



Will Public Health's Response to Terrorism Be Fair?

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The anthrax attacks of 2001, the SARS epidemic of 2002, and the recent concerns about West Nile virus and avian flu demonstrate the importance of preparedness for bioterrorism and emerging infectious diseases. In a bioterrorist or infectious disease emergency, the nation's public health system will be our first line of defense.

Public health's effectiveness will require trust and cooperation on the part of many diverse communities. A severe public health crisis could require onerous or controversial control measures (e.g., isolation, quarantine, travel restrictions, targeted distribution of medicines or vaccines) whose success will depend on the extent to which everyone cooperates. If a sizable group refuses to cooperate, that group could suffer greater mortality in an attack and could jeopardize the success of the overall containment effort.

There are good reasons to be concerned about the level of trust in public health. For example, there are reports that in the 2001 anthrax attacks, African Americans and other vulnerable groups felt betrayed by the United States Postal Service, public health authorities in the District of Columbia, and the Centers for Disease Control and Prevention. Earlier, fear in the African-American community of experimentation and genocide led to opposition to needle-exchange programs for HIV/AIDS in New York City. Unfortunately, these fears are based on historical fact: Public health agencies have a history of discrimination. Recent occurrences have not been frequent, but a number of those that have occurred have been egregious. The Tuskegee Institute syphilis study, in which federally funded investigators observed African Americans through the natural course of syphilis but withheld available treatment, is a frequently recalled example.

RAND and Los Angeles County Department of Health researchers performed the first population-based analysis of perceived fairness in the public health system's response to terrorism. Using the Los Angeles County Health Survey, a telephone survey of a representative sample of Los Angeles County's entire population, RAND analyzed responses by a number of demographic factors, including race/ethnicity, age, language in which the telephone interview was conducted (participants were offered the option of answering in English, Spanish, or one of four Asian languages), and perceived level of neighborhood safety. The results are summarized in the accompanying table.

Overall, 72.7% of respondents perceived that the public health system will respond fairly in a bioterrorist event. However, African Americans and Asian and Pacific Islanders reported lower perceived fairness

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Percentage of Participants Who Reported Perceived Fairness,
by Demographic Characteristics

Total		72.7%
Race	White	76.6
	Latino	73.1
	Asian/Pacific Islander	68.2
	African American	63.0
Age	18 to 29	68.9
	30 to 44	74.1
	44 to 59	77.6
	60 and older	70.2
Language in which interview was conducted	English	73.8
	Spanish	75.2
	Asian	43.3
Neighborhood safety	Very/somewhat safe	74.6
	Very/somewhat unsafe	64.9

(only 63% of African Americans and 68% of Asian/Pacific Islanders feel that the public health system will respond fairly in a terrorist crisis). Young people are more likely than older people to feel that the response will be unfair. Neighborhood safety is also a significant factor: Those living in neighborhoods that they perceive to be unsafe are more likely to mistrust the public health system.

Of all interviewees, those who responded to the survey in an Asian language expressed the lowest level of trust.

Public health agencies must assess their community relationships and, if those relationships are found to need improvement, begin to strengthen their presence and services in the community. Developing culturally tailored educational outreach activities on disaster and terrorism preparedness might improve relationships with minority communities. Partnering with a network of trusted community-based organizations, such as churches and neighborhood associations, and actively integrating this network into response plans could reduce the perception—or occurrence—of a biased response. ■

RAND

Corporate Headquarters
1776 Main Street
P.O. Box 2138
Santa Monica, CA
90407-2138
TEL 310.393.0411
FAX 310.393.4818

Washington Office
1200 South Hayes Street
Arlington, VA 22202-5050
TEL 703.413.1100
FAX 703.413.8111

Pittsburgh Office
201 North Craig Street
Suite 202
Pittsburgh, PA 15213-1516
TEL 412.683.2300
FAX 412.683.2800

New York Office
215 Lexington Avenue
21st Floor
New York, NY 10016-6023
Council for Aid to Education
TEL 212.661.5800
New York External Affairs
TEL 212.661.3166
FAX 212.661.9766

RAND-Qatar Policy Institute
P.O. Box 23644
Doha, Qatar
TEL +974.492.7400
FAX +974.492.7410

RAND Europe Headquarters
Newtonweg 1
2333 CP Leiden
The Netherlands
TEL +31.71 524.5151
FAX +31.71 524.5191

RAND Europe—Berlin
Uhlandstrasse 14
10623 Berlin
Germany
TEL +49 (30) 31.01.91 0
FAX +49 (30) 31.01.91 9

RAND Europe—Cambridge
Grafton House
64 Maids Causeway
Cambridge CB5 8DD
United Kingdom
TEL +44 (1223) 353.329
FAX +44 (1223) 358.845

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