Date: June 10, 2025
From: California APIC Coordinating Council
Subject: A Call to Action: Protecting California's Healthcare System from Regulatory Shifts in Biohazardous and Medical Waste Enforcement

Dear APIC's Government Affairs and Practice Guidance,

We are writing to request a call to action and creating a consortium to review opportunities and significant concern about the recent enforcement actions taken against hospital facilities throughout California, following investigations into hazardous and medical waste handling practices. These actions, led by state and county district attorneys, signal a troubling shift in regulatory interpretation and enforcement, inflating cost for healthcare facilities that jeopardizes the sustainability of our healthcare system and undermine the state's broader environmental goals under Governor Gavin Newsom.

Newsom has invested significantly in the California Climate Commitment, a plan that includes measures to reduce pollution and protect the environment. The management and regulation of biohazardous waste in California began taking formal shape in the late 1980s and early 1990s, during healthcare facilities' peak involvement in the HIV/AIDs epidemic. The Medical Waste Management Act (MWMA) California Health Safety Code, sections 117600-118360, was initially developed during a time of uncertainty and fear, rather than grounded in scientific evidence on disease transmission, yet healthcare facilities worked diligently to comply with the standards. Since then, the MWMA has evolved into a comprehensive state-level framework for the handling, storage, treatment, and disposal of medical waste by hospitals, clinics and laboratories.

Recent actions by District Attorneys of San Francisco, Los Angeles, Orange, Sacramento, San Diego, San Mateo, Ventura and Yolo Counties have included tracking hospital waste from healthcare facilities to landfills and disposal facilities. Third-party waste audits identified several opportunities for improvement across multiple hospitals. Key findings included: pharmaceuticals improperly discarded in biohazard sharps bins, visible blood products in regular trash, protected patient information disposed of unsecured, and personal care products such as toothpaste, soap and shampoo in regular trash.

While we recognize the clear need to improve education around proper waste segregation and disposal across hospitals, clinics, and laboratories, we are concerned that these audits have catalyzed a wave of overly conservative waste management practices. In response, many health systems are now over classifying non-hazardous waste, such as replacing all biohazardous sharps containers with pharmaceutical waste containers or requiring that any material containing even trace amounts of dried blood be managed as biohazardous waste. These changes not only go beyond the scope of the MWMA, which defines biohazardous waste as material that is infectious to humans or contains *fluid* blood, but also drive up disposal costs and environmental impacts without delivering any proven public health benefit.

We urge the state and Associations to publicly recognize the levels of risks and articulate the serious concerns the current action raises:

1. **Lack of Scientific Basis:**
    a. Items such as tampons or bloody bandages, and personal care products commonly disposed of in household or public trash, carry no greater risk than when generated in healthcare settings.
    b. The microorganisms identified in hospital environments are not unique as they are routinely encountered in community sewage and general waste. Labeling items like Band-Aids as hazardous simply because it comes from a hospital lacks scientific basis and poses minimal risk. Patients interact and come from the broader world daily within our communities. A

consortium can play a critical role in stratifying products by actual risk and guiding appropriate, evidence-based disposal practices.

2. **Increased Environmental Harm:**
    a. Overly conservative waste classifications have significantly increased the volume of pharmaceutical and biohazardous waste across California, leading to greater reliance on incineration, a costly and carbon-intensive disposal method. Medical waste incineration from peripheral venous catheters or disposable endoscopes releases toxic pollutants such as dioxins, furans, heavy metals, and volatile organic compounds (VOCs), which pose serious risks to human health and the environment.
    b. The treatment of medical waste, whether through high-temperature autoclaving or incinerations is far more energy-intensive than standard landfill disposal. When applied to non-hazardous items, this practice needlessly increases energy use and contributes to the healthcare sector's already substantial greenhouse gas emissions.
    c. Many regulated waste streams are transported long distances, often across state lines, for final treatment and disposal. These extended transportation requirements add to carbon footprint, consequently air pollution of waste management and directly undermine California's pledge to reduce greenhouse gas emissions by 85%.

3. **Financial and Operational Strain on Hospitals:**
    a. With federal budget cuts looming over the entire nation, hospitals are now diverting critical funds needed to provide quality patient care toward costly waste management practices, without clear evidence of public health benefit. Recent enforcement actions led by District Attorneys have imposed significant legal and compliance costs, placing additional strain on already stretched health systems.
    b. Healthcare providers and staff cannot fully prevent potential violations stemming from patient or visitor behavior, such as bloody tissues, Band-Aids, empty shampoo bottles or stickers with patient safety information discarded in general waste bins on hospital ground.
    c. While we acknowledge that certain materials identified in the recent waste audits were improperly disposed of, we believe a collaborative, solutions-oriented approach is needed. Practical interventions, such as shifting to non-toxic purchasing where safe alternatives exist. Conducting regular internal waste audits, and providing targeted staff education, are more effective and sustainable in addressing the root causes of waste misclassification. Repeated training, clear signage, and department-specific support can go a long way in improving compliance.
    d. It has been recommended in recent audits by the District Attorney's to eliminate general waste bins and replace with only biohazardous waste bins in high-risk departments such as procedural suites in hospitals. Many hospitals in California have previously developed processes in "Greening the OR." By properly segregating waste to reduce disposal volumes and costs. The recommendations will dismantle any green initiatives and increase cost and volume.
    e. Validating and interpreting waste regulations can be labor intensive even for well-trained staff. Engaging key hospital stakeholders, including Environmental Health and Safety, Sustainability, Infection Prevention, Infectious Disease, Risk Management and clinical educators, can ensure that disposal practices are both compliance and operationally feasible.

4. **Statewide Cost and Waste Volume Impact:**
    a. Waste Volume: Hospitals produce more than 5.9 million tons of waste each year, with a single bed generating an average 33 pounds of waste per day. If hospitals generate approximately 16,000 tons of solid waste daily nationwide per Practice Greenhealth, assuming California accounts for about 12% of the U.S. population, this equates to roughly 1,940 tons per day in

California. If 15% of this is classified as regulated medical waste, that's 291 tons daily or approximately 106,000 tons annually impacting California.

b. Disposal Costs: Disposing of regulated medical waste costs between $0.21 and $0.35 per pound. At an average of $0.25 per pound, the annual cost for 106,000 tons is about $53.0 million. Disposing of biohazardous waste in California costs between $0.30 and $0.50 per pound. At an average rate of $0.40 per pound, the annual disposal cost for 106,000 tons of biohazardous waste is approximately $84.8 million.

We respectfully request that the California State Health Department and Associations advocate for:

1. A re-evaluation of the current enforcement protocols and definitions within the MWMA, EPA, and SDS waste disposal guidelines, particularly in light of ongoing disagreements among auditors, regulators, and hospital stakeholders regarding the scope of biohazardous waste.
2. A temporary moratorium on new enforcement actions to allow time for reassessment and realignment with Governor Gavin Newsom's climate goals, including California's pledge to reduce greenhouse gas emissions.
3. Increased transparency and communication from state leaders regarding sudden regulatory changes not reflected in current guidelines, so hospitals may adequately prepare for operational, legal, and financial implications.
4. An independent environmental and economic impact analysis to quantify the increases in regulated waste volumes, financial burden to health systems, and added pollution resulting from current recent enforcement activity.

A growing number of health systems, such as Kaiser Permanente and Santa Clara Valley Healthcare, are already impacted by aggressive enforcement tactics and large financial settlements. Investigations began in 2015 with undercover trash inspectors, leading to large settlements across 16 Kaiser medical facilities statewide. The inspections uncovered over 10,000 paper records containing sensitive information from over 7,700 patients, along with pharmaceutical drugs, syringes, vials, medical devices contaminated with human blood and body fluids, body parts removed during surgery, batteries, and electronic devices, all improperly disposed of in bins. The transition to stricter waste segregation protocols has already begun in many hospitals. Recent data from waste audits have been kept confidential from many key stakeholders, preventing advocacy efforts and opportunities for education and collaboration. The need for a collective response is urgent. We call for a coordinated, evidence-based review to ensure that California's healthcare system can uphold both public health and environmental stewardship without compromising our delivery or financial sustainability.

Thank you for your continued leadership and commitment to a safe, sustainable, and equitable healthcare system for all Californians.

Sincerely,

Jessica Alicdan, MPH CIC

President, California APIC Coordinating Council

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