioned the Reagan-Udall Foundation for the FDA to provide actionable strategies for improving public understanding of FDA-regulated products. [261] Drawing on the Reagan-Udall Foundation report, the FDA launched the Building Public Trust Initiative, where a cross-discipline group of employees from across the FDA work to improve public understanding of the agency's work. Efforts include science language training, improved information sharing, and strategic work with partners and interested parties to improve reach of factual information. FDA also launched a Rumor Control webpage to provide facts in response to the growing spread of misinformation that is putting patients and consumers at risk. [262]
- CDC implemented and expanded the CDCReady responder program so internal CDC staff are trained and ready to mobilize in response to public health emergencies.
- HHS transitioned the Office of the Assistant Secretary for Preparedness and Response into a new operating division within the department, the Administration for Strategic Preparedness and Response, similar to agencies like CDC and FDA. ASPR worked to make permanent capabilities developed during the COVID-19 pandemic, such as the interagency HHS Coordination Operations and Response Element (known as "H-CORE") and the Countermeasures Acceleration Group, formerly known as Operation Warp Speed.
- The U.S. Surgeon General issued an advisory on *Confronting Health Misinformation*, which recommends actions that individuals, educators, health professionals, media organizations, technology platforms, government, and others can do to identify and prevent the spread of health misinformation.[263]

RECOMMENDATIONS:

The Administration and Congress should maintain the existing structure of federal health operating agencies, which have specific roles and expertise in protecting the nation's health. Proposals to fundamentally alter CDC and other public health agencies are detrimental to promoting and protecting the public's health and would be an inefficient use of taxpayer dollars. These proposals would create needless divisions across programs that typically work together and lead to the loss of expertise of each agency's workforce.

The Administration should protect the scientific integrity of public health agencies and leaders. HHS should finalize and implement its updated Scientific Integrity Policy to ensure the independence, transparency, and accountability of scientific processes across the agency. The Administration and public health agencies should uphold scientific decision-making free from any real or perceived political interference. Policy decisions related to public health should be based on the best available science, with collaboration from public health experts in communication and policy to support transparent, clear, actionable, and options-based guidance.

HHS agencies should continue to prioritize development of public health guidance that is timely, rooted in science, and easy to understand and implement. Health agencies should ensure guidance is practicable in the real world by consulting relevant stakeholders and is not influenced by politics. During emerging health threats, HHS agencies should clarify that guidance is based on the best available information and therefore will need to adapt as more evidence becomes available. Guidance may need to be adapted to different regions and audiences, including tribes and territories.

Congress and HHS should invest in and prioritize effective public health communications and reducing the spread of misinformation and disinformation. Agency communications with the public regarding health issues should be timely, clear, credible, and actionable by different audiences. Public health communications funding should include research into best practices for different audiences, creating mechanisms for effectively engaging and listening to communities, incorporating communications into planning and response, and modernizing communication channels. HHS and its agencies should engage with and provide resources to a diverse group of community partners and maintain a trusted messenger network to research and test effective messaging, counter and prevent misinformation and disinformation, assist in message development, and conduct outreach.

HHS programs and grantmaking agencies should encourage meaningful community partnerships in jurisdictions. Rebuilding trust between public health agencies and the communities they serve depends on providing authentic engagement and partnering opportunities among public health agencies and community-based organizations and leadership. HHS and its awardees should direct resources to community organizations and networks to allow them to serve as trusted messengers, conduct outreach and education, advise public health departments, engage in planning, and/or provide relevant services.

HHS grantmaking agencies should streamline and harmonize program evaluation and collection of impact information. For example, HHS agencies should develop a portal for the collection of stories from grantees about the impact and value of public health work across the country.

Lawmakers and courts should reject laws that weaken or preempt public health authorities, which could threaten such basic public health protections as outbreak detection, vaccination, and response. To fulfill their core functions, public health agencies need authority to act effectively and efficiently to support the public's health including but not limited to collecting data to inform policy; administering programs and services including those that help to reduce the spread of disease; and investigating and controlling the spread of disease through testing, tracing, and other effective measures.[264] Courts should strive to support public health authorities by continuing to uphold laws and policies that are reasonably related to public health and safety and properly balance the common good against constitutionally guaranteed individual rights.

Endnotes

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