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First in a series of Turning Point resources
on public health statute modernization

Turning Point

Collaborating for a New Century in Public Health

State Public Health Law Assessment Report

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Table of Contents



Introduction	1
1. A Framework for Public Health Law	5
A. Defining Public Health	5
Table 1. Statutory Definitions of Public Health in Select States	7
B. Defining Public Health Law	10
C. Constitutional Authority for Public Health Powers	11
1. Separation of Powers	11
2. Limited Powers	12
Figure 1. American Federalism	14
3. Federalism	14
D. Governmental Public Health Powers	15
1. Federal Powers	15
2. State Police Powers	16
3. Local Powers	16
4. Tribal Powers	17
2. State Public Health Systems	19
A. Organization of State Public Health Agencies	19
1. Superagency Systems	20
Figure 2. Organizational Chart - Washington State Department of Health	21
a. Collaborative Approach	20
b. Embedded Approach	22
2. Freestanding Systems	22
Figure 3. Organizational Chart - Alabama Department of Public Health	23
B. Distribution of Public Health Responsibilities	24
Table 2. Classification of State and Local Distribution of Public Health Functions	24
1. Centralized (“top-down”) Approach	24
2. Decentralized (“bottom-up”) Approach	25
3. Hybrid Approach	26
C. Statutory Mechanisms for Financing Public Health Systems	27
D. Political and Social Realities Underlying Public Health Financing	29
Figure 4. The Stream of Public Health Funding	29

	3. State Public Health Law – Developments, Trends, Innovations	31
	A. Trends and Innovations in State Public Health Law	31
	B. State Legislative Update	33
	4. The Benefits of a Public Health Law Improvement Process	35
	A. The Role of Public Health Law	35
	B. Update Antiquated Laws	36
	C. Comply with Modern Constitutional and Other Legal Requirements	36
	D. Clarify the Law	37
	E. Improving Relationships	37
	1. Legislative and Public Health Authorities	37
	2. Federal and State	37
	3. State, Tribal, and Local	37
	4. City and Rural	38
	5. Public Health Authorities and the Private Sector	38
	Conclusion	39
	References	41

Introduction



Law is an essential tool of public health practice. Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. Laws define the jurisdiction of public health officials and specify the manner in which they may exercise their authority. Laws can also establish norms for healthy behavior and create the social conditions in which people can be healthy. Legislatures, courts, and administrative agencies serve as conduits for social debates on important public health issues within the legal language of rights, duties, and justice. Within this context, we define public health law as the legal powers and duties of the state to assure the conditions for people to be healthy, as well as the limitations on the power of the state to constrain legally-protected interests of individuals to promote community health.

In its foundational 1988 text, *THE FUTURE OF PUBLIC HEALTH*, the Institute of Medicine (IOM) agreed that law was essential to good public health, but questioned the soundness of public health law in the United States. The IOM concluded that the United States “has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray,”¹ due partly to obsolete and inadequate state laws and regulations. Though this view is not universally accepted,² the IOM further recommended that:

states review their public health statutes and make revisions necessary to accomplish the following two objectives: [i] clearly delineate the basic authority and responsibility entrusted to public health agencies, boards, and officials at the state and local levels and the relationships between them; and [ii] support a set of modern disease control measures that address contemporary health problems . . . , and incorporate due process safeguards (notice, hearings, administrative review, right to counsel, standards of evidence).³

More recently, the United States Department of Health and Human Services recommended public health law reform as part of its *Healthy People 2010* initiative. In a recent report from the Centers for Disease Control and Prevention, public health law reform is considered one of the ten priorities for improving public health outcomes.⁴

In response to these challenges, some states have updated and revised their public health laws. Minnesota updated a 1976 law in 1987 to forge a public health partnership between state and local governments that has worked in the 1990’s to enhance the local infrastructure for public health activities. Texas, North Dakota, West Virginia, New Jersey, Michigan,⁵ and other states have passed public health reorganization acts in the prior decade.⁶ In 1993, Washington followed a series of public health reorganization measures in the late 1980’s⁷ by passing a general health reform law that mandated the creation of a Public Health Improvement Plan⁸ to set minimum standards for public health performance. Other states, like Connecticut⁹ and Illinois,¹⁰ have drafted comprehensive state public health plans through their executive departments.

Public health law in many states, however, remains ripe for reform. Pursuant to a comprehensive survey of communicable disease law in the fifty states, we (and others) have suggested that existing state statutes are ineffective in responding to contemporary health threats for many reasons.¹¹ These statutes often: (1) pre-date modern scientific and constitutional developments; (2) fail to equip public health officials with a range of flexible powers needed to control infectious disease; (3) do not address modern conditions which impact public health; (4) lack adequate standards of privacy, due process, and risk assessment; and (5) are based on arbitrary disease classification schemes that

no longer relate to modern disease threats or epidemiologic methods of infection control.¹² We suggested several guidelines for statutory reform of communicable disease law, many of which apply to public health law generally (see IV):

- Define a broad mission of public health authorities to prevent and control communicable diseases through interventions at the microbial, behavioral and ecological levels;
- Public health law should be based on uniform provisions that apply equally to all communicable diseases;
- Recognize voluntary cooperation as the primary way to obtain compliance with public health measures;
- Base use of compulsory powers on a demonstrated threat of significant risk and pursuant to procedural due process protections;
- Provide a range of options for public health officers through a graded series of less restrictive alternatives; and
- Provide strong protections for privacy and security of public health information with narrowly drawn exceptions for disclosures outside public health.

Although the need for public health law reform is well stated by the IOM and others, uncertainty concerning the framework for public health law has confounded meaningful proposals for reform by public health officials, state legislators, and the general public in many states. The *Turning Point Public Health Statute Modernization National Collaborative*, (hereinafter “National Collaborative”), seeks to strengthen the legal framework for public health law by developing a **Model State Public Health Act** with guidance from a multi-disciplinary panel of experts in public health, law, and ethics.

As part of its initial efforts, the National Collaborative, through its Coordinator, **Deb Erickson**, Deputy Director of the Alaska Division of Public Health, asked the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities to assess state public health law. In particular, the National Collaborative seeks information on the constitutional and legal structure of state public health powers as well as modern developments in state public health legislation and other laws in response to a series of questions:

- How do states define “public health” in statutes?
- What are the different types of state public health systems?
- What state laws could be considered models for best practices concerning legal authority and financing mechanisms for public health?
- What authorities, powers, or duties are assigned to public health agents by statute?
- How are the relationships between federal, state, local, and tribal public health shaped by state constitutional law, statutory law, case law, and administrative regulations?
- What states have recently introduced significant public health law bills (in the past 3 years) or enacted new laws (in the past 10 years)? and
- What are some of the recent innovations of state public health law, including incentives for behavioral change?

This report is intended to provide information to elected and appointed government officials at the state and local levels on the status of state public health law, as well as the benefits of analyzing and reforming (as needed) these laws. Part I of the report provides a framework for examining the concept and definition of public health law, including legal issues of separation of powers, individual rights, and federalism, to provide some context for a discussion state public health law. Part II provides a review of state public health systems—how are they organized, how are public health powers

distributed among state, local, and tribal governments, what are the relationships between these levels of governments, and what are the statutory mechanisms through which public health efforts are financed. Part III discusses developments, trends, and innovations in state public health law based on research on state public health laws and proposals over the last decade, as well as a survey of state public health deputy directors conducted with assistance from **Steve Boedigheimer**, then Deputy Director, Delaware Department of Health and Social Services, and the *Association of State and Territorial Health Officers* (ASTHO). Finally, in Part IV, the report briefly discusses some of the potential benefits of a public health law improvement process, including:

- Examining the role of law as a tool for public health improvements;
- Updating antiquated laws to incorporate modern scientific knowledge;
- Complying with modern constitutional and other legal requirements;
- Clarifying legal powers, duties, obligations, and limitations; and
- Improve relationships between (a) legislative and public health authorities at the federal, state, tribal, and local levels, and (b) public health authorities and the private sector.

1. A Framework for Public Health Law

Conceptualizing public health law is not easy. Federal and state lawmakers, judges, health officials, scholars, and others often view public health law as some part of other fields or disciplines such as health law, health care law, law and medicine, forensic medicine, environmental law, or bioethics. While public health law is conceptually linked to the fields of law and medicine or health care law, it is itself a distinct discipline which is susceptible to theoretical and practical differentiation from other disciplines at the nexus of law and health.¹³ In this section, we briefly define public health law within a constitutional framework and demonstrate the various governmental responsibilities and powers relating to public health consistent with our definition.



A. Defining Public Health

At the crux of the field of public health law is the definition of *public health*. Public health has historically been associated with the control of communicable diseases and the improvement of unsanitary or unsafe conditions in the community. Modern definitions of public health vary widely, ranging from the utopian conception of the World Health Organization of an ideal state of physical and mental health¹⁴ to definitions which merely list common public health practices.¹⁵

The breadth of public health is reflected in state statutory definitions of the concept of public health, as well as state and local powers and duties. As summarized in **Table 1**, below, state legislatures and policymakers have defined public health (or public health duties or powers) in a variety of ways.¹⁶ Some states, such as **New Jersey**, adopt a fairly narrow view of public health: “Promoting the public health of the community includes preventing disease or controlling the communication of disease within the community.”¹⁷ The **California** legislature suggests that public health “includes preventing disease or controlling the communication of disease.”¹⁸

Alternatively, many states conceptualize public health as the sum of multiple responsibilities. **Kentucky**, for example, defines matters of public health to include:

detection, prevention, and control of communicable, chronic and occupational diseases; the control of vectors of disease; the safe handling of food and food products; the safety of cosmetics; the control of narcotics, barbiturates, and other drugs as provided by law; the sanitation of public and semipublic buildings and areas; the licensure of hospitals; protection and improvement of the health of expectant mothers, infants, preschool, and school-age children; the practice of midwifery, including the issuance of permits to and supervision of women who practice midwifery; and protection and improvement of the health of the people through better nutrition.¹⁹

Other states, like **Michigan**, statutorily define public health based on a listing of duties for its public health agency:

The department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs,

including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and agencies and health services delivery systems; and regulation of health care facilities and agencies and health services delivery systems to the extent provided by law.²⁰

Texas and **Nebraska** base their public health powers not so much on a definition of public health, but rather on a listing of public health services. **Nebraska** defines “community public health services” as those:

designed to protect and improve the health of persons within a geographically defined community by (1) emphasizing services to prevent illness, disease, and disability, (2) promoting effective coordination and use of community resources, and (3) extending health services into the community. Such services shall include, but not be limited to, community nursing services, home health services, disease prevention and control services, public health education, and public health environmental services.²¹

Table 1²², on the following pages, sets forth the statutory citations and definitions of public health in select states.

State statutory definitions of public health may empower government to act to promote or protect the public health, but often reflect a narrower vision of what public health is, or at least what it could be. Perhaps the modern paradigm for public health practice is best reflected in the consensus statement of the Public Health Functions Steering Committee (sponsored by the U.S. Public Health Service in 1994).²³ This statement, widely known as *Public Health in America*, organizes public health concepts into 39 categories under two broad categories, (1) Mission and Public Health (including mission statements and other core services) and (2) Concepts in *Essential Services*, (which includes essential public health services as follows):

1. Monitor Health Status to Identify and Solve Community Health Problems
2. Diagnose and Investigate Health Problems and Health Hazards in the Community
3. Inform, Educate, and Empower People About Health Issues
4. Mobilize Community Partnerships and Action to Identify and Solve Health Problems
5. Develop Policies and Plans that Support Individual and Community Health Efforts
6. Enforce Laws and Regulations That Protect Health and Ensure Safety
7. Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable
8. Assure A Competent Public and Personal Health Care Workforce
9. Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-based Health Services
10. Research for New Insights and Innovative Solutions to Health Problems

In 2000, **Kristine M. Gebbie** analyzed the statutory public health laws in each state to determine the congruence of these laws with the concepts set forth in *Public Health in America*.²⁴ Her findings suggest a range of congruence among states’ public health enabling laws with the missions and concepts underlying essential public health services. While the enabling laws of some states (11) could be classified as highly-congruent with *Public Health in America* (*i.e.*, they included 7 or more of the concepts of essential public health services), most states (23) were considered merely to be congruent (*i.e.*, including 4 to 6 concepts), and the remaining states (16) were classified as divergent (*i.e.*, included 3 or fewer concepts). These and other findings led **Gebbie** to agree with “the conventional wisdom among public health practitioners: public health is whatever the legislature has funded it to be for this funding cycle, no more and no less.”²⁵

Clearly the definition of public health is more encompassing than many state statutory codes suggest. The Institute of Medicine has proposed one of the most influential contemporary definitions of public health which, though simply stated, is quite accurate: “Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”²⁶

Table 1. Statutory Definitions of Public Health in Select States²²

STATE	STAT. CITE	STATUTORY DEFINITION OF PUBLIC HEALTH
AL	Ala. Code § 22-21-311 § 22-11A-1; § 22-2-8 (1982).	Public health includes: care of sick, injured, physically disabled or handicapped, mentally ill, retarded or disturbed persons; the prevention of sickness and disease; care, treatment and rehabilitation of alcoholics; and care of elderly persons. Public health includes protection from diseases and health conditions of epidemic potential.
AK	Alaska Stat. § 18.05.010 (2000).	The Department of Health and Social Services shall administer the laws and regulations relating to the promotion and protection of the public health, control of communicable diseases, programs for the improvement of maternal and child health, care of crippled children, and hospitalization of the tuberculous and shall discharge other duties provided by law.
AZ	Ariz. Rev. Stat.-§ 36 104 (1993).	Public health support services include: (i) Consumer health protection programs, including the functions of community water supplies, general sanitation, vector control and food and drugs; (ii) Epidemiology and disease control programs, including the functions of chronic disease, accident and injury control, communicable diseases, tuberculosis, venereal disease and others; (iii) Laboratory services programs; (iv) Health education and training programs; and (v) Disposition of human bodies programs.
CA	Cal. Gov't Code § 855.4 (1995).	Public health of the community includes preventing disease or controlling the communication of disease.
CO	Col. Rev. Stat.-§ 25-1 107	The department has, in addition to all other powers and duties imposed upon it by law, the following powers and duties: (a) (I) To investigate and control the causes of epidemic and communicable diseases affecting the public health. (II) For the purposes of this paragraph (a), the board shall determine, by rule and regulation, those epidemic and communicable diseases and conditions that are dangerous to the public health.
DE	Del. Code Ann, tit. 29 § 7904(b) (2000).	"Public health and preventative services" are defined as activities that protect people from diseases and injury. They include activities that: (i) prevent and control communicable disease epidemics; (ii) promote healthy behaviors to control chronic disease; (iii) monitor the health of the population through data analysis and epidemiological studies; (iv) result in policies to promote the health of the public; (v) assure quality health services and systems for the population; (vi) result in the setting of standards for the protection of the public's health; (vii) provide assistance during disasters; (viii) assess environmental health risks; and (ix) offer health protection strategies to environmental control agencies.

Table 1. Statutory Definitions of Public Health in Select States (continued)

GA	Ga. Code Ann. § 31-2-1 (2000).	In order to safeguard and promote the health of the people of this state the department is empowered to: (1) Provide epidemiological investigations and laboratory facilities and services in the detection and control of disease, disorders, and disabilities and to provide research, conduct investigations, and disseminate information concerning reduction in the incidence and proper control of disease, disorders, and disabilities; (2) Forestall and correct physical, chemical, and biological conditions that, if left to run their course, could be injurious to health; (3) Regulate and require the use of sanitary facilities at construction sites and places of public assembly and to regulate persons, firms, and corporations engaged in the rental and service of portable chemical toilets; (4) Isolate and treat persons afflicted with a communicable disease; (5) Manufacture drugs and biologicals which are not readily available on the market and not manufactured for commercial purposes; (6) Promote health aspects of civil defense; (7) Detect and relieve physical defects and deformities and provide treatment for mental and emotional disorders and infirmities; (8) Protect dental health; (9) Determine the presence of disease and conditions deleterious to health; and (10) Provide education and treatment in order to prevent unwanted pregnancy.
KY	Ky. Rev. Stat. Ann. § 211.180 (2000).	Matters of public health include detection, prevention, and control of communicable, chronic and occupational diseases; the control of vectors of disease; the safe handling of food and food products; the safety of cosmetics; the control of narcotics, barbiturates, and other drugs as provided by law; the sanitation of public and semipublic buildings and areas; the licensure of hospitals; protection and improvement of the health of expectant mothers, infants, preschool, and school-age children; the practice of midwifery, including the issuance of permits to and supervision of women who practice midwifery; and protection and improvement of the health of the people through better nutrition.
MA	Mass. Gen. Laws ch. 111, § 5 (1996).	The department shall take cognizance of the interests of life, health, comfort and convenience among the citizens of the commonwealth; shall conduct sanitary investigations and investigations as to the causes of disease, and especially of epidemics, and the sale of food and drugs and adulterations thereof; and shall disseminate such information relating thereto as it considers proper. It shall advise the government concerning the location and other sanitary condition of any public institution. It may produce and distribute immunological, diagnostic and therapeutic agents as it may deem advisable.
MI	Mich. Comp. Laws § 333.2221 (1992).	The department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and agencies and health services delivery systems; and regulation of health care facilities and agencies and health services delivery systems to the extent provided by law.

Table 1. Statutory Definitions of Public Health in Select States (continued)

MO	Mo. Rev. Stat. § 192.011 (1996).	The department shall monitor the adverse health effects of the environment and prepare population risk assessments regarding environmental hazards including but not limited to those relating to water, air, toxic waste, solid waste, sewage disposal and others. The department shall make recommendations to the department of natural resources for improvement of public health as related to the environment. . . . The department of health shall develop a comprehensive disease prevention plan to expand existing and to develop new programs. . . .
NE	Neb. Rev. Stat. §§ 71-7504, 71-7508 (1992).	Community public health services shall mean services designed to protect and improve the health of persons within a geographically defined community by (1) emphasizing services to prevent illness, disease, and disability, (2) promoting effective coordination and use of community resources, and (3) extending health services into the community. Such services shall include, but not be limited to, community nursing services, home health services, disease prevention and control services, public health education, and public health environmental services. Disease prevention and control services shall mean epidemiology, immunization, case finding and follow-up, continuing surveillance and detection, and prevention of communicable and chronic diseases.
NH	N.H. Rev. Stat. Ann. §§ 125:9, 126-A:4[] (1995).	The commissioner of the Department of Health and Human Services shall: I. Take cognizance of the interests of health and life among the people; II. Make investigations and inquiries concerning the causes of epidemics and other diseases, the sources of morbidity and mortality, and the effects of localities, employments, conditions, circumstances, and the environment on the public health. The Department shall ". . . provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well-being of the citizens of New Hampshire."
NJ	N.J. Stat. Ann. § 59:6-3 (1992).	Promoting the public health of the community includes preventing disease or controlling the communication of disease within the community.
NY	N.Y. Pub. Health § 602 (1990).	Services that promote the public health (including enhancing or sustaining the public health, protecting the public from the threats of disease and illness, or preventing premature death) include (1) family health services . . . ; (2) disease control, which shall include activities to control and mitigate the extent of non-infectious diseases, particularly those of a chronic, degenerative nature, and infectious diseases. . . ; (3) health education and guidance, which shall include the use of information and education to modify or strengthen practices that will promote the public health and prevent illness. . . ; (4) community health assessment. . . ; and (5) environmental health, which shall include activities that promote health and prevent illness by ensuring sanitary conditions in water supplies, food service establishments, and other permit sites, and by abating public health nuisances.
OK	Okla. Stat. tit. 63, §1-206 (1996).	1. Maintain programs for disease prevention and control, health education, guidance, maternal and child health, including school health services, health in the working environment, nutrition and other matters affecting the public health; 2. Provide preventive services to the chronically ill and aged; 3. Maintain vital records and statistics.

Table 1. Statutory Definitions of Public Health in Select States (continued)

OR	Or. Rev. Stat. § 431.416 (1999).	Local public health authorities or health district shall assure activities necessary for the preservation of health or prevention of disease in the area under its jurisdiction . . . including: (a) Epidemiology and control of preventable diseases and disorders; (b) Parent and child health services, including family planning clinics; (c) Collection and reporting of health statistics; (d) Health information and referral services; and (e) Environmental health services.
SC	S.C. Code Ann. § 44-1-140 (1988).	The Department may adopt rules and regulations requiring and providing: sanitation of public places; regulation of milk and milk products; sanitation of meat markets and bottling plants; sanitation in handling mollusks, finfish, and crustaceans; control of disease-bearing insects; control of industrial plants; care and isolation of people having a communicable disease; regulation of disposition of garbage and sewage; thorough investigation and prevention of all diseases; education to prevent disease.
TX	Tex. Health & Safety § 12.031 (1992).	"Public health services" means: (1) personal health promotion, maintenance, and treatment services; (2) infectious disease control and prevention services; (3) environmental and consumer health protection services; (4) laboratory services; (5) health facility architectural plan review; (6) public health planning, information, and statistical services; (7) public health education and information services; and (8) administration services.
WI	Wis. Stat. § 160.05 (1998).	Public health concerns. (a) The department shall designate which of the substances in each category are of public health concern and which are of public welfare concern. (b) In determining whether a substance is of public health concern, the department shall take into account the degree to which the substance may: 1. Cause or contribute to an increase in mortality; 2. Cause or contribute to an increase in illness or incapacity, whether chronic or acute; 3. Pose a substantial present or potential hazard to human health because of its physical, chemical or infectious characteristics; or 4. Cause or contribute to other adverse human health effects or changes of a chronic or subchronic nature even if not associated with illness or incapacity. (c) In determining whether a substance is of public health concern, the department may consider other effects not specified under par. (b) if those effects are reasonably related to public health.



B. Defining Public Health Law

Using the Institute of Medicine's definition of public health, we define *public health law* as:

the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population), and the limitations on the power of the state to constrain the autonomy, privacy, liberty, or other legally protected interests of individuals for protection or promotion of community health.

From this definition five essential characteristics distinguish public health law from other fields of medicine and the law:

- (1) **Government:** Public health activities are the primary responsibility of government, rather than the private sector. This is not to say that the private sector (medical providers, researchers, nonprofit institutions, and others) does not play an important part in public health. Private sector entities make valuable and irreplaceable contributions to public health pursuant to government authorization or independent of explicit

government authority. Ultimately, however, government is accountable for the public's health and thus retains primary responsibility for assuring the health of the people;

- (2) **Populations:** Public health focuses on the health of populations, rather than the clinical improvement of individual patients. Aggregate data based on clinical status of individuals is one way to measure public health outcomes. Yet, public health is concerned with this information at the populational level;
- (3) **Relationships:** Public health contemplates the relationship between the state and the population (or between the state and individuals who place themselves or the community at risk), rather than the relationship between the physician and patient;
- (4) **Services:** Public health deals with the provision of public health services, rather than personal medical services. Public health services may include personal medical services (e.g., vaccinations or treatments for communicable diseases), often as a source of last resort. While the provision of personal medical services may require significant public health expenditures, they are not the exclusive service of any public health agency; and
- (5) **Coercion:** Public health possesses the power to coerce the individual for the protection of the community, and thus does not rely on a near universal ethic of voluntarism. Public health authorities may strongly desire and encourage individuals to voluntarily participate in public health programs and follow public health laws. Where individuals do not voluntarily comply, coercive measures can be taken in some cases pursuant to government authorization.

Although these broad parameters help distinguish public health law from other fields, it is necessary to further examine the concept of public health law through our constitutional system of government.



C. Constitutional Authority for Public Health Powers

The United States Constitution is the starting point for any analysis concerning the distribution of governmental powers. Though the Constitution is said to impose no affirmative obligation on governments to act, to provide services, or to protect individuals and populations, it does serve three primary functions: it (1) divides power among the three branches of government (separation of powers), (2) limits government power (to protect individual liberties), and (3) allocates power among the federal government and the states (federalism).²⁷ In the realm of public health, then, the Constitution acts as both a fountain and a levee; it originates the flow of power – to preserve the public health, and it curbs that power – to protect individual freedoms.²⁸

1. Separation of Powers

The Constitution separates governmental powers into three branches: (1) the legislative branch (which has the power to create laws); (2) the executive branch (which has the power to enforce the laws); and (3) the judicial branch (which has the power to interpret the laws). States have similar schemes of governance pursuant to their own constitutions. By separating the powers of government, the Constitution provides a system of checks and balances which is thought to reduce the possibility of government oppression.

The separation of powers doctrine is essential to public health, for each branch of government possesses a unique constitutional authority to create, enforce, or interpret health policy. Each of the three branches typically works together to

accomplish laudable public health objectives. Yet, each branch of government is also vested with its own qualities and responsibilities that, at times, may influence public health policy. The functions and limitations of the legislative, executive, and judicial branches of government are discussed below.

The legislature creates health policy and allocates the necessary resources to effectuate it. State and local lawmakers may be committed to legislating to improve public health, but this can be complicated. Legislators need reliable, accurate information on public health programs and objectives to help make complex public health decisions that are also consistent with their constituent interests and competing claims.

While the executive branch enforces health policy, its role in setting policy is enormous. State governors and their executive agencies often actively work with lawmakers to determine the course of public health policies. Executive agencies at the federal and state levels are legislatively charged not only with implementing legislation, but with establishing complex health regulations. Executive branch agencies are uniquely positioned to effectively govern public health. They are created for the very purpose of advancing public health, can focus on public health problems for extended periods, and may possess significant expertise and resources to address these problems. Conversely, in some instances, agency officials may focus narrowly on single topics and serve for long durations. This can lead to outdated policies and procedures and complicity with the subjects of regulation.

The judiciary's task of interpreting the law toward resolving legal disputes makes the courts' role in public health deceptively broad. Courts exert substantial control over public health policy by determining the boundaries of legislative and executive government power. Courts decide whether a public health statute is constitutional; whether agency action is authorized by legislation; whether agency officials have gathered sufficient evidence to support their actions; and whether government officials and private parties have acted negligently. The judicial branch has the independence and legal training to make thoughtful decisions about constitutional claims regarding, for example, individual rights or federalism.

While courts are constitutionally required to defer to the judgments of state and local law- and policy-makers, and often strive to decide cases consistent with statutory or administrative laws, there remains considerable room for judicial interpretation. Resolving difficult public health issues through jurisprudence has some pitfalls. Judges are politically unaccountable (at least federal judges — some state judges are elected); are bound by the facts of a particular case; may be influenced by *avant garde* expert opinions; and may focus too intently on individual rights at the expense of communal claims to public health protection.

2. Limited Powers

A second constitutional function is to limit government power to protect individual liberties. Government actions to promote the communal good often infringe on individual freedoms. Public health regulation and individual rights may directly conflict. Resolving the tension between population-based regulations and individual rights requires a trade-off. Thus while the Constitution grants extensive powers to governments, it also limits these powers through the declaration of individual rights which government cannot infringe without some level of justification. The Bill of Rights (the first ten amendments to the Constitution), together with other constitutional provisions,²⁹ creates a zone of individual liberty, autonomy, privacy, and economic freedom that exists beyond the reach of the government.

Public health law struggles to determine the point at which government authority to promote the population's health must yield to individual rights claims. This observation is clearly demonstrated in the United States Supreme Court Opinion, *Jacobson v. Massachusetts*³⁰ in 1905. In *Jacobson*, the Supreme Court considered a constitutional chal-

lenge to a general vaccination requirement for smallpox. Massachusetts enacted a law at the turn of the twentieth century empowering municipal boards of health to require the vaccination of inhabitants if necessary for the public health or safety. The Cambridge Board of Health, under authority of this statute, adopted a vaccination requirement for smallpox. Jacobson refused the vaccination, was convicted by the trial court, and was sentenced to pay a fine of five dollars. The Massachusetts Supreme Judicial Court upheld the conviction,³¹ and the case was appealed to the United States Supreme Court in 1905. Jacobson's argued that "a compulsory vaccination law is unreasonable, arbitrary and oppressive, and, therefore, hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best."³² His claim was grounded in constitutional liberty interests which, he asserted, supported natural rights of persons to bodily integrity and decisional privacy.

Rejecting Jacobson's appeal, the Supreme Court adopted a narrower view of individual liberty while emphasizing a more community-oriented philosophy in which citizens have duties to one another and to society as a whole. Justice Harlan, writing for the Court, stated:

[T]he liberty secured by the Constitution of the United States . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. . . ."³³

Under a social compact theory, then, "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members"³⁴ consistent with a state's traditional police powers which authorize an array of governmental action in the interests of public health, among other priorities.³⁵ The legacy of *Jacobson* surely is its defense of social welfare philosophy and unstinting support of police power regulation.

However, the Court also recognized the limits of these broad powers. Utilizing state police powers in support of vaccination requirements or other public health initiatives is constitutionally permissible only if they are exercised in conformity with the principles of:

(a) **public health necessity.** Justice Harlan, in *Jacobson*, insisted that police powers must be based on the "necessity of the case" and could not be exercised in "an arbitrary, unreasonable manner" or go "beyond what was reasonably required for the safety of the public;"³⁶

(b) **reasonable means.** The *Jacobson* Court introduced a means/ends test that required a reasonable relationship between the public health intervention and the achievement of a legitimate public health objective.³⁷ Even though the objective of the legislature may be valid and beneficent, the methods adopted must have a "real or substantial relation" to protecting the public health, and cannot be "a plain, palpable invasion of rights;"³⁸

(c) **proportionality.** "[T]he police power of a State," said Justice Harlan, "may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong, . . . injustice, oppression or absurd consequence."³⁹ Thus, a public health regulation may be unconstitutional if the intervention is gratuitously onerous or unfair; and

(d) **harm avoidance.** While those who pose a risk to the community can be required to submit to compulsory measures, including vaccination, for the common good, the measure itself should not pose a health risk to its subject. Jacobson presented no medical evidence that he was not a "fit person" for smallpox vaccination. However, requiring a person to be immunized despite

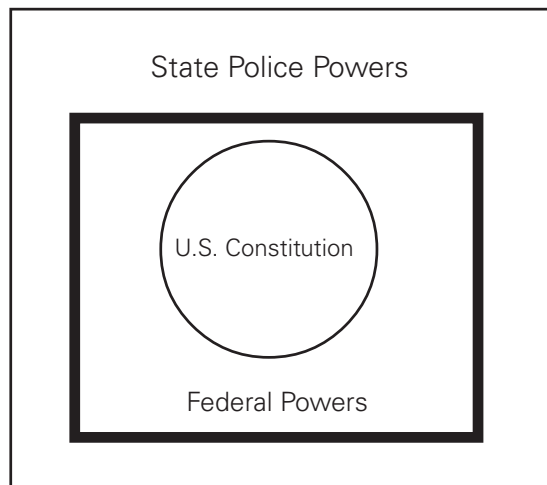


Figure 1. American Federalism

knowing harm would occur would be “cruel and inhuman in the last degree.”⁴⁰

Thus, while *Jacobson* stands firmly for the proposition that police powers authorize states to compel vaccination for the public good, government power must be exercised reasonably to avoid constitutional scrutiny. The acts of a board of health, it has been held, are limited to those which are essential to protect the public health.⁴¹

3. Federalism

Finally, the Constitution attempts to allocate powers among the levels of government, federal and state. Federalism, as a principle of law and governmental design,⁴² distinguishes between the powers among the levels of American governments.⁴³ In **Figure 1**, above, the principle of federalism is represented by the bolded division separating federal and state powers.⁴⁴

The federal government has those limited powers granted pursuant to the Constitution, including the power to enact laws in areas in which the federal government has jurisdiction. To preserve the powers of the federal government from intrusion by the states, the Supremacy Clause⁴⁵ provides that federal laws and regulations override conflicting state laws via the doctrine of preemption.

Likewise, with the passage of the Tenth Amendment, states reserved their sovereign power over “all the objects, which, in the ordinary course of affairs, concern the lives, liberties and properties of the people; and the internal order, improvement, and prosperity of the State.”⁴⁶ These powers, collectively known as police powers, give states broad jurisdiction to regulate matters affecting the health, safety, and general welfare of the public.⁴⁷

Though a consequence of federalism, the distinction between federal and state powers is not always predictable in application.⁴⁸ Federal and state government powers approach each other on a regular basis. It is precisely at the point when these powers collide that federalism takes on many shades and “almost imperceptible gradations.”⁴⁹

Federalism-based issues can be classified into two broad categories: (1) *state intrusions into the federal sphere*. These include instances where states seek to intrude on the constitutional authority of the federal government (e.g., enacting laws which interfere with Congress’ regulation of interstate commerce)⁵⁰ or fail to recognize federal supremacy or authority (e.g., attempting to impose taxes on federal goods).⁵¹ Such examples proliferated during the early history of the nation as states tested the limits of their sovereign powers; and (2) *federal intrusions into traditional state duties*. Originally

federal exercises which interfered with traditional state powers were virtually inconceivable in light of the considerable weight of state police powers.⁵² In theory, federal legislation which touched areas traditionally left to the states was beyond Congress' jurisdiction, and therefore did not reign supreme over state law. However, the expansion of the federal government during the New Deal relaxed such traditional notions of federalism.⁵³ Arguments stemming from federal intrusion over states typify, though not exclusively, modern federalism debates.

Despite the accepted ability of the federal government to enter the field of public health, the American political and judicial process has placed enforceable limits on Congress' powers⁵⁴ in an era of *new federalism*.⁵⁵ Increasingly, federalism has been the focal point of political⁵⁶ and judicial issues. New federalism cases before the United States Supreme Court have resulted in the Court's (1) adoption of a super-strong rule against federal invasion of "core state functions;"⁵⁷ (2) presumption against application of federal statutes to state and local political processes;⁵⁸ (3) disdain for federal action that "commandeers" state governments into the service of federal regulatory purposes;⁵⁹ (4) rejection of federal claims brought by private parties against states;⁶⁰ and (5) adoption of the "plain statement rule" that Congress must ". . . make its intention unmistakably clear in the language of the statute,"⁶¹ that state law is preempted where such may alter the balance of federalism.⁶²

The Supreme Court's decision in *United States v. Lopez*⁶³ is reflective of the judicial trend.⁶⁴ In *Lopez*, the Court held that Congress exceeded its Commerce powers by making gun possession within a school zone a federal criminal offense.⁶⁵ Concluding that possessing a gun within a school zone did not "substantially affect" interstate commerce, the Court declared the statute unconstitutional.

By any account, new federalism has mobilized the Tenth Amendment as a vehicle for challenging federal statutes that compel state legislative or administrative action. As a result, some federal public health laws may be vulnerable to state challenges on Tenth Amendment grounds — for example, environmental regulations that direct states to adopt or enforce a federal regulatory scheme⁶⁶ or loosely preemptive federal laws⁶⁷ which invade core state concerns in public health.



D. Governmental Public Health Powers

In the following sections, the authority and exercise of public health powers of federal, state, and local governments within the constitutional framework are explored.

1. Federal Powers

The federal government must draw its authority to act from specific, enumerated powers. Before an act of Congress is deemed constitutional, two questions must be asked: (1) does the Constitution affirmatively authorize Congress to act, and (2) does the exercise of that power improperly interfere with any constitutionally protected interest?

In theory, the United States is a government of limited, defined powers. In reality, political and judicial expansion of federal powers through the doctrine of implied powers allows the federal government considerable authority to act in the interests of public health and safety. The federal government may employ all means reasonably appropriate to achieve the objectives of constitutionally enumerated national powers.⁶⁸ For public health purposes, the chief powers are the power to tax, to spend, and to regulate interstate commerce. These powers provide Congress with independent authority to raise revenue for public health services and to regulate, both directly and indirectly, private activities that endanger human health.

2. State Police Powers

Despite the broad federal presence in modern public health regulation, states have historically and contemporaneously had a predominant role in providing population-based health services. States still account for the majority of traditional spending for public health services (not including personal medical services or the environment).⁶⁹ The Tenth Amendment of the federal Constitution reserves to the states all those powers not otherwise given to the federal government nor prohibited to the states by the Constitution.

The police power represents the state's authority to further a primary goal of all government, to promote the general welfare of society. Police powers can be generally defined as the inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve and promote the health, safety, morals, and general welfare of the people. To achieve these communal benefits, the state retains the power to restrict, within federal and state constitutional limits, private interests — personal interests in liberty, autonomy, privacy, and association, as well as economic interests in freedom to contract and uses of property.

Police powers in the context of public health include all laws and regulations directly or indirectly intended to improve morbidity and mortality in the population. The police powers enable state and local governments to promote and preserve the public health in areas ranging from injury and disease prevention⁷⁰ to sanitation and water and air pollution.⁷¹ Police powers exercised by the states include laws authorizing vaccination,⁷² isolation and quarantine,⁷³ inspection of commercial and residential premises,⁷⁴ abatement of unsanitary conditions or other health nuisances,⁷⁵ regulation of air and surface water contaminants as well as restriction on the public's access to polluted areas,⁷⁶ standards for pure food and drinking water,⁷⁷ extermination of vermin,⁷⁸ fluoridization of municipal water supplies,⁷⁹ and licensure of physicians and other health care professionals.⁸⁰

3. Local Powers

In addition to the significant roles which federal, state, and tribal governments have concerning public health law in the constitutional system, local governments also have important public health interests. Public health officials in local governments, including counties, municipalities, and special districts, are often on the front line of public health dilemmas. They may be directly responsible for assembling public health surveillance data, implementing federal and state programs, administering federal or state public health laws, operating public health clinics, and setting public health policies for their specific populations.

To the degree local governments set local public health priorities, they do so pursuant to specific delegations of state police powers. Local governments in the constitutional system are recognized as subsidiaries of their state sovereigns. As a result, any powers which local governments have to enact public health law or policies must be delegated from the state. Such delegations of power, which may be narrow or broad, provide local governments with a limited realm of authority, or "home rule," over public health matters of local concern within their jurisdiction. These delegations of power may be protected against withdrawal or infringement by state constitutions or statutes. Absent constitutionally-protected delegations of power to local governments, however, states may modify, clarify, preempt, or remove "home rule" powers of local government at will.

Exercises of local authority in the interests of public health cannot extend beyond limited jurisdictional boundaries or conflict with or impair federal or state law. As a result, the role of local governments in public health law is largely limited by federal and state laws and regulations to which local governments must adhere in setting or implementing public health policies.

4. Tribal Powers

Tribal governments are unlike state executive agencies and local governments which have been established and vested with public health powers via the state constitution and statutory laws. Tribal governments are not “established” pursuant to state law. Rather, their legal existence and many of their public health powers derive from the federal government.

The federal government’s relationship with the American Indians is the product of compromise. In the mid 1800’s American Indians executed treaties with the United States that turned over vast quantities of Indian land to federal control. In return, American Indians were granted limited set-asides of land (reservations), were allowed to form sovereign tribal governments, and were to receive direct federal assistance. As sovereigns, tribal governments retained the traditional powers of government which are associated with state governments. This includes the power to act in the interest of public health. However, protecting the health of the community among tribal populations has traditionally been a shared venture between federal, state, and tribal governments.

Pursuant to the Snyder Act of 1921,⁸¹ Congress directly assumed responsibility for the provision of health care to tribal governments. Such federal assistance continues today through long-term commitments for comprehensive health services administered by the Indian Health Service (IHS) of the federal Department of Health and Human Services (DHHS), and to a lesser extent, the Bureau of Indian Affairs (BIA). Congress has legislatively strengthened its commitment to provide health care benefits to American Indians through the Indian Self-Determination and Education Assistance Act of 1975⁸² and the Indian Health Care Improvement Act of 1976.⁸³ Together these Acts clarified federal objectives for the provision of health-related services and encouraged the direct involvement of tribal governments in planning and operating health programs.

In 1991, Congress began the IHS Tribal Self-Governance Demonstration Project.⁸⁴ This Project, which is scheduled to continue until 2006, specifically authorizes IHS and BIA to execute agreements (or compacts) with American Indians for the purpose of providing federal funds for health programs and facilities without significant federal oversight. Under this law, general management and supervision of such programs and facilities are left to the tribal governments. As a result, the setting of public health goals and objectives are increasingly the responsibility of tribal governments. This movement toward self-governance was further solidified with the Congressional enactment of the Tribal Self-Governance Act of 1994.⁸⁵

Federally recognized tribes may receive their funds directly from IHS. They can use the funds for specific health programs within their discretion, provided the spending is consistent with the general conditions for federal funding. This flexibility allows local tribal governments to target and respond to differing health needs across their populations.

2. State Public Health Systems

As prior sections suggest, protecting the public health is a shared responsibility of federal, state, tribal, and local governments in the United States. How public health is protected through the provision or organization of public health services at the various levels of government is complex.⁸⁶ Absent a national, centralized public health system, public health services are predominantly provided or coordinated at the state and local levels, often with some level of federal funding or other support (e.g., oversight, expertise). Federal support and state-based programs and initiatives that encourage information sharing and collaboration have contributed to the standardization of many public health services across the nation. Yet, as discussed in Part I., above, and in this Part, public health responsibilities and services at the state and local levels vary extensively across states because of differences in (1) the underlying historical bases for public health protections; (2) the constitutional structure of state and local governments (e.g. contrast public health systems in states that constitutionally provide local governments with inherent powers, or home rule, with states that largely have vested state government with the power to protect public health); (3) state and local resources devoted to public health; (4) public health dilemmas which differ across jurisdictions; (5) political views about the importance of public health; and (6) the organization of state and local public health agencies, as well as the distribution of public health responsibilities.

These and others reasons perhaps explain why there is no single model of how states accomplish public health goals and objectives. There are, however, similarities, which we discuss below.



A. Organization of State Public Health Agencies

Nearly every state concentrates their public health powers within a few state agencies.⁸⁷ Most traditional public health functions in **Virginia**, for example, are centrally administered, if not performed directly, by one of three state agencies: the *Virginia Department of Health* (VDH) (which regulates public health matters related to the control of communicable diseases, administration of public health care, and some issues of public safety),⁸⁸ the *Department of Environmental Quality* (DEQ) (which regulates environmental threats to health,⁸⁹ and the *Virginia Department of Agriculture and Consumer Services* (VDACS) (which controls some public health nuisances).⁹⁰

Most states also spread other public health responsibilities across multiple agencies. In **Virginia**, additional state agencies which contribute to public health objectives include the *Department of Emergency Services* (which coordinates the state's emergency preparedness and response efforts for a variety of disasters); the *Department of Labor and Industry* (primarily responsible for occupational safety and health); the *Department of Health Professions* (which provides for the licensure of physicians and nurses); the *Department of Rehabilitative Services*, the *Department for Rights of Virginians With Disabilities*, and the *Council on Human Rights* (which assist individuals with disabilities concerning issues of abuse, neglect, and discrimination); the *Department of Mental Health, Mental Retardation and Substance Abuse Services* (concerned with mental health issues, including research and surveillance); and the *Department of Medical Assistance Services* (which administers the state's Medicaid services to the Commonwealth's low-income population).

State public health systems may also feature state boards of health or high-ranking health officers (e.g., secretary or commissioner) that oversee, supervise, or provide

policy support to state health agencies responsible for public health functions.⁹¹ Many state boards of health were disestablished or devalued in their policymaking roles as part of the consolidation of state health services in the 1970's and 1980's,⁹² although some states (e.g., **New Jersey**⁹³) have established public health-specific councils in the 1990s.

Beyond these similarities, there exists tremendous diversity among state public health systems even as certain organizational patterns have emerged.⁹⁴ State governments have organized state public health systems and allocated responsibilities for “public health functions”⁹⁵ according to at least two distinct organizational structures: (1) **superagency**⁹⁶ (a.k.a. umbrella)⁹⁷ **systems** (where public health functions are the responsibility of a single, comprehensive health department—the superagency). As part of this organizational structure, public health functions may be assigned to multiple divisions under the agency’s control (e.g., collaborative approach) or to a single public health division within the agency (e.g., embedded approach); and (2) **freestanding systems** (where public health functions are largely fulfilled by a freestanding public health agency which is not under the direct control of a larger health department). These classifications are further explained below.

1. Superagency Systems

In superagency systems, public health functions are the responsibility of a *single, comprehensive health department*—the superagency (also referred to as the umbrella agency). Among its many other functions, the superagency has virtually complete authority to create and implement public health policies and programs. States that feature superagency systems may allocate some public health-related functions (e.g., mental health programs) to agencies outside of the superagency’s direct control, but an overwhelming majority of core public health functions are performed within the superagency.

Public health functions in **Washington** are fulfilled by the *Washington State Department of Health* (www.doh.wa.gov/), a superagency that, according to its broad mission statement “works to protect and improve the health of people in Washington State.” The *Department of Health* contains multiple subagencies, including *Health Systems Quality Assurance, Community and Family Health, and Epidemiology, Health Statistics, and Public Health Laboratories*. Unlike most states, environmental health services are also under located in the *Department of Health*. **Figure 2**, on the following page, provides the modern, organizational structure for the *Washington State Department of Health*.

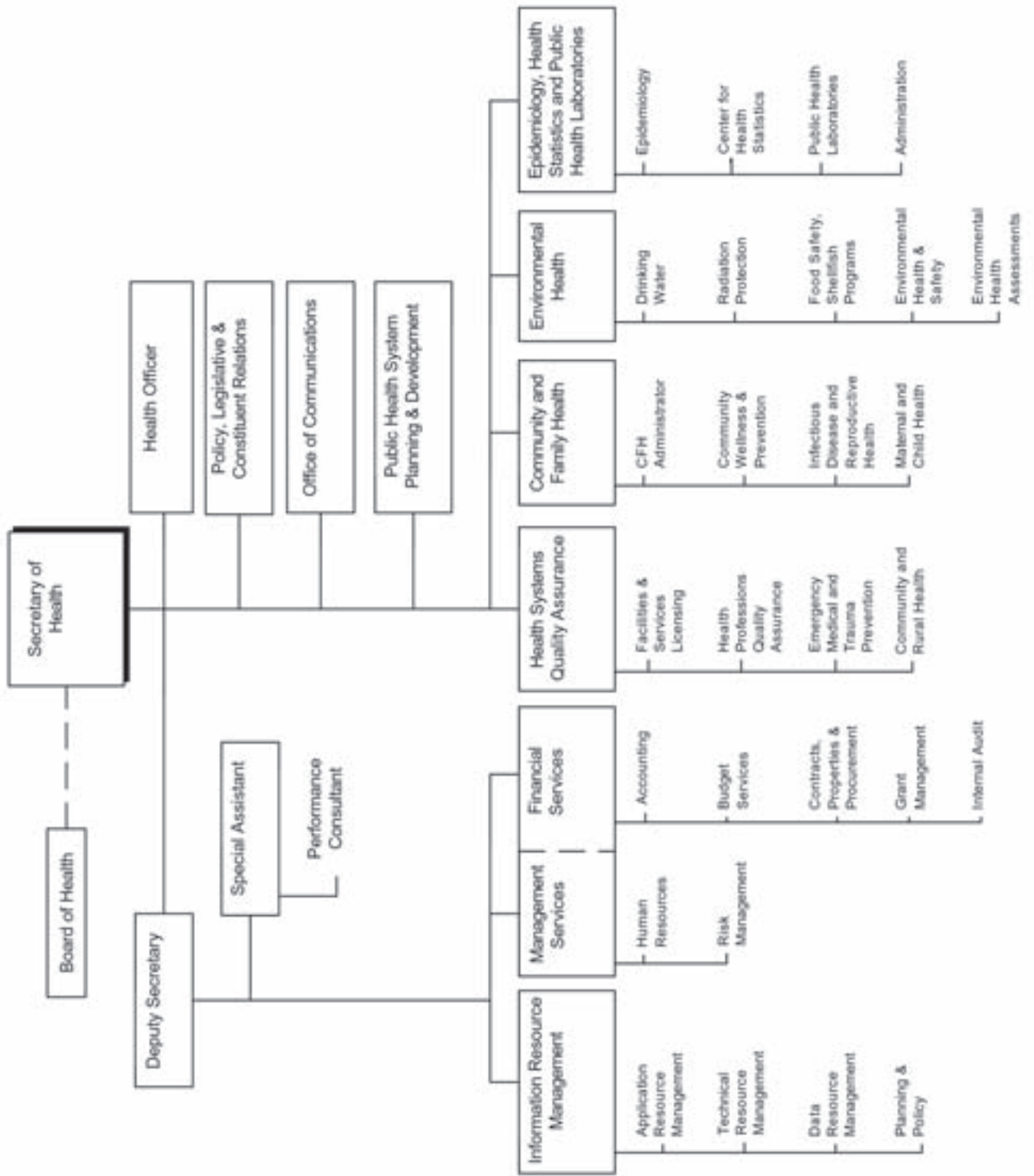
Some superagencies feature a collaborative or embedded approach that further organizes public health functions into specific divisions, departments, or offices within the agency itself.

a. Collaborative Approach

In a collaborative approach, core public health functions are the responsibility of *multiple divisions under the control of a larger superagency* charged with ensuring the general health of the state. Each division within the larger agency fulfills one or more of the defined public health functions. Through the collaborative efforts of multiple divisions, all public health functions are provided.

Virginia’s core public health functions are fulfilled through a collaborative approach. The *Virginia Department of Health* (VDH) (www.vdh.state.va.us/commish/041.htm) accomplishes its public health goals through ten (10) primary departmental subdivisions, or “offices,” including: the *Center for Quality Health Care, Emergency Medical Service, Environmental Health Services* (a unique inclusion among states), *Epidemiology, Family Health Services, Health Statistics, Internal Audit, Medical Examiner, Vital Records, and Water Programs*. Additional departments within the *Department of Health* handle administrative functions of the agency and facilitate the relationship between the Depart-

Figure 2. Organizational Chart—Washington State Department of Health



ment and **Virginia's** thirty-five (35) local health districts, and public health nurses. The *Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services* provides mental health services independently from VDH.

b. Embedded Approach

Superagencies that feature an embedded approach tend to rely upon a *single public health division* within the larger health department for the fulfillment of most core public health functions. Public health functions are provided through subdivisions of a distinct division that is responsible solely for the public health. Thus, public health functions are *embedded* within a division of a larger department responsible for the state's health activities instead of being directly implemented by a department of health.

North Carolina's public health structure typifies an embedded system (www.dhhs.state.nc.us/dph/). The *Division of Public Health* resides within the *Department of Health and Human Services*. All core public health functions are fulfilled within the *Division of Public Health's* subdivisions: *Health Promotion and Disease Prevention, Dental Health, Epidemiology and Communicable Diseases, Local Health Services, Office of the Chief Medical Examiner, Officer of Minority Health, State Center for Health Statistics, State Laboratory of Public Health, and Women's and Children's Health*.

Like **Virginia, North Carolina's** mental health services and environmental health services are handled outside of the *Division of Public Health*. The *Division of Mental Health, Developmental Disabilities, and Substance Abuse Services* handles all mental health activities. A majority of environmental health services are provided by the *Department of Environment and Natural Resources*, an agency outside of, and parallel to, the *Department of Health and Human Services*.

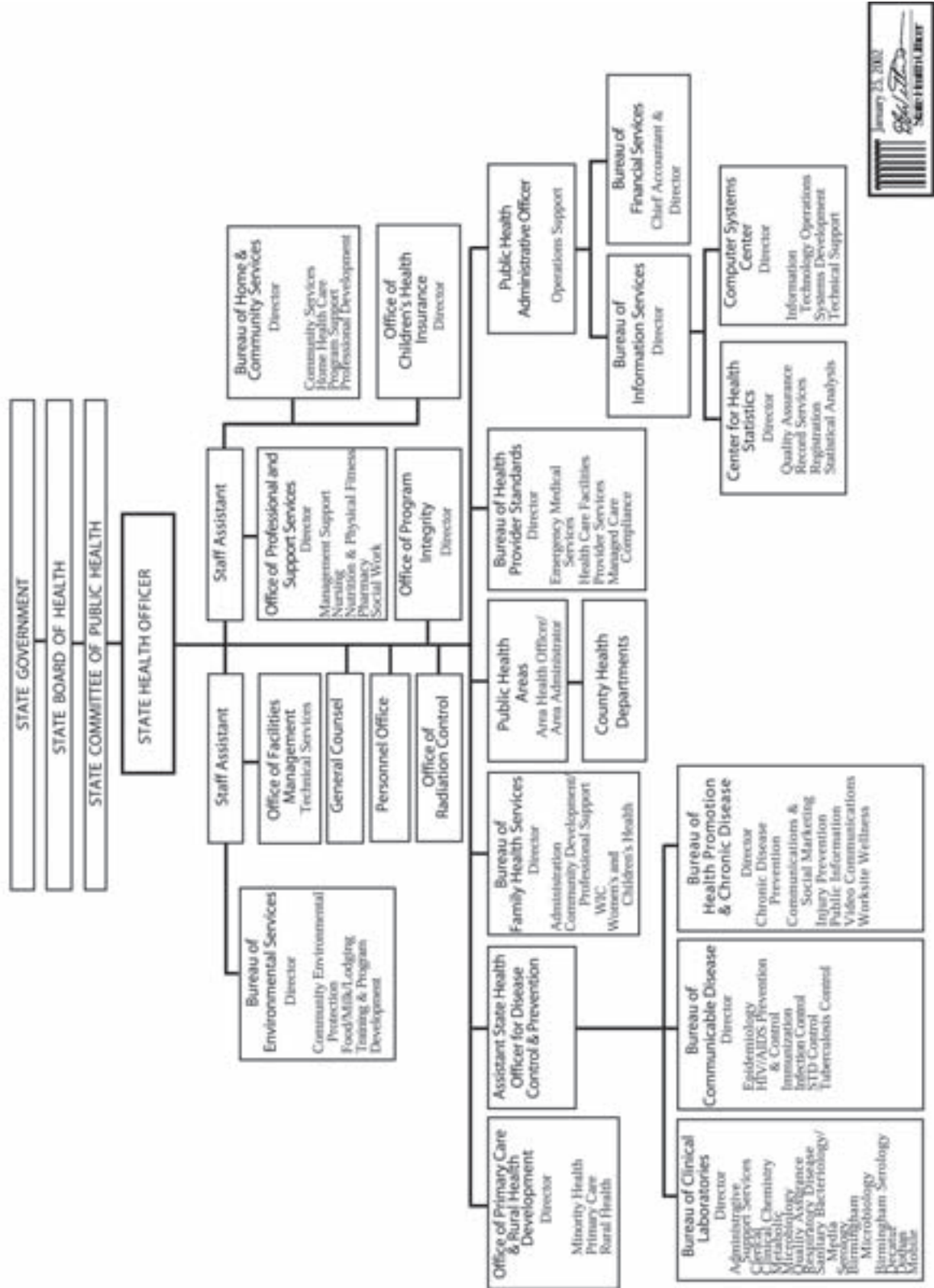
2. Freestanding Systems

Freestanding systems are characterized by the fulfillment of nearly all public health functions by a freestanding public health agency which is not under the direct control of a larger health department. Like other public health agencies, freestanding agencies likely answer directly to the governor, a secretary or commissioner of health, or a board of health. A freestanding system is different from a superagency system—in a superagency system, fulfilling core public health functions is one of numerous activities that the agency is responsible for. A freestanding public health agency's responsibility is limited to the fulfillment of public health functions.

The **Alabama** *Department of Public Health* (www.alapubhealth.org) is a freestanding, executive agency that reports to the *State Board of Health* and the Governor. The *Department of Public Health* fulfills public health functions and, unlike most states, provides some environmental health services. However, the majority of environmental services are provided by the *Department of Environmental Management*. Likewise, mental health services, as in most states, are provided through a separate agency, the *Department of Mental Health and Mental Retardation*. Several key areas of the *Department of Public Health's* over twenty divisions and subdivisions include: the *Assistant State Health Officer for Disease Control and Prevention, Bureau of Family Health Services, and the Public Health Administrative Officer*. **Figure 3**, on the following page, provides the organizational structure for the *Alabama Department of Public Health*.

Figure 3. Organizational Chart—Alabama Department of Public Health

ORGANIZATION OF THE ALABAMA DEPARTMENT OF PUBLIC HEALTH





B. Distribution of Public Health Responsibilities

Beyond the organization of public health functions at the state level, jurisdictions differ in how they distribute public health responsibilities between the state and local levels of government. State and local government law concerning local public health powers reveals multiple distributive patterns which vary from state to state according to constitutional, statutory, and case law. The intricacies of these relationships between state and local public health entities extend well beyond the scope of this report, but are generally classifiable into three approaches:

(1) **centralized, “top-down” approach** [state public health agencies have extensive legal and operative control over local level public health authorities (e.g., **Virginia**)]; (2) **decentralized, “bottom-up” approach** [local governments are allowed significant control and authority over local public health responsibilities (e.g., **Oregon**)]; or (3) **“hybrid” approach** [some public health responsibilities are provided directly by the state while others are assumed primarily by local governments (e.g., **Alaska**)]. For a relatively modern classification of states under these three approaches, see **Table 2** below. The underlying bases for these three differing approaches may stem from constitutional, political, or financial factors in each state. Ultimately, these approaches reflect statutory preferences for the types of relationships between state and local public health entities.

Table 2 - Classification of State and Local Distribution of Public Health Functions⁹⁸

Distributional Approach	Brief Description	States	Total
Centralized ("top-down") Approach	The state public health agency either performs directly or regulates the level and extent of public health services provided at the local county or city levels.	AR, FL, LA, MS, NM, SC, VA	7
Decentralized ("bottom-up") Approach	The authority and direct responsibility for many public health functions lies at the local county or city level of government.	AZ, CO, CT, ID, IN, IA, ME, MO, MT, NE, NV, NJ, ND, OR, UT, WA, WI	17
"Hybrid" Approach	The direct responsibility for public health functions are shared between state and local governments.	AL, AK, CA, GA, IL, KA, KY, MD, MA, MI, MN, NH, NC, NY, OH, OK, PA, SD, TN, TX, WV, WY	22

1. Centralized (“top-down”) Approach

Many states (such as **Florida**, and **Mississippi**⁹⁹) create a highly-centralized structure for the regulation, delivery, and enforcement of various public health responsibilities at the state level. As discussed in Part II.A, above, general and specific public health responsibilities are often legislatively assigned to a comprehensive department of health or subdivision. In some cases, these agencies are legislatively granted broad authority which they exercise in a top-down fashion in the interests of public health. Thus, the state agency either performs directly or regulates the level and extent of public health services provided at the local county or city levels. Local public health agencies at the

county or city levels carry out public health responsibilities consistent with significant state oversight and subject to state control. In some cases, local public health authorities are actually employed by the state, not the local governments where they work.

The **Virginia** public health system is again instructive. Like nearly every state, **Virginia** has constitutionally provided for the establishment of counties, cities, towns, and regional governments.¹⁰⁰ **Virginia** statutory law further classifies these divisions of local government, conveys the general power to municipalities to promote the general welfare, safety, and health,¹⁰¹ and assigns them some minimal public health powers.¹⁰²

While counties and cities are allowed some discretion in the exercise and passage of public health ordinances via authorization pursuant to state law, most public health functions are undertaken through local departments of health which are contractually overseen by VDH. Each county and city in **Virginia** is statutorily required to “establish and maintain a local department of health which shall be headed by a local health director.”¹⁰³ These local departments of health are statutorily and contractually bound to administer many public health duties in accordance with state requirements. Counties and cities may enter into contracts with the *State Board of Health* to assist, financially and otherwise, with the operation of the local health departments.¹⁰⁴ The *State Health Commissioner* has broad discretion in managing such health departments, is responsible for appointing a local health director, and may consolidate these departments into district health departments to allow for the performance of their functions in a more efficient and economical manner.¹⁰⁵ There currently exist 35 local health districts in **Virginia**.¹⁰⁶ While statutorily centralized in nature, the state and local relationship is more cooperative in practice.

2. Decentralized (“bottom-up”) Approach

Oregon’s public health laws suggest a variation of the centralized, top-down structure for the provision and delivery of many public health services in the state. Unlike most states,¹⁰⁷ **Oregon** has statutorily enacted a basic statement regarding the protection of the health and safety of its citizens which reflects its decentralized approach:

The Legislative Assembly of the State of Oregon finds that each citizen of this state is entitled to basic public health services which promote and preserve the health of the people of Oregon. To provide for basic public health services the state, in partnership with county governments, shall maintain and improve public health services through county or district administered public health programs.¹⁰⁸

Like other states (including **Washington** and **Wisconsin**¹⁰⁹) **Oregon** utilizes a decentralized, bottom-up approach in relation to core public health responsibilities (besides environmental protection). Each of the state’s 36 counties is statutorily authorized to regulate in the interests of public health at the local level.¹¹⁰ County departments of health may align to form district health departments.¹¹¹ **Oregon’s** cities are prohibited from organizing public health departments.¹¹²

These county or district health departments work together as partners with state public health agencies. Apart from the requirements to meet state standards and follow state laws and regulations (a standard consequence of state preemption), counties have a great deal of autonomy that allows them to exercise their public health powers to meet local needs. State agencies serve a supervisory role, but do not generally provide public health services directly. The *Oregon Health Division* is statutorily required to concur with local health departments concerning, for example, the minimum standards which dictate the operation and organization of the departments.¹¹³

District or county boards of health have the power to adopt rules necessary to carry out their duties and responsibilities.¹¹⁴ Local public health authorities administer and enforce local and state rules and laws concerning public health. They provide services necessary for the preservation of health or prevention of disease as provided in their annual plan including (a) epidemiology and control of preventable diseases and disorders; (b) parent

and child health services, including family planning clinics; (c) collection and reporting of health statistics; (d) health information and referral services; and (e) environmental health services.¹¹⁵

Through this relationship, the authority and direct responsibility for public health in **Oregon** largely lies at the local, county level of government. Interestingly, while **Oregon's** public health system is configured on a bottom-up approach, its public health laws do not absolutely require it. Rather, several statutory provisions reflect a degree of flexibility among state and local powers which could allow for fundamental changes in the existing structure (if such is desired) without significant legislative action.

3. Hybrid Approach

The majority of state and local public health systems utilize a hybrid approach to distributing public health powers, or at least have some features of this approach. Under a hybrid approach, direct responsibility for public health functions are shared between state and local governments. The state legislature may assign primary responsibility for communicable disease control to the state department of health and simultaneously delegate specific functions (such as environmental protections) to local governments. These local public health authorities enjoy a level of independence from state control over those responsibilities which they are assigned (as seen in a decentralized system), but must defer to the state department of health on matters for which the department is responsible (as seen in a centralized system).

Alaska's public health system is characteristic of a hybrid approach. Unlike the federal Constitution and most other state constitutions as well, the **Alaska** Constitution explicitly authorizes the State legislature to "provide for the promotion and protection of public health."¹¹⁶ Pursuant to explicit constitutional authorization, the **Alaska** legislature has enacted an array of statutes which generally authorize various state and local governmental agencies and departments to regulate and carry out traditional public health functions.¹¹⁷

Most core public health functions in **Alaska** are centrally administered, if not performed directly, by one of two state agencies, the *Department of Health and Social Services* (DHSS)¹¹⁸ and the *Department of Environmental Conservation* (DEC).¹¹⁹ DHSS is primarily responsible for regulating public health matters related to the control of communicable diseases, administration of public health care, and some issues of public safety. DEC is delegated the authority to regulate environmental threats to health, including the control of public health nuisances through licensing and monitoring of relevant commercial and noncommercial establishments.

Alaska has also constitutionally provided for the establishment of boroughs and cities and delegated home rule authority to these subsidiary governments. **Alaska** statutory law classifies boroughs and cities, and subsequently clarifies their home rule powers. The state's 17 incorporated boroughs are classified as either first, second, or third class. Cities in the state may be designated as first or second class.¹²⁰ Boroughs or cities are further classified as either "home rule municipalities," which are local governments that have adopted a home rule charter. These local governments have legislative powers not otherwise prohibited by state law or charter.¹²¹ "General law municipalities" are unchartered boroughs or cities. Their legislative powers must be specifically conferred by state law.¹²²

The classification of these subsidiary governmental units is important toward examining the degree of public health powers delegated to the local government. For example, first-class boroughs (the functional equivalent of counties in many states) may ordain area wide regulations concerning water pollution, air pollution, animal control, and the licensing of day-care facilities, as well as any non-area wide regulations not otherwise prohibited by state law.¹²³ Second-class boroughs may regulate in similar fashion on an area wide basis, but are limited to defined subjects of regulation on a non-area wide basis.¹²⁴

First- or second-class boroughs may acquire additional powers by holding an area wide election.¹²⁵ Third-class boroughs (the functional equivalent of special service districts in many states) lack any public health regulatory powers absent the power shared by first and second-class boroughs to prevent the release of oil or other hazardous substances into the environment.¹²⁶

Alaska delegates some public health functions to all municipalities, whether home rule or general law, borough or city. For example, any municipality may establish a local air quality control program,¹²⁷ regulate the sale and consumption of alcoholic beverages,¹²⁸ create a program for the reporting of hazardous chemicals, materials, or wastes,¹²⁹ take advantage of incentives in the form of state funds to establish health facilities and hospitals,¹³⁰ and receive grants of state funds to clean up or prevent oil and hazardous substance spills.¹³¹ These delegations do not include, however, traditional public health functions assigned to state agencies, such as communicable disease control.



C. Statutory Mechanisms for Financing Public Health Systems

No matter how state and local public health systems are organized or structured via state law, funding public health programs and services is critical to the success of various initiatives. In many states, funding limitations for public health present a significant barrier to achieving state and local public health objectives. Many public health agencies suggest that they are under-funded by comparing their expenditures to the enormous sums allocated to health care services.¹³² Using 1991 figures, **Bernard Turnock** suggests that state and local public health expenditures in the United States constitute a mere 1.9% of all health expenditures.¹³³ **Susan Wall** suggests that this figure was closer to 1% in 1993,¹³⁴ a figure that has been confirmed by the Public Health Foundation as late as 1996.¹³⁵

William Roper, who has served in several major federal posts including head of the Centers for Disease Control and of the Health Care Financing Administration, described his own experiences with funding for public health services:

From my perspective, as a White House official watching the budgetary process, and subsequently as head first of a health care financing agency and then of a public health agency, I was continually amazed to watch as billions of dollars were allocated to financing medical care with little discussion, whereas endless arguments ensued over a few millions for community prevention programs. The sums that were the basis for prolonged, and often futile, budget fights in public health were treated as rounding errors in the Medicare budget.¹³⁶

Comparing public health expenditures to expenditures for individual health care, is complicated by the fact that there is considerable disagreement over how to measure public health funding. Accurately assessing levels of public health funding is difficult because there is no agreed methodology to determine the source and amount of public health funds. As **Christopher Atchison, Kristine Gebbie**, and their colleagues suggest, the *Essential Services* from the 1994 report, *Public Health in America* (see Part I.A) may be a workable framework for the classification of public health expenditures.¹³⁷ Following initial pilot studies using the *Essential Services* framework to classify state and local public health spending, **Atchison, Gebbie**, and others concluded that great variations exist in public health funding across states. Among nine states that reported state and local expenditures based on the *Essential Services* framework, per capita public health spending varied from \$51 to \$232.¹³⁸

Although the amounts vary from year to year and from state to state, the bulk of public health funding comes from state and federal governments. In some states, the federal share may exceed state contributions. Local government funds and fees, reimbursements, or other generated funds comprise a much smaller portion of public health funds nationally.¹³⁹

State funds for public health expenditures may come from a variety of sources, including:

- Distributions from general revenues pursuant to state budget requests¹⁴⁰ or emergency appropriations;¹⁴¹
- Specific set-asides based on ad valorem (real property) taxes, product sales taxes (e.g., tobacco¹⁴²), or generated fees;¹⁴³
- State grants for need-based local initiatives, including matching grants;¹⁴⁴
- Fee-based programs (e.g., distribution of vital statistics records,¹⁴⁵ government-run nursing programs¹⁴⁶);
- “Superfund-styled” assistance accounts (e.g., to assist in the clean-up of leaking underground petroleum storage tanks¹⁴⁷);
- Other expenditure funds (e.g., tobacco settlement funds¹⁴⁸). Like many states, **Nebraska** has created a fund to hold tobacco settlement proceeds (the *Tobacco Prevention and Control Cash Fund*) and limited the use of funds to specific public health objectives, including (a) programs to reduce tobacco use, (b) counter-market-ing initiatives, (c) cessation programs, and (d) surveillance and evaluation;¹⁴⁹
- Reimbursement authorizations. **Nebraska**, for example, allows its state department of health to seek reimbursements for the provision of care to an individual’s children through garnishments of the individual’s state income tax refunds;¹⁵⁰ and
- Private sector gifts, donations, or grants. State public health authorities are increasingly encouraged statutorily to seek support through private sector sources. The **South Carolina Department of Health** is specifically authorized to accept “gifts, bequests, devises, grants, and donations of money, real property, and personal property for use in expanding and improving services to persons with mental retardation” and other disabilities.¹⁵¹

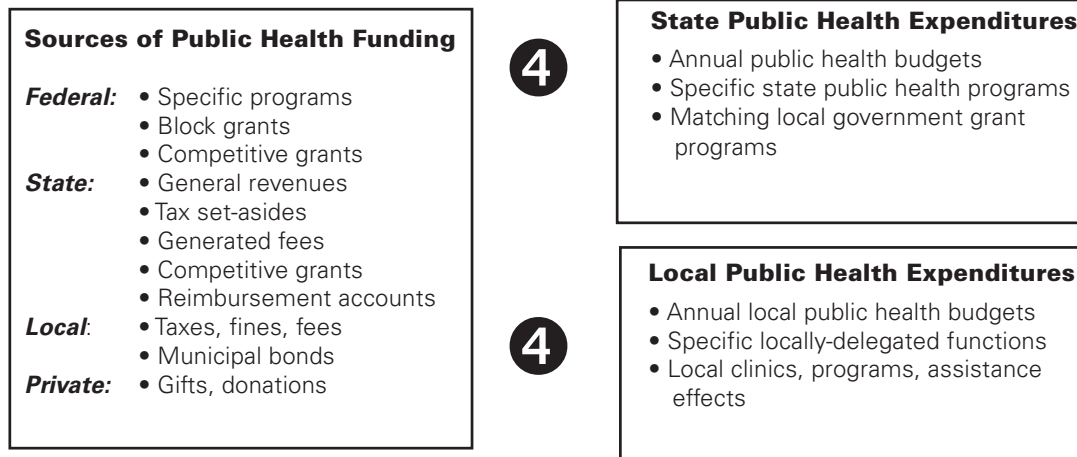
Federal public health dollars may derive from specific federal programs (e.g., WIC, SCHIPs, Medicaid), federal block grants, or federal grants distributed on competitive or need-based criteria. States often statutorily authorize their departments of health (or local public health departments) to seek federal funds, which upon receipt, are tabbed for specific public health programs.¹⁵² For example, the **Delaware Department of Health and Social Services** is authorized to:

apply for and receive funds made available to the Department by any agency or department of the federal government authorized to make grants-in-aid of any of the present or future health programs undertaken, maintained or proposed by the Department All moneys received from any federal agency or department . . . shall be paid into the State Treasury and shall be . . . used solely for the purpose or purposes for which the grant or grants shall have been made.¹⁵³

Local public health funds may come directly from the state or from local revenues generated from specific ad valorem, insurance, or other taxes,¹⁵⁴ fines,¹⁵⁵ as well as fee-based services of public health departments, clinics, or laboratories (particularly in decentralized states).¹⁵⁶ Some jurisdictions also allow local public health authorities to raise revenue through the issuance of municipal bonds or other securities.¹⁵⁷ Increasingly, local health departments are statutorily required to submit annual budgets to state or intrastate regional funding sources who base funding decisions on expected needs. In **Wisconsin**, which statutorily allows contiguous counties and cities within counties to form multiple health departments, these departments must annually prepare a budget of their proposed expenditures for the next fiscal year and determine the proportionate cost to each participating county and city on the basis of equalized valuation. These budgets are used to distribute local funds appropriately between adjoining members.¹⁵⁸ **New York** distributes state funds to local departments of health according to a preset formula, a practice common among other states.¹⁵⁹ During public health emergencies, some states, like **Oregon**, allow local public health authorities to use any available revenues to respond.¹⁶⁰

Figure 4, below, summarizes the stream of public health funding at the federal, state, and local levels.

Figure 4. *The Stream of Public Health Funding*



D. Political and Social Realities Underlying Public Health Financing

Although there exist numerous statutory mechanisms for funding, many state and local public health officials struggle to balance political and social realities which can lead to under-funded programs and, consequently, unmet objectives. Federal, state, and local resources are limited and competitively balanced with other governmental priorities.

Public health funding dilemmas in **Oregon** are demonstrative. First, public health has not been given priority in funding and visibility within the **Oregon’s Department of Health Services**. While this is changing, the *Health Division* still has relatively low funding levels. Even if the executive branch wanted to significantly increase state funding for public health, **Oregon** has severe fiscal limitations. While many states have experienced budget surpluses in the past few years and also have unexpected funds from the tobacco settlement for use for public health purposes, initiatives at the state and local levels have severely restricted revenue services. At the state level, there is no sales tax and there are limits on income tax and possible restrictions on the use of tobacco settlement resources.¹⁶¹ The state has also made an important, but expensive, commitment to achieving near universal access to health care through the **Oregon Health Plan**.

The *Health Division* not only has limited funds for its own work, but has almost no general funding that it can allocate to counties or tribal governments. The federal government provides funds for specific programs. Counties receive these federal funds after they are distributed to the state.¹⁶² As a result, the main state-level funding of counties are “pass-through” funds. This presents two dilemmas: (1) the state merely channels federal program funds to counties which tends to devalue the leadership role of the *Health Division*; and (2) federal categorical funding complicates the performance of public health functions at the local level. Counties may have to create programs they may not need and discontinue programs they do need to meet federal requirements for obtaining funds. By relying on “silos” of programmatic funding, counties lose the flexibility of needs-based assessments that are important to local governance.

The second source of money for public health services at the county level in **Oregon** is from county revenues which can be used for general purposes. Counties, however, are quickly losing these sources of revenue. In particular, state-wide ballot initiatives have set limits on property taxes. In addition, revenues from timber have fallen dramatically in

recent years. Counties, therefore, are not always in a strong financial position to assure all essential public health services. As a result, they may decide to reduce the level of public health services consistent with their fiscal limitations. An **Oregon** court has agreed that counties have the authority under statutory law to reduce the level of services where needed given fiscal constraints.¹⁶³

These and other funding dilemmas in **Oregon** are shared across state and local public health systems. In some cases, state or local law may limit funding sources or access. On the other hand, funding constraints may be the result of politics. In **Nebraska**, for example, the state legislature has authorized local governments to fund public health services primarily through politically unpopular ad valorem (property) taxes.¹⁶⁴ Individuals are not eager to vote for increases in property taxes to fund public health services which they may perceive as unneeded. Even where a community may favor increased property taxes to pay for public health services, statutory caps on tax rates may limit these increases. Statutory caps serve an important function of protecting the population from excessive, repeated tax hikes at the local levels. However, overly-restrictive limits [except for emergency cases] on public health funding can actually stymie public health practice by prohibiting citizens in counties which may favor greater public health protections from authorizing the needed tax levy to pay for these protections.

3. State Public Health Law—Developments, Trends, Innovations

Since the Institute of Medicine’s initial challenge to states in 1988 that public health laws need to be reformed, many states have responded with multifarious proposals for public health law reform that reflect new innovations or improvements of existing standards. Literally thousands of public health law bills have been introduced in state legislatures. Many of these bills, however, have sought minimal changes to existing public health laws. Even among those bills that may be considered as substantive public health reform proposals, a large majority of these bills have failed in state legislatures. Still other state public health authorities have considered and abandoned introducing public health reform proposals to their legislatures, often on fears that such proposals could somehow harm the existing structure, funding, or status of public health. In this section, we examine these developments, trends, and innovations in public health law reform through a discussion of the results of our survey of state public health officials. As well, we examine some successful (and unsuccessful) public health reform proposals at the state and local levels.



A. Trends and Innovations in State Public Health Law

As part of our research for this report and with invaluable assistance from **Steve Boedigheimer**, then Deputy Director, Delaware Department of Health and Social Services, and the *Association of State and Territorial Health Officers* (ASTHO), we conducted an informal survey of state public health deputy directors. Beginning in October, 2001, we contacted these high-ranking public health officials in each state and asked them to volunteer answers to the following questions:

- Have any bills been introduced (or laws passed) in your state since 1990 concerning the public health infrastructure at the state or local levels [e.g., laws reforming the relationship between state and local governments concerning public health]?
- Has your state, through its legislature or executive branch, developed or considered legislative or policy proposals for comprehensive public health reform since 1990?
- What are some of the “hot topics” in your state concerning public health?
- What areas of public health in your state typically receive the most legislative or policy-making attention?
- What public health programs, initiatives, or laws would you identify in your state as innovative or creative? and
- Can you identify an effective public health initiative in your state which is not commonly found in other state public health systems?

Twenty-four states¹⁶⁵ responded to the survey over the past 6 months. Their responses are discussed below in a non-identifiable manner (to protect the respondent’s privacy).

Concerning bills on public health infrastructure at the state or local levels, a majority of respondents (71%) indicated that such bills have been introduced to the state legislature since 1990. Three respondents (13%) specifically indicated that their introduced bills failed to pass. Many of these proposals were limited to specific or minimal refinements of existing laws governing state and local relationships or responsibilities in public health. Other state bills, specifically in **Florida, Delaware, North Dakota, Minnesota,** and **Vermont**, represented fairly comprehensive proposals.

Considerably fewer states (46%) have developed comprehensive public health reform proposals. Even among the 11 states which suggested that such proposals have been or were currently being developed, the success of these proposals is either unclear or unmeasured. Numerous respondents (33%) specifically suggested that their attempts to develop comprehensive public health reform proposals have failed (resulting either in abandonment at the departmental level, rejection by state or local constituents, or inactivity in the state legislature). Nearly 30% of respondents indicated that their states have not considered any comprehensive public health reform proposals since 1990.

Although the public health topics which respondents considered “hot” in their respective states were diverse, the following topics were indicated by numerous respondents:

- Tobacco controls and/or use of tobacco settlement proceeds - 11 states;
- HIV/AIDS (including HIV reporting) - 6 states;
- Minority health issues - 6 states;
- Bioterrorism and emerging infections - 6 states;
- Immunization rates and registries - 5 states;
- Cancer prevention - 4 states;
- Oral health - 4 states;
- Privacy/confidentiality of health data - 4 states;
- West Nile Virus - 4 states; and
- Children’s health care coverage - 3 states.

Interestingly, these same topics differed greatly from those topics which respondents suggested received the most legislative or policy-making attention, which are as follows:

- Regulation of the health care industry - 9 states;
- Maternal and children’s health - 7 states;
- Environmental issues - 5 states;
- Long-term care quality assurance - 3 states; and
- Cancer prevention - 2 states;
- Minority and community health - 2 states; and
- Mental health - 2 states.

Other respondents suggested that the issues which receive significant legislative or policy-making attention are not topic-specific. Rather, public health issues which involve hefty federal and state expenditures, have powerful political constituents supporting them, or garner significant media attention are most likely to be addressed by state legislatures or executive branch policymakers.

State respondents identified dozens of public health programs, initiatives, or laws as innovative, creative, and uncommon. Some of these innovations relate to uses of federal grant dollars pursuant to the Preventive Health and Health Services Block Grant administered by the Centers for Disease Control and Prevention since 1982.¹⁶⁶ Leading this diversified list, however, are tobacco control laws or innovative grants for local public health initiatives funded with tobacco settlement proceeds. Additional examples mentioned by one or more states include:

- Smoke-free Workplace Law;
- Statewide paramedic system;
- Universal infant hearing screening law;
- Initiatives related to West Nile Virus;
- Public health training institutes;
- Marketing efforts to attract future public health workers; and
- Door to Door Campaign to Eliminate Health Disparities.



B. State Legislative Update

The survey results, above, suggest significant activity in state legislatures on issues of public health law, including numerous bills on public health infrastructure and comprehensive public health reform proposals. These results directly correspond with our examination of state public health bills introduced and enacted in the 1990's to date. State legislatures have actively considered a variety of comprehensive and limited public health laws over the last decade.

Not surprisingly, a great portion of the bills reviewed were unsuccessful toward passage in state legislatures. In **Georgia**, for example, a 1994 bill to separate the *Division of Public Health* from its larger parent, the *Department of Human Resources*, failed during last minute negotiations on the composition of an oversight board. Later, in 1999, the **Georgia** legislature transferred several functions that were previously in the *Division of Public Health* (e.g., *Offices of Minority Health, Primary Care, and Rural Health*) to a newly-created *Department of Community Health*.

Numerous states sought to reorganize public health systems at the state level.¹⁶⁷ Statutes in **Michigan, New Jersey, and West Virginia** are illustrative. Like **Georgia, Michigan** also created a *Department of Community Health* in 1996. The **Michigan** legislature consolidated various statutory duties of its former *Department of Mental Health*, the existing *Department of Social Services, Liquor Control Commission, and Food Service Sanitation Program*, as well as various licensing, monitoring, and accreditation functions, into the new executive agency.¹⁶⁸ Multiple, additional transfers of public health functions were also made. Most notably, **Michigan** transferred virtually all public health duties previously held by its *Department of Public Health* into a new sub-agency, the *Community Public Health Agency*, which became a division of the *Department of Community Health*.

New Jersey reorganized its *Department of Health* and created a new *Public Health Council*, comprised of eight citizens (three of whom must be medical professionals). The *Council* serves mostly in an advisory capacity, but also has the power to modify or annul any order, regulation, or ordinance enacted by local boards of health.¹⁶⁹ The *Department of Health* is vested with the broad mandate to “formulate comprehensive policies for the promotion of public health and the prevention of disease within the State.”¹⁷⁰ In addition, the *Department* shall (1) maintain vital statistics; (2) administer a state-wide program of health education; (3) prepare and make available to practicing physicians and local boards of health technical information concerning public health; (4) prepare and distribute health bulletins in public schools; (5) coordinate local programs concerning control of preventable diseases in accordance with a unified State-wide plan which shall be formulated by the department; (6) administer maternal and child health services, dental health services, and public health nursing and industrial hygiene programs; and (7) establish serological, bacteriological, and chemical laboratories for routine examinations and for original investigations and research in matters affecting public health.¹⁷¹

West Virginia modified its state and local public health systems in a single enactment in 2000.¹⁷² A proposed Assembly Bill in **Wisconsin** would allow certain county public health departments to align with city health departments pursuant to mutual agreement.¹⁷³ Other states, such as **North Dakota**¹⁷⁴ and **Texas**, have focused reorganizational efforts on local public health. Through its *Local Public Health Reorganization Act of 1999*,¹⁷⁵ the **Texas** legislature redesigned its local public health system. **Texas** empowered county and city governments to create local public health departments and local boards of health. These local health departments were further authorized to join to create public health districts. The state board of health was also allowed to create public health regions for providing public health services. These changes, though important toward reorganizing local public health in **Texas**, are unremarkable. Many states feature similar provisions. However, the **Texas** legislature also authorized its state department of health to issue grants to local departments of health to provide “essential public health services” modeled after those identified in *Public Health in America* (see Part I.A.). Furthermore, a public health consor-

tium of the state's many academic health sciences centers was created to provide training to local public health officials, conduct research, and develop local performance standards.

In addition to public health laws with a largely organizational purpose, a few states have addressed public health reforms through affirmative enactments regarding the missions and objectives of public health.¹⁷⁶ In 2000, **Alaska's** legislature passed a law that required new mission statements and performance measures for each state agency. As part of this law, the new mission statement for the *Division of Public Health* is simply "to preserve and promote the state's public health."¹⁷⁷ The mission statement of a similar division of public health of the **Delaware Department of Health and Social Services** is equally short: "to protect and promote the health of the people."¹⁷⁸ However, the **Delaware** Code further stipulates that the *Division* provide "core public health and preventive services," which are defined based on the Institute of Medicine's 1988 report as:

those activities that lay the groundwork for health[y] communities. They are activities that protect people from diseases and injury. . . [and that] (i) prevent and control communicable disease epidemics; (ii) promote healthy behaviors to control chronic disease; (iii) monitor the health of the population through data analysis and epidemiological studies; (iv) result in policies to promote the health of the public; (v) assure quality health services and systems for the population; (vi) result in the setting of standards for the protection of the public's health; (vii) provide assistance during disasters; (viii) assess environmental health risks; and (ix) offer health protection strategies to environmental control agencies.¹⁷⁹

Currently, **Oregon** public health officials are working to pass a bill that declares the public health policy for the state and clarifies the roles of state and local public health actors, as well as the private sector.¹⁸⁰ If passed, the statutory public health policy of **Oregon** would include:

that the health of the public be promoted to the greatest extent possible through the public health system. . . . [that] [1] prevents epidemics and the spread of disease; [2] promotes and encourages healthy environments, behaviors and communities for healthy people; [and 3] . . . responds to public health emergencies, assists communities in recovery and strives to ensure the quality and accessibility of health services.¹⁸¹

4. The Benefits of a Public Health Law Improvement Process

Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. As such, public health law serves as a foundation and a framework for public health activity. Public health law should assure that public health agencies are fully capable of responding to current and upcoming public health threats. Unfortunately, existing public health laws too often fail to support health departments in carrying out their essential services and accomplishing their goals. Reform of the law can promote more effective decision-making and protect individual rights. In this final section, we explain some of the reasons why public health law improvement can yield many benefits.

Before discussing these reasons, it is important to be candid about the limitations of the legislative approach. We recognize the law as merely one tool toward the improvement of public health. Many of the problems observable in public health are remedied not primarily through law reform but, rather, through better leadership and training, improved infrastructure for surveillance and epidemiological investigations, comprehensive counseling and health education, and innovative prevention strategies. In making policy, public health authorities will have to consider prevailing social values and respect multiple constituencies, including scientists, politicians, and community leaders.



A. The Role of Public Health Law

There are at least four possible roles for the law in advancing public health. Law can (1) define the objectives of public health and influence its policy agenda, (2) authorize and limit public health actions, (3) serve as a tool of prevention, and (4) facilitate planning and coordination of governmental and non-governmental health activities.

Public health statutes should establish the purposes, goals, and core functions of public health, the personnel and infrastructure realistically needed to perform these functions, and budgeting mechanisms that will provide reliable levels of support. By doing so, the law can inform and influence the activities of government and the expectations of society about the scope and fundamental importance of public health. Courts give deference to statements of legislative intent and may permit a broad range of activities that are consistent with legislative objectives. No government program can be assured full funding during budgetary crises. However, structuring public health law to embrace defined functions, minimum infrastructure and personnel needs, and funding mechanisms can provide a measurement for health departments and policy makers in the future.

Public health law must provide broad authority for the exercise of public health powers and coextensively limit that authority where necessary for the protection of individual rights. In considering law reform, it is important to distinguish between duties and powers in public health. The legislature should impose duties on health departments¹⁸² to initiate a broad range of activities relating, for example, to surveillance, communicable disease control, environmental protection, sanitation, and injury prevention. It is important that health officials retain *flexibility* in the powers used to achieve public health purposes to respond to changes in risk factors (e.g., West Nile Virus), science and technology (e.g., advances in human genetics), and evolving relationships with public and private sector entities.

While providing for a flexible range of public health powers, the law must also place appropriate limits on those powers to protect human rights. This is best accomplished by adhering to certain strategies:

- Establishing clear criteria for the exercise of compulsory powers by requiring health authorities to use scientific evidence of a significant risk to the public health;
- Providing procedural due process for all individuals who face serious constraints on their liberty; and
- Safeguarding the privacy of individuals and preventing or punishing unlawful discrimination.

Public health law is, and should remain, a tool of prevention. Public health law should use a wide variety of legal means to prevent injury and disease by creating the conditions for people to be healthy. The following benefits could be achieved through a public health law improvement process.¹⁸³



B. Update Antiquated Laws

Most public health laws in the United States have been passed piecemeal in response to specific disease threats such as tuberculosis, sexually-transmitted diseases, and HIV/AIDS. The law has thus developed, layer-upon-layer, from one time period to another. Certainly, older laws are not necessarily bad laws. A well-written statute may remain useful, efficacious, and constitutional for many decades. However, older laws are often outmoded in ways that directly reduce their efficacy and conformity to modern legal standards. Older laws may not reflect contemporary scientific understanding of disease, current medical treatments of choice, or constitutional limits on the state's authority to restrict individual liberties. They may fail to allow public health agencies the discretion to modernize such enactments through administrative regulation.



C. Comply with Modern Constitutional and Other Legal Requirements

Some public health laws predate contemporary developments in constitutional law, disability discrimination law, health information privacy, and other modern legal requirements. As a result, state law may not meet evolving standards enunciated by state and federal courts and legislatures.

At the constitutional level, the United States Supreme Court now has more exacting standards for equal protection of the laws, substantive due process, and procedural due process. Public health powers that affect liberty (e.g., quarantine and directly observed therapy), privacy (e.g., reporting and partner notification), and autonomy (e.g., compulsory testing, immunization, or treatment) may undergo more careful scrutiny under the federal Constitution. At the same time, the Constitution may require more rigorous procedural safeguards before exercising compulsory powers.

Federal disability law prohibits discrimination against persons based on their health status, such as an infectious disease. This may require health officials to adopt a standard of "significant risk" before resorting to compulsion. A significant risk may be defined as a direct threat to the health or safety of others that cannot be eliminated by modification of policies, practices, or procedures. Thus, under this standard, adverse treatment, such as a decision to use compulsory powers, would only be permitted if the person posed a significant risk to the health or safety of others. A significant risk regarding communicable diseases would be determined through an individualized assessment of the mode of transmission, probability of transmission, severity of harm, and the duration of infectiousness.¹⁸⁴



D. Clarify the Law

General or overlapping provisions concerning public health duties and responsibilities sometime result in confusion about who has what public health powers and when to exercise those powers. This confusion is understandable. Given the multiplicity and layer-upon-layer approach of public health law, even the most expert lawyers have difficulty providing clear answers to public health officials about their authority to act. One major benefit of public health law reform would be to provide greater clarity about legal powers and duties.



E. Improving Relationships

Improving the working relationships in public health is an important goal. Public health practice involves complex relationships between governmental and non-governmental entities and actors. These relationships are of several kinds.

1. Legislative and Public Health Authorities

Legislators and public health officials may sometimes have markedly different understandings about public health and the role of government. Public health authorities frequently seek greater freedom to exercise their discretion in matters concerning the health of the community. Legal requirements and the political process can be viewed as impediments to a well-functioning health department. Concerns exist over how legislators approach issues of public health law, funding, and development of an adequate public health infrastructure. Coextensively, legislators may see a need for clear criteria and procedures under which public health officials can operate.

Legislators and public health authorities must listen to one another through discussions which are motivated on the sole issue of improving a state's public health system. Such communications should not occur mainly in response to the latest public health issue. Rather, a primary benefit of public health law reform would be the coming together of public health authorities and legislators for the common good.

2. Federal and State

The federal government is intricately involved in public health in every state, and thus, there remains a need for strong relationships among federal and state public health officials.

3. State, Tribal, and Local

State, tribal, and local dialogue on public health is critical given the diversity of urban, suburban, and rural populations in most states. Maintaining channels of communication between state, tribal, and local public health authorities is important. A lack of regular communication between these authorities could carry serious implications for the public health. If a state, for example, had to discontinue a public health service because of budgetary constraints or otherwise, local governments should be made aware of the decision in order to prepare for their potential responsibility to provide these services. Otherwise there may be temporary, serious gaps in public health services. Clearly local governments may not be able to assume public health functions previously funded or provided by the state, but early communication may facilitate local resource allocation and perhaps avoid public health repercussions from sudden discontinuances of programs.

4. City and Rural

Closely related to state and local relationships are the different perspectives of city and rural dwellers. State legislators from urban areas have distinctly different visions of public health and financial responsibilities than persons from rural communities. Each constituency may lack some trust in the other. A constructive and systematic dialogue process may improve relationships.

5. Public Health Authorities and the Private Sector

Increasingly government public health authorities have aligned with private sector health care providers, insurers, managed care companies, and nonprofit and religious organizations to provide, directly or indirectly, various public health services. The private sector can play a valuable role in public health, especially where government funding for public health programs remains static, if not in decline. Establishing and nurturing these relationships between public and private sectors may serve to improve the public health.

Conclusion



We have attempted to discuss similarities among state and local public health systems related to their organizational structures, missions, goals, and proposals for reform. In reality, however, state public health systems and laws are diversified and complex. In many ways, the complexity of public health should be celebrated. State and local governments have traditionally been viewed in our federalist system of government as laboratories for experimentation and reform. Public health needs vary extensively across the nation, and state and local governments are poised to respond to these differing needs in ways that the federal government may not.

On the other hand, the diversity of state public health law presents significant challenges. The difficulty of reforming state public health law extends not only to modernizing the legal bases for public health practice, but also to accomplishing these changes through a diverse and sometimes fragmented public health system in the United States. Many states have laid groundwork for these reforms. However, it will take vision, ingenuity, and the hard work of multiple persons and organizations in the public and private sectors to develop a model state public health act within a national public health infrastructure. This is the next step toward reforming state public health law as a tool for public health improvements.

References



1. INSTITUTE OF MEDICINE, *supra* note 1, at 19; *see also* LAURIE GARRETT, THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE 512 (1994) (claiming that the United States' public health system exhibit levels of chaos and inaccuracy comparable to those of third world countries); Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39 ST. LOUIS U. L.J. 7, 16 (1994) (claiming that an array of public health services, not simply personal medical services, reduces morbidity and premature mortality).
2. *See* Leonard Robbins & Charles Backstrom, *The Role of State Health Departments in Formulating Policy: A Survey on the Case of AIDS*, 84 AM. J. PUB. HEALTH 905 (1994) (finding that health agencies took leadership role in HIV policy).
3. INSTITUTE OF MEDICINE, *supra* note 1, at 10; *see, e.g.*, Centers for Disease Control & Prevention, *Public Health Care Functions—Alabama, Maryland, Mississippi, New Jersey, South Carolina, and Wisconsin, 1993*, 43 MORBIDITY & MORTALITY WKLY. REP. 13 (1994) (concluding that existing public health law too often fails to support public health departments in carrying out their core functions). More broadly, the IOM criticized health departments' alleged failure to provide clear political leadership in the legislative responses to important issues, such as HIV. INSTITUTE OF MEDICINE, *supra* note 1.
4. CENTERS FOR DISEASE CONTROL AND PREVENTION, PUBLIC HEALTH'S INFRASTRUCTURE: A STATUS REPORT (2001).
5. *See* Susan Wall, *Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 64 (May/June 1998).
6. *See, infra*, III.B.
7. *See* Kristine M. Gebbie, *Washington State Reorganization: More of the Story*, 18 J. PUB. HEALTH POLY. 188 (1997).
8. WASH. REV. CODE § 43.70.520 *et seq.* (2000).
9. *See* CONNECTICUT DEPARTMENT OF PUBLIC HEALTH, LOOKING TOWARD 2000: AN ASSESSMENT OF HEALTH STATUS AND HEALTH SERVICES (2000).
10. *See* ROADMAP IMPLEMENTATION TASK FORCE, THE ROAD TO BETTER HEALTH FOR ALL OF ILLINOIS (1990).
11. *See, e.g.*, Lawrence O. Gostin, Scott Burris, and Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COL. L. REV. 59 (1999).
12. *Id.* at 101-118.
13. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000).
14. *See, e.g.*, LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 27-30 (1997).
15. *See, e.g.*, C.E.A. WINSLOW, THE EVOLUTION AND SIGNIFICANCE OF THE MODERN PUBLIC HEALTH CAMPAIGN (1923).

16. *See, e.g.* Kristine Gebbie, *State Public Health Laws: An Expression of Constituency Expectations*, 6 J. PUB. HEALTH MGMT. PRACTICE 46-54 (2000).
17. N.J. STAT. ANN. § 59:6-3 (1992).
18. CAL. GOV'T CODE §855.4 (1995).
19. KY. REV. STAT. ANN. § 211.180 (2000).
20. MICH. COMP. LAWS § 333.2221 (1992).
21. NEB. REV. STAT. §§ 71-7504, 71-7508 (1992).
22. Please note that the information provided in this table has in some cases been paraphrased from the original statutory citation for clarity or brevity.
23. PUBLIC HEALTH FUNCTIONS STEERING COMMITTEE, USPHS OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, PUBLIC HEALTH IN AMERICA (1994).
24. Kristine M. Gebbie, *State Public Health Laws: An Expression of Constituency Expectations*, 6 J. PUB. HEALTH MANAGEMENT PRACTICE 46 (2000).
25. *Id.* at 54.
26. INSTITUTE OF MEDICINE, *supra* note 1, at 19.
27. ERWIN CHERMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 1-6 (1997).
28. JUDITH AREEN ET AL, LAW, SCIENCE AND MEDICINE 520 (2d ed. 1996).
29. *See, e.g.*, U.S. CONST. Art. I, § 9 (federal and state government may not criminally punish conduct that was lawful when committed); U.S. CONST. Art. I, § 10 (no state shall impair the obligation of contracts); U.S. CONST. Art. IV ("Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States.").
30. 197 U.S. 1 (1905).
31. Commonwealth v. Pear, 66 N.E. 719 (Ma Sup. Jud. Ct. 1903).
32. 197 U.S. at 15–16, 26.
33. *Id.* at 26–27 (*citing* Commonwealth v. Alger, 7 Cush. 53, 84 (Mass. 1851)).
34. *Id.* at 27.
35. Police powers refer to the broad power of a sovereign state to regulate matters affecting the health, safety, and general welfare of the public. *See, e.g.*, ERNST FREUND, THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS 3-4 (1904); James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J. L. & HEALTH 309, 318-320 (1998).
36. 197 U.S. at 28.
37. *See, e.g.*, JAMES A. TOBEY, PUBLIC HEALTH LAW 90 (1926).
38. 197 U.S. at 31. *See also* Nebbia v. People of State of New York, 291 U.S. 502, 510–511 (1933) (public welfare regulation must not be "unreasonable, arbitrary, or capricious, and the means selected must have a real and substantial relation to the object sought to be obtained.").
39. 197 U.S. at 38–39.
40. *Id.* at 39.
41. State v. Speyer, 32 Atl. 476 (Vt. 1985).

42. See *Texas v. White*, 7 Wall. 700, 725 (1869) quoting *Lane County v. Oregon*, 7 Wall. 71, 76 (1869) (“The Constitution, in all its provisions, looks to an indestructible Union, composed of indestructible States”); see also A REPORT OF THE WORKING GROUP ON FEDERALISM OF THE DOMESTIC POLICY COUNCIL, THE STATUS OF FEDERALISM IN AMERICA 5 (1986) (“federalism is a constitutionally based, structural theory of government designed to ensure political freedom. . . .”).
43. See, e.g., Editorial, *The Court and Federalism*, WASH. POST, Jan. 14, 2000, at A26 (“The proper question [of federalism] is whether . . . policy issues [should] be addressed by the appropriate level of government, rather than which level is likely to deliver a particular favored outcome.”).
44. See James G. Hodge, Jr., *National Health Information Privacy and New Federalism*, 14 NOTRE DAME J. OF L., ETHICS, AND PUB. POLY. 791 (2000).
45. U.S. CONST. art. VI, par. 2 (“ . . . [t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof; . . . shall be the supreme Law of the Land; . . .”).
46. JAMES MADISON, THE FEDERALIST PAPERS, No. 45, at 292-293 (C. Rossiter ed. 1961), as quoted in *Gregory v. Ashcroft*, 501 U.S. 452 (1991).
47. See, e.g., ERNST FREUND, THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS 3-4 (1904); James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J. L. & HEALTH 309, 318-320 (1998).
48. See *New York v. United States*, 505 U.S. 144, 112 S. Ct. 2408, 2417 (1992) (“ . . . the task of ascertaining the constitutional line between federal and state power has given rise to many of the Court’s most difficult and celebrated cases”).
49. See 16 AM. JUR.2D *Constitutional Law* § 277 (1979); Alan R. Arkin, *Inconsistencies in Modern Federalism Jurisprudence*, 70 TUL. L. REV. 1569 (1996).
50. See, e.g., *South Carolina Highway Dep’t v. Barnwell Brothers*, 303 U.S. 177 (1938) (finding constitutional a South Carolina law that prohibited trucks over 90 inches wide or weighing over 20,000 gross pounds on state highways despite infringement on interstate commerce).
51. See *McCulloch v. Maryland*, 17 U.S. (4 Wheat) 316 (1819) (invalidating the attempt by Maryland to tax the issuance of bank notes by the newly created national bank).
52. States were considered essential to the functioning of government because they retained the majority of powers. See A REPORT OF THE WORKING GROUP ON FEDERALISM, *supra* note 67, at 10. See also *New York v. United States*, 505 U.S. 144 (1992) (“The Federal Government undertakes activities today that would have been unimaginable to the Framers in two senses; first, because the Framers would not have conceived that any government would conduct such activities; and second, because the Framers would not have believed that the Federal Government, rather than the States, would assume such responsibilities”).
53. See, e.g., Daniel S. Herzfeld, *Accountability and the Nondelegation of Unfunded Mandates: A Public Choice Analysis of the Supreme Court’s Tenth Amendment Federalism Jurisprudence*, 7 GEO. MASON L. REV. 419 (1999).
54. Richard C. Reuben, *The New Federalism*, ABA J., Apr. 1995, at 76-77 (the resurgence of federalism is partially the result of increased political efforts of the states to move toward greater autonomy from the federal government and the effects of such efforts on the political processes on Capitol Hill); see also Juliet Eilperin, *House GOP’s Impact: Transforming an Institution*, WASH. POST, Jan. 4, 2000, at A4 (chronicling the failures of former House of Representatives Speaker, Newt Gingrich, Eilperin comments that “ . . . while Gingrich had once hoped to lead the country from the speaker’s chair, some of the changes he set in motion may well diminish the

legislative's branch's power in the years to come by transferring powers to state and local governments. . . "). *Id.*

55. The term "new federalism" may have first been used by Donald E. Wilkes, Jr. in his article, *The New Federalism in Criminal Procedure: State Court Evasion of the Burger Court*, 62 Ky. L.J. 421 (1974).
56. Although several state governors failed in their 1994 effort to organize a "Conference of States" to draft federal constitutional amendments in support of greater state rights (see William Claiborne, *Supreme Court Rulings Fuel Fervor of Federalists*, WASH. POST, June 28, 1999, at A2.), Congress has recently introduced several bills which would require it to consider federalism issues prior to the passage of legislation. Ron Eckstein, *Federalism Bills Unify Usual Foes*, LEGAL TIMES, Oct. 18, 1999, at 1. In August, 1999, President Clinton signed the second draft of his executive order concerning federalism. This initial draft of the order was roundly rejected by state and local government associations for its failure to appropriately reflect new federalism principles. David S. Broder, *Federalism's New Framework*, WASH. POST, Aug. 5, 1999, at A21. The revised order disfavors federal preemptive laws or policies, requires executive officials to defer to states whenever possible in setting national standards, and features an enforcement mechanism against implementation of federal executive policies that lack a federalism "impact statement" (i.e. a written assessment of the potential impacts of a national executive policy or plan on state-based functions or powers). *Id.*
57. See *City of Boerne v. Flores*, 521 U.S. 507 (1997) (pursuant to a challenge based on the decision of a local zoning authority to deny a church a building permit, the Court invalidated the Religious Freedom Restoration Act of 1993 as beyond Congress authority under § 5 of the Fourteenth Amendment); *United States v. Lopez*, 514 U.S. 549 (1995) (Congress lacked the commerce power under U.S. Const. art. I, § 8 to enact the Gun-Free School Zones Act of 1990, making criminal the knowing possession of a gun by a student while at school).
58. See *City of Columbia v. Omni Outdoor Advertising, Inc.*, 499 U.S. 365, 373 (1991).
59. See *Printz v. United States*, 521 U.S. 898 (1997) (1997) (declaring unconstitutional the federal requirement under the Brady Handgun Violence Prevention Act that state chief law enforcement officers temporarily conduct background checks on prospective handgun purchasers); *New York v. United States*, 505 U.S. 144 (1992) ("take title" incentive provisions of the federal Low-Level Radioactive Waste Policy Amendments Act of 1985 are constitutionally invalidated); *Hodel v. Virginia Surface Mining and Reclamation Association, Inc.*, 452 U.S. 264 (1981) (Congress may not commandeer the state legislative processes by directly compelling them to enact and enforce a federal regulatory program).
60. See, e.g., Joan Biskupic, *Justices, 5-4, Strengthen State Rights*, WASH. POST, June 24, 1999, at A1.
61. See *Atascadero State Hospital v. Scanlon*, 473 U.S. 234 (1985).
62. See *Gregory v. Ashcroft*, 501 U.S. 452 (1991).
63. *United States v. Lopez*, 514 U.S. 549 (1995).
64. See, e.g., *Printz v. United States*, 117 S.Ct. 2365 (1997); *Seminole Tribe v. Florida*, 517 U.S. 44 (1996); *New York v. United States*, 505 U.S. 144 (1992).
65. *Lopez*, 514 U.S. 549 (1995).
66. *New York v. United States*, 505 U.S. 144 (1992).
67. *Gregory v. Ashcroft*, 501 U.S. 452 (1991).

68. *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316 (1819).
69. INSTITUTE OF MEDICINE, *supra* note 1, at 178-183.
70. TOM CHRISTOFFEL & STEPHEN P. TERET, PROTECTING THE PUBLIC: LEGAL ISSUES IN INJURY PREVENTION 25-28 (1993).
71. 39 AM. JUR.2d *Health* §§ 22, *et seq.* (1968) (state citations omitted).
72. *Zucht v. King*, 260 U.S. 174 (1922).
73. *Leisy v. Hardin*, 135 U.S. 100 (1890).
74. *Givner v. State*, 124 A.2d 764, 774 (Ct. App. Md. 1956); *See v. Seattle*, 387 U.S. 541, 550-52 (listing historical examples of state inspection) (Clark, J., dissenting) (1967).
75. *Jones v. Ind. Livestock Sanitary Bd.*, 163 N.E.2d 605, 606 (Ind. 1960); *Francis v. La. St. Livestock Sanitary Bd.*, 184 So.2d 247, 253 (La. 1st Cir. 1966).
76. *Oklahoma ex rel. Corp Comm'n v. Texas County Irrigation & Water Res. Ass'n, Inc.*, 818 P.2d 441 (Okla. 1991).
77. *Strandwitz v. Board of Dietetics*, 614 N.E.2d 817, 824 (Ct. App. Oh. 1992).
78. *Kaul v. Chehalis*, 277 P.2d 352, 354 (Wash. 1955) (en banc).
79. *Safe Water Ass'n, Inc. v. Fond Du Lac*, 516 N.W.2d 13, 15 (Ct. App. Wis. 1994); Douglas A. Balog, *Note, Fluoridation of Public Water Systems: Valid Exercise of State Police Power or Constitutional Violation?*, 14 PACE ENVTL. L. REV. 645 (1997).
80. *State v. Otterholt*, 15 N.W.2d 529, 531 (Iowa 1944); *Adams v. Dept. of Health & Human Resources*, 458 So.2d 1295, 1298-99 (La. 1985).
81. 25 U.S.C. § 13 (1997).
82. P.L. 93-638.
83. 25 U.S.C. §§ 1601-1683 (Supp. 1998).
84. 25 U.S.C. § 450f (Supp. 1998).
85. 25 U.S.C. § 450 (Supp. 1988).
86. *See Susan Wall, Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 64 (May/June 1998).
87. GEORGE E. PICKETT AND JOHN J. HANLON, PUBLIC HEALTH ADMINISTRATION AND PRACTICE 108 (1990).
88. VA. CODE ANN. §§ 32.1-16 *et seq.* (Michie 1999).
89. VA. CODE ANN. §§ 10.1-1183 *et seq.* (Michie 1999).
90. VA. CODE ANN. §§ 3.1.1 *et seq.* (Michie 1999).
91. GEORGE E. PICKETT AND JOHN J. HANLON, PUBLIC HEALTH ADMINISTRATION AND PRACTICE 108 (1990).
92. Susan Dandoy, *The State Public Health Department*, in PRINCIPLES OF PUBLIC HEALTH PRACTICE (F. Douglass Scutchfield and C. William Keck, eds) 75 (1997).
93. *See, infra*, III.B.
94. GEORGE E. PICKETT AND JOHN J. HANLON, PUBLIC HEALTH ADMINISTRATION AND PRACTICE 108 (1990).
95. For the purposes of classifying state public health systems, "public health functions" are defined as activities of a state's public health system that are essential to

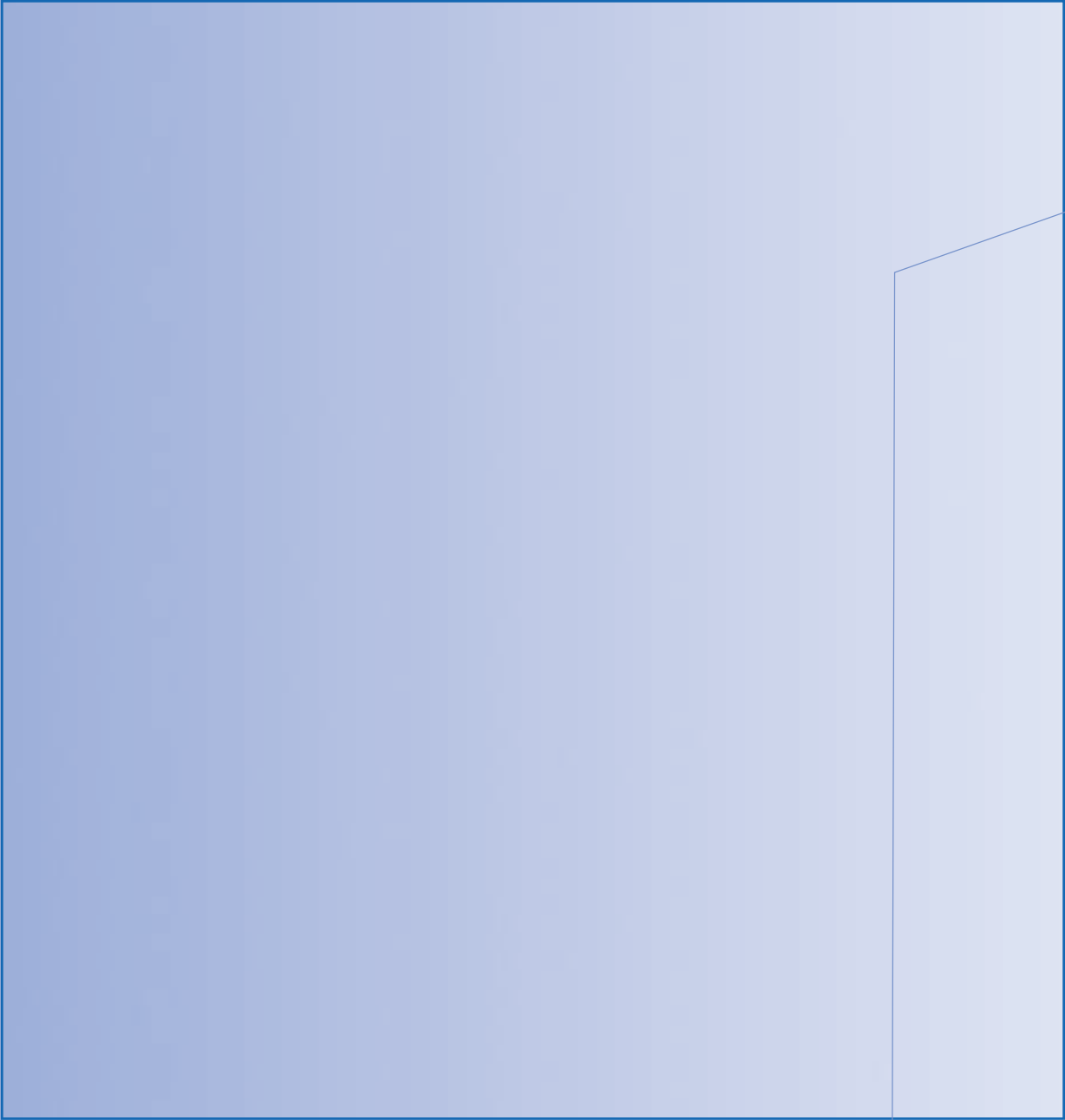
ensuring the public's health, including those essential health services identified in Public Health in America. See, *infra*, I.A; PUBLIC HEALTH FUNCTIONS STEERING COMMITTEE, USPHS OFFICE OF DISEASE PREVENTION AND HEALTH PROMOTION, PUBLIC HEALTH IN AMERICA (1994). Environmental health services are not considered core public health functions for the purpose of this classification scheme, nor are mental health services. Many states have environmental and mental health agencies that function independently of the agency or agencies that are primarily responsible for core public health functions.

96. See Susan Dandoy, *The State Public Health Department*, in PRINCIPLES OF PUBLIC HEALTH PRACTICE (F. Douglass Scutchfield and C. William Keck, eds) 73 (1997).
97. GEORGE E. PICKETT AND JOHN J. HANLON, PUBLIC HEALTH ADMINISTRATION AND PRACTICE 108 (1990).
98. See GEORGE E. PICKETT AND JOHN J. HANLON, PUBLIC HEALTH ADMINISTRATION AND PRACTICE 104 (1990), *citing* F. Mullan and J. Smith, *Characteristics of State and Local Health Agencies*, unpublished paper, Johns Hopkins University School of Hygiene and Public Health, 1988 (listing states according to a centralized, decentralized, shared, and mixed approaches). For the purposes of Table 2, states listed under "shared" and "mixed" are grouped together under the "hybrid" approach.
99. See Susan Wall, *Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 64, 68 (May/June 1998).
100. VA. CONST. Art. VII, § 2.
101. VA. CODE ANN. §§ 15.2-1102, 15.2-1200 (Michie 1999).
102. Among their limited public health powers, municipal corporations (counties and cities) can regulate in the interests of (1) abating public nuisances, VA. CODE ANN. § 15.2-900 (Michie 1999); (2) requiring trash removal, *id.* at § 15.2-901; (3) removing or repairing dilapidated buildings, *id.* at § 15.2-906; and (4) requiring the installation of smoke detectors in certain buildings, *id.* at § 15.2-922.
103. VA. CODE ANN. § 32.1-30 (Michie 1999).
104. VA. CODE ANN. § 32.1-31 (Michie 1999).
105. VA. CODE ANN. § 32.1-31(C) (Michie 1999).
106. Counties and cities which choose not to enter into such contracts with the Board of Health are authorized to operate independent local health departments and appoint their own health directors, although the Commissioner retains significant oversight over these departments as well. VA. CODE ANN. § 32.1-32(B) (Michie 1999). Only the Cities of Richmond and Arlington, and Fairfax County, have established independent health districts. The Board of Health is authorized to perform the duties of local health directors and departments for those counties and cities which do not enter into contracts with the Board or which do not establish independent health departments. VA. CODE ANN. § 32.1-33 (Michie 1999).
107. Kristine M. Gebbie & Inseon Huang, *Identification of Health Paradigm in Use in State Public Health Agencies*, Columbia Univ. School of Nursing, Center for Health Policy and Health Services Research (Oct. 28, 1997).
108. OR. REV. STAT. § 431.375(1) (Michie 1997).
109. See Susan Wall, *Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 64, 67 (May/June 1998).
110. OR. REV. STAT. § 431.375(2) (Michie 1997).
111. OR. REV. STAT. § 431.414 (Michie 1997).

112. OR. REV. STAT. § 431.480 (Michie 1997).
113. OR. REV. STAT. §§ 431.330 - 431.350 (Michie 1997).
114. OR. REV. STAT. § 431.415(2) (Michie 1997).
115. OR. REV. STAT. § 431.416 (Michie 1997).
116. ALASKA CONST. Art. VII, § 4.
117. As in most states, there are multiple state agencies in Alaska which regulate in the interests of public health. These include the Department of Labor (which is primarily responsible for occupational safety and health), the Department of Commerce and Economic Development (which provides for licensure of physicians and nurses), and the Department of Public Safety (which provides support for victims of domestic violence and sexual assault).
118. ALASKA STAT. §§ 44.29.010 *et seq.* (Michie 1997).
119. ALASKA STAT. § 44.46.010 (Michie 1997).
120. ALASKA STAT. § 29.04.030 (Michie 1997).
121. ALASKA STAT. § 29.04.010 (Michie 1997).
122. ALASKA STAT. § 29.04.020 (Michie 1997).
123. ALASKA STAT. § 29.35.200 (Michie 1997).
124. ALASKA STAT. § 29.35.210 (Michie 1997).
125. ALASKA STAT. § 29.35.300 (Michie 1997).
126. ALASKA STAT. § 29.35.220 (Michie 1997).
127. ALASKA STAT. § 29.35.055 (Michie 1997).
128. ALASKA STAT. § 29.35.080 (Michie 1997).
129. ALASKA STAT. § 29.35.500 (Michie 1997).
130. ALASKA STAT. § 29.60.120 (Michie 1997).
131. ALASKA STAT. § 29.60.500 (Michie 1997).
132. *Contra* Susan Wall, *Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 64, 69 (May/June 1998) ("States, with the exception of Texas, have reported that their public health budgets have fared well in recent years.").
133. BERNARD TURNOCK, PUBLIC HEALTH: WHAT IS IT AND HOW IT WORKS 148 (1997).
134. *See* Susan Wall, *Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 64, 68 (May/June 1998).
135. K.W. Eilbert, et. al., *Measuring Expenditures for Essential Public Health Services*, Public Health Foundation (1996).
136. William Roper, *Why the Problem of Leadership in Public Health?* In: LEADERSHIP IN PUBLIC HEALTH 20, 21 (1994).
137. Christopher Atchison, et al., *The Quest for an Accurate Accounting of Public Health Expenditures*, 6 J. PUB. HEALTH MANAGEMENT PRACTICE 93, 95 (2000).
138. Christopher Atchison, et al., *The Quest for an Accurate Accounting of Public Health Expenditures*, 6 J. PUB. HEALTH MANAGEMENT PRACTICE 93, 98 (2000).

139. BERNARD TURNOCK, *PUBLIC HEALTH: WHAT IS IT AND HOW IT WORKS* 148, 152 (1997); *see also* KAY W. EILBERT, *et al.*, *MEASURING EXPENDITURES FOR ESSENTIAL PUBLIC HEALTH SERVICES*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES iii (1996).
140. DEL. REV. STAT. Tit. 16, § 5106 (West 2000).
141. DEL. REV. STAT. Tit. 16, § 130(b) (West 2000).
142. *See, e.g.*, ALASKA STAT. § 43.50.350 (Michie 1997); OR. REV. STAT. § 323.455 (Michie 2000).
143. OR. REV. STAT. § 431.210 (2000).
144. *See, e.g.*, ALASKA STAT. § 29.60.600 (Michie 1997) (establishing human services community matching grants program); Or. Rev. Stat. § 431.210 (2000) (creating the Rural Health Services Fund).
145. DEL. REV. STAT. Tit. 29, § 6436 (West 2000).
146. NEB. REV. STAT. § 71-7607 (2000).
147. S.C. REV. STAT. ANN. § 44-2-40 (West 2000).
148. DEL. REV. STAT. Tit. 16, § 137 (West 2000) (creating the Delaware Health Fund and setting strict criteria for the use of tobacco settlement proceeds for health-related purposes).
149. NEB. REV. STAT. § 71-5714 (2000) (Interestingly, the statute further stipulates that the “Legislature is not required to appropriate all available revenue from the fund for such purpose[s] in any given year.”).
150. NEB. REV. STAT. § 77-27.163.01 (2000).
151. S.C. REV. STAT. ANN. § 44-20-320 (2000). *See also* DEL. REV. STAT. Tit. 16, § 9909 (West 2000) (authorizing the Delaware Health Care Commission to find private support for its Healthy Children Program).
152. *See, e.g.*, NEB. REV. STAT. § 68-703.01 (1999); OR. REV. STAT. § 431.250 (Michie 2000).
153. DEL. REV. STAT. Tit. 16, § 105 (West 2000).
154. *See, e.g.*, OR. REV. STAT. 440.395 (2000).
155. *See, e.g.*, S.C. REV. STAT. ANN. § 44-1-152 (2000) (allowing county health departments to retain fines for shellfish violations).
156. *See* Susan Wall, *Transformations in Public Health Systems*, 17 *HEALTH AFFAIRS* 64, 71 (May/June 1998).
157. *See, e.g.*, OR. REV. STAT. § 440.375 (Michie 2000).
158. WISC. STAT. ANN. § 251.11 (West 2001).
159. *See* Susan Wall, *Transformations in Public Health Systems*, 17 *HEALTH AFFAIRS* 64, 70 (May/June 1998).
160. OR. REV. STAT. § 294.455 (Michie 2000).
161. OR. REV. STAT. § 431.832 (Michie 1997).
162. OR. REV. STAT. §§ 431.210 *et seq.* (Michie 1997).
163. *Burks v Lane County*, 72 Or. App 257 (1985).
164. NEB. REV. STAT. § 71-1621 (2000).

165. The following states provided responses: AK, AR, CA, CT, DE, GA, IN, HI, MD, MN, MS, ND, NE, NC, NJ, NY, OH, PA, RI, TX, VA, VT, WA, and WY.
166. See ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, *MAKING A DIFFERENCE: THE PREVENTIVE HEALTH AND HEALTH SERVICES BLOCK GRANT* (2000).
167. See, e.g., W. VA. CODE § 16-2-1 *et seq.* (2000).
168. M.C.L.A. §§ 330.3101 *et seq.* (2000).
169. N.J.S.A. § 26:1A-2. *et seq.* (2000).
170. N.J.S.A. § 26:1A-37 (2000).
171. N.J.S.A. § 26:1A-37 (2000).
172. 2000 W.V. Sen. B. 542.
173. Wis. 2001 Assembly Bill 377 (introduced May 8, 2001) (available at www.legis.state.wi.us/2001/data/AB-377.pdf).
174. N.D.S.A. §§ 23-35-01 *et seq.* (2000).
175. V.T.C.A. §§ 121.001 *et seq.* (2000).
176. Kristine M. Gebbie & Inseon Huang, *Identification of Health Paradigm in Use in State Public Health Agencies*, Columbia Univ. School of Nursing, Center for Health Policy and Health Services Research (Oct. 28, 1997).
177. 2000 Alaska Sess. Law S. B. 281, § 80.
178. DEL. CODE. ANN. Tit. 29, § 7904 (2000).
179. DEL. CODE. ANN. Tit. 29, § 7904(b) (2000).
180. 2001 Or. Laws H.B. 2267.
181. 2001 Or. Laws H.B. 2267, § 1.
182. The term "health" department is used in the generic sense to include all public health functions carried out by the Commonwealth.
183. See, e.g., Lawrence O. Gostin, Scott Burris, and Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUMBIA L. REV. 59 (1999).
184. See Lawrence O. Gostin, Chai Feldblum, & David W. Webber, *Disability Discrimination in America*, 281 JAMA 745, 746 (1999).



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