

## CALIFORNIA HEALTH POLICY ROUNDTABLE

### RESPONDING TO THE THREAT OF BIOTERRORISM: IS CALIFORNIA'S PUBLIC HEALTH SYSTEM READY?

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**DR. HELEN SCHAUFFLER:** Good afternoon. Hi, I'm Helen Schaffler, Professor of Health Policy at the University of California, Berkeley School of Public Health, and I'd like to welcome you all here this afternoon to talk about the important issue of public health preparedness and the state's attorney effort in responding to bioterrorism threats.

First, I'd like to thank the Kaiser Family Foundation and, specifically, Janet Lundy and Larry Levitt for their generous support and their involvement in making these health policy roundtables possible.

I'd also like to acknowledge and very much thank, if she would stand for just a minute, Juliette Cubanski of Harvard University, who has done an outstanding job in preparing the issues raised forward today, as well as for putting together this amazing panel of speakers and respondents.

I'd like to start with just a brief introduction to the problem and then, we'll go straight to our panelists.

I think there seems to be broad agreement among many of us that investment in the public health system in the United States and in California has been neglected for decades. This neglect has taken the form of under-investment in the basic public health infrastructure that can support public health's core functions of planning, data collection and reporting, disease surveillance and monitoring, education and communication about risk and disease, rules and regulations to protect the public's health, assuring access to needed health care services, and preparedness for threats to the public's health. It's also taken the form of laws that are outdated, contradictory and inadequate to protect public health in the 21st century.

The events of September 11th have brought these problems into sharp relief as the threats of bioterrorism and other means of producing mass casualties, and our society thinking more and more a matter of "when," rather than "if," they will happen.

The public health system gets very little attention in the public policy or political arenas because there's one thing reasonably wrong. It operates silently, protecting each of us every minute of every day in a myriad of ways. It's only in the face of a public health threat that the war on public health becomes visible.

Public health is about protecting, preserving and promoting the health of populations and communities. It's widely understood by public health professionals that, in the case of an epidemic of contagious disease, the interests of a few must often be sacrificed for the survival of the whole community.

Public health, since its inception, has been adaptable to these powers that give the government the authority to restrict individual liberties for the sole purpose of preventing harm to others. This is probably one of the most controversial issues facing public health, balancing the rights of individuals with the needs of communities.

Today, at this roundtable, we're first going to be hearing from Larry Gostin, who is the primary author of the model state law addressing planning and preparedness for bioterrorism and other emergencies that threaten public health, which he developed through the Centers for Disease Control. We'll then hear from Senator Keith Richman, who's introduced a bill to the California State Legislature based on model law. And then from three respondents, Ignatius Bau will discuss issues of civil liberties and privacy, Dr. John Burton will discuss the Administration's current activities as they relate to preparedness and with public health infrastructure, and Dr. Poki Namkung will discuss the use of local public health offices in California with respect to this issue. And then we'll open it up for discussion in the audience.

So first, I'd like to introduce Dr. Larry Gostin. He's a professor of law at Georgetown University and a professor of public health at the Johns Hopkins University, and he's presently on the Oxford University and has flown from London to the U.S. today. He's also the Director and the Principal Investigator of the CDC Cooperating Center for Law and the Public's Health, and his latest book is *Public Health Law: Power, Duty and Restraint*. He's also a member of the Institute of Medicine and serves on several committees. We're very privileged to have him here today and he'll begin the roundtable with a presentation of his model law, State Emergency Powers Act. Welcome.

**DR. LAWRENCE GOSTIN:** Good afternoon. I appreciate very much being invited here and particularly want to express my appreciation to Assemblyman Richman and to the Kaiser Family Foundation for supporting this really important event.

I'm going to talk a little bit about my law and some of the tensions that exist whenever you have compulsory public health powers and the trade-offs that you have with civil liberties and property rights, but I thought what I might do at the start is really to explain the purposes of the law.

We have had, I think, a new awareness about public health, safety and security since September 11th and the subsequent anthrax attacks in Washington, D.C. and various places around the country. And I think it's really shaken us from a deep complacency that we've had.

Helen referred to this already, but we have very badly neglected our public health system in the United States for many years. In fact, I'm a member of the Institute of Medicine Committee up in Washington that is going to report on the state of public health in the country within the next couple of months, and the story will not be pleasant. We have under-funded a system that has deteriorated, we don't have the most basic things that we need, like surveillance, nor do we have laboratory capacity or a sufficiently trained and adequate work force. We've spent so much time on developing a biotechnology infrastructure that we've really forgotten the importance of

infectious disease control, sanitation, and other public health interventions. That's the backdrop as far as the public health system is concerned.

Just as we've neglected public health system, we've just as badly neglected the public health law system in the United States. Most people would not believe or even understand the fact that public health laws in the United States date back to, in some cases, the late 19<sup>th</sup> or early 20<sup>th</sup> century and they then literally amended layer upon layer and so, if you look at infectious disease law in the United States, it literally tells us the story of infectious diseases in America. Plague and small pox through to tuberculosis and then polio, HIV/Aids and West Nile Virus and so, as a result, all those have consecrated. We don't have the kind of powers that we need. They're confusing. People don't even know what the law is. You can go to the Public Health Commissioner or even the State Attorney General in any state and they won't know what powers do or do not exist. And there are vast inconsistencies in the powers within individual states so that you might have power for disease X but not for disease Y. There are multiple inconsistencies among states and, of course, infectious diseases don't respect borders and so, as a result, if you had, say, an attack in New York, there would be very little approach between New York Health--New York, Connecticut, New Jersey, down the line. So there is much that we need to do to make sure that we have the kinds of powers that are adequate to meet this threat.

As a result, the model law was written at the request of the Administration, particularly since the Disease Control and Prevention in collaboration with leaders of major state organizations like the National Governors Association, the National Association of Attorneys General, Association of State and Territorial Health Commissioners, and the National Conference of State Legislatures. So one of the silver linings behind September 11th is that constituencies--political constituencies that rarely come together have come together and I think that, with the leadership of Senator Richman, here is a good example of that kind of bringing together district political communities for the good of the population.

So let me tell you a little bit about what the law says and why it was important. Essentially, there are two sets of powers that would be immediately in place and two that would occur only after the governor has declared a state of public health emergency.

The first pre-emergency power provision is simply--it's surprising and even a little disappointing that, in most states in the United States, there's been no formal comprehensive systematic planning for bioterrorism. That really does need to change because those who understand bioterrorism and also naturally occurring infectious diseases understand that the risk of bioterrorism in the United States is significant. Some recent studies have suggested that these kinds of events may very well happen, that the technology is there, the delivery systems are there, and we were, in some cases, fortunate in relation to anthrax. It could have been much worse. It's not well known, for example, that in a single postal packet that was sent to the Hart Senate building in Washington, D.C., that there were a million lethal doses of anthrax. Had the delivery system been different, we would have been faced with a catastrophic health event and one that we would have been very badly prepared for.

And so it requires planning in a collaborative, systematic way with public health officials, law enforcement, emergency management, and other agencies that would be necessary to plan for

and deal with a bioterrorist attack. Even those simple things that would be incredibly important we haven't thought through, and think for a minute, the stress on our health care system that would be posed by bioterrorism. We do not have the search capacity; we would have to get vaccines, pharmaceuticals, hospitals and other kinds of facilities available quickly.

Well, what do we do in terms of the allocation of that scarce resource? Do we have a plan for rationing and/or is our plan simply no plan at all? Or do we give these vaccines and pharmaceuticals first to the rich, the powerful, the influential? Do we ration on the basis of need or do we ration on the basis of those who would be most useful, like emergency workers, hospital workers and others? Literally, we have no plan and this really struck us in a small way in Washington, D.C. where there was great suspicion. Postal workers felt that they were being disadvantageously (sp) treated from the more powerful people in the Senate.

A constitutional democracy demands an open delivery of process that people can understand and trust. We don't have that at the moment and that's why planning is so important.

The second pre-emergency declaration power would be the power of surveillance. Bioterrorism is not like other forms of terrorism. It would be silent, odorless, and our need to detect it quickly will be--make all the difference in the world.

For example, in the tabletop exercises that the Federal government entered upon, actually before anthrax, one was the TOPOFF exercise and the other was Dark Winter, involving plague and small pox, respectively. The ability to detect the outbreak was poor and, as a result, for example, in the small pox modeling exercise, many tens of thousands of people would die.

So detection is very, very important but, at the moment, the law not only doesn't facilitate surveillance and monitoring, it actually thwarts it. So, for example, even those basic things that no common sense person would ever think would be useful occur. For example, there are prohibitions in many states from sharing information between public health agencies, law enforcement and emergency management. Imagine a system where health data could not be shared in the case of an emergency. Or there are positive prohibitions on sharing information and monitoring between the public health agency and managed care, hospitals, emergency rooms. Think about how we would detect a bioterrorist event, and one of the ways that we'd do it is if there would be, say, a run on anti-diarrheal medications, unusual fevers, or symptoms that managed care organizations discover. And yet, there's no systematic attempt to monitor that from public health agencies and, as I say, the law actually thwarts it.

The law communication between different states, so that a state public health department couldn't talk to another state public health department. There are problems of communication between Federal, State and local. In short, the laws at present are inadequate for surveillance and these laws would help.

Let me give you another startling example. In a recent study by the Centers for Disease Control and Prevention, a state reporting requirement that goes with the requirement that states need to--that laboratories, health care professionals and others--have to report cases of infectious diseases to the state health department. No state in the country--I think that's now changed--I know of

one state--has a reporting requirement, all the critical agents of bioterrorism identified by the CDC and most states don't require reporting for most of the critical bioterrorist agents. That would change under law reform.

There now are two sets of powers that are triggered once the governor declares a state of emergency and these are the more controversial but, I think, still very badly necessary and, when one thinks through, I think it's common sense provisions. One has to do with property and the other has to do with persons.

In terms of property, the law would make provision for the destruction of property that was a danger or if a facility required to be closed because it was a danger--it could be. And that's not as scary as things are getting. Think about anthrax when we had to close the Senate Hart building. When we had to destroy drugs because it was thought that it might be contaminated with anthrax. There's a long tradition in the United States for nuisance abatement, that is, the public health agencies having to deal with property that's dangerous. There are also problems of getting sufficient stockpiles of pharmaceuticals, vaccines and others and (inaudible) things where a public health agency may have to try to use those stores that exist in the public sector--in the private sector, rather.

A fact of the case is we need to have rules and powers to enable that to occur, and what the model law does is it really makes sure that what the public health agency does is constitutional and that is critical in a constitutional democracy and so we have literally and rigorously followed Supreme Court jurisprudence so that, if there needs to be a compensation for taking--that private property owners would be compensated according to constitutional law.

There has been lots of lobbying by almost every industry that you can imagine, hospitals, transportation, food, pharmaceuticals and others, each wanting to make sure that they're treated fairly and advantageously. The model law tries to treat all property owners with the respect that they deserve but it is also important that we're prepared and that nobody in American history or company in America would say that, if a property was needed in the state of a potential catastrophic health event and it was done fully constitutionally and legally and above board, that the government should have its hands tied, and that would not happen with law reform.

And then finally, and probably the most controversial part of this model law has to do with the protection of persons. There are provisions in the law for vaccines, treatment, testing, screening, medical examination and, if necessary, isolation and quarantine. I just want to take a minute to talk about the civil liberties aspects because I'm actually a person with a strong civil liberties background. I was on the National Board of Directors and Executive Committee of the ACLU. I was the head of British Civil Liberties Union for many years and so I'm very conscious of the importance of civil liberties.

What this law does is bend over backwards to make sure that there are rights and protections with those who are vulnerable and at risk. You have to ask yourself, first of all, "Would powers of isolation or quarantine or vaccination or treatment be necessary?" Well, for the great majority of Americans, it would not be. They would voluntarily comply (a) because it was in their own interests, and (b) because it was in--for the common good. So we're only talking about a very,

very small number of people. Can you imagine that it would--that government should not have power, that if somebody had small pox or another contagious infection, that there would be no power to keep them from going to school or the workplace or some other congregate setting? It only makes common sense that we should have these powers.

It also makes common sense that we should have safeguards against abuses of power and the law bends over backwards to make sure that's true. It provides procedural due process, accountability, balance of powers between the governor and the state legislature and, most importantly, has protections of people in isolation or quarantine that go well beyond those protections that exist under current law. People in quarantine would be able to have the right to communicate to legal counsel, to have treatment, health care and the like that simply doesn't exist.

So, in many ways, I'm very, very proud of the law. What the law tries to do is it tries to give the kind of powers and authorities that would be needed to protect the health, safety and security of the State of California and the nation and, at the same time, tries to balance that with respect to individual rights' toleration of groups of injustice. And that's the kind of balancing that we need in a constitutional democracy.

Now, is it possible that in certain parts of the bill that we got the balance wrong? Absolutely. That's why it's important to put this on the table, to have open hearings like this, and to have the kinds of discussions that we need in a constitutional democracy that are long overdue.

We've neglected the public health system and the public health law system for nearly a century and September 11th was a wake-up call. We can no longer ignore and neglect probably the most important thing that our nation holds dear, which is the health, safety and security of the population.

Thank you very much.

**DR. SCHAUFFLER:** Thank you very much. That was excellent.

I'd like now to turn to Assemblyman Keith Richman, who has introduced AB 1763 to the Legislature and that bill is based on the Model State Emergency Health Powers Act.

Assemblyman Richman.

**ASSEMBLYMAN KEITH RICHMAN, M.D.:** Thank you, Ms. Schauffler, and thank you for arranging this panel this afternoon and also, "thank you" to the Kaiser Family Foundation and Dr. Gostin, also "thank you" to you, for all the hard work that you've put into this bill. It's been quite a bit of work.

I did introduce AB 1763 right at the beginning of this session, almost essentially verbatim to the way Dr. Gostin and others have drafted it, with only a change that included the exclusion of HIV and Aids because that was something that I felt was important here in California and that was not

a battle that I wished to fight in this bill. I thought it was important to focus on the issues in the bill.

Rather than speaking specifically about the bill, I'd like to start off in talking about why I think we need a bill like this. Last fall, we were all faced almost on a daily basis with information and news about the anthrax attacks and anthrax, in reality, is not a very contagious or communicable disease. It's not a disease that's easily passed from one person to another. What I'm really concerned about it as a member of the State Legislature and somebody who is responsible for protecting--for helping to protect the citizens of California.

Our diseases, like small pox or hemorrhagic viruses like Ebola virus, these are viruses that are really weapons of mass destruction. In our non-immunized society and, what I mean by that is really none of us are immunized to small pox anymore, if we were to be faced with a small pox attack, small pox, which is highly contagious it would run rampant throughout our society and the estimates are 30 percent of the people that would contract the disease would die. In other words, we would be looking at tens of thousands of deaths in the State of California if we had small pox or potentially Ebola virus used as a weapon.

Now, besides intelligence gathering to prevent such an attack, we do need to plan and prepare and have systems in place to defend against and respond to such an attack. Any delay, as Dr. Gostin said, could result in thousands or tens of thousands of additional deaths.

Now, during the Cold War, our country had a defense policy that was based upon mutual assured destruction, massive nuclear retaliation. That doesn't work for bioterrorism or a chemical attack. It won't work in these instances.

Here, our defense for a bioterrorist attack is a defense of the public, a robust public health system and a health care infrastructure that can handle this type of situation and we need to have a coordinated local, State and Federal response.

And, at the current time, we don't have these things. California is not prepared currently for this type of situation. California probably is as well prepared as any state because of our preparation for natural disasters, earthquakes in the past, but it would be fair to say at the best that we are under-prepared for this type of situation. Any bioterrorism attack--in any bioterrorism attack, we must be able to respond rapidly and effectively to any potential or actual public health emergencies.

Remember, in a bioterrorist attack, you may not even know that there's been an attack. There can be a covert bioterrorist attack or an overt bioterrorist attack or there just be somebody who's trying to cause chaos and confusion in this society without any attack. The response that we have must promote the common good, it must be grounded in a thorough understanding of public health threats and disease transmission, a scientific basis and, as Dr. Gostin also said, our response must be guided by principles of justice and anti-discrimination with tolerance toward individuals and groups and I will tell you that these principles are throughout the bill as it's written.

We also need a public health system that can identify problems rapidly and track disease spread in real time. We need a good surveillance system, we need disease tracking, and we need laboratories that are up to date. We need laboratories that can quickly and interactively identify whether there has been a bioterrorist attack.

We also need well-trained and adequate numbers of personnel. Community physicians, nurses, pharmacists, adequate numbers of public health personnel, public safety personnel, and we don't have all that we need now. I'd also like to just interject, I've also introduced AB 1921, which is a bill, which would require physicians, nurses and pharmacists to undergo disaster preparedness training every two years in their communities.

We also need to make sure that we have adequate supplies, whether they be medical supplies, vaccines, antibiotics, food, shelter, clothing, so that we can care for people who might be involved in this type of bioterrorist attack.

We need to plan for the distribution of supplies, we need to plan for isolation and quarantine, treatment and vaccination, and we need to make sure that we communicate well, that we communicate between governmental agencies and that we also communicate to the public well.

And we need to have in place appropriate public health law. We need that law to define, as the model health law does, planning, provisions for surveillance and tracking, isolation, quarantine, protection of property, and the protection of people or persons with treatment and vaccination.

And, as I said before, we're not as prepared as we need to be. We are absolutely under-prepared. The government has run scenarios such as Dark Winter and TOPOFF. Responses in those scenarios to small pox and plague were confused, they showed a lack of planning and preparedness, and resulted in chaos, confusion and excessive numbers of deaths. These scenarios were run as recently as last year.

Here in California, our public health system is inadequate. We don't have enough people or funding, our health care system is strained on a daily basis with closures of emergency rooms, diversion of patients, and trauma systems throughout the state are collapsing. It would be fair to say that, not only are we not prepared for a bioterrorist attack, we're not prepared for a bad flu season. Planning, thus far, has been inadequate and there is no clear public health law that can cover such an emergency.

Interestingly enough, the Department of Health Services, I think three or four years ago, went through the statutes in the State of California. It took them weeks, first of all, to delineate all of the statutes that dealt with public health, just to put them in a single collation and then, even after they did that, they were left with multiple ambiguities and throughout their collation advised that health officers speak with their own county attorneys so that they would be clear on what their powers would be. That type of ambiguity is not okay when we're going to be faced with a bioterrorist or chemical emergency.

So I think that what's important is that we plan and prepare for such an eventuality and we hope that it never comes. As Dr. Gostin also said, there are certainly some controversial issues that

are in this bill. They need to be openly discussed, they need to be debated, it needs to be done in an open fashion. That's a lot better than just sticking our heads in the sand and not being prepared for an eventuality that we all hoped would never happen, and I look forward to having this open discussion on an ongoing basis.

Thank you.

**DR. SCHAUFFLER:** Thank you, Assemblyman. Well, we're going to actually start a discussion with our three respondents to my right. And first, I'd like to introduce Ignatius Bau. He's a lawyer by profession and is presently the Deputy Director of Policy and Programs at the Asian and Pacific Islander American Health Forum. And we've specifically asked him to address some of the civil liberties and privacy issues inherent in this bill.

**DR. IGNATIUS BAU:** Thank you. I think I've been called out because, I think, after the event of the fall those--the attacks on the World Trade Center and the Pentagon and then the anthrax scares, it's very difficult to speak, I think, with a sense of proportionality, with a sense of balancing what is obvious, which is the need, as the previous speakers have said, to bolster and strengthen our capacity and our ability to respond to bioterrorism, but also to do that in the context of what is going on in our communities and in our society when it comes to health and public health. But anyway to attempt to do so.

I'll start by telling a story that a couple of years ago before all of this happened. I was asked to be part of a Centers for Disease Control focus group process. The Centers for Disease Control was looking for a new slogan and it wanted to know what would resonate in the community as its mission and, therefore, as its slogan. And among the things that it suggested as a slogan were things such as, "Your first line of defense against bioterrorism," and at that point in time, I and probably many other people said--sort of refuted that idea and said, "That's not what the Centers for Disease Control should be about." The Centers for Disease Control is our primary public health agency in this country and it should be about preventing disease and then trying to work with the other agencies in the Federal government as well as with State and local governments and private providers to control or treat those diseases.

I think though, then, with the experience of the fall, we may all feel differently because I think we all suddenly have a change of heart and we have these expectations and these demands on the CDC to be more responsive, to be more prepared to bioterrorism and, specifically, to the anthrax scares at that point. So I think our opinions are also changing on these kinds of issues and our perceptions of what the appropriate role of various agencies, various levels of government, might be may also be changing.

So I'd like to say a few things about the model law and the way that it might play out here in California. First, I think it's important to recognize that, despite the fact that there is no such comprehensive law in California, there are existing laws in the California Health and Safety Code, which provide for many of the provisions that are discussed under the model law. There are currently provisions for the declaration of public health emergencies. There are currently provisions that go to the extreme of isolation and quarantine and the provisions for local health authorities to engage in those kinds of measures. There are also currently in California law

provisions for the kinds of occasions that Professor Gostin talked about, of seizing private property, either to destroy it in case of contamination or to use it for things like quarantine and isolation.

What is missing in California is the comprehensive nature of those kinds of legal authorities. It's not clear, under the current California law, who really should or could have the authority to make these kinds of declarations and yet, what the model law does is offer one alternative which I think we should all think about as whether or not that is a wise alternative and that is to rest the entire decision on the governor of the state.

The governor of the state, without the necessity of consultation--of optional consultation with public health authorities, can make this declaration a real public health emergency. So, it's not by local officials, it's not even by state public health officials, it's simply by the governor. And this law is explicit that says the governor need not consult with public health authorities if it's not--it's against in response to what the governor perceives as a public health emergency.

Secondly, what would allow this law to go into effect, once Assemblyman Richman's legislation is passed--is enacted, is a six month period in which a commission largely politically appointed by the governor and by leaders of the legislature would come up with a plan in order to implement all the provisions of the law and so we'd only have six months to do the kinds of things that I'm going to spend a few more minutes talking about later on, and I presume some of my colleagues on this panel will also talk a little bit about, how long it takes to put some of these processes and procedures in place. So it's simply a six month window of opportunity to adopt a state plan and, once that plan is into effect, the government can go ahead and, at any time, declare a public health emergency and all these authority and legal powers would go into effect.

The third, I think, issue is that neither that plan is subject to any sort of review by the legislature or by the courts or by any other authority, including public health officials or local governments until, again, it's this politically appointed commission that we've created this plan without any sort of review or further public review.

The fourth issue I would raise is that there's no scaling of the powers that are triggered by the model act. In other words, we have, I think, in constitutional law, a principle which is voiced in the model legislation when it comes to the protection of persons that we would use in these kinds of instances the least restrictive means and that's a legal principle that you try to balance people's individual rights with the general good and so the principle is you can do things that otherwise we wouldn't want done if it's the least restrictive means of achieving any kind of important public interest or goal.

That principle doesn't necessarily exist in the way that the powers are exercised because it's an open ended authority for the governor to declare this emergency and declare the powers until there's no sense of proportionality, there's no sense of scaling up in response to any sort of situation. The powers are again open ended up to the governor and the governor's declaration.

And then, finally, I think that there are some issues that I would raise probably, Professor Gostin would say, at a nitpicking level, in terms of some of the due process requirements that, while I

think the model law greatly makes much more comprehensive and thorough and much more thoughtful, the issues around the seizure of property and the use of property and the taking over of private industry, as well as the protection of persons, isolation and quarantine, I would suggest that there are provisions that don't go far enough. So, for example, notice to individuals about their isolation and quarantine is provided for but, again, almost as an afterthought, while they're being quarantined or isolated, and while provisions are made for emergency judges to have jurisdiction over--to see whether or not these persons might be released or challenge the isolation and quarantine. There's no provisions for emergency counsel. There's a right to counsel and there's a right to communicate with counsel but, if we really are in a worst case emergency disaster bioterrorism situation and we have to make provisions for emergency judges, I would suggest we need to make provisions for an entire quasi-judicial system or parallel to the judicial system to function, including counsel for those folks who might be subject to that.

And then, finally, in terms of those kinds of provisions, the CDC in its interim planning guidance for states is actually much stronger on issues that are near and dear to my heart, my community's heart, which are making sure that there's language access and that there's respect to culture. And, the CDC guidance is much more explicit in saying, "you must provide notice to persons who don't speak English as their primary language," whereas this law simply says you should consider that. And I would suggest that what you're really looking at is comprehensive planning and you really need to account, in this state in which people speak dozens of languages as their primary languages and not as English that that need not be an option but that needs to be an integral part of any sort of planning.

So I conclude by saying that the principles that I would suggest that we look at is not just simply a legal response but a response that looks at public health and a response to ongoing health crises and ongoing health needs in our community in a much more comprehensive way. And that includes, first of all, information. I think there's a great deal of education that needs to be done, not only among policy makers, but in the community around the issue of bioterrorism. And information that is both accurate but yet also information that doesn't cause more hysteria or panic. And I think we've learned through the anthrax situation that, oftentimes, putting a scientist up there to explain the symptoms of a disease is not the most useful public communications message that you want to get out there. But you need someone who has skills in public health communication that can calm those fears but also provide accurate information so that people could take preventive measures.

I would draw a contrast of experiences here in the state that, when there were some toxic leaks in Contra Costa County, those communities that were not English speaking primarily, the ocean communities there did not receive notice to stay in their homes and take precautions and, therefore, missed out on those precautions, whereas when anthrax happened, the same county department of public health immediately translated notices about anthrax into Vietnamese and Spanish and distributed them along with notices in English. So two different sponsors at a local level that I think we need to consider.

Second, I think we need to plan in terms of building up the public health infrastructure not just a test for small pox, but it's a test for all kinds of diseases, not just to be ready to immunize against anthrax, but to make sure that childhood immunization is happening, to make sure that

immunization for pneumonia and influenza is happening for our seniors, that we don't just have access to Cipro in terms of drugs, but that we have access to drugs for ongoing health issues, and so that we aren't simply seizing assets and seizing of the industry to make the drugs and make the antibiotics when there's a health disaster or a bioterrorism attack. We should be looking at better planning and better integration and better use of resources today. And, rather than looking again at simply taking over the kind of health authority to impose measures like isolation and quarantine, much, much better communication, much, much better coordination between Federal, State and local government levels, as well as between government and non-government health providers is needed. That kind of communication is critical to public health today and not just for bioterrorism.

**DR. SCHAUFFLER:** Okay, thank you very much. I think you've raised a number of issues (inaudible). Thank you.

Next, I'd like to introduce Dr. Richard Burton. He is the newly appointed Associated Director of the California Department of Health Services and is taking the lead for the Department of Bioterrorism Issues. Until recently, he was a public health officer for Placer County and now we've asked him to stay to address what the Davis administration was doing to address some of these issues. Thank you.

**DR. RICHARD BURTON:** Thank you. I'd also like to thank you for the opportunity to come and discuss in this roundtable the issues that are very important to all Californians.

I'd offer a--we agree, as an administration was something of a regimen that California is as well prepared as any state in the nation when it comes to preparedness for bioterrorism. There are also evident opportunities that we will identify each and every day to be better prepared and that's the assurance that we would offer as the Administration that partnering with our 61 local health jurisdictions and the professionals that work every day at the state Department of Health Services that each and every day California is more prepared to deal with the threats of bioterrorism.

I think, also, the Administration has shown evidence of commitment toward being prepared even before last fall and partnering with our Federal colleagues and bringing in Centers for Disease Control grants that have helped build our laboratory capacity. We have probably one of the best public health laboratories in the states, in the western United States enrichment, and that's a result of work that's been ongoing for years.

There's also been work ongoing for years in the areas of information technology and disease reporting and laboratory reporting and those technologies are leading the nation in public health information systems and our efforts that will be continued to proceed during our public health preparedness programs in the near future.

I also want to identify and remember the fact that the Administration, recognizing the crucial role that local health jurisdiction play in public health preparedness, allocated \$5 million last fall to go to local jurisdictions to assist them as they dealt in the aftermath of the anthrax issues throughout the nation.

I think when it comes to the next steps that the Administration is looking to take goes very much in parallel with what Mr. Gostin mentioned, as far as openness and a planning process. A month ago, the Centers for Disease Control and Secretary Thompson's Health and Human Service agency at the Federal level identify guidelines for states and locals to take in public health preparedness. Those guidelines were delivered through the governor's office to the Department of Health Services and the Department of Health Services has identified what we feel is a very open process involving the leadership from our local health jurisdictions in working through the various different focus areas. There are several focus areas that need to be addressed and putting together a plan for how we're going to address our bioterrorism preparedness going into the future.

That plan, in fact, needs to be delivered to the Centers for Disease Control by April 15<sup>th</sup>, so it's been a very active last number of weeks and we've held conferences and face to face meetings and drafts and editing going on with our local partners, and the plan is not complete at this point, but we would hope by the first part of April to have an initial draft plan to be able to forward on to agency and the governor's office. According to guidelines, the plans have to be submitted to the governor's office and--with his endorsement and approval before they'd be considered at the Centers for Disease Control.

I'd like to also acknowledge that, in California, the strength of the public health laws have long addressed the importance of reporting of different communicable disease of public health significance and, in December, there were emergency regulations put in place so in California we do, in fact, have all significant biologic agents that are mandatory reported illnesses and those were included as of December of last year.

There are also--a lot of the worries at the state and local level in public health law in California. The need for local health officers and public health officials to take any measure necessary to prevent the transmission of communicable disease and protect the public's health.

I think the Administration and, I know, the Administration looks forward to every opportunity to evaluate the effectiveness of our current infrastructure and look for opportunities for improvement, to evaluate the effectiveness and adequacy of our legal system as far as public health law here in California. The Administration, at this point, is not taking a position. I look forward to evaluating the--Senator Richman's bill more thoroughly and working with him to the degree that we can to improve on public health law here in California.

**DR. SCHAUFFLER:** Okay, thank you very much.

And finally, last but not least, I would like to introduce Poki Namkung. She is the Health Officer for community of Berkeley and I just met her today for the first time and she's also President of the California County and Local Health Officers' Association and is directing the bioterrorism efforts.

Now, we have asked her to share the views of health officers to oversee our public health system in California. Thank you.

**DR. POKI NAMKUNG:** Thank you very much for this invitation to participate on this roundtable. I would also like to thank the Kaiser Family Foundation for their support on this very critical topic.

I think we're fortunate but, let me just say, it's fortunate for me being last, because many of you who have spoken have actually stated some of the comments that I wished to make. However, I think we're fortunate in California to have a well structured, organized local public health system consisting of 58 county and three city health jurisdictions. I have, in my position, health officers who are both clinicians and administrators.

How officers understand the commitment and the urgency necessary in dealing with threats of bioterrorism and other emerging infectious diseases because these are the issues in which we are the experts.

I now need to talk about the meeting that Rich and I attended in San Francisco, that was to clarify that the Centers for Disease Control's guidelines for the unprecedented allocation of \$1 million in Federal funds in support of "state and local public health measures to strengthen the nation against the threat of biological weapons."

I want to speak first on what I learned at that meeting, because some of it was really surprising, to even someone such as me working in public health. And then I want use the CDC guidelines as a framework for discussing the role and readiness of local public health.

The group at the meeting in San Francisco was Dr. D.A. Anderson, who is now the head of the Office of Public Health Preparedness and the Office of Homeland Security, probably best known as the person who knows the idea for every successful effort to eradicate small pox in the 1970's.

He's--you could almost say he's a curmudgeon. He's a very crusty, feisty guy who really speaks his mind and, at this meeting he did speak with compelling urgency. His primary message was that the United States is at war. The war on terrorism. And it is the weapons of bioterrorism that open most to the potential because of their ease of dispersal and their difficulty in detection as far as massive death, disease as simple cast.

I'll admit that we're all concerned with nuclear chemical and explosive weapons, but none of these terrible weapons has the technical ease and the magnitude of affect that's intrinsic in biological weapons.

As President George Bush said on October 1, 2001, "Disease has long been the deadliest enemy of mankind."

But Republicans state that frankly that these Federal funds were so large and the method of allocation so unusual because at the federal level, they're all waiting for the other shoe to drop.

Dr. Schauffler said that it's not if, but when, and this is what their intelligence tells me. It is when a biological attack will--next will occur and to give you some guidelines as to how they

came to these conclusions you need to know that, as Dr. Gostin said, in relating the danger of these anthrax incidents in October, that the one letter to the Hart Senate Building had a million lethal doses. Well, all the anthrax and all those incidents that sickened 22 people and killed five in September and October of last year, amounted to 10 grams of anthrax in total. That's the equivalent of approximately one-third of an ounce. You could take 10 packets of Sweet-N-Low and that would be what caused the disruption of the Federal government, incapacitated the U.S. Postal system, caused local health departments across the country to be overwhelmed with over 40,000 pounds of environmental specimens.

We know that the perpetrator in this deadly campaign was probably from the U.S. but we don't know where the anthrax came from. We know that the Soviet Union had, at one time, 33 metric tons of anthrax in storage. We know that they had the capacity to produce 100 times the small pox virus per year. We know they have 60 scientists working in busy labs across the Soviet Union. The scope of this program was greater than anything that we could have even committed to the nuclear effort. We know that the location of these--most of these scientists is currently unknown.

So I hope that the logic and the urgency of focusing on biological terrorism is clear.

I have one minute, and approximately 20 minutes more to say.

I don't know if--I suspect that I'm speaking to the choir right now, but a lot of local public health adversaries buy into bioterrorism. We know terrorism is local and the key to expected response to bioterrorism is early recognition of the occurrence of an unusual disease or running recognition of the occurrence of an unusual pattern of any disease.

The diagnosis--or suspect diagnoses--would be made in emergency departments, clinics, doctors' offices, but that's just the beginning. Most disease providers are, as Dr. Burton said, we have a communicable--required communicable disease reporting system in California and across the nation, really. The powers of a surveillance system began putting these pieces together. So we, with the clinical presentation, establish case definitions and differential diagnosis guidelines for institutes source and contact investigation, activate surveillance systems to determine gross factors for disease, gross mass treatment, as well as to begin prophylactic vaccination and quarantine, and it would be nice if public and the media communications. Perhaps the spectrum of communicable disease control at local public health in coordination with federal and state, is responsible for--we don't do it alone. We do it in partnership in the larger public health infrastructure and in partnership with both public and private health care providers.

I'd love to just, if I could, please, to go over the social areas that the CDC considers critical areas in which capacity must be felt to respond to bioterrorism. The first one is focus area A, which seems preparedness planning and readiness. You've heard a lot about how there is not a comprehensive plan. Well, though we think of these bioterrorism monies that the state does comprehensive plan that takes down, by rule of thumb, the capacities at the State and local level.

For the State, generally, they have to take the issues of developing uniform tools to assess capacity and monitor progress. Their needs to establish training systems, require mutual aid

agreements and resulting in electronic linking systems that we could also link in between the training state, local and general care providers and federal government.

However, if the state and it looks like they are, take leadership in these areas which has to be done at the state level because these things have to be uniform across the state, we locals stand ready to implement these plans given adequate personnel.

For my local health department, the most worrisome task is the ability to respond 24/7 to notification and then activate a response. My local health department which cares for, you know, a well-leading city of over 100,000 people has one at will physician - me. I would certainly say I'm committed, but it wouldn't be wise nor prudent to rest the responsibility entirely on my shoulders. Our personnel will not suffice. And this is the situation in most health departments across the state and that's why I stress the need for adequate staffing.

And in the surveillance and epidemiological capacity we are supposed to have the capacity to receive and evaluate urgent disease reports 24/7. This is problematic for most health departments. We need to have the capacity to rapidly investigate and maintain an effective epidemiological response.

I think it's pretty well known that most health departments in California close their doors at five o'clock on Friday night and don't come back till eight o'clock on Monday morning. To develop this capacity to aid people it doesn't take hard work, it doesn't take soft work, it doesn't take equipment. It takes people - people to manage systems and do the work.

Rich talked about our excellent PolyCal (sp) laboratory system in California. And it's true. However, the anthrax attacks in October--or the hoaxes trailing in California, we had no real anthrax, totally overwhelmed our public health system. So, our labs need a lot of capacity building both for every day communicable disease control, as well as urgent capacity.

I--I know I sound like a broken record, but I want to make something indelibly clear. Local health departments need staff to make these accepted critical capacities. We need to hire staff who work for the government and understand that they are disaster response workers.

In California, what have we dedicated to rebuilding our own public health infrastructure since September and October of last 2001. Last December, Governor Gray Davis allocated \$5 million for emergency funds to local health departments. This amounted to approximately 56,000 per local health department for the majority of local health departments in California. Compare this expenditure with 20.7 million to the California Highway Patrol, 2.1 million for National Guard soldiers who stand at the entrance to bridges, 17.5 million for Caltrans during the same time period. Don't mistake my intent, perhaps all these expenditures are necessary. I certainly don't begrudge other public safety agencies the funding for preparedness and response. However, none of these expenditures will protect the public in the event of a bioterrorist attack.

When public health systems are rated in terms of their readiness to respond, we almost uniformly respond that we're at two to three out of ten. Other public safety agencies state that in terms of

adequate personnel training and equipment, they're at seven to nine out of ten. Police and firemen always have the capacity to respond 24/7 and that's understood.

What we now need to understand is one, bioterrorism is the threat that looms the largest for this nation; two, public health is the first line of defense against bioterrorism; and three, the public health infrastructure is seriously eroded in California and across the nation and needs to have the capacity to respond 24 hours a day, 7 days a week in order to protect the people of California. It will take serious sustained allocated funding to build a public health staffing to make this critical capacity.

And I think I'll end there. Thank you.

**DR. SCHAUFFLER:** All right. Thank you. Before I open up to the audience, I just wanted to give Dr. Gostin and Assemblyman Richman a chance to respond to anything that the respondents said.

**ASSEMBLYMAN RICHMAN:** Thank you. Let me just pick up first of all where Dr. Namkung left off. I can't emphasize more than she did the importance of enhanced and ongoing funding of local public health policies. \$5 million is a drop in the bucket. That amounts to 15 cents for every Californian that was allocated for public health. We need to not only invest in capital resources, but we need to invest every single year in people in our public health agencies. If we don't do that, we won't be able to have an adequate response to a bioterrorist attack. The estimates are that that may run in the range of \$50-60 million every single year for the state of California. And that's what needs to be committed.

I would also emphasize that the money that we get hopefully from the federal government and the CDC absolutely needs to be committed to local public health agencies and should not be lost in the overall state budget in this time of an almost \$20 billion budget deficit.

As Dr. Namkung said, our public health system is seriously eroded and it's something that we need to rebuild. Let me answer--or make a couple of other comments regarding the public--the Emergency Health Powers Act here in California and some of the discussions that we've had.

We do recognize the measures that--that the act as it's written places the power at the government level and Department of Health Services. We've had a number of discussions with the local health officers to assure that the response will be down at the local health officer level also and that in fact, there will be adequate discussion with people who are experts in public health - physicians, health officers.

The planning commission that you spoke about that needs to be done in six months, it's important that that plan be done in six months. The bill also remarks that it be annually updated. And we also intend to have that plan reviewed on an annual basis by the state legislature.

As far as scaling of powers, clearly we anticipate having the least restricted means as you spoke about. That would be part of the planning process. Again, we think that the bill has provided protections for persons and would hope that those least restricted means are part of the plan.

In due process issues, we are always to open to improving due process, keeping in mind that the ultimate goal is protection of the common good and public safety. I think that that's--I think that that's really it.

**DR. GOSTIN:** I agree with much of what's been said, certainly the importance of local public health capacity, the Institute of Medicine report will reinforce all that you have said.

In terms of the administration's response, I--I hope, I welcome the comment and hope very much that the administration will be engaged, that it won't sit back, you know, not take a position, but actually work with the legislature to try to identify those areas where there are gaps. I mean, nothing could be more important in the administration's point of view. And I would just kind of want to encourage that. I think that's what you intend.

In terms of the law, I mean, you make very good points about the law. And they involve trade offs. The power is placed with the governor and we thought that that was actually quite important. We had a lot of consultation about that. The governor is the chief executive of the state. We don't think--we think that the governor should be politically and publicly accountable.

It is very important as the statute says for the consultation--or the consultation of public health. And I do agree with that. The reason that it has an escape clause that's just God forbid there was something that was so urgent that you couldn't wait around for the consultation. And so it was just simply an acknowledgment that at some times you can't in a devastating emergency.

In terms of planning, the plan does require and encourage widespread participation from all the major public health and political constituencies. So again, we've really tried to do that and more can be done. We would certainly support it.

In terms of language and culture, I applaud that. If the law doesn't--we thought we had dealt with that in the law. If you feel that it isn't adequate, it should be made adequate.

And then due process, we think the law does provide very strong due process as the Assemblyman quite rightly said. If it can be made better, we would make it better. The idea about having notice sometimes while the person is in isolation is again just simply intended as common sense. Sometimes if someone has an infectious disease like smallpox, you first get them into isolation and then provide due process. You can't--you can't risk the public by doing it any other way. And it was just intended to do that.

So I really welcome this. This has been a wonderful example of delivered democracy that we're kind of trying to struggle with issues that have challenged the nation for some--since inception.

**DR. SCHAUFFLER:** Okay. Thanks. I'd like to open it up to comments and questions to the audience. And if you want to direct your question to a specific panel member, please do so. Okay. Patty. Please say your name and/or affiliation.

**MS. PATTY HANDLEY:** I'm Patty Handley (sp) and I was the former Assistant Director for Health Policy at the Department of Health Services. I'm now an independent consultant. I have not worked in this area but I'm fascinated by what I've learned today. I have long been concerned about capacity issues and certainly have been raising them for many years in the state of California. I don't think they've at all improved during the time that I've been watching.

But I'm curious whether there's anything going on in terms of provider emergency supply. For instance, requiring all licensed physicians, nurses, et cetera to do something equivalent to guard duty - National Guard duty in our public health departments. I don't know whether there's any discussion of that going on but if there isn't, I think perhaps one should take place.

**ASSEMBLYMAN RICHMAN:** You know, I--as I said, I introduced Assembly Bill 1921 which would require four hours of training every two years for physicians, nurses and pharmacists. Even that proposal is deeming quite a bit of debate and discussion and contention. It really is four hours of disaster preparedness with two hours focused on overall disaster preparedness and then two hours at the local hospital where the physician or nurse is on staff or works, and then the pharmacists affiliated with the local hospital also so that it can be a local response. That in fact is getting quite a bit of discussion and debate.

Also within the Model Emergency Health Powers Act, there is provisions that would require as a means of licensure for physicians and pharmacists that they participate in a disaster response. And that also has generated quite a bit of contention.

In my own experience in talking with physicians, nurses and pharmacists in the community, they really do not know where they fit in to the system. And I think we need to remedy that situation. I assure you that provisions like this generate a lot of opposition from those various parties whether it's the California Medical Association, California Nurses Association, or the pharmacists. And that's something that we're going to have to try to overcome.

**DR. SCHAUFFLER:** I think we'll—yes, go ahead.

**DR. NAMKUNG:** I think your question is a very important one because when you look at the overall structure of public and health care in the United States, 99 percent of resources, whether it be people, goods, historically whatever in the private sector versus the public sector. And so we all have a lot discussion about how to use those resources wisely and effectively once, you know, it's necessary.

I think that each of us at the local level depends upon our relationships with our medical societies and our local providers to build that so it realizes--Dr. Gostin said, we use these issues of isolation, quarantine more quieter, the vast majority of people they'll step forward voluntarily. I think that's true of health care providers in our local communities where we really don't have systems in place in order to use people effectively or have supplies ready.

You know, a huge concern for me is protecting the people, building my own staff and anyone else who I would have volunteer. I mean, I heard Dr. Henderson, as I said he's an expert on

smallpox, talk about pre-vaccination of people with smallpox because it really is smallpox that we're all dreading the most as the most lethal.

And I think until we can actually pre-vaccinate contracted people so that they know they are protected, we're not going to get very many volunteers. So, all this requires such a tremendous amount of work on our part, which we're willing to do.

**DR. SCHAUFFLER:** Yes. In the far back.

**MS. NANCY CONNOLLY:** Hi. My name is Nancy Connolly and I'm here for Blue Cross of California. I'm a clinical research manager down south.

And one of the things I've noticed that's really a omission from both the federal level and then down through the state is I don't hear any mention of the inclusion within the health care delivery system of the health plans who already have I believe organizational, structural capability and capacity to cover the entire state - not just any one health plan but all of them. They are able to epidemiologically identify diseases pretty much real time. And if you have something that was spread through the mail or some other airborne methodology, you would be able to potentially track and trend what was going on and send out a warning system.

I do know that the CDC is looking at including plans and they're having some high level talks with the Blue Cross/Blue Shield Association out of Chicago. But in terms of the money that the federal government is giving, it sounds like a lot but it's not going to go very far nor can it develop as fast as we really need. And all you have to do is go to New York to see what has occurred there - the capacity and the training.

I'm also a health care professional. And two years from now when my license comes up, okay, I'll go get some you know, bioterrorism training. It's just not adequate to what we're going to face as you say, when it happens. Has there been any consideration at the state level through the Department of Health Services in including the health plans as a part of your surveillance and your epidemiology because they do have the capacity and many as you know, are more than willing to be good corporate citizens? And this is really an open question for any of you.

**DR. BURTON:** I'll initiate maybe a comment that I know about four weeks ago there was a state department health services sponsored at least a forum for health plans to come together and be briefed upon some of the recent developments in the public health preparedness plans and the hospital preparedness plans in trying to start at least some opportunities to benefit from the health plan structure that exists currently in California that's very strong. Those--that was an initial discussion. There will be follow on discussions and we look forward to working with the health plans as, you're correct, they represent a great strength in the state of California.

I think you touched on a few--the importance of continuing education and appropriate training for health care professionals. And I want to highlight any one taking in this roundtable forum the importance that local health professionals - both the public health professionals that played ever since last fall, along with state public health professionals that have provided continuing education forums at county medical societies, in hospitals, around say community forums in a

formal continuing education programs that public health--or that health care professionals are more commonly attending.

So, there have been a number of forums that have already existed to build capacity for a continuing education training standpoint and there will be ongoing opportunities for the health plans in California to participate in this plan.

**DR. SCHAUFFLER:** Do you have anything to say that, Assemblyman Richman?

**ASSEMBLYMAN RICHMAN:** Yeah. I would just say I would look forward to health plans doing as much as they can, too. But to think that the health plans can participate in real time identification and tracking and trending, I really question that. We're not talking about looking at claims experience. We're not talking about looking the next day at hospital admissions. We're talking literally about real time identification and surveillance here in a public health emergency.

Furthermore, the state of California, the majority of our patients are in delegated, managed care plans where the identification of services and tracking is done at the medical group level and is not done at the health plan level at a real time basis. So we have to go a long way from where we are now to having real time data at the health plan level that would be useful in a public health emergency such as smallpox.

Again, I welcome the health plans participating as much as they can but to think in a delegated model as we have in California that they're going to be able to provide real time identification or tracking and trending, I just don't see how that's going to happen.

**DR. SCHAUFFLER:** Yes. Here up front. You. Yes. Thank you.

**MR. STEPHEN RAND:** Hi. I'm Stephen Rand (sp). I'm the principle (inaudible) and coordinator for the county of San Diego.

And I have a question for Dr. Bau and Dr. Gostin and Assemblyman Richman. The power-- we've looked at the power of the health officer in the model law and the question is what would the advice to the enforcement component? Somebody breaks the law and do burglary. They're taken to jail. You've got a situation where you've got 6,000 people surrounded in case patient who've been now quarantined. And we're not going to take them to jail if a few--select few that decided to run it. And I know I've had the discussions with our law enforcement community about we're not going to leave until the health officer or in this case, the governor, with the new model law would give us advice, you know, can we shoot them, can we detain them? What are we going to do to keep them in there?

Second thing, the due process that you discussed and the emergency lawyer--I mean the emergency judge acts, et cetera, bring into account those numbers of people that would like due process brought forward. But that's fine if you're talking 10 to 15 and it's an isolation case. What are you going to do or what's the plan when we're talking 6,000, 7,000 people that are now

beginning to question, hey look, I need to go to work. My family--I need to go to the store. Have that--has that enforcement component been addressed?

**DR. SCHAUFFLER:** Who would like to start? Ignatius?

**DR. BAU:** I was going to defer to the office. I think those are the kinds of details that we currently need to identify in the current planning. In other words, it cannot be in the abstract. And it also has to be, as you correctly point out, the scale, of whether we're talking about a dozen individuals or whether we're talking about thousands of individuals. Which is the most appropriate? What measures are the most appropriate? Who should be involved in the original quarantine? Whether critical or not it can simply be a matter of using locked facilities and health facilities or whether or not or not we actually have to move into more penal facilities or criminal facilities or create new facilities who spontaneously. And so I think that range of planning needs to be again, not just addressed as the abstract, and I think also not only detailed in terms of legal authorities but in terms of operational practicality, in terms of actually what is going to take place.

**DR. GOSTIN:** We actually spent a fair amount of time discussing both those issues. On the problem of many thousands of people meeting here, we do have provisions in the model law for class actions. And so we have thought that through and do have provisions to make sure that there are due process protections even if there's a large class.

On the enforcement question, the--that is a judgment call. We decided not to have very punitive criminal measures as Helen and I had talked about because we didn't like to make isolation and quarantine seem like it was a criminal punishment.

On the other hand, the act and provision for enforcement of isolation and quarantine to use all reasonable force to make sure that persons who are a danger to the public remain in an isolated or quarantined conditions.

**DR. SCHAUFFLER:** Just to follow on, I guess my concern was that to the extent that the consequences of not complying were simply a misdemeanor. But my concern was that that was not enough of a deterrent. But a misdemeanor these days doesn't seem to be that big of a deal. And so I don't know what the right answer is. Clearly you have made a decision not to make it stronger than that. I think this is a question that requires a great deal more debate.

Yes. Yes. Right there. Who is that? Oh.

(inaudible).

**UNIDENTIFIED MAN:** --And there seemed to be a lack of a real--a medical leadership - informed medical leadership and process. So the question in terms of the state level, is there a rule for kind of taking the medical spokesperson or a state medical health officer for this process?

**DR. BURTON:** What I would say, yes, is that part of the planning is going on and recent developments within the state health department are to have a definite focus in bioterrorism preparedness. I'm part of that focus team that will be working for the director. We also know that we recognize that if we had a 61 local health jurisdiction, very capable local health physicians that know their communities and know the best concerns and of ways to communicate within the communities. And, that part of this public health preparedness plan that will be delivered to Centers for Disease Control on April 15th, will include an initial draft plan on risk communication and how best to have a coordinated PIO response in the event that we do have an occurrence. And actually a plan that will address also proactively, how we might be communicating with our communities most effectively in order to help them be as prepared also.

**DR. SCHAUFFLER:** I have a question. Is there any training that has been done since September 11th with local and state health officials with respect to how to communicate most effectively in a high risk situation?

**DR. BURTON:** Well, I know there have been a number of more informal settings. I know also Centers for Disease Control, had a Webcast training that a number of folks were able to participate in some degree. And it's also available for the next 20 days I think or so at this point. So that I know that a number of other health officials are taking advantage of it over the next couple of weeks.

**ASSEMBLYMAN RICHMAN:** Just a quick comment on that. As part of a disjointed response, I'd like to invite Dr. Burton, I've invited the administration on multiple occasions since November to work constructively on the Model Emergency Health Powers Act. And I would only extend the invitation again to work in a proactive manner on that so that we can get appropriate legislation in place.

And I would invite you or whoever represents the administration to participate on a regular basis in drafting that legislation in the best way that it can be. Not to put you or the administration on the spot, but I think I've written two or three letters, had multiple phone calls inviting the administration to participate in the discussions and the debate around this bill and there has been none to this point in time.

**DR. SCHAUFFLER:** Okay. Any other questions or comments? Yes, sir.

**MR. TOM BANKS:** Tom Banks (sp) with the California Academy of Family Physicians. Quick question and follow up with I think Dr. Richman brought up the point that we're not adequately prepared to deal with an outbreak of flu, influenza.

I guess my question is has there been any real debate about terrible workforce disparities in California, the fact that there's essentially in the state, 58 counties that are below the standard of adequacy for primary care physicians, population ratios, the issue with nurses, that's it's kind of a monster issue that I think everybody's afraid to grapple with because the ratio of nurses to population is so low. Has there been discussion around other than just kind of the health officer problem and how we have the workforce out there to detect sentinel cases when they come in to a clinic or in to an emergency room?

**ASSEMBLYMAN RICHMAN:** Tom Banks, I think you know I talk about the basic health care infrastructure in the state of California all the time. I've very worried about the health care infrastructure in California, not only that we cut out the fat but we've cut through muscle and into bone. To expand upon what you're saying, Dr. Gostin mentioned the surge capacity of our health care system. Currently, two-thirds of the hospitals in our state are losing money. The average operating margin is negative. Emergency rooms are closing, diverting patients. Trauma systems are on the brink of collapse. We have a nursing shortage that's estimated between 35,000 and 45,000 people. We have physicians leaving the state and leaving practice. We have many medical groups that have gone bankrupt. The majority that survived do not meet the financial solvency requirements set by the state.

So we have a health care infrastructure that's teetering. And it's not just a workforce problem. I mean, it's certainly problems with our workforce, with physicians, nurses, pharmacists, you can go down the line. But it's also the basic health care infrastructure. And in my view, it comes from an inadequate financing of the entire health care infrastructure.

We know that Medicare rates have not kept up with the cost of care. Medi-Cal here in the state of California is at the bottom in the country and reimbursement rates are typically 55 to 60 percent of Medicare rates. We have nearly 7 million or now 6.2 million people who are uninsured in the state of California.

And so our health care system is really teetering, whether you're talking about the hospitals or the workforce. And we do need to answer those problems and I think that they need to be answered in a coordinated fashion. Not only is it necessary to bolster our public health system, but we in fact, need to bolster our entire health care infrastructure. We are just not prepared for this.

**DR. SCHAUFFLER:** Anyone else. Okay. Other questions. Yes? This woman right here has been trying for a while.

**MS. HELEN LASKU:** Hi. My name's Helen Lasku (sp) representing home health care in California.

And our members are wondering what is the role for home health care. We haven't really talked about that component of it. We talk more about the hospitals, but I know that our nurses are out. And they're at the forefront when we do the immunizations for the flu and we talk about smallpox there. And they see a role that they're not really sure how they tie into it or how they impact it.

**DR. SCHAUFFLER:** Richard?

**DR. BURTON:** I think it's an excellent point. And I think every venue that I've been it where there's been local health officers and state public health officials that have been involved in discussions about how to best plan, each and every time it's needed to address the needs of many medically fragile individuals, those that are being cared for in the home health care environment,

those with disabilities, those that depend on a different ancillary health care providers in the community for a good deal of their health care.

And so, I think each one of those venues that we validated that there's every aspect of our health care delivery system in California needs to be a part of our preparedness and planning to some degree. Each one has its unique role and expertise but we need to include all health care providers as we address bioterrorism preparedness.

**DR. SCHAUFFLER:** So how would their organization go about becoming involved, they contact you?

**DR. BURTON:** That would be an effective way.

**DR. SCHAUFFLER:** Okay. Any other questions, comments. Yes. Oh, sorry. Ignatius.

**DR. BAU:** I think we're still learning from the anthrax experience. And one of the things I think we have learned unfortunately from that experience is that often times those populations that again in any sort of public health or health strategies, that we often characterize the hardest to reach are in fact some of the most vulnerable to this. So that's the case--in rural New York, where there was again no sort of clear correlation that we can now tell and yet those that were relatively isolated from use and we thought from contact ended up being at risk.

And so, I think again, part of looking at any sort of planning to turn that equation on its head. And then start with those kinds of populations as priorities rather than simply saying oh, how do we deal with folks who can't speak English, how do we deal with folks that are homebound, how do we deal with folks with disabilities as sort of an afterthought as opposed to saying those folks, in fact, may be at the greatest risk and the most vulnerable.

**DR. SCHAUFFLER:** Okay. Thank you.

Are there any others? Yes.

**MS. ESSIE BALDWIN:** Hi. I'm Essie Baldwin (sp) with Kaiser Permanente.

And Assemblyman Richman, you mentioned that there's a need in California for real time identification and tracking of diseases. So, I have a two part question. What are we doing now in California to do that and what do you think is the best approach that we should use to assure that?

**ASSEMBLYMAN RICHMAN:** Sure. I think Dr. Namkung and Dr. Burton can probably answer even better than I can, but I think that that real time surveillance and tracking is a very important function of the local public health agencies. And what Dr. Namkung was talking about was the staffing that's currently not adequate, having people around--enough people around to in fact identify diseases, track the information, having the communication processes in place.

Most of our counties in the state of California do not have electronic communications that allow for real time surveillance. It includes in fact provisions which we expect to include in the bill regarding syndromic surveillance so we can in fact pick up syndromes and diseases as early as possible from different hospital emergency rooms, different locales. And put that information together, so that we would be--then become aware first of all that an attack has taken place and then be able to make the decisions to prevent the spread of that disease as well as we can.

But I think Dr. Namkung really spoke better than any of us as far as the inadequacies of personnel, laboratories and communications that currently exist in our public health systems. And if you could respond a little bit more to that.

**DR. NAMKUNG:** Well, I was going to speak more in terms of process. And we're talking about participation in health plans because Kaiser has been unusual. And working in this state on several model projects that do provide real time surveillance. But, Rich, you know more about these projects than I do, but we certainly do influenza surveillance at both Northern and Southern Kaiser. And the offer certainly is running there which is crucial, our ability to both forecast and allocate resources.

I think it's wonderful to hear that the other, you know, major insurance plans are interested in participating in this because we certainly need them. I think the problem has been a uniform system, something that we all agree on will work and will be easy to use and can communicate, you know, to all the world in public/private, you know, from local to national. We won't be on that yet.

Do you know more about the electronic disease reporting?

**DR. BURTON:** Yes. I think that there, as we talk about preparedness and planning and implementation and the interventions that will better prepare us and enhance our preparedness on a daily basis, it's important to look at incremental improvements that we can make. And I think what Dr. Namkung and Dr. Richman mentioned as far as there have been initiatives in place in the state looking at electronic disease reporting in from the laboratory standpoint that Kaiser's been involved in looking at influenza like illness or febrile illnesses that again Kaiser's been involved with as looking at model applications.

And I think also though as reassurance of our communities, we have a system in place right now that really is the real time system and essentially in every jurisdiction around the state and that it's up to alert and train providers. And we have a wealth of skilled providers in this state that are now increasingly aware of the signs and symptoms of biologic agents that might be linked to terrorism and also an increased awareness of how they can link to local health jurisdictions which is how we got reporting laws set up in California, they report with the local health.

And I think that the technology systems that we have in place such as our phones and pagers serve us well on a daily basis in a broader array of issues. And those current technology can also serve us right now with the longer term fixes and more complicated technological approaches.

But we do have some--systems are in place today and are mostly dependent on skilled health care providers which we have in California and the more routine reporting processes to the local health jurisdictions.

**DR. SCHAUFFLER:** Peter.

**MR. PETER HASKELL:** Thank you. Hi. Peter Haskell (sp) with the Center for Research.

I guess in addition to the differences between the model act and California statute in the areas of planning and the process for declaration of public health emergency, it looks to me looking at the two side by side that one of the main differences is the level of specificity of powers that are granted to public health authorities or health officers.

And you know, certainly a case conveyed, I think Assemblyman Richman mentioned the problems that health officers might have getting legal interpretation of their authorities can be raised as an argument in favor of more specificity. I guess is there an argument to the--to counter that that less specificity might be better in some cases on legal or other grounds?

**ASSEMBLYMAN RICHMAN:** Yeah. I think you make that an extremely good point. In fact, we've had that discussion with the public health officers. And what we looked for is the Model Emergency Health Powers Act not replacing current health law but in fact being in addition importantly, so there is one section of law that's comprehensive, that defines it in a specific act-- in this specific act but does not replace what's there for exactly the reasons you're saying. Is that, Poki, did I--?

**DR. SCHAUFFLER:** Yes.

**MR. BOB EISERMAN:** Hello. Bob Eiserman (sp) with Kaiser Permanente.

We heard the discussion today sort of reinforced the need for comprehensive planning at lots of levels around public health and provider level and for sort of all levels of the disaster planning in addition to bioterrorism. But we seem to concentrate more on the sort of Emergency Powers Act law and different aspects of that which is important, but that's one aspect.

Could the panel comment on other aspects of the sort of efforts that they see or are aware of in California to coordinate and bring into being sort of all the other pieces that need to take place to really adequately be prepared for as the forum talked about, terrorism or bioterrorism or some other kind of major disasters for that matter.

**DR. BURTON:** Well, I think you make an excellent point in that while we are preparing for bioterrorism, we need to address other aspects of terrorism preparedness also and then all kinds of disaster whether they be natural or related to terrorist events.

And I think that in the public health community consistently while we've had our focus and the funding is being directed to make sure that we're prepared for possible bioterrorism, we're

looking to leverage that preparedness to benefit us in all those other realms to, in all hazard response, both natural and terrorist related.

As far as some other activities going on in California, there is a state strategic committee on terrorism that the governor's appointed with a subcommittee on public health--protection of public health which has a focus area on preparedness across these different aspects of bioterrorism - chem, explosive and nuclear. And then also there's the advisory committee to the hospital preparedness plan that's being put together that also has broad perspective and a broad membership in relation to general disaster and a hospital's role in that situation.

**DR. BAU:** And I just wanted to emphasize that it's not again simply limited to the governmental departments of public health at whatever level, but it certainly with the health plans with private providers but all employers, folks in the community. I think again, what the events of the fall has done is it has made that kind of awareness. But again, I'm not sure how systematic those kinds of emergency preparedness are now still being sustained in terms of making sure that communities are aware.

I also think that on a negative note, the unfortunate experience about sort of recruiting blood donations by the Red Cross and then not using them, I'm not sure how that's going to play out in terms of sort of a call to action to the community the next time there is a serious need for blood. And I think being ahead of the curve in thinking about those kinds of communications in the public is going to really critical.

**DR. SCHAUFFLER:** Yes. Did you want to make a--one moment, Hattie.

**DR. NAMKUNG:** I think you bring us to another important issue. When we talk about beginning to build a comprehensive plan - we talked about it in a sense, but I'm very anxious to see this Institute of Medicine's report on the state of public health in the nation because I think it will be devastating. And to her Assemblyman Richman's comments about the state of the private health care in California, it's really equally devastating. It really--it's a matter of grave concern when we think we're getting some goal assisted money here and you're never near equal to--when someone talk about enhancement.

Let's talk about getting back to, you know, a real functional level so that we can protect people. It is really of grave, grave concern.

I think--and it's something that it strikes me as very ironic to be aligned with a Republican federal administration, a Republican governor who do seem to understand the importance, the national security issues of preparedness - bioterrorism preparedness. When we in California are enforcing the figures that (inaudible) in this budget, I just read a newspaper article, where he's planning to spend up to \$353 million in the next two years. And I highly doubt that any of that really is going to go to health care or to public health. I think we need to look at our priorities seriously and change them.

**DR. SCHAUFFLER:** Patty.

**MS. HANDLEY:** I know that we still have 50 minutes or 40 minutes left of discussion so I'd like to ask about the Institute of Medicine and national discussions and state level discussions about how we're using computing capacity, for instance super computing capacity, to track. Are we using the capacity that we have available? Are we tapping into our private sector resources? Is this a golden opportunity for public health to marry where we are in computing capacity with our needs in public health and really advance the public health of the country tremendously by simply getting up to date and tapping into those private sector resources?

**DR. GOSTIN:** I can go at the national side and then perhaps you can deal with the local and state side. I don't think there is--we're at the level of one out of ten in terms of electronic and computing capacity as far as the country's concerned. There is very little there. In fact, if you send faxes to local health departments across the country, most of them won't get it or respond.

What you're talking about is way above what exists. The CDC and the IOM are both have electronic data systems and data systems generally as one of the core capacities. So it's very much on the agenda. But it will take a lot more resources.

But you also think that even with bioterrorism, I do agree with you that bioterrorism has been a leverage point for improving public health generally. But even at the federal level with the large influx of funding on bioterrorism and particularly with President Bush's recent budget proposals, if you look at those, the lion's share of the resources go to not public health or population based prevention. They go to advanced biotechnologies and things which has always been the way we've dealt with thing in the United States.

And I think we need to try to get back to basics to try to get the kinds of--the laboratory capacity, a capacity for data systems, workforce that are desperately needed at the state and local level in the United States. I think that's what the Institute of Medicine will say. It's what the CDC's been saying.

**DR. NAMKUNG:** I think that if we had the kind of system that you've described and envisioned, it would be wonderful. It would be wonderful and it would certainly help us to be more effective and efficient. However, we still need the people, you know, people in that system. I think that--I was very interested to hear Dr. Henderson talk about the role of technology and all this information gathering, et cetera and I mean the earlier part of intelligence. You know, we have reams of information, I mean, there's tons of information coming in. You know, then you've got the people on the ground. And that's what--there's nothing wrong with a little drum shoe epidemiology here. You know, people on the ground and those of us at the local level who've developed a relationship, when I think of all the major outbreaks that I've had in my community, notification has come to me from relationships that are nurses and our staff have built with progress in the community.

And they haven't come through any electronic communications. They've come because, you know, the local Y noticed that something was happening with a family and they called us. So, it's been that way over and over and over again. That really is what public health is about. It's people to people. And can't (inaudible) to do that. You need to have the people here.

**DR. BAU:** I wanted to make a couple of comments. One, I think in terms of surveillance generally, I think many people are surprised at how patchwork it is. Again, the local, the state, the federal level, even with our currently reported goals inconsistency which each level collects, analyzes and then re-decimates that data. And what it does with it is very, very suspect across major categories like race and ethnicity, across what field data fields were actually collected and analyzed. So, that's an ongoing issue.

I think there's two other issues there. One is I think there's a healthy step this is on about the use of surveillance in epidemiology in a way that's ultimately helpful, that a lot of times the data has been collected but not being used. And a lot of the attention that we've now given to the notion of health disparities amongst different population is not anything new. The surveillance data has been there all along, simply because there are now groups that are highlighting it like the Institute of Medicine and other organizations that are weighing and saying, look this is what the data shows. And, therefore, the response needs to be different. It's simply not pointing out that this data is there.

I think the final thing that will drive that ultimately comes around the other side and September points that I think until that--the need for data around conditions, around the quality of care, around access to care is the kind of issue that consumers demand from the providers in their health plans and from their government and in a way that is much more uniform and understandable so that they can also proactively participate in that kind of planning and program design to meet those kinds of issues is ultimately--and again, I'm not sure what the opposition is going to be in terms of bioterrorism response. But again, I think health consumers can also be of help of us in shaping what kind of information is out there and how it's collected.

**DR. SCHAUFFLER:** Does anyone else have a question? We don't have to stay till five if no one has anything else to say. All right. Thank you all very much for coming today. Really great roundtable. Thanks.

END

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