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House Homeland Security Committee

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and representing

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on the topic of

Medical Countermeasures: Protecting the Protectors

before

Emergency Preparedness, Response, and

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Chairman Bilirakis, Ranking Member Richardson, and members of the Subcommittee, thank you for giving me this opportunity to discuss the issue of the protections afforded by medical countermeasures and their distribution from the perspective of the emergency services sector. I am Bruce Lockwood, Deputy Director, Emergency Management, Town of New Hartford, CT, here representing the Emergency Services Coalition on Medical Preparedness. I am the 2nd Vice President of the US Council of the International Association of Emergency Managers (IAEM), which has more than 5,000 members worldwide. It is a non-profit educational organization dedicated to promoting the "Principles of Emergency Management" and representing those professionals whose goals are saving lives and protecting property and the environment during emergencies and disasters.

On behalf of the Coalition I thank you for the time devoted to this topic because these are important hearings in developing and promoting policies that prepare the Nation and ensure our resilience. As James Glassman recently noted, bioterrorism remains a current concern, and that "compared with other defense expenditures, this one – on a cost-benefit calculation – looks awfully cheap . . . budgets are constrained, but to cut back on the only truly effective method of fighting bioterror may be worse than foolish. It could be lethal."

Since last May when Lawrence E. Tan (Chief of Emergency Medical Services, New Castle County, Delaware) representing the Coalition provided testimony in front of this Subcommittee there has been insufficient progress in protecting the protectors at the local level. This lack of progress means citizens cannot be guaranteed continuity of emergency services in all areas of the country during a large-scale biological event. I believe there are some simple, immediate and commercially sound methods to start providing protections that would substantially increase our resilience.

I urge you to express your support for a voluntary anthrax immunization program for emergency services and first receivers. To complement this immunization program I urge your support of the immediate development of a Medkit for all emergency services personnel and their households. Public Health research has shown that the availability of medical countermeasures for responders and their families may increase their willingness to report for duty. I believe these are primary, necessary first steps in ensuring the continuity of emergency services during a large-scale anthrax event.

These steps will mitigate additional demands on emergency services during an event, and ensure responders can stay on-the-job without fear their families are unprotected. During bioterrorism incidents, protective antibiotics should be available immediately for the household members of responders as well as for responders themselves. The critical task established by DHS is that communities "develop processes to ensure that first responders, public health response, critical infrastructure personnel and their families receive prophylaxis prior to POD opening." The simplest and most effective manner to achieve this critical task is by

combining immunization with pre-positioning Medkits in the homes and workplaces of emergency services.

The Coalition supports the Institute of Medicine 2011 report that rejects the idea of distributing antibiotics to the general community in favor of targeted, population-specific distribution. Emergency services are that specific population, with specific needs and specific circumstances.

There is strong and consistent evidence that we cannot assume emergency services providers are confident in their ability to serve in a number of large-scale events, most notably a biological event. In no professional category can emergency providers be guaranteed to report or duty; in cases where they might infect family members less than half might report.

I want to draw your attention to an area of acute concern: the protection of children. From 2008 until 2011 I served on the congressionally chartered National Commission on Children and Disasters. The Commission report states: "Congress, HHS, and DHS/FEMA should ensure availability of and access to pediatric medical countermeasures (MCM) at the Federal, State, and local levels for chemical, biological, radiological, nuclear, and explosive threats." To ensure this happens stockpiles must specifically be developed for children. Further, the children of emergency services providers need specific measures to ensure their safety while their protectors are deployed in defense of the community.

The DHS Office of Health Affairs has provided the Coalition a background briefing on a pilot anthrax immunization program. I support the intent of the program to protect emergency services personnel. This use of expiring vaccine could have the material benefit for the preparedness of the nation, but we must emphasize that the protection of the protectors is paramount, not the expediency of stockpile management. The vaccine was acquired many years ago; a lack of policy on its use is thankfully now being addressed.

I hope that the voluntary anthrax immunization program goals and outcomes will be developed with local emergency services personnel, and that the true cost of administering the program is part of future Administration budget requests. Additionally, I hope this new policy direction of support for pre-event vaccination spurs HHS and the vaccine development community to further research and development efforts that will produce a simpler “next generation” vaccine that does not require five doses for full protection.

The Office of Health Affairs in its budget hearing before this committee on March 27 requested an expansion of their countermeasure program for all DHS employees. I believe this program is informed by the careful analysis that DHS employees are subject to disproportionate threats and require special protections. As our nation’s emergency response system is primarily local, the key component of our system is left unprotected by a DHS only focus. The same protections should be afforded all emergency services

personnel, state, local and tribal. Having one leg (the federal) of the three-legged stool (federal, state and local) response system protected, is no protection at all.

The federal government and other private programs have gathered the evidence to show these antibiotic Medkits can be safely administered, and that antibiotic resistance is not a scientific concern. For more than four years antibiotic Medkits have been provided to volunteers in the US Post Office employees and their families. More than 97% of these kits were returned for renewal unopened. Emergency services personnel routinely handle equipment and materials that are more lethal and have more profound consequences than the antibiotics that would be included in the Medkits. Some responders carry guns; others administer medications to critically ill patients outside of the hospital, yet others work with hazardous materials in life-threatening situations on a daily basis. Entrusted with these powers and responsibilities, there is no basis for assuming Medkits will be widely abused in the homes of emergency services personnel.

In a country where it is estimated that there are more than 50 million inappropriate antibiotic prescriptions are issued for viral infections the prospect of resistance is a public health concern. Pre-positioning Medkits with first responders is a microscopic component of overall antibiotic use, representing less than one hundredth of one per cent. Trained personnel in command structures with clinical oversight can be trusted, as has been demonstrated daily as well as in times of great stress.

The Coalition supports the development and distribution of FDA-approved antibiotic countermeasures to protect from anthrax to all emergency services personnel and their families, as a critical protective measure against anthrax and other agents. Private companies are interested in developing these Medkits; potentially bringing efficiency to the distribution and administration of a program that could cover federal workers (DHS, USPS) and the entire national emergency services sector. The prospect of having a protected federal workforce operating alongside unprotected local emergency services personnel is something we must avoid, because perceptions that there are different classes of responder could undermine overall preparedness.

The current methods of distributing medical countermeasures have not proven capable of meeting our national goals, including the protection of the emergency services sector. New supplementary approaches are required to ensure that those on the front lines of the response community and their families are protected.

Pre-event voluntary immunization and the development with commercial developers of a Medkit are part of a next generation protection and national stockpile effort. The specter of critical infrastructure failure is real, and would be compounded by a lack of a national strategy to protect first responders. The protection of the protectors and their families has been overlooked, and must be addressed.