

Statement of  
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Hearing on  
“HOMELAND SECURITY: IMPROVING PUBLIC HEALTH SURVEILLANCE”

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Representing  
THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS  
(ASTHO)

Mr. Chairman and distinguished members of the Subcommittee, my name is Mary C. Selecky. I am the Secretary of the Washington State Department of Health, and I am honored to be testifying before you today as the President of the Association of State and Territorial Health Officials (ASTHO). I would like to thank the Chair and subcommittee members for your past support for public health matters, including public health preparedness.

This hearing focuses on one of our most important, although often invisible and forgotten, public health tools – public health surveillance. As early as 1878, Congress recognized the importance of surveillance when it authorized the U.S. Marine Hospital Service to collect morbidity reports concerning cholera, smallpox, plague, and yellow fever from U.S. consuls overseas. These data were to be used for instituting quarantine measures to prevent the introduction and spread of these diseases into our nation. By 1928, all states, the District of Columbia, Hawaii, and Puerto Rico were participating in national surveillance and reporting on 29 specific diseases. In 1950, ASTHO created its affiliate, the Council of State and Territorial Epidemiologists, one of the group's purposes was to determine which diseases should be reported nationally to the Public Health Service. All states now voluntarily report nationally notifiable diseases to the Centers for Disease Control and Prevention (CDC).

One of the core functions of state health departments is to collect, analyze, interpret, and disseminate public health data. States do this to identify health problems, determine the programs or other responses needed to address specific public health concerns, and evaluate the effectiveness of the responses. Health departments depend upon the receipt of quality public health data to identify and track emerging infectious diseases such as

SARS and West Nile virus. Equally important, although often overlooked, is the collection of public health surveillance data that identifies the burden and causes of our nation's leading causes of death - chronic diseases (such as heart disease and diabetes) injury, and risk factor analysis.

State health departments have a unique role to play in public health surveillance. Public health threats do not respect political borders. Reporting of disease entities, therefore, needs to be uniform within any given state in order to work with federal and local colleagues to assure an adequate, immediate response to public health emergencies. In many parts of the country, only the state health department has the sophisticated laboratory and highly trained laboratorians, epidemiologists and other public health professionals needed to tackle the most serious public health challenges. As a former health officer for the Northeast Tri-County Health District in rural eastern Washington state, I know firsthand about the importance of the critical synergies that must be in place to assure that all citizens are protected. Just as there are differences in capacities among states, there are differing response capacities within communities in every state. As a local health official, I worked hand in hand with the state health department on foodborne outbreaks and other public health emergencies. Local, state, and federal health agencies, including the CDC, each have a distinct and important role in public health surveillance activities.

In this testimony, I would like to make four points:

- 1) Since the 1988 Institute of Medicine's *Future of Public Health Report* recognized the inadequacies of our public health infrastructure in general, and public

health surveillance in particular, we have made great strides in strengthening these areas. Substantial Congressional investments in preparedness funding have enabled states to develop surveillance capacities that are being used to address potential terrorist and naturally occurring public health threat emergencies.

2) We must continue our efforts to integrate and coordinate public health surveillance systems.

3) While tremendous efforts are focused on developing high-tech surveillance systems, and technology is critically important to enhancing our capabilities, a computer without the right software and without a trained user is just an expensive paperweight. We must proceed with caution and ensure that any new systems are tested by local and state health agencies and are determined to be usable and effective.

4) Despite the progress that has been made since the Institute of Medicine issued its report, much more needs to be done. As our affiliated organizations – the Council of State and Territorial Epidemiologists and the Association of Public Health Laboratories -- have indicated, we face a serious shortage of trained public health laboratorians and epidemiologists. A significant portion of our present workforce is expected to be lost in the next 5 years to retirement or other career opportunities. We can have all of the sophisticated equipment in the world, but without trained professionals to gather, analyze, interpret and disseminate data, our public health surveillance system will falter. We need to address workforce issues at the same time as we address hardware, bricks and mortar, and other aspects of our infrastructure.

To illustrate my points about the importance of public health surveillance, I would like to offer three examples from Washington state.

SARS – The public health system relies on physicians to identify possible SARS cases. The SARS epidemic has required extensive interaction between local and state health agencies and physicians to relay the rapidly changing knowledge about the epidemic. Health care providers must know in real time what to look for and what to do to manage suspect cases and protect their patients, the public and themselves. We have used traditional public health mechanisms – a notifiable condition regulation that requires reporting of new and emerging diseases, basic communication tools such as telephones and fax machines, and trained local and state staff to answer questions and investigate cases. We have also begun to use systems that have been developed as part of our state's emergency preparedness efforts. We take part in frequent conference calls with the CDC and with local health agencies to relay information, answer questions and assure consistency of approach. We also use the national Health Alert Network to disseminate official messages from the CDC across the public health system, and through local health agencies to physicians. These new systems have greatly enhanced our surveillance and response efforts for SARS.

West Nile virus – Washington has not yet been hit as hard as many other states, but we know the disease is coming. West Nile virus has been identified in birds, mosquitoes and horses in our state. We expect a significant increase in animal cases and a number of human cases this year. We are preparing for this by developing communication and

response plans at the state and local level, by training local health staff on surveillance and control measures, and by communicating with physicians on how to recognize and report the disease. We are using the same surveillance and response systems and staff for West Nile virus that we do for other communicable diseases and for potential bioterrorism threats.

E. coli O157:H7 – Washington has a lot of experience identifying and responding to this foodborne disease, but these outbreaks are certainly not limited to Washington. A large multi-state outbreak last year highlights the need for standardization of surveillance systems and information. Twenty-eight people across seven states were sickened in an outbreak associated with ground beef from a meat packer in Colorado. Close work between local and state health agencies and the CDC allowed rapid assessment of the extent of the outbreak and identification of the likely source. The successful response to this outbreak was a result of physicians who recognized E. coli O157:H7 and knew how to report the case; trained local and state epidemiologists who knew how to do investigations; and systems such as the National Electronic Disease Surveillance System and the PulseNet laboratory network that facilitated the rapid sharing of standardized information across the country.

In closing I want to reiterate some key points. First, thanks to Congress' early recognition of the importance of public health surveillance and its commitment to provide funding to strengthen our surveillance capability; we now are able quickly to identify and address some key threats to the public health. Great progress has been made in this area,

but much more can and must be done. Second, public health workforce issues must be addressed immediately. Without adequate numbers of well-trained public health professionals involved in our surveillance efforts, we run the risk of not being able to rapidly detect and address public health emergencies. Third, we must continue to coordinate our existing surveillance systems and ensure that new surveillance approaches work before asking state and local health departments to use them. And finally, because of decades of neglect of our nation's public health infrastructure, continued federal investments in public health surveillance at the federal, state, and local levels are urgently needed. The preparedness funding of last year was a critical beginning, but it cannot be a "one shot" effort. Sustained support is essential.

Thank you for this opportunity. I would be pleased to answer any questions you may have.