Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science
Volume 11, Number 2, 2013 © Mary Ann Liebert, Inc.
DOI: 10.1089/bsp.2013.0022

Commentary

The Changing Nature and Scope of Public Health Emergencies in Response to Annual Flu

James G. Hodge, Jr.

The rapid spread of influenza during the 2012-13 season brought a series of public health challenges and corresponding response efforts. For decades, responses to annual flu have been undertaken routinely without extensive legal intervention. With the recent declaration of states of public health emergencies in Boston (January 9, 2013) and New York State (January 12, 2013), however, the legal baseline is changing. Propelled by a slate of state and local emergency declarations during the 2009-10 H1N1 pandemic, public officials are beginning to show cause for the issuance of formal emergency declarations in support of flu response efforts. The legal effects of these types of declarations are profound. Public and private actors are given significant, expedited public health powers. Scarce resources like vaccines can be more efficiently allocated. Laws relating to licensure, scope of practice, and liability can be effectively waived. Though originally conceptualized and once reserved for catastrophic, long-term health–related or bioterrorism events, public health emergency declarations are evolving to address temporary impacts on health care and public health services arising annually from flu outbreaks. This commentary explores the changing nature of public health emergencies and their current and potential impact on the provision of healthcare services in response to national or regional threats to the public's health.

With the rapid spread of influenza during the 2012-13 season came a series of public health challenges and healthcare response efforts. Public health agencies activated flu preparedness plans and immediately urged people, especially the young and elderly, to get vaccinated. Predictable vaccine shortages arose in some locales (even though only about 40% of Americans get vaccinated annually). Antiviral supplies ran out in some places. Urban hospital emergency rooms faced temporary surges in symptomatic patients. Some hospitals opened auxiliary screening areas staffed in part by healthcare volunteers. Others hosted vaccine drives. Hospital administrators encouraged—and, in some cases, required—their staff to be vaccinated (with support from the American Medical Association, the American College of Physicians, and the American Nurses Association).[1] Social distancing techniques were implemented to limit the spread of flu. For example, healthcare workers with flu symptoms were encouraged to stay home. Healthcare entities temporarily curtailed patient access to visitors presenting with flu symptoms or forbade the

James G. Hodge, Jr., JD, LLM, is the Lincoln Professor of Health Law and Ethics; Director, Public Health Law & Policy Program; and Director, Network for Public Health Law – Western Region; Sandra Day O'Connor College of Law, Arizona State University, Tempe, AZ.

entrance of minors (a prime vector for spreading infectious diseases) as influenza swept through their communities.

For decades, these and other traditional response efforts have been undertaken without much debate or significant legal consequences. Although the type and spread of flu virus in 2012-13 were more severe than in other years, in many ways the season followed the norm, or so it seemed. Accompanying this year's preparedness and response efforts, however, was a subtle change in public health law and policy in at least 2 key jurisdictions. On January 9, 2013, Boston Mayor Menino declared a formal state of public health emergency in response to flu prevalence in his city.[2] Three days later, New York Governor Cuomo followed suit, issuing a statewide public health emergency.[3]

Subject to variations across jurisdictions, these types of emergency declarations can literally change the legal landscape in furtherance of response efforts. During an emergency, public and private actors can exercise expedited public health powers. Government is authorized to quickly acquire and allocate vaccines, medicines, or other scarce resources. Shifts from conventional to crisis standards of care may be facilitated. Laws relating to licensure, scope of practice, and liability of healthcare workers and entities are subject to alteration or waiver. The use of these profound emergency legal powers not only represents an evolution in public health law; it may change the game of how healthcare providers and public health officials handle annual waves of flu patients in years to come.

Public Health Emergencies in Conception

At first glance, declaring a public health emergency in response to yearly flu outbreaks makes sense. Annual flu waves kill thousands of Americans and temporarily disable millions more. Schools, commercial establishments, and events may be shut down for brief periods, leading to billions of dollars in lost productivity. To be sure, flu is serious business. What other naturally occurring national event produces such extensive societal impacts and excessive costs each year?

Still, categorizing something as predictable as the annual flu season as an "emergency" seems specious. Just over a decade ago, the very notion of declaring a "public health emergency" concerning flu (or any hazard for that matter) was largely unheard of. Governments' existing powers to declare more generalized states of "emergency" or "disaster" could be used to address a public health crisis, but these powers were typically reserved for earthquakes, floods, hurricanes, or other natural catastrophes. The legal concept of "public health emergency" largely did not exist.

Much changed after the anthrax bioterror attacks in the fall of 2001. A national call for legal action led to the development of the Model State Emergency Health Powers Act (MSEHPA), which set forth new standards focused on major communal health threats. MSEHPA defined "public health emergency" as an occurrence or imminent threat of an illness or health condition that:

> (1) is believed to be caused by … bioterrorism; the appearance of a novel or previously controlled or eradicated infectious agent or biological toxin [or other causes]; … *and* (2) poses a high probability of … a large number of deaths, … serious or long-term disabilities, … or widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population.[4]

Though labeled by some as "draconian" (among other barbs), the federal government, over half the states, and many localities incorporated key provisions of MSEHPA into law soon after its completion.[5] Legislators and policymakers understood the relevance of the act's modern "cause and effect" criteria for declaring a public health emergency. Absent an executive finding in real-time events, neither the emergency nor its extensive public health powers may take effect. Given its high threshold for such a declaration, a state of public health emergency seemed destined to remain on the shelf, invoked only in response to some future bioterrorism attack, mass toxic exposure, or spread of a highly virulent disease that could quickly kill or disable large numbers across a population.

Public Health Emergencies as Applied

Not long after national implementation of legal reforms based on MSEHPA, however, the concept and role of public health emergencies began to evolve. Public health emergency declarations arose in response to differing threats with variable impacts. Government declarations at the federal, state, and local levels proliferated to support emergency response efforts during natural disasters like Hurricanes Katrina and Rita (2005) and later Isaac and Sandy (2012). The rapid spread of novel, infectious diseases (an original target of concern for the drafters of MSEHPA) also garnered such declarations. Most notably, the 2009-10 H1N1 pandemic led the federal government and multiple states and municipalities to issue public health emergencies (many for several months) in support of response efforts. Some states' leaders declared general states of emergency or disaster as well. In 2012, an uptick in human cases of West Nile virus led Dallas County, Texas, and other jurisdictions to declare states of public health emergency.[6]

None of these events, though significant, arguably affected the public's health as greatly as the influenza outbreak in 2012-13 (or many prior seasons). Even the 2009-10 H1N1 pandemic did not actually negatively affect the public's health more extensively than conventional flu seasons, as had originally been feared.[7] Still, due in part to its novelty, few challenged the legitimacy of public health

emergency declarations in response to the H1N1 pandemic, especially to the extent they were issued preemptively to forestall an emerging global pandemic. To this end, these declarations in 2009-10 provided a pathway for their future use to address routine flu outbreaks—one taken in Boston and New York in 2013.

Even though existing, day-to-day public health powers and efforts may sufficiently authorize many flu preparedness and response efforts, officials may predictably declare emergencies in response to future outbreaks. By altering the legal environment, these declarations can assist public and private actors in thwarting the spread of a viral disease that kills thousands, impairs millions, alters societal activities, and strains the economy. Others may argue that public health emergencies should be reserved only for truly seminal events to avoid potentially infringing civil liberties or igniting public concerns. Indubitably, emergency powers should be used only where justified and always in limited scope and duration. Such boundaries are a hallmark of modern public health emergency laws. Ultimately, however, a new era of flu preparedness under an expanded understanding and use of public health emergency powers may facilitate healthcare responses and improve health outcomes.

Acknowledgment

The author acknowledges Chase Millea, BA, Research Associate, Sandra Day O'Connor College of Law, Arizona State University, for his research and editing contributions.

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Manuscript received January 30, 2013;
accepted for publication February 28, 2013.

Address correspondence to:
James G. Hodge, Jr., JD, LLM
Lincoln Professor of Health Law and Ethics
ASU Sandra Day O'Connor College of Law
Ross-Blakley Law Library, Room 318
1100 S. McAlister Ave.
Tempe, AZ 85287

E-mail: james.hodge.1@asu.edu