BUREAUCRACY

A Pandemic of Planning

Years of planning did not help the United States during the pandemic.

BY JUDGE GLOCK

The coronavirus pandemic intensified concerns that the United States was ill-prepared for disaster. Many bemoaned the absence of a plan for what seemed like a predictable crisis. A bipartisan bill now before the Senate, the PREVENT Pandemics Act, contains mandates and funds for new pandemic planning.

Yet, there is little evidence that America's failures in the pandemic came from a lack of planning. If anything, the crisis highlighted the incredible proliferation of federally mandated pandemic plans across all levels of government and the private sector. The abundance of these often-conflicting plans was both the result and symptom of the increasing number of government pandemic response authorities. The spread of both government planning and planning authorities inhibited a coherent response to the crisis.

PERVASIVE PLANNING

The federal government has been engaged in supporting, subsidizing, and mandating emergency planning since the Cold War. Pandemic planning emerged out of this tradition, but it only came into its own in the 21st century. In 2006, following the avian influenza scare, Congress passed the Pandemic and All-Hazards Preparedness Act, mandating federal planning for a future pandemic. The act led to the issuance of a White House Homeland Security Council National Strategy for Pandemic Influenza, and then a National Strategy for Pandemic Influenza Implementation Plan. These would be updated in 2009 and 2017.

The World Health Organization also began mandating the creation of pandemic plans for its member states. That, in turn, led to a U.S. Department of Health and Human Services Health Security National Action Plan. The United States also worked with Canada and Mexico to draft a North American Plan for Animal and Pandemic Influenza, which was created after a meeting of the three nations' leaders in 2012. The United States also has a National Biodefense Strategy, which emerged out of a congressional mandate in the National Defense Authorization Act of 2017. Then there is the HHS's National Health Security Strategy and a Homeland Security Biodefense for the 21st Century plan. And just months before the coronavirus outbreak, Congress passed the Pandemic Preparedness Act of 2019 to further encourage such work. Most of these plans do not note or reference the other pandemic plans.

All of these plans were supposed to align with the Federal Emergency Management Agency's National Response Framework plans, which are supposed to deal with all emergencies and which include a Biological Incident Annex to deal with pandemics in particular. And there are separate federal departments' Pandemic Workforce Protection Plans, which govern how the departments themselves would function in a pandemic. The Department of Homeland Security has its own Pandemic Workforce Protection Plan, and its eight component units each have one as well.

These plans are all in addition to state and local pandemic plans, which themselves are often mandated by the federal government. The 2006 Pandemic Preparedness Act and subsequent iterations require each state to create its own pandemic preparedness plan and submit it to the Centers for Disease Control and Prevention for approval. The CDC also offers state grants for Public Health Emergency Preparedness and supports what it calls Pre-Pandemic Planning Guidance for Pandemic Influenza. These must be part of states' "all-hazards" emergency plans, which are also required by the federal government.

Before FEMA distributes aid to a state for any emergency, including a pandemic, a state must certify that its request for

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funds is in conformity with the state's general emergency plan. Congress has added more and more requirements to such plans. Following scenes of stranded cats and dogs after Hurricane Katrina, for instance, Congress passed the PETS Act in 2006, requiring that such emergency plans include details about how to rescue animals.

The government also has begun mandating and subsidizing private-sector plans. The Occupational Safety and Health Administration requires large employers to have "emergency action plans" for all hazards, including pandemics. The HHS offers grants for Hospital Preparedness Programs so that hospitals can engage in pandemic planning in particular. In 2016, HHS issued a new rule mandating emergency plans for health systems participating in Medicare and Medicaid, which encompasses most of the health care industry. It requires an "all-hazards risk assessment" as part of "emergency preparedness planning." Such plans are deemed necessary for "improving the national response to … any infectious disease threats." The HHS estimated that such planning would take 3 million hours of labor and cost about $300 million to implement and $100 million more to maintain for each following year. The agency noted that it was "unable to specifically quantify the number of lives saved as a result of this final rule."

Who oversees these plans? / The proliferation of pandemic plans is symptomatic of a proliferation of pandemic response authorities. For instance, the 2006 Pandemic Preparedness Act created the Office of the Assistant Secretary of Preparedness and Planning in HHS, which was supposed to "coordinate the Federal interagency response to a pandemic." Yet, the CDC, as demonstrated by its title, has its own authority for coordinating a response. Inside the CDC are a Division of Global Mitigation and Quarantine and a National Center for Emerging and Zoonotic Infectious Diseases, each of which has its own authorities for dealing with issues like quarantines. The U.S. surgeon general also has the duty to "make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases." These powers are separate from the general authority of the HHS secretary, who, according to the agency website, must work toward "preventing the introduction, transmission, and spread of communicable diseases."

Outside of the health bureaucracy, FEMA was created in response to what it says was a "lack of coordination [in emergency situations] and the fact that, at the Federal level, no single entity was responsible for coordinating Federal response and recovery efforts." It therefore would seem to be the lead agency in such an emergency. Agencies like the Food and Drug Administration and the National Institute of Allergy and Infectious Diseases would seem to have some authority as well, not to mention such strange tertiary organizations as the National Pandemic Influenza Economics Advisory Committee. The White House itself has its National Security Council, which has written and approved previous pandemic plans, and which was supposed to coordinate interagency security threats, including from diseases. Yet, in this pandemic, President Donald Trump created, and President Joe Biden has maintained (under a different name), a separate White House task force to lead the fight against COVID-19. This body includes many individuals who are designated by various plans as "coordinators" of emergency responses. The task force, naturally, created its own pandemic plan.

From early on, the federal government barely consulted and generally did not adhere to existing pandemic plans. Officials seemed unaware of how many plans existed.

HOW PLANS RESPONDED TO THE PANDEMIC

We know that, from early in the crisis, the federal government barely consulted and generally did not adhere to its existing pandemic plans. When one reporter noted that the Trump administration was not following the Obama administration's National Security Council Playbook for Early Response to High-Consequence Infectious Disease, Trump officials claimed it was following some combination of the Biological Incident Annex to the National Response Framework, the Biodefense Strategy, and a Pandemic Crisis Action Plan (a plan that I didn't mention above). In fact, just weeks after the outbreak, the administration wrote its own 100-plus page plan for responding to the coronavirus, which mentioned only one previous plan, and that in passing. It seems that after almost two decades of pandemic planning, many government officials were not even aware of the vast number of pandemic plans in existence.

Focus on influenza / When comparing the existing government plans to the response itself, one finds little overlap. Much of the policy debate around the coronavirus has centered on "nonpharmaceutical interventions" (NPIs) such as mask mandates and social distancing. As part of its general pandemic planning, the CDC had created a distinct plan for influenza NPIs. Yet, an examination of the plan shows that most of its recommendations were not carried out or were carried out for only a short time because they were quickly deemed inappropriate to the coronavirus (correctly in some cases, but not in others). And many interventions

that weren't mentioned in this or previous plans became central to the COVID response.

For instance, the CDC influenza plan recommended against the general use of face masks for healthy individuals in community settings. That was, of course, the original recommendation of the CDC on COVID, until an abrupt shift in April 2020.

The CDC plan said that only those people with symptoms of the pandemic disease should "practice voluntary home isolation." Officials suggested canceling only mass gatherings and merely encouraging offices to "offer" telecommuting in the workplace. Nowhere in the CDC or other planning documents was the idea of long-term and mandatory "lockdowns" proposed to reduce overall disease transmission. Yet, lockdowns or long-term social distancing mandates became one of the most prominent responses to the pandemic. In the CDC plan and others, there was also no provisions for mass-testing. Despite the earlier outbreaks of Severe Acute Respiratory Syndrome (in 2002–2004) and Middle East Respiratory Syndrome (2012), the CDC and most other federal plans focused on influenza.

Other federal planning documents recommended similar strategies that were not carried out. The National Strategy for Pandemic Influenza recommended testing people coming into the country across its borders, a strategy that was never implemented. The plan advocated against total border closures from some countries because "modeling suggest[s] that border closure would not decrease the total number of illnesses and deaths." Yet, such border closures were one of the few direct federal NPIs carried out in the pandemic.

Judged by either their use or effects, most of these pandemic plans were either ineffective or counterproductive. By contrast, Operation Warp Speed, one of the few successful federal pandemic policies, was an ad hoc effort created amid the pandemic and not the result of previous planning.

After-action analyses / Government offices have begun to conduct after-action analyses on their COVID responses, assessments that are often mandated by federal laws or regulations for emergency planning. The resulting reports illustrate how the spread of mandated plans and pandemic authorities confused responses to the pandemic.

FEMA was one of the first federal bureaucracies to issue an after-action report on the coronavirus in late 2020. It noted that the existing plans were not helpful:

> Federal pandemic planning was insufficient for a national incident and did not account for interagency operations, resource shortages, and an integrated federal approach to supporting [state, local, tribal, and territorial] partners effectively.... FEMA regional pandemic plans either did not exist or did not account for jurisdiction-specific capabilities or deficiencies.

The FEMA report also argued that there was insufficient authority for any one agency to lead a response, even though the number of different agencies involved in pandemics made such coordination essential.

FEMA's concerns about its response in fact echoed similar concerns that had been raised following pandemic training simulations. A report on a 2019 exercise called Crimson Contagion found a lack of clear authority to coordinate government operations in a pandemic. It noted specifically that "HHS has no mechanisms to coordinate across or task other Federal Departments and Agencies during an influenza pandemic or other biological incident." It also explained that existing plans like the Biological Incident Annex and the Pandemic Crisis Action Plan did not outline the organizational structure of the federal response or explain who had what authority. This presaged an inspector general report released after the coronavirus outbreak on the hospital planning regulations for pandemics, which found that the HHS's "authority is not sufficient for it to ensure preparedness at accredited hospitals."

Other after-action reports have described the inability of previous plans to account for changing circumstances. The Oregon Disaster Recovery Plan and Economic Recovery Plan was written just two years before the COVID emergency, but a state COVID after-action report noted that the plan did not consider "a long-term fluid incident such as the COVID-19 pandemic." A Texas after-action report noted that the COVID pandemic "varied significantly from assumptions made in existing plans." Other after-action reports emphasized again and again that coordination between authorities was essential but admitted that this was impossible under current laws and that existing plans did not elucidate or clarify such issues.

It seems that the focus of many plans on influenza led to false and potentially dangerous assumptions early in the COVID pandemic. The former head of the FDA, Scott Gottlieb, wrote that the government's plans for influenza led to misdirected efforts, including a false reliance on NPIs directed at the flu, such as handwashing recommendations. More generally, he argued that "many of the plans and preparations turned out to be a technocratic illusion" and were unable to cope with changing conditions.

While in some senses the plethora of pandemic plans was especially acute in the United States because of its fragmented bureaucracy, the failures of pandemic planning were international. The United Kingdom created pandemic preparedness strategies in 2011 and 2017 that also relied heavily on influenza scenarios and on recommendations such as handwashing. They recommended against mask-wearing by the general public, rejected closed borders, and had no policies for extended lockdowns. They even recommended against closing large public events because such events "may help maintain public morale during a pandemic." A WHO report on NPIs in 2019 made similar suggestions: arguing only for voluntary isolation for sick individuals, advising against contact tracing, specifically recommending against "reusable cloth face masks," noting that, at most, "large-scale workplace

closures could delay the epidemic peak for more than 1 week," and recommending against border closings. Examining which of these recommendations may or may not have been correct is less important than the fact that such recommendations had little to no effect on actual practices, and where they did have an effect, it was often inappropriate for the coronavirus.

In October 2019, just weeks before the first coronavirus outbreak, a group called the Global Health Security Initiative (GHSI) created what it described as the "first comprehensive assessment" of pandemic preparedness across 195 countries. The group ranked all countries by how robust they planned and prepared for a pandemic. The three top-rated countries were the United States, the United Kingdom, and the Netherlands. Yet, for most of the pandemic, those three countries have had among the highest death tolls per capita of all the countries on earth. In fact, a report found that there was an inverse relationship between a country's rank on the GHSI index and its coronavirus deaths in the first year of the pandemic. It seems that extensive planning for pandemics did little good and may even have caused harm.

CONCLUSION

There is a deep pool of wisdom on the futility of planning. As Helmuth von Moltke, one of the earliest military planners, noted in the 19th century, "No plan survives first contact with the enemy." Or as boxer Mike Tyson famously put it, "Everybody has a plan until they get punched in the mouth."

On the other hand, there is an alternative tradition that argues that plans can have value even if they do not match reality. As Gen. Dwight D. Eisenhower said, "Plans are worthless, but planning is everything." Research has shown that some types of plans, including those dealing with concrete situations such as environmental spills, can help clarify responsibilities.

But most broad plans mandated by an outside entity do not encourage flexible responses or buy-in from those who implement them. A study of state urban planning mandates found that they degraded the quality of local planning and made for "much more rigid and standardized" policies than non-mandated equivalents. A 2005 study of North Carolina state-mandated environmental planning for local governments found that "resistance to the imposition of state-level policies through local planning requirements" caused local planners to do no more than the bare minimum required and led them to fight against requirements. A 2017 analysis of pandemic planning in Texas found that while most planners believed in the efficacy of their own plans, they disparaged federal mandates and argued that "federal engagement lacks consistency" because of changing administrations and bureaucrats.

Plans that deal with an array of diverse and hypothetical scenarios also seem ineffective. Rutgers sociologist Lee Clarke's 1999 book *Mission Improbable* declared that most disaster plans were "fantasy documents" that gave no more than the illusion of control over very fluid situations. He argued that while rigorous "planning is possible under conditions of relatively low uncertainty," most speculative plans were completely ineffective. Even one of the few articles defending disaster planning, "In Defense of Emergency Plans" by economist Jeffrey N. Rubin, notes that such plans are often far too prolix and deal with too many possible scenarios. Concedes Rubin, "I'm actually not a big fan of most plans."

Yet, the growth of federal mandates, programs, and subsidies and the "thickening" of federal bureaucracy as a result of ever more hierarchical and intricate organizational charts have increased the demand for more advance planning to "coordinate" federal efforts.

The proposed PREVENT Pandemics Act offers more of the same. It would create yet another coordinator, an Office of Pandemic Preparedness and Response Policy in the White House, with further planning powers, along with a National Science Advisory Board for Biosecurity. It would also create 68 new mandates demanding "coordination" of existing and new offices in planning for the next outbreak.

The proliferating number of plans, created by different authorities and for different purposes, and their inability to coordinate or direct real behavior show that such efforts are futile. As the ambit of government grows, it is inevitable that its contrasting efforts and mandates will appear more chaotic and unplanned. In an actual crisis such as another pandemic, the proliferation of such contrasting mandates and plans will further hamper an effective response. R

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