Public Health Law Reform

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Public health law is often perceived as an arcane set of rules buried deep within indecipherable statute books and regulatory codes. It does not have to be this way. Law can be transformed to become an essential tool for creating the conditions for people to be healthy. Law creates a mission for public health authorities, assigns their functions, and specifies the manner in which they may exercise their authority. The law influences norms for healthy behavior, identifies and responds to health threats, and sets and enforces health and safety standards. The most important social debates about public health take place in legal fora—legislatures, courts, and administrative agencies—and in the law's language of rights, duties, and justice.[1,2] It is no exaggeration to say that the field of public health "could not long exist in the manner in which we know it today except for its sound legal basis."[3]

The Institute of Medicine (IOM), in its foundational 1988 report, *The Future of Public Health*, acknowledged that law was essential to public health, but cast serious doubt on the soundness of public health's legal basis. Concluding that "this nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray," the IOM recommended reform of an obsolete and inadequate body of enabling laws and regulations.[4]

Three Concepts of Public Health and Liberty: Duty, Power, Restraint

A model public health statute should reflect at least three principles— duty, power, and restraint. First, the law should impose *duties* on government to promote health and wellbeing within the population. Surprisingly, government possesses few, if any, affirmative responsibilities for the public's health. The Supreme Court strongly resists the notion that the Constitution imposes an affirmative obligation on state and local governments. For example, in *DeShaney v. Winnebago County Department of Social Services*,[5] the Court held that Wyoming social services authorities had no obligation to protect 4-year old Joshua DeShaney, even though they were aware that he was being severely abused by his father. Joshua was beaten so badly that he was left profoundly retarded and institutionalized.

State statutes, moreover, rarely impose affirmative obligations on public health agencies. Legislators may be reluctant to do so because it may expose agencies to liability for failure to meet standards or guarantee minimum funding levels to assure adequate services. However, the creation of specific statutory duties to perform essential public health functions and to protect the community's health and safety would be beneficial in several ways: (i) legislatures would have a standard by which health authority performance could be assessed; (ii) the electorate would have higher expectations for adequate services and health protection; and (iii) government would demonstrate its enduring commitment to a strong public health infrastructure. Many public health professionals would welcome high standards and more stable funding, but if legislators were concerned about liability and state budgets, they could craft statutory language that would ameliorate these concerns— e.g., duties "within the limits of available resources" or limitations on agency liability.

Second, the law should afford public health authorities ample power to regulate individuals and businesses to achieve the communal benefits of health and security. This idea of regulatory power is counterintuitive to a civil libertarian, but natural and instinctive to the public health community. The power to regulate is the power to make people secure in the most important aspect of their lives—people's health and well-being. Individuals cannot exercise civil or political rights, or enjoy a life full of contentment without a certain measure of health. One important way of assuring the health of the community is by giving government adequate powers, and flexibility, to regulate. Individuals acting independently, without organized community activity, cannot assure many of the essential conditions of health— clean air and water, safe products, healthy workplaces, or control of infectious diseases. Sound and effective public health statutes, therefore, should afford agencies ample authority to set standards of health and safety and to assure compliance.

Third, the law should restrain government in the exercise of regulatory power to achieve the benefits of liberty and freedom. This idea of regulatory restraint is found in most liberal formulations of a good society. Government should refrain from interference with autonomy, liberty, or privacy unless it has a sound justification. Sound and effective public health statutes, therefore, should set clear substantive and procedural limits on government powers. Substantively, government should demonstrate: (i) a significant risk based on scientific methods; (ii) the regulation is effective; (iii) the costs and burdens are reasonable when compared with the benefits; and (iv) the policy is just and non-discriminatory.[6] Procedurally, government should provide citizens with a fair opportunity to be heard to ensure objective and fair decision-making.

Effective public health protection is technically and politically difficult.[7] Law cannot solve all, or even most, of the challenges facing public health authorities. Yet, law can become an important part of the ongoing work of creating the conditions necessary for people to live healthier and safer lives. A public health law that contributes to health will, of course, be up-to-date in the methods of assessment and intervention it authorizes. It will also conform to modern standards of law and prevailing social norms. It should be designed to enhance the reality and the public perception of the health department's rationality, fairness, and responsibility. It should help health agencies overcome the defects of their limited jurisdiction over health threats facing the population. Finally, both a new law and the process of its enactment should provide an opportunity for the health department to challenge the apathy about public health that is all too common both within the government and the population at large.

Create Modern, Consistent, and Uniform Public Health Laws

The law relating to public health is scattered across countless statutes and regulations at the state and local level. Problems of antiquity, inconsistency, redundancy, and ambiguity render these laws ineffective, or even counterproductive, in advancing the population's health. In particular, health codes frequently are outdated, built up in layers over different periods of time, and highly fragmented among the fifty states and territories.

Problem of Antiquity. The most striking characteristic of state public health law and the one that underlies many of its defects, is its overall antiquity. Certainly, some statutes are relatively recent in origin, such as those relating to health threats that became salient in the latter part of the twentieth century (e.g., environmental laws). However, a great deal of public health law was framed in the late 19th and early-to mid-20th century and contains elements that are 40 to 100 years old. Nevertheless, old public health statutes are often outmoded in ways that directly

reduce their effectiveness and conformity with modern standards. These laws often do not reflect contemporary scientific understandings of injury and disease (e.g., surveillance, prevention, and response) or legal norms for protection of individual rights. Rather, public health laws utilize scientific and legal standards that prevailed at the time they were enacted. Society faces different sorts of risks today and deploys different methods of assessment and intervention. When many of these statutes were written, public health (e.g., epidemiology and biostatistics) and behavioral (e.g., client-centered counseling) sciences were in their infancy. Modern prevention and treatment methods did not exist.

At the same time, many public health laws pre-date the vast changes in constitutional (e.g., equal protection and due process) and statutory (e.g., disability discrimination) law that have transformed social and legal conceptions of individual rights. Failure to reform these laws may leave public health authorities vulnerable to legal challenge on grounds that they are unconstitutional or that they are preempted by modern federal statutes. Even if state public health law is not challenged in court, public health authorities may feel unsure about applying old legal remedies to new health problems within a very different social milieu.

Problem of Multiple Layers of Law. Related to the problem of antiquity is the problem of multiple layers of law. The law in most states consists of successive layers of statutes and amendments, built up in some cases over one hundred years or more in response to existing or perceived health threats. This is particularly troublesome in the area of infectious diseases which forms a substantial part of state health codes. Because communicable disease laws have been passed piecemeal, in response to specific epidemics, they tell the story of the history of disease control in the United States (e.g., smallpox, yellow fever, cholera, tuberculosis, venereal diseases, polio, and AIDS).

Through a process of accretion, the majority of states have come to have several classes of communicable disease law, each with different powers and protections of individual rights: those aimed at traditional STDs (or venereal diseases), including gonorrhea, syphilis, chlamydia, herpes; those targeted at specific currently or historically pressing diseases, such as tuberculosis and HIV; and those applicable to “communicable” or “contagious” diseases, a residual class of conditions ranging from measles to malaria whose control does not usually seem to raise problematic political or social issues. There are, of course, legitimate reasons to treat some diseases separately. Nevertheless, affording health officials substantially different powers, under different criteria and procedures for different diseases, is more an accident of history than a rational approach to prevention and control.

The disparate legal structure of state public health laws can significantly undermine their effectiveness. Laws enacted piecemeal over time are inconsistent, redundant, and ambiguous. Even the most astute lawyers in public health agencies or offices of the Attorney General have difficulty understanding these arcane laws and applying them to contemporary health threats.

Problem of Inconsistency Among the States and Territories. Public health laws remain fragmented not only within states but among them. Health codes within the fifty states and territories have evolved independently, leading to profound variation in the structure, substance, and procedures for detecting, controlling, and preventing injury and disease. In fact, statutes and regulations among American jurisdictions vary so significantly in definitions, methods, age, and scope that they defy orderly categorization. Ordinarily a different approach among the states is

not a problem and is often perceived as a virtue; an important value of federalism is that states become laboratories for innovative solutions. Nevertheless, there may be good reason for greater uniformity among the states in matters of public health. Health threats are rarely confined to single jurisdictions, but pose risks within whole regions or the nation itself. For example, geographic boundaries are largely irrelevant to issues of air or water pollution, disposal of toxic waste, or the spread of infectious diseases.

Public health law, therefore, should be reformed so that it conforms with modern scientific and legal standards, is more consistent within and among states, and is more uniform in its approach to different health threats. A single set of standards and procedures would add needed clarity and coherence to legal regulation, and would reduce the opportunity for politically motivated disputes about how to classify newly emergent health threats.

Define a Mission and Functions: Responsibility for Assuring the Conditions of Health

State public health statutes should define a cogent mission for the agency and identify a full set of essential public health functions that it should, or must, perform. Broad and well considered mission statements are important for organizational, political, and legal reasons. From an organizational perspective, they establish the purposes or goals of public health agencies. By doing so, they inform and influence the activities of government. From a political perspective, mission statements provide a measure of the kinds of activities that are politically sanctioned. When it is acting under a broad mission statement, a public health agency can better justify its decisions to legislators, the governor, and the public. Further, legislative language that provides a mandate for the health department to take the lead within the executive branch in devising strategies for health promotion and disease prevention. From a legal perspective, courts pay deference to statements of legislative intent, and may permit a broad range of activities consistent with mission statements. Thus, even if the aspirational qualities of mission statements do not produce the desired results, they can help support agency action.

Public health statutes that hold agencies responsible for providing essential public health functions support good practice for many of the same reasons. By creating agency duties, the legislature can ensure that the full range of public health services will be available to the population in a given geo-political area. Researchers, and the legislature itself, can also use these essential functions as a way to monitor and evaluate agency performance.[8]

Despite their importance, few state public health statutes define a cogent mission for the health department or identify a full set of essential public health functions.[9] One notable exception is Texas which recently passed a statute defining public health mission and functions consistently with modern public health guidelines.[10,11,12]

Provide a Full Range of Public Health Powers

Voluntary cooperation is the primary way to obtain compliance with public health measures. However, where voluntary strategies fail, public health officials need a full range of powers to assure compliance with health and safety standards. At present, public health officials in many states have a sterile choice of either exercising draconian authority, such as deprivation of liberty, or refraining from coercion at all. The temptation is either to exercise no statutory power or to reach for measures that are too restrictive of individual liberty to be acceptable in a democratic society. As a result, authorities may make wrong choices in two opposite directions:

failing to react in the face of a real health threat or over-reacting by exercising powers more intrusive than necessary.

Public health authorities need a more flexible set of tools, ranging from incentives and minimally coercive interventions to highly restrictive measures. Reformed public health statutes should expressly grant agencies the authority to employ a broad variety of measures to encourage and, if necessary assure, safer behaviors: traditional prevention strategies (e.g., counseling, education, and health communication campaigns); incentives for behavior change (e.g., tax breaks, cash allowances, food, transportation, or child care); means for behavior change (e.g., condoms or sterile drug injection equipment); mandatory attendance for counseling, education, testing, or treatment; directly observed therapy; out-patient care or treatment in a clinic for STDs, TB, or drug dependency. These less restrictive powers would enable public health authorities to encourage, supervise and/or control persons who pose a significant health risk.

Impose Substantive Limits on Powers: A Demonstrated Threat of Significant Risk

While public health authorities should have all the powers they need, statutes should place substantive limits on the exercise of those powers. The legislature should state clearly the circumstances under which authorities may curtail autonomy, privacy, liberty, and property interests. At present, a few state statutes articulate clear criteria for the exercise of public health powers; others provide vague or incomplete standards; still others leave their use partly or wholly within the discretion of public health officials. While public health authorities may prefer an unfettered decision-making process, the lack of criteria does not serve their interests or the interests of regulatory subjects.

Statutes that fail to provide clear criteria hamper public health work in a variety of ways. Paradoxically, a lack of statutory guidance may lead public health officials either to overuse or to underuse coercive powers. Without clear criteria, public health officials may restrict an individual's liberty without valid public health grounds or may be so unsure of their authority to act that they do not use these measures to respond to actual threats. Broad discretion and the absence of criteria also invite abuse of compulsory powers, their discriminatory use against stigmatized or marginalized groups, or create the perception of such abuse against the vulnerable even when health officials have no malevolent intentions.

Effective and constitutionally sound public health statutes should set out a rational and reliable way to assess risk to ensure that the health measure is necessary for public protection. Public health authorities should be empowered to employ a compulsory intervention only to avert a significant risk (not speculative, theoretical, or remote). Risk assessments in public health statutes should be based on objective and reliable scientific evidence and made on an individualized (case-by-case) basis.[13]

In addition to incorporating the significant risk standard, statutes should also require health officials to choose the least restrictive alternative that will accomplish the public health goal. This does not require authorities to adopt a less effective measure, but only to choose the least intrusive measure that would achieve the public health end as well or better. This would help align public health statutes with evolving standards of both antidiscrimination law and constitutional law, by allowing only those measures that are reasonably necessary to contain a serious health threat without unduly interfering with personal liberty.

Impose Procedural Limits on Powers: Procedural Due Process

There are good reasons, both constitutional and normative, for legislatures to require health authorities to use a fair process whenever their decisions seriously infringe upon autonomy, liberty, proprietary, or other important interests. For example, if health authorities seek to close a restaurant, withdraw a professional (e.g., physician) or institutional (e.g., restaurant) licence, or restrict liberty (e.g., quarantine), they should provide due process. Procedural protections help to ensure that health officials make fair and impartial decisions and reduce community perceptions that public health agencies arbitrarily employ coercive measures. Where few formal procedures exist, public health officials risk rendering biased or inconsistent decisions and erroneously depriving persons and businesses of their rights and freedoms. While public health authorities may feel that due process is burdensome and an impediment to expeditious action, it can actually facilitate deliberative and accurate decision-making.

Because of the importance of a fair process, public health statutes should require due process prior to serious interference with personal and property interests. The procedures required in any given case depend on the nature, severity, and duration of the public health power. If authorities are exercising powers that are minimally invasive, statutes may have few, if any, procedural requirements. However, if authorities intend to exercise highly coercive powers (e.g., quarantine), due process may require the full panoply of procedures: written notice of the threat the person is alleged to pose and the behavior required of him by the agency, appointment of counsel, discovery, presentation of evidence at an impartial hearing, cross- examination, a written decision, and an appeal.[14]

Provide Strong Protection Against Discrimination

Throughout the modern history of disease control, the stigma associated with serious diseases and the social hostility that is often directed at those with, or at risk of, disease have interfered with the effective operation of public health programs.[15] The field of public health has always had to grapple with issues of race, gender, sexual orientation, disability, and socio-economic status. Persons who fear social repercussions may resist testing or fail to seek needed services. As part of any effort to safeguard the public's health, legislators must find ways to address both the reality and perception of social risk.

A great deal of protection against discrimination is already found in disability discrimination law and, to a lesser extent, in disease-specific statutes. These laws apply to persons with a wide range of injury and disease, typically those with substantial physical or mental impairments or those perceived as having such impairments. Disability statutes usually proscribe discrimination in a variety of different contexts, such as employment, public services, and public accommodations. Public health statutes should have non-discrimination provisions that are as strong as those in disability discrimination law. At the very least, public health statutes should not have provisions that are inconsistent with, or undercut, the safeguards afforded in disability discrimination and disease-specific statutes.

There exist strong reasons, moreover, for public health statutes to have anti-discrimination provisions that are even stronger than those found in many disability laws. The Supreme Court has narrowed the definition of disability, excluding large numbers of persons from the protection of the Americans with Disabilities Act (ADA).[16] Moreover, federal courts have held that Title II of the ADA, which proscribes discrimination by public entities, is

unconstitutional because it authorizes law suits against agencies without the state's permission; some courts see this as an unconstitutional abrogation of the state's sovereign immunity.[17]

State public health statutes could remedy these, and other, problems of scope and effectiveness that exist under disability discrimination law. Since the ADA expressly does not preempt stronger safeguards against discrimination and, particularly, does not preempt public health efforts, state laws could provide much needed protection against discrimination.

Provide Strong Protection for Privacy and Security of Public Health Information

Privacy and security of public health data are highly important from the perspective of the individual and the public at large. Individuals seek protection of privacy so that they can control intimate health information. They have an interest in avoiding the embarrassment and stigma of unauthorized disclosures to family or friends. They similarly have an interest in avoiding discrimination that could result from unauthorized disclosures to employers, insurers, or landlords. At the same time, privacy and security protection can advance the public's health. Privacy assurances can facilitate individual participation in public health programs and promote trust between health authorities and the community. Public health laws, therefore, should have strong safeguards of privacy to protect these individual and societal interests. Public health legislation, however, should not grant individuals absolute privacy. Authorities need reasonable access to data and the power to use those data for important public health purposes, such as surveillance and response to health threats. If privacy rules become overly strict, legislatures undermine important public interests.

Legislation, therefore, cannot both provide absolute privacy protection while still affording reasonable access to data to achieve important public health purposes. What legislation can do is create fair, comprehensive rules to ensure that data are acquired, used, and disseminated according to unambiguous criteria and procedures, under mandated security arrangements, with strict penalties for breaches of privacy.

State legislatures should enact the following standards for collection, use, storage, and disclosure of personally identifiable information: require agencies to justify collection of data for an important public health purpose; provide information for persons and populations about the legitimate uses of personal information; proscribe secret data systems; assure access by individuals to their personal records; mandate the technology necessary to secure health data; and institute an independent review of privacy and security arrangements within health agencies.[18]

The Process of Law Reform as a Public Health Activity

The methods and goals of public health are often misunderstood and undervalued within government and society.[19] Health departments receive modest funding, particularly in comparison to resources allocated to medical services. The fact that public health often polices the commons and champions population-based risk reduction through behavior change (e.g., smoking cessation, designated drivers, exercise, and diet modification) deprives it of specific beneficiaries who are motivated to form political constituencies. The prevalence of an individualistic, market ideology makes it difficult even to speak of public health in the vocabulary of contemporary politics.[20] Public health needs opportunities to draw attention to its resource needs and achievements, and to develop constituencies for programs.

The lawmaking process provides just such an opportunity. A bill is the first step towards a coalition. It is an occasion for contact with interest groups and affected communities, some of whom may be motivated to act in support. Contact and cooperative effort also help to establish long-term ties and to identify important sources of support for other programs. Moreover, the process of negotiating for support can be a useful and concrete way for health agencies to incorporate the views of persons who receive public health services or are subject to regulation.

Legal reform also has the potential to enhance the agency's relationship with the legislature. Positive lawmaking offers a different sort of contact with legislators than tends to occur in the appropriations process. Public health law reform may offer an occasion to deal with a far greater range of legislators outside the context of contentious budget discussions. The drafting, negotiating, and hearing process provides a variety of fora for educating lawmakers and their staffs about public health needs and methods, and also provides health planners with better information about legislative views and priorities.

Law reform, of course, cannot guarantee better public health. However, by crafting a consistent and uniform approach, carefully delineating the mission and functions of public health agencies, designating a range of flexible powers, specifying the criteria and procedures for using those powers, and protecting against discrimination and invasion of privacy, the law can become a catalyst, rather than an impediment, to reinvigorating the public health system.

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1. Gostin LO, Burris S, Lazzarini Z. Improving State Law to Prevent and Treat Infectious Disease. NY: Milbank Memorial Fund;1998.

2. Gostin LO, Burris S, Lazzarini Z. The law and the public's health: a study of infectious disease law in the United States, Colum L Rev 1999;99:59-128.

3. Grad FP. Public Health Law Manual. Washington DC: American Public Health Association;1990.

4. Institute of Medicine. The Future of Public Health. Washington DC: National Academy Press; 1988.

5. DeShaney v. Winnebago County Dep't of Soc. Services, 489 U.S. 189 (1989).

6. Gostin LO. Public health in a new century: Part III— Public health regulation: a systematic evaluation. JAMA 2000;283:3118-3122.

7. Fox DM. The politics of public health in New York City: contrasting styles since 1920. In Rosner D, ed. Hives of Sickness: Public Health and Epidemics in New York City, pp. 197-210. New Brunswick, NJ: Rutgers University Press; 1995.

8. Institute of Medicine. Improving the Health of Communities: A Role for Performance Monitoring. Washington DC: National Academy Press;1997.

9. Gebbie KM, Hwang I. Identification of Health Paradigms in Use in State Public Health Agencies. NY: Columbia University School of Nursing;1997.

10. Texas Health and Safety § 121.002 et seq (Vernon 2000).

11. Department of Health and Human Services. Healthy People 2010. Washington DC: Government Printing Office;1999.

12. Public Health Functions Project. Public Health in America. Washington DC:APHA;1994.

13. School Board of Nassau County, Fla. v. Arline, 480 U.S. 273 (1987).

14. Greene v. Edwards, 265 S.E. 2d 662 (W. Va. 1980).

15. Burris S. Law and the social risk of health care: lessons from HIV testing. Albany L Rev 1998;61:831–895.

16. Sutton v. United Airlines, Inc., 527 U.S. 471 (1999).

17. Alsbrook v. City of Maumelle, 184 F. 3d 999 (8th Cir. 1999).

18. Gostin LO, Hodge Jr J. Model Public Health Information Privacy Act, <http://www.critpath.org/msphpa/privacy.htm>.

19. Baker EL et al., Health Reform and the health of the public: forging community health partnerships. JAMA 1994;272:1276-1279.

20. Burris S. The invisibility of Public health: population-level measures in a politics of market individualism. AJPH 1997;87:1607-1611.