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Local Public Health in California: Responsibility, Authority, and Capacity

Testimony to the Little Hoover Commission

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INTRODUCTION

Post-September 11th investigation and analysis holds many lessons for policy makers, but one of the starkest is that good news passes up the chain while bad news is either deleted or submerged. For local public health in California, there are outstanding strengths as well as frightening gaps in critical capacities. We welcome the opportunity to examine what a prior report of this commission termed "the largest single weakness revealed by the terrorist attacks" and that is, the long neglected state of our public health infrastructure.

From the perspective of a local health officer, I discern confusion as to what this all-encompassing term, "public health infrastructure" might mean. In the chapter, *Rebuilding Public Health* of the report entitled, Be Prepared: Getting Ready For New and Uncertain Dangers, recommendations for addressing public health infrastructure are heavily weighted toward emergency medical response. While medical response capacity is critical and necessary, it is a limited and narrow piece of the responsibilities of public health to protect the health of the public. The noted surgeon and writer, Atul Gawande states that medicine may be one of the most complex of human endeavors. The practice of public health layers two more dimensions upon the practice of medicine, that of breadth and depth. Breadth comes from the fact that public health deals not only with the health of individuals, but entire populations and communities. Depth is due to public health's allegiance to the spectrum of prevention that begins with individual care and treatment and moves up a ladder of response of motivating communities through education, participatory research and advocacy to substantive policy change.

BACKGROUND

The American health system is a union of two components: the personal health care or medical system and the public health system. As different as these two systems are, neither is independent of the other, and both must complement and interact with the other. While these two systems often address the same

health concerns, they focus on different stages of illness and injury. The personal health care system focuses on the diagnosis and treatment of health conditions after they have occurred to individuals—reactively. Public health looks at risk factors and behaviors and tries to proactively alter the equations in favor of health and safety. Public health lacks the glamour associated with hospitals, organ transplants, emergency medical response and does not compete well with crisis health care. Indeed, public health done well is invisible—an outbreak that never happened is difficult to see.

How important is public health? If you were born in 1900 and were now over the age of 45, you would have reached your expected life span and half of your compatriots would be dead. However, since 1900, thirty years have been added to the average American life expectancy. Twenty-five of those years are directly attributable to public health measures of improved sanitation, nutrition and lifestyle changes. Only a small fraction of the gain is due to conventional medical treatment. This is known as the "quiet miracle"—public health is at the bottom of preventing 70% of deaths with less than 1% of the health care dollar. Public health is the underpinning of this nation's health and has proven to be overwhelmingly cost-effective yet ironically, while total health expenditures increased by more than 210% between 1981 and 1993, spending for public health declined by 25%. During this period, the acquired immune deficiency syndrome epidemic surfaced, tuberculosis and measles outbreaks reemerged and the problems of substance abuse, teen pregnancy and violence escalated. We do not understand that public health measures have done more and can continue to do more to improve the status of the nation's health than all the personal health care measures combined. Former Surgeon General C. Everett Koop said it well, "While health care is vital to each of us some of the time, public health is vital to all of us, all of the time."

LOCAL PUBLIC HEALTH AND BIOTERRORISM

Now how does all of this relate to terrorism and the state of the world in which we now live post September 11, 2001? Specifically, the bedrock core function of public health is communicable disease control. Bioterrorism constitutes an infectious disease outbreak, albeit greatly expanded and involving the added element of a criminal or war action. We in California are fortunate to have a well-structured, organized local public health system consisting of 58 county and 3 city health jurisdictions headed by physician health officers who are both clinicians and administrators. Health Officers understand the commitment and the urgency necessary to deal with threats of bioterrorism and other emerging infectious diseases and we understand that the most effective response is a marriage of medical practice and public health expertise. The response to a bioterrorism event will be local and it is local public health that bears the responsibility for communicable disease control in California.

Why is local public health the first responder to bioterrorism? We all know that all terrorism is local. The basic response, the direction, the control, and most of the personnel will be local and mutual aid will have to be supportive to that effort. In terms of effective response to bioterrorism, the key is early recognition of the occurrence of an unusual disease or unusual patterns of the occurrence of any disease. Determining a diagnosis or suspected diagnoses in Emergency Departments, clinics and doctors' offices is just the beginning. All these providers are required to report to their local public health jurisdiction by law. When that report occurs, public health surveillance systems begin putting the pieces together. We can immediately assess the clinical presentations, establish case definitions and differential diagnosis guidelines, institute

source and contact investigation, establish active surveillance measures, determine risk factors for illness, organize treatment facilities, begin prophylaxis, isolation and/or quarantine, and organize the public and media communications. This is the spectrum of communicable disease control and it is much larger than treatment of those affected. The robustness and the rapidity of this response will ultimately determine the course and the duration of the crisis, and the character and the magnitude of the consequences. We do not do this alone, but in partnership with public and private health care providers and other public safety entities in the framework of a local/state/federal public health infrastructure.

FINANCING OF COMMUNICABLE DISEASE CONTROL IN CALIFORNIA

The chart in the Little Hoover report, Be Prepared: Getting Ready For New and Uncertain Dangers, speaks volumes.

State Contributions to Local Health Departments
For Disease Surveillance

Fiscal Year	Allocation for Disease Surveillance
1947-48	$3 million: adjusted to 2001 dollars = $23,986,500
2001-02	$1 million: adjusted to 1947 dollars = $135,200

Source: Deadly Diseases: Surveillance required but underfunded. Sacramento Bee. November 15, 2001.

Compare the world in 1947 with our world today. Add the influences of changing ecosystems, new and emerging infections, bioengineering, international travel, over population, diverse populations, increasing numbers of immunocompromised people, antibiotic resistance, mega-production agricultural practices, and, now, bioterrorism. Then try to rationalize spending approximately 24 times less on communicable disease control in California than was spent fifty years ago.

At the highest reaches of the federal government, there is an understanding that rebuilding the public health infrastructure is a matter of national security. Given California's prominence in terms of population, agricultural resources, and economic power, the following enhancements of the public health communicable disease infrastructure are of paramount importance for the health and well being of our people.

- Invest in the development of a public health workforce that is well-trained, well-staffed and prepared to respond
- Establish 24/7 notification and coordinated response capacity for local health departments
- Build systems to rapidly detect health threats, including the establishment of 24/7 communication between Emergency Departments and Health Departments
- Increase capacity for laboratory diagnosis and investigation
- Educate health care providers
- Create mass vaccine and antibiotic distribution systems
- Improve Public Information systems

PUBLIC HEALTH LAW

The Institute of Medicine in its Report on the Future of Public Health singled out public health law as part of, indeed the foundation of, the public health infrastructure. Public health law involves three basic concepts: the authority of public health officials, legal restraints on the exercise of authority, and the duties of public health officials and agencies. Historically, California law has given cities and counties the responsibility to protect the public's health and these duties fall under the responsibility of each local health officer in California. The authority to enforce state statute and county and city orders and ordinances is grounded in the authority of the local health officer. State law does not give the State Department of Health Services the same degree of responsibility to take steps to protect the public's health as it assigns to local government. Indeed, city and county local health officers retain the authority to take "any preventive measure that may be necessary to protect and preserve the public health from any public health hazard" in either a local emergency or in a gubernatorially-declared state of emergency (Gov't. Code Sec. 101040, 101475).

California, because of its many natural disasters, has less antiquated laws dealing with public health threats than most states. However, the laws are still reactive and discretionary. Their genesis is often political rather than scientific and broad powers rather than specific, limited powers are often mandated. Our communicable disease control laws are organized layer upon layer and began with cholera and smallpox, and then advanced to encompass polio, tuberculosis and HIV/AIDS.

The California Conference of Local Health Officers (CCLHO), comprised of all legally appointed physician health officers in California's 61 health jurisdictions, was mandated in 1947 to advise government at all levels on rules, regulations, and other matters affecting health. CCLHO recognized the local health officers' roles and responsibilities in directing the public health response to bioterrorism. Moreover, we were fully aware of the breakdowns in communication and lack of clarity in authority in every disaster response to date that necessitated strong coordination between multiple agencies. These problems were amply demonstrated in exercises involving simulations of large-scale bioterrorism attacks. We recognized that without a clear, legal framework for planning and response to bioterrorism in California, all of us would be improvising in the event of a real attack. For these reasons, CCLHO supported AB 1763, the Emergency Health Powers Act. We believed and still believe that we must pre-plan criteria for contentious civil libertarian issues such as quarantine in order to fairly balance police powers with individual rights. We believe that the interaction between authority, duty, and restraint should be judicious, rather than discretionary in extraordinary circumstances such as responding to a bioterrorist event.

The Emergency Health Powers Act, first and foremost, recognized the new world we now live in where the threat of the unthinkable has become a reality. It defined a public health emergency and its provisions applied only to that extraordinary, defined circumstance. Those who persist in thinking that we can rely on present law to guide our response do not recognize that the spectrum of risk is so broad , ranging from very few casualties such as in the October, 2001 anthrax attacks to potentially hundreds of thousands to millions. Even though the lethality of the October attacks was low, thousands of people were prophylaxed, our postal system was shut down, our government disrupted, and millions of people were terrified. All this was caused by approximately 10 grams of weaponized anthrax, the equivalent in

weight of ten packets of sweetener. We all know that since the eradication of natural smallpox, the appearance of one diagnosed case of smallpox will be an international disaster. An *American Journal of Public Health* report detailed an outbreak of smallpox in New York City in 1947 that resulted in 12 cases, 2 deaths and 6,350,000 people vaccinated in less than a month. The consequences of public health threats are immense and the potential for massive public hysteria are great even when the death rate is low.

RECOMMENDATIONS

A comprehensive, collected, coordinated, and effective response to terrorism will be far more likely with the following understanding and commitment to implement:

1) A well-trained, well-staffed and equipped public health workforce is the basis for a strengthened public health infrastructure that has the capacity to detect, control and prevent illness and injury resulting from biological terrorism or other infectious disease outbreaks;
2) Seamless coordination of the public health, medical care and emergency/disaster management systems is critical;
3) Real-time, secure, technically advanced and user-friendly communication systems must be established between public health and the public-private medical sectors;
4) California statute must be strengthened to mandate preparedness: planning resource acquisition and allocation, clarifying authority, and establishing clear delineation of roles and responsibilities.

On behalf of the California Conference of Local Health Officers, I thank you for the opportunity to address the legal structure and financing of local public health in California in the context of preparedness and response to bioterrorism and other public health threats and emergencies.