The Opioid Epidemic and the Future of Public Health Emergencies

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Introduction

On October 26, 2017, after weeks of internal deliberations, President Donald Trump directed Acting Secretary of Health and Human Services (HHS) Eric Hargan to declare a national state of public health emergency (PHE) in response to the escalating opioid epidemic.¹ In so doing, the President classified the opioid epidemic as the deadliest PHE to ever be so designated since the nomenclature originated in 2001. Over the last two decades, overuse and abuse of prescription and illicit opioids have contributed to rampant morbidity and mortality across the country. Since 1999 over 600,000 deaths among all ages, sexes, races, and classes are attributable to opioid abuse.² Solutions to this “Medusa of epidemics”³ are not easy, quick, or cheap. Absent enhanced and innovative public health interventions funded by a sizable infusion of resources, hundreds of thousands more may die by 2020.⁴

Like opioid-related declarations issued already by a half-dozen states and multiple tribal governments and localities,⁵ the federal PHE declaration is a purposeful step. Alongside other interventions, it legally authorizes federal, state, tribal, and local authorities to allocate existing personnel and resources toward opioid prevention efforts, waives some key legal inhibitions, ramps up critical public health surveillance, and facilitates greater coordination across federal agencies.⁶
Still, HHS’ declaration has generated considerable controversy. Some favor classifying the opioid epidemic as a PHE, but wish President Trump would have declared a full-blown national emergency to free up more resources. Others seriously question the utility of labeling a long-term, complex epidemic of opioid abuse as an emergency at all. They assert that PHEs are typically reserved for rapidly-escalating infectious disease threats or quick responses to humanitarian disasters. Debating the utility of a PHE declaration in response to the opioid epidemic, however, is misplaced for several reasons: (1) PHEs have been declared in response to threats far less serious than the opioid epidemic; (2) while a PHE declaration may not solve the crisis, it can diminish its impacts; and (3) innovations undertaken during a PHE can become standard practice post emergency. The primary question is not whether the opioid epidemic qualifies as a PHE, but rather what other conditions might also constitute PHEs going forward. This article suggests a series of criteria designed to better clarify PHEs for the future.

**Legal Scope and Range of Public Health Emergencies**

The terrorist attacks of September 11, 2001 and ensuing anthrax exposures prompted public health law scholars at Johns Hopkins and Georgetown Universities to develop model legislation for state and local officials to rapidly respond to emergency events. The resulting Model State Emergency Health Powers Act (MSEHPA), disseminated in December 2001, has been adopted by legislatures and agencies in almost all states and D.C., and used to declare PHEs in response to acts of bioterrorism, emerging infectious diseases, or other threats posing a “high probability” of deaths, disabilities, or exposures to harm-causing agents.

As illustrated in Table 1 below, PHEs have been declared under diverse circumstances necessitating a heightened legal response to protect the public’s health. Multiple PHEs have been issued to curb the spread of highly contagious, sometimes fatal diseases such as H1N1 (2009),
Ebola virus (2014), and Zika virus (2016) through strengthened medical countermeasures and enhanced authorizations of social distancing efforts. Humanitarian disasters, including Hurricanes Katrina (2005), Sandy (2009), and Harvey (2017), have sparked numerous other emergency declarations, allowing redirection of government funds and personnel to bolster local response efforts in devastated and overwhelmed regions.

Table 1 – Select Examples of PHE Declarations

<table>
<thead>
<tr>
<th>Date</th>
<th>Jurisdiction</th>
<th>Declaring Entity</th>
<th>Event/Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/6/08</td>
<td>Pima County (AZ)</td>
<td>County Board of Supervisors</td>
<td>Measles</td>
</tr>
<tr>
<td>4/26/09</td>
<td>United States</td>
<td>Acting HHS Sec’y Charles Johnson</td>
<td>H1N1</td>
</tr>
<tr>
<td>10/5/10</td>
<td>City of Oakland (CA)</td>
<td>Oakland City Council</td>
<td>Shortage of medical cannabis</td>
</tr>
<tr>
<td>3/19/12</td>
<td>County of Hawai’i (HI)</td>
<td>Council of the County of Hawai’i</td>
<td>Food insecurity</td>
</tr>
<tr>
<td>10/7/14</td>
<td>State of Connecticut</td>
<td>Gov. Daniel Malloy</td>
<td>Ebola</td>
</tr>
<tr>
<td>3/26/15</td>
<td>Scott County (IN)</td>
<td>Gov. Mike Pence</td>
<td>HIV</td>
</tr>
<tr>
<td>12/15/15</td>
<td>City of Flint (MI)</td>
<td>Mayor Karen Weaver</td>
<td>Lead levels in drinking water</td>
</tr>
<tr>
<td>8/12/16</td>
<td>Puerto Rico</td>
<td>HHS Sec’y Sylvia Burwell</td>
<td>Zika</td>
</tr>
<tr>
<td>8/26/17</td>
<td>State of Texas</td>
<td>Gov. Greg Abbott</td>
<td>Hurricane Harvey</td>
</tr>
</tbody>
</table>

Government officials have increasingly issued PHEs for events or conditions less sudden and severe than deadly outbreaks or humanitarian disasters. For example, PHEs of limited scope have been declared for food insecurity in Hawai’i County (2012), seasonal influenza in New York (2013), and homelessness in Seattle (2015). Though dissimilar in origin and trajectory,
these conditions mirror traditional emergencies in their need for additional funding, medical countermeasures, and skilled personnel to curb imminent and preventable threats to morbidity and mortality.\textsuperscript{24} Interventions proving successful during declared emergencies, such as allowing pharmacists to administer flu vaccines, can be incorporated long-term through routine public health practice.\textsuperscript{25}

**Qualifying the Opioid Epidemic as a Public Health Emergency**

Like a deadly infectious disease outbreak, recent mortality related to opioid misuse surpasses historically low rates. Since 2010, annual opioid overdose deaths more than quadrupled, reaching 64,000 deaths in 2016\textsuperscript{26} (and far exceeding comparable rates from motor vehicle crashes and gun violence over the same period).\textsuperscript{27} Despite emerging policies to control opioid prescribing,\textsuperscript{28} overdose mortalities continue to rise. This is due in part to increased trafficking of cheaper, illicit, and highly potent heroin and synthetic opioids such as fentanyl. These drugs are flooding the nation almost like agents of bioterrorism.\textsuperscript{29} Public health repercussions of the opioid epidemic are extensive. Heightened transmission rates of HIV and hepatitis C, for example, are attributable to unsafe opioid injection practices.\textsuperscript{30} Overwhelmed localities are in dire need of state and federal assistance to address preventable morbidity and mortality through additional funding, resources, and healthcare and addiction treatment personnel.

Six states and several tribes preceded HHS in declaring opioid emergencies to expedite essential interventions.\textsuperscript{31} These include enhanced data collection efforts in Arizona,\textsuperscript{32} naloxone standing orders in Alaska,\textsuperscript{33} and major funds devoted to drug addiction treatment and prevention in Maryland.\textsuperscript{34} In directing HHS to declare a nationwide PHE on October 26, 2017, President Trump promised increased Medicaid coverage for addiction treatment as well as actions against
prescription drug companies and illicit drug traffickers. In its final report on November 1, 2017 the President’s Commission on Combatting Drug Addiction and the Opioid Crisis further recommended increasing the affordability and accessibility of naloxone and additional criminal justice interventions such as drug court programs.

Clarifying the Criteria for Future Public Health Emergencies

The opioid epidemic inarguably constitutes a national PHE consistent with model legal approaches and prior applications. However, its classification within the spectrum of PHEs necessitates clarification to better distinguish other types of multifarious health threats. In 2017, for example, 30 million Americans will likely abuse alcohol. Millions will die of heart disease, cancers, stroke, and Alzheimer’s disease. Thirteen million American children will suffer food insecurity. Nearly that many kids face obesity. These and other serious conditions present real risks to human health, but classifying them as PHEs may (1) embroil legal and political controversies surrounding their legitimacy, (2) exhaust emergency resources, and (3) lead to unwarranted exercises of authority. How can PHE declarations be qualified to avoid these outcomes? Table 2, below, presents a series of criteria that can be used collectively to distinguish PHEs from non-emergencies.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>A PHE May Be Justified…</th>
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<tbody>
<tr>
<td><strong>Urgency</strong></td>
<td>where preventable morbidity or mortality due to a public health threat are likely to continue unabated absent more substantial interventions</td>
</tr>
<tr>
<td><strong>Escalation</strong></td>
<td>when the ascendancy of a public health condition leads to morbidity and mortality rates surpassing historic lows</td>
</tr>
<tr>
<td><strong>Imminence</strong></td>
<td>to prevent a potential threat (e.g., prospective release of a bioterrorism agent) from developing into a mega-threat</td>
</tr>
</tbody>
</table>
**Severity**
in response to potential or actual impacts presenting serious or irreversible public health risks for affected populations

**Scope**
if public health threats may significantly impact subgroups (e.g., infants, elderly) or smaller regions or locations (e.g., daycares, schools, hospitals)

**Interventions**
to authorize interventions, including removal of legal obstacles, that may obviate negative public health repercussions

**Efficacy**
to facilitate proven, otherwise unavailable measures known to effectively address similar threats

**Ethicality**
in furtherance of efficacious interventions that may be ethically questionable outside an emergency

**Duration**
where emergency measures of limited duration can lead to the termination, diminishment, or control of the public health threat

**Incorporation**
to promote positive reforms of routine interventions through demonstrated successes of emergency measures

*Urgency* may be the most persistent commonality characterizing PHEs. Rapid deployment of countermeasures against slowly-developing conditions like obesity or heart disease may be disfavored over incremental interventions. In the context of the opioid crisis, however, expanding naloxone access could curb on average 100 overdose deaths each day. Unremitting patterns of *escalation* absent rapid intervention may further qualify a PHE, though some declarations may hinge on the *imminent potential* to cause widespread harm. Under either circumstance, severe risk to morbidity and mortality lays the groundwork for a PHE declaration. When Connecticut’s Governor Dannell Malloy declared a PHE for Ebola virus in 2014,⁴² the *imminence* of Ebola to impact local populations, combined with *severity* (e.g., a high risk of death for exposed persons), spurred the ramped-up response despite no reported cases in the state.

PHE declarations are less contentious when their classification is limited in *scope* to definitive populations or locations afflicted by the threat. PHEs may also be justified by the commitment of *interventions* with known or predicted effectiveness to address the emergency. A
national PHE allows the U.S. Food and Drug Administration (FDA) to issue an Emergency Use Authorization for an unapproved drug, device, or intervention if anticipated benefits determinedly outweigh the risks of the condition left untreated. Aside from efficacy, PHE interventions must also be ethical. Unleashing a series of powers to address a perceived or known public health threat is untenable if those efforts are impractical, underfunded, or disproportionately encroaching on individual or community rights. Declaring PHEs to implement efficacious, legal, and ethical interventions augments public trust and confidence in public health authority.

By law, the national opioid PHE lasts 90 days (absent reauthorization). Temporary efforts made possible by declarations should hold promise to diminish or control the suspected or known threat. Limiting the duration of PHEs allows for strategic funneling of resources without disinherit ing other public health priorities. Resolving emergencies like the opioid epidemic entails a coupling of immediate actions and long-term reforms. Interventions demonstrating efficacy during a PHE can be incorporated later into routine public health practice. Calls for the FDA to convert naloxone from a prescription to over-the-counter drug during the opioid emergency, for example, may result in a permanent reclassification if the drug is demonstrated safe and effective.

**Conclusion**

HHS’ declaration of the national opioid PHE reflects a modern trend of utilizing emergency efforts to address a broad range of calamitous conditions. While there are no set rules guiding determinations of PHEs, re-examining criteria for their declarations is critical to meaningfully respond to future emergency-level crises. The factors presented above help identify
conditions where a PHE declaration is legally warranted. As public health threats evolve, emergency authority must adapt as well to protect and promote population-level health.

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*Research Scholar, Center for Public Health Law and Policy; Staff Attorney, Network for Public Health Law – Western Region Office, Sandra Day O’Connor College of Law, Arizona State University (ASU). This article is based in part on the following publication: James G. Hodge, Jr., Sarah A. Wetter, Danielle Chronister, Alexandra Hess & Jennifer Piatt, Redefining Public Health Emergencies: The Opioid Epidemic, 58 JURIMETRICS J. (forthcoming December 2017).

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4 Gostin et al., supra note 2.


13 Oakland City Council, Res. No. 82994 (Oct. 5, 2010).
21 Authority to declare a PHE varies across jurisdictions. Most states adopting the MSEHPA authorize their Governors to declare a PHE. However, some jurisdictions also allow the declaration to be made by officials such as state health officers or health agency directors. ASTHO LEGAL PREPAREDNESS SERIES, EMERGENCY AUTHORITY AND IMMUNITY TOOLKIT: EMERGENCY DECLARATIONS AND AUTHORITIES (2012).
24 While the utility and political motive behind these less-traditional emergency declarations may have been questioned, none has garnered the level of controversy as the national PHE declared for the opioid crisis.


The White House Office of the Press Sec’y, supra note 1.


No Kid Hungry, Hunger Devastates Children: Facts on Childhood Hunger in America (2016).


For additional description of criteria, see James G. Hodge, Jr., Sarah A. Wetter, Danielle Chronister, Alexandra Hess & Jennifer Piatt, Redefining Public Health Emergencies: The Opioid Epidemic, 58 JURIMETRICS J. (forthcoming December 2017). MSEHPA authorizes an emergency declaration to confront an “imminent threat” believed to be caused by bioterrorism, infectious agent, or biological toxin; or a “high probability” of death, disability, or future harm. Supra note 10. However, MSEHPA does not otherwise describe emergency-level criteria. Id.

Malloy, supra note 16.