TurningPoint

Collaborating for a New Century in Public Health

Public Health Law: Power, Duty and Restraint

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Introduction*

The preservation of the public health is among the most important goals of government. The enactment and enforcement of law, moreover, is a primary means with which government creates the conditions for people to lead healthier and safer lives. Law creates a mission for public health authorities, assigns their functions, and specifies the manner in which they may exercise their authority. The law is a tool in public health work, which is used to influence norms for healthy behavior, identify and respond to health threats, and set and enforce health and safety standards. The most important social debates about public health take place in legal fora (legislatures, courts, and administrative agencies) and in the law's language of rights, duties, and justice.(2) It is no exaggeration to say that "the field of public health ... could not long exist in the manner in which we know it today except for its sound legal basis.(3)

> *The mission of public health is fulfilling society's interest in assuring the conditions in which people can be healthy. - Institute of Medicine[1]*

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

The IOM recommended that (5)

> 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 relationship between them; and [ii] support a set of modern disease control measures that address contemporary health problems such as AIDS, cancer, and heart disease, and incorporate due process safeguards (notice, hearings, administrative review, right to counsel, standards of evidence).

This *Resource Guide* for government, public health, and community leaders reviews the state of public health law in America. Chapter One offers a definition and theory of public health law. This chapter proposes five characteristics of public health law: government, populations, relationships, services, and coercive power. Chapter Two explains public health powers within the constitutional design. This chapter demonstrates the constitutional basis for public health powers at the federal (e.g., tax, spend, and commerce powers) and state (e.g., police powers) levels and the limits on those powers. Chapter Three proposes a public health law impact assessment.

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*This *Resource Guide* is based on a book on public health law. Lawrence O. Gostin, *Public Health Law: Power, Duty, Restraint* (University of California Press and Milbank Memorial Fund, 2000)

This chapter provides a step-by-step approach to evaluating the benefits and burdens of public health regulation. Chapter Four examines the current structure of federal, state, and local health agencies. This chapter describes modern public health agencies and demonstrates the breadth of powers they exercise. Chapters Five and Six discuss the various legal tools available to health agencies to prevent injury and disease and promote the public's health and safety. Chapter Five examines the regulation of personal behavior: case finding, immunization, treatment, civil confinement, and the criminal law. Chapter Six examines the regulation of commercial activity: licenses, inspections, and nuisance abatements. Chapter Seven looks at the future of public health law. This chapter explains the current deficiencies in state public health statutes and proposes guidelines for law reform.

Chapter 1: A Theory and Definition of Public Health Law

Public health law is often used interchangeably with other terms that signify a connection between law and health (e.g., health law, law and medicine, and forensic medicine). Despite the similarity of these names, public health law is a distinct discipline capable of definition.

> ***Public health law can be defined as:*** *the study of 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, proprietary, or other legally protected interests of individuals for protection or promotion of community health.*

Public health law has, at least, five characteristics that help separate it from other fields at the intersection of law and health: government, populations, relationships, services, and coercion.

Government's Essential Role in Public Health Law

Public health activities are the primary (but not exclusive) responsibility of government. The importance of government in assuring the conditions for the population's health is demonstrated by its constitutional powers and its role in a democracy. The Preamble to the Constitution reveals the ideals of government as the wellspring of communal life and mutual security: "We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution . . . ." The Constitutional design reveals a plain intent to vest power in government at every level to protect community health and safety. Government is empowered to collect taxes and expend public resources, and only government can require members of the community to submit to regulation.

The role of government in a democracy also helps explain its importance in advancing the public's health. People form governments precisely to provide a means of communal support and security. Acting alone, individuals cannot assure even minimum levels of health. Individuals may procure personal medical services and many of the necessities of life; any person of means can purchase a home, clothing, food, and the services of a physician or hospital. Yet, no single individual, or group of individuals, can assure his or her health. Meaningful protection and assurance of the population's health require communal effort. The community as a whole has a stake in environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. Each of these collective goods, and many more, are essential conditions for health. Yet, these goods can be secured only through organized action on behalf of the population.

This discussion is not intended to suggest that the private and voluntary sectors are not important in public health. Manifestly, private (e.g., managed care), charitable (e.g., the Red Cross), and community (e.g., HIV support) organizations play roles that are critical to public health. Nevertheless, communal efforts to protect and promote the population's health primarily are a responsibility of government, which is why government action represents a central theoretical tenet of what we call public health law.

Serving the Health Needs of Populations

Public health focuses on the health of populations, rather than the clinical improvement of individual patients. Generally, public health focuses on communal health, while medicine focuses on the health of individuals. Classic definitions of public health emphasize this population-based perspective: "As one of the objects of the police power of the state, the 'public health' means the prevailingly healthful or sanitary condition of the general body of people or the community in mass, and the absence of any general or widespread disease or cause of mortality."(6) Public health services are those shared by all members of the community, organized and supported by, and for the benefit of, the people as a whole. Thus, while the art or science of medicine seeks to identify and ameliorate ill-health in the individual patient, public health seeks to improve the health of the population.

Relationships Between Government and the Public

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. Public health practitioners and scholars are interested in organized community efforts to improve the health of populations. Accordingly, public health law observes collective action–principally through government–and its effects on various populations. The field of public health law similarly examines the benefits and burdens placed by government on legally protected interests. This is in direct contrast to the field of health care law, which concerns the micro-relationships between health care providers and patients as well as the organization, finance, and provision of personal medical services.

Population-Based Services

Public health deals with the provision of public health services, rather than personal medical services. The core functions of public health agencies are those fundamental activities carried out to protect the population's health: *assessment*–collection, assembly, and analysis of community health needs; *policy development*–development of public health policies informed through scientific knowledge; and *assurance*–assurance of the services necessary for community health.

"Essential" public health services monitor community health status and investigate health risks; inform, educate, and empower people about health; mobilize community partnerships; regulate individual and organizational behavior; evaluate effectiveness, accessibility, and quality of personal health

services; and pursue innovative solutions to health problems.(7) Moreover, the public health community is increasingly interested in scientific methodologies to monitor the efficacy of services.(8)

Demand Conformance with Health and Safety Standards

Public health possesses the power to coerce individuals for the protection of the community, and thus does not rely on a near-universal ethic of voluntarism. While government can do much to promote public health that does not require the exercise of compulsory powers, it alone is authorized to require conformance with publicly established standards of behavior. The degree of compulsory measures necessary to safeguard the public health is, of course, subject to political and judicial resolution. Yet, protecting and preserving community health is not possible without the constraint of a wide range of private activities. Absent an inherent governmental authority and ability to coerce individual and community behaviors, threats to public health and safety could not easily be reduced.

Having defined public health law and distinguished it from other fields, it will be helpful in the next chapter to further examine the public health law in our constitutional system of government.

Chapter 2: Public Health in the Constitutional Design

No inquiry is more important to public health law than understanding the role of government in the constitutional design. If public health law is principally about government's assurance of the conditions for the population's health, what must government do to safeguard human health? Analyzing this question requires an assessment of *duty* (what government must do), *authority* (what government can, but is not required, to do), *limits* (what government cannot do), and *responsibility* (which government, whether federal, state, local, or tribal, is to act).

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: (1) it allocates power among the federal government and the states (federalism); (2) it divides power among the three branches of government (separation of powers); and (3) it limits government power (protection of individual liberties).(9) 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.(10)

If the Constitution is a fountain from which governmental powers flow, federalism represents a partition in the fountain that separates federal and state powers.(11) By separating the pool of legislative authority into these two tiers of government, federalism preserves the balance of power among national and state authorities. Theoretically, the division of governmental powers is distinct and clear. The federal government is a government of limited power whose acts must be authorized by the Constitution. The states, by contrast, retain the powers they possessed as sovereign governments before ratification of the Constitution.(12) The most important state authority is the power to protect the health, safety, morals, and general welfare of the population. In practice, however, the powers of the federal and state governments intersect in innumerable areas, particularly in areas of traditional state concern, like public health.

Federalism functions as a sorting device for determining which government (federal, state, tribal, or local) may legitimately respond to a public health threat. Often, federal, state, local, and tribal governments exercise public health powers concurrently. Where conflicts among the various levels of government arise, however, federal laws likely preempt state or tribal actions pursuant to the Supremacy Clause: the "Constitution, and the Laws of the United States . . . and all Treaties made . . . shall be the supreme law of the Land.").(13)

In addition to establishing a federalist system, 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 that is thought to reduce the possibility of government oppression.

The separation of powers doctrine is essential to public health. Each branch of government possesses a unique constitutional authority to create, enforce, or interpret health policy. The legislative branch creates health policy and allocates the necessary resources to effectuate that policy. Some believe that legislators are ill-equipped to make complex public health decisions. Yet, as the only "purely" elected branch of government, members of federal or state congresses are ultimately politically accountable to the people.

The executive branch, which enforces health policy, has an equally significant role in public health. Most public health agencies reside in the executive branch and are responsible for implementing legislation, which may often require establishing and enforcing complex health regulations. The executive branch and its agencies are uniquely positioned to govern public health. Public health agencies are designed and created for the purpose of advancing human health. They have sufficient expertise and resources to focus on health problems for extended periods of time. Agencies, however, may occasionally suffer from stale thinking, complicity with the subjects of regulation, and the inability to balance competing values and claims for resources.

The judicial branch, which interprets the law and resolves legal disputes, also has an important role concerning public health. Courts can exert substantial control over public health policy by determining the boundaries of government power and the zone of autonomy, privacy, and liberty to be afforded individuals. Courts decide whether a public health statute or policy is constitutional; whether agency action is legislatively authorized; whether agency officials have sufficient evidence to support their actions; and whether government officials or private parties have acted negligently. Although the exercise of judicial power may serve public health, courts may fail to review critically the substance of health policy choices. Federal judges, once appointed, are politically unaccountable (although state and tribal judges may be elected). Courts are bound by the facts of a particular case or controversy, may be overly influenced by disfavored expert opinions, or may focus too intently on individual rights at the expense of public health protections.

It is worth noting that the separation of powers doctrine is not a model of efficiency. Dividing broad powers among branches of governments significantly burdens governmental operations, which may actually thwart public health. The constitutional design appears to value restraint in policy making: legislative representatives reconcile demands for public health funding with competing claims for societal resources; the executive branch straddles the line between congressional authorization and judicial restrictions on that authority; and the judiciary tempers public health measures with individual rights. As a result, the possibility of strong public health governance by any given branch is

compromised in exchange for constitutional checks and balances that prevent overreaching and assure political accountability.

A third constitutional function is to limit government power in order 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 that power by protecting individual rights and freedoms. The Bill of Rights (the first ten amendments to the Constitution), together with the Reconstruction Amendments (13th, 14th, and 15th Amendments) and other constitutional provisions,(14) create 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 and freedoms.

Understanding and defining the limits of public health powers by the federal, state, tribal, and local governments is an integral part of our constitutional system of government. In the following sections, the constitutional authority and exercise of public health powers by each of these levels of government are explored.

Federal Public Health 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. Under the doctrine of implied powers, the federal government may employ all means "necessary and proper" to achieve the objectives of constitutionally enumerated national powers.(15) 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.

The taxing power is a primary means for achieving public health objectives by influencing, directly and indirectly, health-related behavior through tax relief and tax burdens. Tax relief encourages private, health-promoting activity and tax burdens discourage risk behavior. Through various forms of tax relief, the government provides incentives for private activities that it views as advantageous to community health (e.g., tax benefits for self-insured health care plans).

Public health taxation also regulates private behavior by economically penalizing risk-taking activities. Tax policy discourages a number of activities that government regards as unhealthy, dangerous, immoral, or adverse to human health. Thus, the government imposes significant excise or manufacturing taxes on tobacco, alcoholic beverages, and firearms; penalizes certain behaviors such as gambling; and influences individual and business decisions through taxes on gasoline or ozone-depleting chemicals that contribute to environmental degradation.

The spending power provides Congress with independent authority to allocate resources for the public good or general welfare without the need to justify its spending by reference to a specific enumerated power. (16) Closely connected to the power to tax, the spending power authorizes expenditures expressly for the public's health. The grant of such expenditures can be conditioned on a number of terms or requirements. The conditional spending power is thus like a private contract: in return for federal funds, the states agree to comply with federally imposed conditions. Such conditions are constitutionally allowed provided the conditions are clearly authorized by statute(17) and a reasonable relationship exists between the condition imposed and the program's purposes.(18)

The need for federal public health funds effectively induces state conformance with federal regulatory standards. Congress and federal agencies use conditional spending to induce states to conform to federal standards in numerous public health contexts, including direct health care, prevention services, biomedical and health services research, public health regulation and safety inspection, and workplace safety and health.

The commerce power, more than any other enumerated power, affords Congress potent regulatory authority. Congress has the power to regulate (1) all commerce among foreign nations and Indian tribes; and (2) interstate commerce among the states.(19) Although the scope of the interstate commerce power has been judicially limited during the course of our constitutional history, the current conception of Congress' commerce powers is extensive.

The Court's modern construction of the interstate commerce power has been described as "plenary," or all embracing,(20) and has been exerted to affect virtually every aspect of social life. The expansive interpretation of the commerce clause has enabled the national government to invade traditional realms of state public health power, including the fields of environmental protection, food and drug purity, occupational health and safety, and other public health matters. The commerce clause, thus, gives national authorities the power to regulate throughout the public health spectrum.

Any legitimate exercise of federal taxing, spending, or commerce power in the interests of public health may be determined to trump state public health regulation. By authority of the Supremacy Clause, Congress may preempt state public health regulation, even if the state is acting squarely within its police powers. Federal preemption occurs in many areas of public health law, such as with cigarette labeling and advertising regulations and occupational health and safety.

The federal government, however, often does not preempt state laws. Congress may offer states the choice of either establishing regulatory schemes that reflect federal standards or having federal regulation preempt state law. This model, known as "cooperative federalism," is found in federal public health statutes concerning water quality, occupational health and safety, and conservation, and it is the predominant approach to federal-state relations in environmental law.

As a result of broad interpretations of its supreme, enumerated powers, the federal government has a vast presence in public health. It is nearly impossible to find a field of public health that is not heavily influenced by United States government policy. Public health functions, including public funding for health care, safe food, effective drugs, clean water, a beneficial environment, and prevention services, can be found in an array of federal agencies. The bulk of all federal health responsibilities lies with the Department of Health and Human Services and its many sub-agencies, including the Centers for Disease Control and Prevention, National Institutes of Health, and the Food and Drug Administration. The Department of Agriculture, the Department of Labor, and the Environmental Protection Agency, to name a few, also have important public health functions.

State Police Powers

Despite the broad federal presence in modern public health regulation, states have historically had a predominate role in providing population-based health services. States still account for the majority of traditional public health spending for public health services (not including personal medical services or the environment). The Tenth Amendment of the federal Constitution reserves to the states all powers that are neither given to the federal government nor prohibited by the Constitution. These reserved powers, known as the police powers, support a dominant role in protecting the public's health.

The police power represents the state's authority to further the goal of all government, to promote the general welfare of society.

> ***Police powers can be 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 of contract and uses of property.*

This definition of "police power" reflects three principal characteristics: (1) the governmental purpose is to promote the public good; (2) the state authority to act permits the restriction of private interests; and (3) the scope of state powers is pervasive. States exercise police powers for the common good, that is, to ensure that communities live in safety and security, in conditions conducive to good health, with moral standards, and, generally speaking, without unreasonable interference with human well-being.

Government, in order to achieve the common good, is empowered to enact legislation, regulate, and adjudicate in ways that necessarily limit, or even eliminate, private interests. Thus, government has inherent power to interfere with personal interests in autonomy, liberty, privacy, and association, as well as economic interests in ownership and uses of private property. The police power affords state government the authority to keep society free from noxious exercises of private rights. The state retains discretion to determine what is considered injurious or unhealthful and the manner in which to regulate, consistent with constitutional protections of personal interests.

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 have enabled states and local governments to promote and preserve the public health in areas ranging from injury and disease prevention to sanitation, waste disposal, and water and air pollution. Police powers exercised by the states include vaccination, isolation and quarantine, inspection of commercial and residential premises, abatement of unsanitary conditions or other nuisances, regulation of air and surface water contaminants as well as restriction on the public's access to polluted areas, standards for pure food and drinking water, extermination of vermin, fluoridization of municipal water supplies, and licensure of physicians and other health care professionals.

Local Public Health Powers

In addition to the significant roles that federal and state governments have concerning public health law in the constitutional system, local governments also have important public health powers. Public health officials in local governments, including counties, cities, 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.

While states have inherent powers as sovereign governments, localities have delegated power. Local governments in the constitutional system are subsidiaries of their states. As a result, any powers that local governments have to enact public health law or policies must be granted either in the state constitution or state statute. Sometimes state grants of power are so broad and generic that they afford cities "home rule." For example, if the state constitution expressly affords a city the power to protect the health, safety, and welfare of local inhabitants, this is an important guarantee of home rule. Absent constitutionally protected delegations of power to local governments, however, states may modify, clarify, preempt, or remove home rule powers of local government.

Tribal Public Health Powers

Unlike the state and local executive agencies that have been established and vested with public health powers via the state constitution and statutes, many tribal governments predate statehood. These rich and diverse Native and Indian populations 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 Congress has recognized the unique status of Native and Indian tribal governments in the constitutional system.

The federal government's relationship with the American Indians is the product of compromise. In the mid-1800s 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.

Pursuant to the Snyder Act of 1921,(22) 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 Natives and Indians through the Indian Self-Determination and Education Assistance Act of 1975(23) and the Indian Health Care Improvement Act of 1976.(24) Together these Acts clarify federal objectives for the provision of health-related services and encourage the direct involvement of tribal governments in planning and operating health programs.

In 1991, Congress began the IHS Tribal Self-Governance Demonstration Project.(25) This Project, which is scheduled to continue until 2006, specifically authorizes IHS and BIA to execute agreements (or compacts) with Natives and 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 is left to the tribal governments. As a result, the setting of public health goals and objectives has become a primary responsibility of local tribal governments. This movement toward self-governance was further solidified with the Congressional enactment of the Tribal Self-Governance Act of 1994.(26)

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

Despite their distinct existence and relationship with the federal government, Natives and Indians (other than those living within reservations) are also citizens of the state. Natives and Indians outside reservations, therefore, generally are bound by state regulation. For example, in *Alaska v. Native Village of Venetie Tribal Government,*(27) the United States Supreme Court held that non-reservation tribal land allotted to Alaskan Natives through the Alaska Native

Claims Settlement Act of 1971 was not "Indian country" and did not form a territorial basis for certain types of tribal jurisdiction related to the exercise of general governmental powers. The State, therefore, had primary civil and criminal jurisdiction over the villages and tribal lands of Alaska Natives and Indians. Although the Court's decision in *Venetie* confirmed that Alaska has primary jurisdiction over non-reservation tribal lands, the extent of state powers remains conditioned on the recognition of the federal partnership with tribal governments.

Less certain are the responsibilities tribal governments share with state and local governments for the public health. Tribal governments undertake public health initiatives with their federal funds, such as monitoring diseases and designing prevention strategies. Disputes sometimes arise as to when and whether tribal governments must adhere to state public health initiatives and regulations. Though overall responsibility for public health likely resides with the State, theoretical, practical, and political issues complicate the achievement of purely state public health objectives where tribal organizations dispute state jurisdictional authority.

Constructive and cooperative relationships between public health authorities at the federal, state, local, and tribal levels are extraordinarily important. If public health officials from each of these different governmental entities do not communicate regularly and design strategies in a coordinated and predictable way, the health of communities suffer.

New Federalism

Since the founding of the United States, the division of federal and state governmental powers has been an important, and highly controversial, part of our federalist system of government. The Supreme Court, at least since Franklin Delano Roosevelt's New Deal, has liberally interpreted the federal government's enumerated powers leading to an unprecedented expansion of national public health authority. More recently, however, the Rehnquist Court has emphasized that there exist enforceable limits on Congress' powers. Known as new federalism, federal courts have begun to hold that federal police powers should be circumscribed with more authority returned to the states.

The Supreme Court has narrowed the scope of the commerce power, holding that the federal government cannot regulate purely intra-state police power matters. In *United States v. Lopez* the Court held that Congress exceeded its commerce clause authority by making gun possession within a school zone a federal offense. Concluding that possessing a gun within a school zone did not "substantially affect" interstate commerce, the Court declared the statute unconstitutional.(28)

In addition to *Lopez*, the Court has held in a series of recent cases that Congress, even if empowered to act for the public good, must exert its authority in ways that do not excessively intrude on state sovereignty. In *New York v. the United States*, the Supreme Court struck down a federal statute providing for the disposal of radioactive waste as violating the Tenth Amendment.(29) The Constitution, stated the Court, does not confer upon Congress the ability to "commandeer the legislative processes of the States by

directly compelling them to enact and enforce a federal regulatory program." The Supreme Court used the same reasoning to overturn provisions in the Brady Handgun Violence Prevention Act, which directed state and local law enforcement officers to conduct background checks on prospective handgun purchasers.(30)

In this era of new federalism, some federal public health laws may be vulnerable to state challenges. National environmental regulations are particularly at risk because they invade core state concerns and are being challenged in the court system.

In summary, a highly complex, politically charged, relationship exists between various levels of government regulating for the public's health: federal, state, local, and tribal. The Constitution ostensibly grants the federal government limited powers, but these powers have been construed in ways that have facilitated an enormous growth of national public health authority. The Constitution does not grant states any power because, as sovereign governments that predated the Republic, the states already had broad powers. Known as the police powers, states may act to protect the health, safety, and well-being of the population. Local governments, as subsidiary entities of states, possess only those public health powers delegated by the state. Tribal governments are highly complex and and variable. They derive much of their authority in a series of complicated arrangements with the federal government, based on treaty and determined by federal statute. In a era of new federalism, the Supreme Court has gradually limited federal public health powers and returned them to the states. Even so, the vast majority of public health functions currently exercised by the federal government are likely to survive constitutional scrutiny.

Chapter 3: A Public Health Law Impact Assessment: A Step-by-Step Approach

Public health regulation entails potential trade-offs between public goods and private interests. When public health authorities act, they face troubling conflicts between the collective benefits of population health on the one hand, and personal and business interests on the other. These trade-offs between the collective benefits of public health and personal interests in liberty and property are much discussed in the public health literature. But how do we know when the public good to be achieved is worth the infringement of individual rights? This chapter offers a step-by-step evaluation of public health regulation. Under this *public health law impact assessment*, government bears the burden of justifying a coercive regulation and, therefore, must evaluate the risk, the intervention's effectiveness, the economic costs, the personal burdens, and the policy's fairness.

Step 1: Assess the Risk Based on Scientific Methods

Public health regulation is an attempt to control risk. To evaluate the validity of public health regulation, it is first important to assess the risk to the population. As a general matter, public health authorities should (1) base risk assessments on objective scientific inquiries; (2) make judgments on an individualized basis; and (3) find significant, as opposed to remote or speculative, risks.

First, risk assessments should be based on objective and reliable scientific evidence. Relevant evidence should be provided by the multiple disciplines of public health, including virology, bacteriology, bio-statistics, and epidemiology. The sciences of public health provide the grounding for determinations of the nature, likelihood, and severity of the risk and the effectiveness of policies and practices for averting the risk.

Second, public health authorities should take account of the particular facts of the health threat presented. Thus, risk assessments should be made on a case-by-case basis, and not under any type of blanket rule, generalization about a class of persons, or assumptions about the nature of injury or disease. This requires a fact-specific, individualized inquiry resulting in a well-informed judgment grounded in a careful and open-minded weighing of risks and alternatives.

Third, the risk must be "significant," not speculative, theoretical, or remote. The level of risk needed to justify a regulatory response varies depending on the policy's economic costs and human burdens. If the costs and burdens are small, public health authorities need to demonstrate lower levels of risk to justify the intervention. As the policy's costs and burdens increase, public health authorities should demonstrate ever greater levels of risk. For example, where individual liberty is at stake, the risk must be substantial.

Several factors are helpful in risk assessments: (i) nature of risk: some risks are immediate (e.g., contaminated food or water), some longer-term (e.g., toxic exposures resulting cancer), and some depend on mechanism of transmission (e.g., airborne, food-borne, or blood-borne); (ii) duration of risk: coercive regulation is appropriate only for the period of time that the risk continues to exist (e.g., during the period of infectiousness); (iii) probability of harm: the likelihood that the risk will materialize and cause harm; severity of harm: if the risk materializes the degree of harm that will be caused to populations.

In assessing the validity of public health powers, a rough inverse correlation exists between the severity of harm and the probability of its occurrence. As the seriousness of potential harm to the community rises, the level of risk needed to justify the public health power decreases. Central to the understanding of the "significant risk" standard is the fact that even the most serious potential for harm does not justify public health regulation in the absence of a reasonable probability that it will occur. Parents of school children, for example, have difficulty comprehending why children who are infested with lice may be excluded from school, but not those infected with HIV. The reason is that a very high probability exists that other children will become infested with lice, but that the risk of contracting HIV in that setting is highly remote.

Step 2: Assess the Intervention's Effectiveness

As we have just seen, the objective of public health regulation is to avert or diminish a significant risk to health. While courts and the public readily understand the need for a substantial public health objective, they pay less attention to the methods used to achieve the goal. Instead, the intervention's effectiveness is simply assumed or, more likely, the courts and the public trust the experts to develop, implement, and evaluate the intervention. However, since the proposed regulation entails personal burdens and economic costs, government must affirmatively demonstrate, through scientific data, that the methods adopted are reasonably likely to achieve the public health objective. This is what is called the "means-ends" test; it is the government's burden to defend, and rigorously evaluate, the effectiveness of a coercive intervention. The fact that government regulates in a particular area does not necessarily mean that it is "doing something" about the problem. The better questions are whether public health authorities accurately measure the health hazard, effectively reduce the risk or ameliorate the harm, and rigorously evaluate the intervention.

Public health authorities should accurately measure relevant health risks as a prerequisite to meaningful action. If a regulatory response to radioactivity, magnetic fields, or lead paint is considered, public health authorities must understand the health risks posed and ask: how much is known about the hazard? how much exposure, and of what duration, is safe? how much reduction in exposure is necessary to reduce the risk to acceptable levels? If the hazard is not well understood, then risk reduction strategies are unlikely to be successful.

Public health authorities should not simply measure the health risk but, in fact, reduce that risk or ameliorate the ensuing harm. Regulatory activities are

frequently justified by historical convention. For example, traditional infectious disease control strategies such, as compulsory testing, partner notification, and isolation, are assumed to be effective. Yet, traditional measures rarely have been subject to modern scientific assessment.

The need to demonstrate an intervention's effectiveness, therefore, requires ongoing evaluation. The Institute of Medicine proposes the adoption of performance monitoring, a process of selecting and analyzing indicators to measure the outcomes of an intervention strategy for health improvement. (31) Admittedly, scientific evaluation is complex because many behavioral, social, and environmental variables confound objective measurement of the causal connection between an intervention and a health outcome. Nevertheless, requiring public health authorities to demonstrate an intervention's effectiveness is necessary to ensure that the community health benefits outweigh the personal burdens and economic costs.

Step 3: Assess the Economic Costs

Public health regulations impose economic costs: agency resources to devise and implement the regulation, costs to individuals and businesses subject to the regulation, and lost opportunities to intervene with a different, potentially more effective, technique (opportunity costs). A major issue, much debated in the literature, is the relevance of cost in regulatory decisions designed to safeguard human health. Under standard accounts, government should prefer regulatory responses that provide the most health benefits (e.g., saving the most years of life, or quality adjusted years of life) at the least cost. Known as "cost-benefit" or "cost-effectiveness" analysis, health economists estimate the net health effects of a regulatory program or intervention.

While many people in public health understandably contest the idea that market exchanges are an appropriate measure of the value of a human life, cost does matter. Few people question the premise that American society has finite, and relatively scarce, resources available for public health regulation. Given the reality of scarcity, hard choices must be made between regulatory alternatives. Do we spend large sums to avert relatively trivial risks, or do we devote resources to rather more serious risks that can be ameliorated at significantly lower cost? While society cannot tally up costs and benefits into a tidy number, it can make sensible choices in prioritizing regulatory expenditures.

Why is it a problem if public health regulations impose inordinate expense with relatively modest benefits? At least part of the answer is that whenever government regulates, it forgoes opportunities for other interventions that improve community health. If government adopts an *ineffective* strategy, it loses opportunities to intervene with a different, potentially more beneficial, technique. If government adopts an unduly *costly* strategy, it wastes scarce resources. There is usually limited political will and agency resources to adopt multiple methods of intervention simultaneously. When ineffective or expensive regulations are seen as lost opportunities, it becomes clearer that the operable trade-off is not "money-for-lives," a choice that understandably generates public concern. Rather, the trade-off is "health-for-health" or "lives-for-lives," because a choice to spend excessively wastes not only dollars, but also opportunities to promote health and longevity.

Step 4: Assess the Personal Burdens and Choose the Least Restrictive Alternative

Public health regulations impose not only economic costs, but also human rights burdens. A public health policy may be well-designed, cost-effective, and likely to promote the health and well-being of the population, but still be unacceptable from an individual rights perspective. In thinking about personal burdens, it is important to measure the intervention's (i) *invasiveness*: to what degree does the public health intervention intrude on the right in question? (ii) *frequency* and *scope*: does the infringement of rights apply to one person, a group, or an entire population? and (iii) *duration*: how long of a period is the person or group subject to the infringement?

Public health regulations impose various kinds of personal burdens, many of which implicate constitutionally protected interests. Consider the effects of public health regulations on personal autonomy, privacy, liberty, non-discrimination, and the freedoms of expression, association and religion.

Autonomy *refers to a person's freedom to make decisions, particularly choices about bodily integrity and reproduction. The Supreme Court has said that the right to refuse medical treatment(32) and procreative liberties(33) are constitutionally protected. Several public health interventions invade bodily integrity by physical intrusion without informed consent: compulsory testing and screening, medical examination and treatment, and directly observed therapy.*

Health information privacy *is a person's interest in controlling the circumstances in which identifiable information is collected, stored, used, and transmitted. While the Constitution does not expressly mention privacy, the Supreme Court has found a limited constitutional interest in privacy.(34) A person's privacy interests are affected whenever government collects identifiable health information (e.g., surveillance, epidemiologic investigations, and reporting).*

Liberty *is being free from physical restraint, control, or captivity. The Supreme Court has held that the right to travel is a "fundamental interest" under the Constitution.(35) Public health regulations restrict liberty through civil commitment (e.g., confinement in tuberculosis sanitariums or mental hospitals), criminal confinement (e.g., HIV- or STD-specific offenses), cease and desist orders (e.g., prohibition of unsafe activities), isolation (e.g., separation of contagious persons), and quarantine (e.g., closing off geographical areas).*

Non-discrimination *is a principle that requires people to be treated fairly and not according to stereotypic assumptions about their race, gender, religion, sexual orientation, disability, or other invidious classification. The Fourteenth Amendment guarantees equal protection of the laws. Thus, government has a responsibility to treat similarly situated people similarly. Furthermore, there are numerous anti-discrimination laws at the federal, state, and local levels covering areas such as race, sex, HIV/AIDS, and disabilities. Notably, the Americans with Disabilities Act prohibits discrimination against persons with serious health conditions in employment, public accommodations, and public services.(36)*

Problems of differential treatment occur in almost all public health regulations since, by definition, regulations impose unfavorable personal, social, or economic consequences on some persons or entities, but not others (e.g., a quarantine that applies only to certain racial or ethnic groups, or targeting of prostitutes and not "Johns").

***Freedom of expression** is the right of individuals to speak, publish, and engage in other forms of communication without government interference. The First Amendment protects the freedoms of expression and association: "Congress shall make no law . . . abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances." Public health authorities affect freedoms of expression in several ways, including labeling requirements and advertising restrictions (commercial speech). Public health authorities also restrict the* freedom of association*, for example, by closing bathhouses to prevent the spread of sexually transmitted diseases.*

***Freedom of religion**, also protected by the First Amendment, permits people to hold religious convictions and to act consistently with their religious beliefs. Public health regulations that require medical interventions are sometimes contested on grounds of religious freedom; e.g., a Christian Scientist who uses prayer to treat a sick child, a Jehovah's Witness who refuses a blood transfusion, or an individual who resists immunization based on religious convictions.*

When considering regulations that affect personal burdens, public health authorities should choose the least-restrictive alternative*. This means that agencies should prefer minimally intrusive interventions that achieve the public health objective as well, or better, than more restrictive interventions. This principle does not require public health authorities to adopt measures that are ineffective, but only those that will accomplish the agency's mission with the fewest burdens on human rights.*

Summary of the Public Health Law Impact Assessment

The systematic evaluation of public health policies that has been proposed will not invariably lead to the best policy because any analysis is fraught with judgments about politics and values and is confounded by scientific uncertainty. Nevertheless, the evaluation at least requires public health authorities to think systematically and apply consistent standards when making policy. Public health authorities bear the burden of justification and, therefore, must demonstrate:

- Significant risk based on objective scientific methods;
- The intervention's effectiveness by showing a close fit between means and ends;
- Economic costs are reasonable when compared with the probable benefits; and
- Human rights burdens are reasonable when compared with the probable benefits;
- Public health authorities use the least-restrictive alternative.

Chapter 4: The Modern Public Health Agency

The deep-seated problems of modern society caused by industrialization and urbanization pose complex, highly technical challenges that require expertise, flexibility, and deliberative study over the long term. Solutions cannot be found within traditional government structures such as representative assemblies or governors' offices. As a result, governments have formed specialized entities within the executive branch to pursue the goals of population health and safety. These administrative agencies form the bulwark for public health activities in America. Public health agencies are found at all levels of government: federal, state, and local.

Federal Public Health Agencies

The modern role of the federal government in public health is broad and complex. Public health functions, which include public funding for health care, safe food, effective drugs, clean water, a beneficial environment, and prevention services, can be found in an array of agencies. The bulk of all health responsibilities lies with the Department of Health and Human Services and its many sub-parts. However, the Department of Agriculture, the Department of Labor, and the Environmental Protection Agency, to name a few, also have important public health functions.

The Department of Health and Human Services (DHHS) is the umbrella agency under which most public health functions are located. Under the aegis of DHHS, various programs promote and protect health. The Health Care Financing Administration was created in 1977 to administer the Medicare and Medicaid programs. The Centers for Disease Control and Prevention (CDC) provides technical and financial support to states in monitoring, controlling, and preventing disease. The CDC's efforts include initiatives such as childhood vaccination and emergency response to infectious disease outbreaks. The National Institutes of Health (NIH) conducts and supports research, trains investigators, and disseminates scientific information. The Food and Drug Administration (FDA) ensures that food is pure and safe, and that drugs, biologicals, medical devices, cosmetics, and products that emit radiation are safe and effective.

The Department of Labor (DOL) administers a variety of federal labor laws, some of which pertain to workers' rights to safe and healthy working conditions. Specifically, the Occupational Safety and Health Administration (OSHA) develops occupational safety and health standards and monitors compliance. In 1970, the Environmental Protection Agency (EPA) was created to control and reduce pollution in the air, water, and ground. The EPA develops national standards, provides technical assistance, and enforces environmental regulations.

State Public Health Agencies

The state's plenary power to safeguard citizens' health includes the authority to create administrative agencies devoted to that task. State legislation determines the administrative organization, mission, and functions of public health agencies. Contemporary state public health agencies take many different forms that defy simple classification. Before 1960, state public health functions were located in health departments, with policy-making functions residing in a Board of Health (e.g., issuing and enforcing regulations). As programs expanded (e.g., increased federal funding for categorical programs and block grants), certain public health functions were assigned to other state agencies (e.g., mental health, medical care financing for the indigent, and environmental protection). Currently, there exist 55 state-level health agencies (including the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands), each of which may be a freestanding, independent department or a component of a larger state agency.(37)

The trend since the 1960s has been to merge state health departments with other departments, often social services, Medicaid, mental health, and/or substance abuse, to form superagencies. Under this framework, the public health unit is often called a Division of Health or Public Health. Another common framework is to assign public health functions to a cabinet-level agency. Under this framework, the public health unit is often called a Department of Health or Public Health.(38)

The trend has also been to eliminate or reduce the influence of Boards of Health. These Boards, once ubiquitous and highly influential, are now often replaced or supplemented with specialized boards or committees established by state statute to oversee technical or politically controversial programs (e.g., genetics, rural health, expansion of health care facilities).(39) The chief executive officer of the public health agency (the commissioner, or less often, the secretary) is usually politically appointed by the Governor, but may be appointed by the head of a superagency or, rarely, the Board of Health. Qualification standards may include medical and public health expertise, but increasingly chief executives with political or administrative experience are appointed.

Local Public Health Agencies

Local government exercises voluminous public health functions derived from the state: e.g., air, water and noise pollution, sanitation and sewage, cigarette sales and smoking in public accommodations, drinking water fluoridation, drug paraphernalia sales, firearm registration and prohibition, infectious diseases, rodents and infestations, housing codes, sanitary food and beverages, trash disposal, and animal control. Local government also often regulates (or owns and operates) hospitals or nursing homes.

Municipalities, like the states, have created public health agencies to carry out their functions.(40) Local public health agencies have varied forms and structures: centralized (directly operated by the state), decentralized (formed and managed by local government), or mixed.(41) Local boards of health, or

less often government councils, still exist in most local public health agencies, with responsibility for health regulation and policy. The courts usually permit local agencies to exercise broad discretion in matters of public health, sometimes even beyond the geographic area if necessary to protect the city's inhabitants (e.g., during a waterborne disease outbreak).(42)

Local public health agencies serve a political subdivision of the state such as a city (a municipality or municipal corporation), town, township, county, or borough. Some local public health functions are undertaken by special districts, which are limited government structures that serve special purposes (e.g., drinking water, sewerage, sanitation, or mosquito abatement).

Rule Making, Enforcement, and Quasi-Judicial Powers

Public health agencies are part of the executive branch of government but wield considerable authority to make rules to control private behavior, interpret statutes and regulations, and adjudicate disputes about whether an individual or company has conformed with health and safety standards. Under the separation of powers doctrine, the executive branch is supposed to enforce law, but not enact or interpret it. Nevertheless, the lines between law making, enforcement, and adjudication have become blurred with the rise of the administrative state.

The courts, at least theoretically, can carefully scrutinize legislative grants of power to public health agencies. Conventionally, representative assemblies may not delegate legislative or judicial functions to the executive branch. Known as "nondelegation," this doctrine holds that policy-making functions should be undertaken by the legislative branch of government (because assemblies are politically accountable), while adjudicative functions should be undertaken by the judicial branch (because courts are independent).

The nondelegation doctrine is rarely used by federal courts to limit agency powers.(43) The doctrine, however, has received varying interpretations at the state level; some jurisdictions liberally permit delegations, while others are more restrictive. New York State's highest court, for example, found unconstitutional a health department prohibition on smoking in public places because the legislature, not the health department, should make the "trade-offs" between health and freedom. "Manifestly," the court said, "it is the province of the people's elected representatives, rather than appointed administrators, to resolve difficult social problems by making choices among competing ends."(44)

> ***Rule Making:*** *While public health agencies possess considerable power to issue detailed rules, they must do so fairly and publically. Federal and state administrative procedure acts (as well as agency enabling acts) govern the deliberative processes that agencies must undertake in issuing rules. (Unless specified by statute, state administrative procedure acts generally have been held not to apply to local government agencies). Administrative Procedure Acts often require two different forms: (i)* informal*: simple and flexible procedures often consisting of prior notice (e.g., publication in federal or state register), written comments by interested persons, and a statement of basis and purpose for the rule; and (ii)* formal*: more elaborate procedures often requiring a hearing.*

Enforcement: *Health departments do not possess only legislative power. They also have the executive power to enforce the regulations that they have promulgated. Enforcement of laws and regulations is squarely within the constitutional powers of executive agencies. While legislatures set the penalty for violation of health and safety standards, the executive branch monitors compliance and seeks redress against those who fail to conform. Pursuant to their enforcement power, health departments may inspect premises and businesses, investigate complaints, and generally monitor the activities of those who come within the orbit of health and safety statutes and administrative rules.*

Quasi-Judicial: *Modern administrative agencies do not simply issue and enforce health and safety standards. They also interpret statutes and rules as well as adjudicate disputes about whether standards are violated. Federal and state administrative procedure acts, and agency enabling legislation, often enumerate the procedures that agencies must follow in adjudicating disputes. Rarely, these laws require formal adjudications.* Formal adjudications *typically are conducted by an administrative law judge (ALJ), followed by an appeal to the agency head. Formal adjudications usually include notice, the right to present evidence, and agency findings of fact and law as well as reasons for the decision. Even in the absence of statutory requirements, federal and state constitutions require procedural due process if the regulation deprives an individual of "property" or "liberty" interests.*

In summary, modern administrative agencies exercise *legislative power* to issue rules that carry heavy penalties; *executive power* to investigate potential violations of health and safety standards and prosecute offenders; and *judicial power* to interpret law and adjudicate disputes over violation of governing standards. Agency powers have developed for reasons of expediency (because of agency expertise) and politics (because "specialists" are presumed to act according to disinterested scientific judgments).

While ample agency power is critically important for achieving public health purposes, it is also troubling and perplexing in a constitutional democracy. One important problem is that commercial regulation may simply transfer wealth from one private interest group to another rather than promoting a public good. For example, licenses can exclude competitors from the market or regulation of one industry may benefit another providing comparable services (e.g., coal, electrical, or nuclear energy). A related problem is that agencies may be unduly influenced, or "captured" by, powerful constituencies or interest groups. Agencies, over the long term, may come to defend the economic interests of regulatory subjects. Finally, agencies may operate in ways that appear unfair or arbitrary, inefficient or bureaucratic, or unacceptable to the public. The very strengths of public health authorities (e.g., neutrality, expertise, and broad powers) can become liabilities if they appear politically unaccountable and aloof from the real concerns and needs of the governed. This is why governors' offices, representative assemblies, and courts struggle over the political and constitutional limits that should be placed on agency action nominally intended for the public's health and safety.

Chapter 5: Regulation of Personal Behavior

The law can be a powerful tool for the protection and advancement of the population's health. Public health agencies have at their disposal numerous techniques for influencing and sanctioning risk activities by persons and businesses. This chapter concerns regulation of personal behavior while the next concerns regulation of commercial activity.

Public health authorities possess a wide range of powers to control risk behavior. Many of these powers are contained in state laws relating to infectious diseases: communicable diseases, sexually transmitted diseases, and specific diseases (e.g., tuberculosis or HIV/AIDS). This chapter will briefly cover case finding (testing, screening, and reporting), mandatory immunization and treatment, civil confinement (isolation, quarantine, and civil commitment), and the criminal law (the general criminal law and public health offenses).

Case Finding

Case finding can be defined as any method used to identify previously unknown or unrecognized conditions in apparently healthy or asymptomatic persons. There are multiple methods used by health authorities to identify persons with health conditions including testing individuals, screening populations, reporting to the health department, and partner notification.

Testing and Screening

Although the terms are often used interchangeably, a distinction exists between "testing" and "screening." Testing refers to a medical procedure that determines the presence or absence of disease, or its precursor, in an individual patient. Individuals are often selected for testing because of a history of risk or clinical symptoms. In contrast, screening is the systematic application of a medical test to a defined population. Typically, medical testing is administered for diagnostic or clinical purposes, while screening is undertaken for the broader public health purposes such as case finding.

The justification for screening is that public health authorities cannot effectively respond to an epidemic unless they are aware of persons who are infected. Screening, however, is often fraught with political controversy. Legislatures may wish to be seen to be "doing something" about an urgent health problem. But screening also reveals the identity of individuals and subjects them to potential stigma and discrimination. Screening is particularly troubling for persons with diseases such as HIV that are associated with socially disfavored behaviors (e.g., homosexuality and drug use) and which disproportionately affect minorities. This section explores the problem of compulsion in screening and offers a brief legal analysis of mandatory screening from constitutional and disability rights perspectives. It is possible to identify several forms of screening:(45)

(1) Voluntary screening is the norm in medicine and public health, and any deviation from the norm requires a careful justification. Voluntary screening requires information about the nature of the test in advance, full understanding by a competent person, and the freedom to choose to be tested or to decline. Non-directive counseling is thought to be "best-practice" where individuals are informed of the options and the choice is left to them.

(2) Routine screening is sometimes meant simply to refer to population screening, with each member of a defined population routinely tested. However, this definition fails to explain the essential characteristics of the screening; i.e., whether persons are informed they are being tested, how they are informed, when they are informed, and whether they can withhold consent. Routine screening can either be with ("opt-in") or without ("opt-out") advance notification. In "opt-in" screening, individuals are told that they have right to give, or to withhold, consent; they are not actually tested until they have consented. In "opt-out" screening, all individuals are automatically tested unless they expressly ask that the test not be performed. "Opt-out" screening verges on compulsory because individuals may not be aware they are being tested and, even if they are, they may not fully understand the purposes of the test or their right to withhold consent.

(3) Compulsory screening makes it lawful to require persons to submit to testing without informed consent. Compulsory screening is authorized in a range of statutes relating to communicable diseases, STDs, TB, and HIV. These, and other, statutes usually define a class of persons to which the compulsory power applies; e.g., sex offenders, prostitutes, pregnant women, newborns, or inmates.

The courts frequently evaluate compulsory screening programs under the 4th Amendment or anti-discrimination statutes.

Screening and the 4th Amendment. The primary constitutional impediment to testing is the 4th Amendment's right of people to be "secure in their persons" and not subjected to "unreasonable searches and seizures." The Supreme Court has long recognized that the collection and subsequent analysis of biological samples are "searches."(46) Governmental officials usually must obtain a judicial warrant for a search in criminal cases. However, the Supreme Court has held that if the government has a "special need" (e.g., public health or safety) that does not involve law enforcement, the warrant and probable cause requirements are not be applicable.(47) Most public health screening programs are not conducted for law enforcement purposes so they fit within the "special needs" doctrine. If testing is genuinely for public health–rather than criminal justice–purposes, the courts often uphold the screening. Even for highly stigmatized diseases such as HIV, the courts have upheld screening of firefighters,(48) military personnel,(49) overseas employees in the State Department,(50) and sex offenders.(51)

Screening and disability discrimination law. The Americans with Disabilities Act of 1990(52) (ADA) and state anti-discrimination legislation are also relevant to screening because the information acquired can be used to discriminate based on health status. Screening programs are common in employment, public

services (e.g., government conducted or authorized screening), and public accommodations (e.g., hospitals and managed care organizations). The ADA prohibits discrimination against qualified persons with disabilities. The ADA's definition of disability covers most serious medical conditions. The Supreme Court, for example, found that all stages of HIV disease, including asymptomatic infection, are covered disabilities.(53)

The ADA's prohibition against discrimination in employment (Title I) specifically includes medical testing, physical examinations, and inquiries:(54) (1) *pre-offer*: an employer is not permitted to screen applicants before offering a job; (2) *post-offer*: an employer is permitted to screen after a job offer is made, provided that all entering employees receive the same test and the medical information is kept confidential; and (3) *current employees*: an employer may screen current employees only if job-related and consistent with business necessity. Even where employers are permitted to screen, they may not withdraw a job offer or adversely treat a current employee if the person is qualified.

Reporting

States possess constitutional authority under their police powers to mandate health care providers and laboratories to report the occurrence of specified diseases and other health conditions. The Supreme Court has upheld reporting requirements against challenges that they violate personal privacy.(55) States effectuate their police powers by enacting legislation that enumerates reportable health conditions or delegates that task to state or local health agencies. Where legislation delegates authority, courts afford health agencies considerable discretion in deciding how to classify particular diseases. For example, the New York Court of Appeals, that state's highest court, rejected a challenge by physician organizations that insisted the Commissioner classify HIV as a sexually transmitted disease; the Court viewed the Commissioner's exercise of discretion as reasonable.(56)

All states and territories participate in a national morbidity notification system by regularly reporting aggregate or case-specific data to the CDC; reporting of data from states to the CDC is voluntary.(57) Currently, approximately 60 reportable conditions are included in the national morbidity reporting system.(58) The Council of State and Territorial Epidemiologists (CSTE), in conjunction with the CDC, annually proposes additions and deletions to the list of diseases under national surveillance, and most states conform to these recommendations. The CDC creates standardized case definitions for infectious diseases.(59) The CDC is also developing standardized case definitions for injury, chronic, environmental, occupational, and other health conditions.

Conflicts of values and politics have been omnipresent in mandatory reporting almost from the beginning.(60) Public health saw its first duty to the population, while medicine saw its first duty to patients. Public health authorities justified reporting by invoking science and the ethics of collective responsibility, while private physicians accorded higher priority to the sanctity of their relationships with patients. Mandatory duties to report require physicians to notify the government of their patients' names and other sensitive

information, which is regarded as a breach of confidentiality. This tension – between public health surveillance and physician/patient confidentiality – has remained to the present day, as the current controversy over named HIV reporting illustrates.(61)

Partner Notification

Partner notification is a highly complex concept that has at least three distinct, if at times overlapping, meanings:(62) (1) *contact tracing*: statutory powers of public health agencies to identify and locate sexual partners and other "contacts" at risk of infection, and to notify them of the risk; (2) *duty to warn*: the power or duty of private health care professionals to inform their patient's sexual or other partners of foreseeable risks; and (3) *right-to-know*: common law duty of infected persons to disclose their serological status to a sexual or other partner placed at risk. This section discusses contact tracing because it is a quintessential function of state and local governments.

States have enacted legislation to empower public health agencies to implement partner notification as part of STD or HIV prevention programs. Since public health is traditionally within the domain of state government, the federal government does not require partner notification. However, Congress has influenced contact tracing policy through the exercise of its conditional spending power. Despite being classified as an STD since 1988, Congress has treated HIV separately from other STDs. The Ryan White Act of 1990 provides grants to states to implement partner notification programs for HIV infected persons.(63) In 1996, the Act required states to notify spouses of persons infected with HIV as a condition of the receipt of partner notification funds.(64)

Public health authorities utilize two primary models of partner notification: patient and provider referral; conditional referral is a hybrid of the two that often prevails in modern practice. With *patient referral*, index patients, who are identified through testing at public health clinics, and physician referrals, are asked to contact their partners. *Provider referral* switches the responsibility for notification to trained public health personnel who locate contacts based on names, descriptions, and addresses provided by index patients. Information regarding their exposure, possible infection, and treatment is provided to partners in a counseled environment, preferably during a face-to-face meeting between the contact and a public health professional. The confidentiality of the index patient is protected by declining to reveal the patient's name to contacts (although in many instances, contacts are aware of the source of their exposure through their own deduction or other means).

Stigmatized groups (e.g., commercial sex workers and gay men) have expressed concern about the privacy and discrimination risks inherent in partner notification. At the same time, the partners of infected persons have claimed that they have a right to be informed of the risks they face. Partner notification has strived mightily to straddle a fine line between the interests of infected persons and their partners. Public health officials rely on a strong tradition of voluntary cooperation, nondisclosure of names, and the provision of support services to minimize social risk while still affording partners the necessary information to protect themselves.

Immunization

Modern immunization statutes were enacted in response to measles outbreaks in schools in the 1960s and 1970s. Currently, all states, as a condition of school entry, require proof of vaccination against a number of diseases on the immunization schedule such as diphtheria, measles, rubella, and polio. These statutes often require schools to maintain immunization records and to report information to health authorities.(65)

While the exact provisions differ from state-to-state, all immunization laws grant exemptions for children with medical contraindications to immunization. Thus, if a physician certifies that the child is susceptible to adverse effects from the vaccine, the child is exempt. Virtually all states also grant religious exemptions for persons who have sincere religious beliefs in opposition to immunization.(66) A minority of states also grant exemptions for parents that profess philosophical convictions in opposition to immunization.(67) These statutes allow parents to object to vaccination because of their "personal," "moral," or "other" beliefs. The process for obtaining an exemption varies depending on the specific state law. In practice, exemptions for all reasons constitute only a small percentage of total school entrants,(68) but disease outbreaks in religious communities that have not been vaccinated do periodically occur.(69)

From a public health perspective, state vaccination laws have been a great success. The rate of complete immunization of school-age children in the United States (>95%) is as high, or higher, than most other developed countries.(70) More important, common childhood illnesses, such as measles, pertussis, and polio, which once accounted for a substantial proportion of child morbidity and mortality, have been substantially reduced.(71) Yet, organized groups of parents have struggled against mandatory vaccination and actively lobbied legislatures for liberal exemptions.

The judiciary, not surprisingly, has firmly aligned itself with the community of experts and with the overriding importance of communal well being. In its seminal case, *Jacobson v. Massachusetts,*(72) the Supreme Court upheld mandatory vaccination laws. The courts have also widely upheld the states' power to require children to be vaccinated as a condition of school entrance.(73) In *Zucht v. King*, the Supreme Court specifically upheld a local government mandate for vaccination as a prerequisite for attendance in public school.(74)

Mandatory Physical Examination and Treatment

Medical treatment for an infectious disease affords both individual and collective benefits. Treatment benefits individuals by ameliorating symptoms and sometimes providing a cure. Treatment also benefits society by reducing or eliminating infectiousness. Persons who do not take the full course of their treatment, however, pose risks to themselves and the public's health. Inconsistent treatment can result in drug-resistance so that modern therapies become less effective. Because of the benefits to individuals and the community, and the problem of drug-resistance, public health authorities have an abiding interest in compulsory treatment. However, mandatory treatment

(as well as physical examinations that are antecedent to treatment) represent serious intrusions into a person's bodily integrity. A competent person's right to refuse treatment is protected under the common law, state statutes, and the Constitution.

Common law: Patients have a deeply rooted common law right to refuse treatment that is embodied in the doctrine of informed consent.(75) Absent a statutory power to impose treatment, public health authorities are bound to respect the patient's wishes. The doctrine of informed consent has the following components: (i) *competency* to understand the nature and purposes of the treatment); (ii) *information* concerning the material benefits, risks, adverse effects, and alternatives; (iii) *voluntariness* so that the patient can make a free choice, without undue influence; and (iv) *specificity* so that the patient gives consent to the actual treatment and not a "blanket" consent.

Statutes: Public health statutes frequently authorize mandatory treatment, which has the effect of overriding common law. For example, most sexually transmitted disease and tuberculosis laws grant health officials the power to compel physical examination and medical treatment. Statutes often impose certain conditions for mandatory treatment such as a danger to the public; others may require a violation of some rule or order such as noncompliance with a health directive or refusal to be treated; still others limit treatment to active, or contagious, cases of infection.

Constitution: The right to refuse treatment, most importantly, has been grounded in the federal and state constitutions.(76) In a series of cases during the last two decades, the Supreme Court has recognized that a competent person has a constitutionally protected "liberty interest" in refusing unwanted medical treatment.(77) The Supreme Court's recognition of a right to bodily integrity, however, does not mean that the right is absolute. The Court balances a person's liberty interests against relevant state interests. Public health authorities may impose serious forms of treatment if the person poses a danger to himself or others; the treatment must also be medically appropriate.(78) In fact, where it adopts a balancing test, the Court almost always supports state interests over individual "liberty" interests.(79) In the context of infectious diseases the courts have consistently affirmed the constitutionality of compulsory treatment.(80)

Civil Confinement: Isolation, Quarantine, and Compulsory Hospitalization

Public health authorities possess a variety of powers to restrict the autonomy or liberty of persons who pose a danger to the public. They can direct individuals to discontinue risk behaviors ("cease and desist" orders) and detain them temporarily or indefinitely. This section discusses three different, but overlapping, powers of detention: *isolation* of known infectious persons, *quarantine* of healthy persons exposed to disease, and *civil commitment* (compulsory hospitalization) for care and treatment. All of these powers are civil measures designed to prevent risks to the public. They are not intended to punish individuals for morally culpable behavior as with criminal prosecutions. Civil remedies, therefore, are forward-looking, aiming to prevent harm and improve health, while criminal penalties are backward-looking, aiming to punish

wrongdoers. Although the terms "isolation," "quarantine," and "compulsory hospitalization" are often used interchangeably, both in public health statutes and in common parlance, there is a technical distinction among them.

> ***Quarantine*** *is the restriction of the activities of* healthy *persons who have been exposed to a case of communicable disease during its period of communicability to prevent disease transmission during the incubation period if infection should occur.(81) Deriving from the Italian* quaranta*, the period of observation originally was forty days, which was assumed to be the maximum duration of acute, as opposed to chronic, forms of disease.*
>
> ***Isolation*** *is the separation, for the period of communicability, of* known *infected persons in such places and under such conditions as to prevent or limit the transmission of the infectious agent.(82) Modern science usually can detect, through testing and physical examination, whether a person actually has an infectious condition. Accordingly, "isolation" is the appropriate term.*
>
> ***Civil commitment*** *is the detention (usually in a hospital or other specially designated institution) for the purposes of care and treatment. While civil commitment, like isolation and quarantine, is a preventive measure designed to avert risk, it is also a rehabilitative measure designed to benefit persons who are confined. Consequently, persons subject to commitment usually are offered, and sometimes required to submit to, medical treatment. Civil commitment is normally understood to mean confinement of persons with mental illness or mental retardation, but it is also used for containing persons with infectious diseases, notably tuberculosis, for treatment.*

Constitutional Review of Civil Confinement

Civil confinement is a uniquely serious form of restraint because it constitutes a "massive curtailment of liberty."(83) Under contemporary constitutional standards, the state has to demonstrate a compelling public health interest. Consequently, only persons who are truly dangerous (i.e., pose a significant risk of transmission), can be confined.*(84) For example, in *New York City v. Doe* the court required clear and convincing evidence of the person's inability to complete a course of TB medication before permitting restraint.(85) The state, moreover, must use the least-restrictive alternative necessary to achieve its objective.(86) For example, if the state could avoid deprivation of liberty by directly observe therapy, it could be required to do so. However, the state probably does not have to go to extreme, or unduly expensive, means to avoid confinement.(87) For example, the judiciary would be unlikely to require the government to provide economic services, benefits, and incentives to persuade individuals to take their medication. Nor must the state adopt less-effective measures. In the context of tuberculosis, New York City health officials aptly argued that it could not be required "to exhaust a pre-set, rigid hierarchy of alternatives that would ostensibly encourage voluntary compliance ... regardless of the potentially adverse consequences to the public health."(88)

Persons subject to detention are entitled to procedural due process. As the Supreme Court recognized, "there can be no doubt that involuntary commitment to a mental hospital, like involuntary confinement of an individual

for any reason, is a deprivation of liberty which the State cannot accomplish without due process of law."(89) In *Greene v. Edwards*, the West Virginia Supreme Court reasoned that there is little difference between loss of liberty for mental health reasons and the loss of liberty for public health rationales.(90) Persons with infectious disease, therefore, are entitled to similar procedural protections as persons with mental illness facing civil commitment. These procedural safeguards include the right to counsel, a hearing, and an appeal. Such rigorous procedural protections are justified by the fundamental invasion of liberty, the serious implications of an erroneously finding, and the value of procedures in accurately determining complex facts.

The Criminal Law: Knowing or Wilful Exposure to Infection

In 1997, public health authorities in Chautauqua County, New York, discovered that a man infected with HIV had sexual intercourse with 50–75 women over a two-year period. Authorities further discovered that he had infected 13 women, and they, in turn, infected others.(91) Similar cases have been documented in other states.(92) Countless additional detected and undetected cases of knowing or wilful exposure to infectious disease likely exist. Research suggests that a substantial minority of persons infected with HIV engage in unprotected sex or needle sharing without disclosing the risk to their partners.(93)

There is a powerful appeal in using the criminal law in response to the problem of wilful or knowing exposure. The criminal law deters risk behavior and sets a clear standard for behaviors that society will not tolerate. The Presidential Commission on the HIV Epidemic said that criminal liability is "consistent with society's obligation to prevent harm to others and the criminal law's concern with punishing those whose behavior results in harmful acts."(94) Despite its social and political appeal, the use of the criminal law against persons with infectious disease is highly complex, raising fundamental issues of fairness and effectiveness as a public health measure. There exist two main approaches to criminal prosecutions of persons with infectious diseases: traditional crimes of violence and public health offenses.

Traditional Crimes of Violence

The legal definition of a crime is an act performed in violation of duties that an individual owes to the community.(95) It includes both harmful conduct (*actus reus*) and a culpable state of mind (*mens rea*). The traditional crimes of violence that are most often used to prosecute persons with an infectious disease are attempted murder and assault.

Prosecutions for *attempted murder* have been brought for a broad range of conduct, but with mixed results. The criminal law uses a subjective standard for criminal attempts so that if the facts are as the person believes them to be, it is an offense.(96) This is important in the infectious disease context because a person could be convicted of attempted murder if his intent is to kill, regardless of whether the method used poses a significant risk of transmission. Under this theory, persons with HIV infection have been convicted of attempted murder for conduct that has exceeding low risks: biting,(97) spitting,(98) and splattering of blood.(99)

*A **simple assault** is a purposeful, knowing, or reckless causing of bodily injury.(100)*

Defendants with infectious diseases who engage in harmful behavior, such as biting(101) or throwing "body waste,"(102) have been convicted of assault instead of attempted murder.

***Aggravated assault** is when a person causes a "serious" bodily injury or uses a "deadly weapon."(103)*

Two federal courts of appeal have convicted inmates of aggravated assault, holding that teeth, under certain circumstances, can constitute a deadly weapon.(104)

Despite the spate of prosecutions for traditional crimes of violence, the mental elements of "purpose" or "knowledge" can be difficult to prove. A person acts with purpose only if he actually desires to transmit the infection. A person acts knowingly only if he is "practically certain" that his conduct will cause harm.(105) Since risks of disease transmission are highly variable, and frequently low, a person cannot realistically know that any single act will transmit the infection.

Public Health Offenses

Partly in frustration with proving intentionality or knowledge, and partly in response to political pressure, legislatures have sought other avenues to criminalize the risk of transmission. Infectious disease statutes create public health offenses that vary from state to state. A few states have broad provisions that criminally punish behavior that risks transmission of any contagious disease. Most statutes, however, create "disease-specific" offenses that were often enacted in waves in response to public misapprehensions about epidemics of the day. In the early 20th century states enacted statutes directed to TB, followed by STDs, and, in the latter part of the Century, HIV/AIDS. The federal government has enacted an HIV-specific offense relating to blood and tissue donation(106) and conditioned receipt of AIDS-related funding based on state certification that its criminal laws are adequate to prosecute persons who risk transmission of HIV.(107)

Public health offenses generally take the same form so that a person is criminally liable if he: (1) knows he is infected; (2) engages in sexual intercourse or other specified behavior (e.g., donates blood or tissue, spits or bites, or simply "exposes to bodily fluids" or "intimate contact"); and (3) fails to inform his partner of his serologic status. Thus, under a strict reading of the statutes, use of a condom would not excuse the person if he also failed to inform his partner of his status.

Evaluating the Criminal Law as a Tool of Public Health

In thinking about the value of the criminal law in the context of infectious disease, it is helpful to inquire whether prosecution would achieve any of its traditional goals: deterrence, retribution, incapacitation, and rehabilitation. The answer is not simple, but instead depends on the severity of the case

prosecuted. Most everyone would agree with prosecuting a person who truly intends to kill and who uses a means reasonably calculated to achieve that end (e.g., the father who injects his son with a contaminated needle to avoid paying child support). So too, would most people agree with prosecuting a person who, knowing he has a serious infection, exposes many people (e.g., the person in Chautauqua County who hid his HIV status from multiple sexual partners). In these cases, society legitimately holds people with infectious disease criminally accountable for the same reasons it would hold anyone accountable: the person has a culpable state of mind and poses a significant risk. In these cases, prosecution achieves several of the objectives of the criminal law: deterrence of high risk behavior, punishment of morally blameworthy individuals, and incapacitation and rehabilitation of dangerous persons.

It is much more difficult to judge the utility of prosecutions in the majority of cases that involve minimal risks and behaviors that are common in society. After all, many prosecuted cases involve epidemiologically low risks such as biting, spitting, or donating blood; and defendants, in fact, very rarely transmit infection. The criminal justice system does not achieve its goals if the behavior deterred involves negligible risk and the effect is to incapacitate and rehabilitate a minimally dangerous person.

An important question is whether use of the criminal law discourages individuals from being tested and participating in clinical and public health programs. Criminal sanctions may provide an incentive not to be tested because, legally, it is better not to discover one's serologic status. (A person may not be prosecuted for "knowing" transmission if he has not been tested). Similarly, if having sex while infected is a crime, individuals may be less likely to discuss their symptoms and behavior with health care professionals or to seek treatment. The criminal law, therefore, may break down the trust that is vital to the success of clinical and public health programs.

In summary, public health authorities possess a broad range of powers to compel individuals to conform with health and safety standards. These powers include case finding (testing, screening, reporting, and partner notification), medical interventions (immunization and treatment), civil confinement (isolation, quarantine, and civil commitment), and the criminal law (traditional crimes of violence and public health offenses). In each of these cases, authorities strive to prevent injury and disease and promote the public's health. In doing so, however, there exists a cost to personal autonomy, privacy, and liberty. Next, we discuss another set of legal interventions designed to control commercial activities.

Chapter 6: Regulation of Commercial Activities

Commercial regulation creates a tension between individual and collective interests. In a well-regulated society, public health authorities set clear, enforceable rules to protect the health and safety of workers, consumers, and the population at large. Yet, regulation, by its very nature, impedes economic freedoms and business interests. It is not surprising, therefore, that public health regulation of commercial activity, like the regulation of personal behavior, is highly contested terrain.

Industry and commerce are widely, and legitimately, thought to be essential to social progress and economic prosperity. Business and trade create greater productivity, more employment, and higher living standards. These benefits are highly relevant to healthy populations because of the positive correlation between health and socioeconomic status. Yet, public health advocates are opposed to unfettered private enterprise and suspicious of free market solutions to social problems. They are concerned more with the manifest harms to the community resulting from an industrial economy and resulting urbanization (e.g., pollution, contaminated foods or beverages, impure drugs or cosmetics, unsafe or unsanitary buildings, and unqualified professionals or tradespeople). Public health authorities possess a number of tools to regulate commercial activities: licensing trades, professions, and institutions; inspecting for violations of health and safety standards; and abating public nuisances.

Licenses and Permits

One important way that government monitors and controls the affairs of persons, businesses, and institutions is to require licenses for the pursuit of an activity. A license literally is formal permission from government to perform certain activities. Licenses are required only if the conduct involved is first prohibited; in the absence of a prohibition, governmental permission obviously is unnecessary. A license, therefore, is an administrative act whereby government sanctions conduct that would otherwise by unlawful. Consequently, legislative language is phrased in terms of a prohibition and then a permission: "No person shall engage in the [specified] activities unless she has obtained a license from the [a specified agency]."(108) Licenses are administered principally by state or local public health agencies or a body authorized by the legislature or agency. Licensing authorities may be the health department, a board of regents, a special licensing agency, or a professional or occupational board.

Licenses are part of an active regulatory system that involves setting standards for entering a field or engaging in an activity. First, agencies license a broad range of *professions, trades, and occupations*. They license and credential health care professionals (e.g., physicians, nurses, and pharmacists) as well as people engaging in trades or occupations that affect the public's health and

safety (e.g., barbers, plumbers, and electricians). Licensing authorities set standards relating to qualifications, experience, and safe practice of professionals and trades persons. Second, agencies license various *public health institutions* (e.g., hospitals, nursing homes, and laboratories). Here, they can set standards relating to the security and health of patients or residents. Finally, agencies license businesses (e.g., alcohol beverage retailers and food services). The agency can set standards relating to the safety of workers, purity of goods, and protection of consumers (e.g., from fraud, deception, or unreasonable risks).

A licensing system does not merely sift out the unqualified or unsafe, but also offers continuous monitoring and supervision through inspecting, monitoring, and punishing violators (e.g., withdrawal of licenses as well as civil or criminal penalties). Consequently, licensing systems regulate prospectively by limiting entry into the field and imposing operational requirements and retrospectively by punishing transgression of standards.

State and local government have the power to impose reasonable license fees. However, fees must be proportionate to the government's regulatory costs. Thus, if the license has a revenue-raising purpose (e.g., the fee is considerably higher than the administrative and policing costs), then it may be invalidated as an impermissible tax.(109)

Social and Economic Fairness

While licensing achieves important public goods in the form of consumer health, safety and fraud prevention, it can present problems of social and economic justice. Licensing, by its very nature, can be unfair because it parcels out a privilege based upon the discretion of officials. This discretionary authority can be exercised in a discriminatory fashion against disfavored groups such as racial or religious minorities and women. The problem of economic and social discrimination is compounded by the fact that members of the regulated profession may dominate, or influence, licensing authorities (e.g., medical licensing boards comprised primarily of practicing physicians) creating the appearance, or reality, of exclusionary practices. Licensing grants a certain amount of monopoly power to the profession or occupation. This can enable private actors to exclude classes of people for anti-competitive reasons.

Constitutionally Troublesome Conditions

Regulations requiring a license for the exercise of a fundamental right or freedom raise important constitutional concerns. For example, licenses may burden the free exercise of religion (e.g., religious processions), expression (e.g., adult cinemas), or assembly (e.g., bathhouses). Courts will not necessarily overturn licensing decisions that burden the exercise of constitutional rights, but they will require neutral health and safety standards as well as the absence of unbridled discretion and arbitrary decision making.(110)

Administrative Searches and Inspections

An inspection, or administrative search, is perhaps the most important and commonplace method of monitoring and enforcing health and safety standards. (It also is among the oldest state powers, being mentioned expressly in the Constitution).(111) An inspection represents a formal and careful examination of a product, business, or premises to ascertain its authenticity (e.g., possession of a valid license), quality (e.g., purity and fitness for use), or condition (e.g., safe and sanitary). Inspection laws authorize and direct public health authorities to conduct administrative searches to assure private conformance with health and safety regulations. Inspection systems operate in many different public health contexts assuring the safe construction and maintenance of buildings or residences, purity of food or drugs, sanitary condition of restaurants, safe workplace environment, and control of pesticides or toxic emissions.

Search and Seizure Under the 4th Amendment

While administrative searchers are conducted in the public interest, they invade a sphere of privacy protected explicitly in the Constitution. The 4th Amendment guarantees the "right of people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures." For most of the Nation's history public health inspections were rarely challenged and presumed to be constitutional. However, in 1967, in the companion cases of *Camara v. Municipal Court(112)* and *See v. City of Seattle*,(113) the Supreme Court held that public health inspections are governed by the 4th Amendment and are presumptively unreasonable if conducted without a warrant.(114)

Administrative search warrants, therefore, are generally required for health or safety inspections of both residential and private commercial property. However, the judiciary permits searches without a warrant in at least three circumstances. First, a *legally valid consent* justifies an administrative search and, in practice, most health and safety inspections are conducted with the permission of an authorized person (e.g., the owner or occupier of the property). Second, public health authorities may inspect a premises in an *emergency* to avert an immediate threat to health or safety. Third, under the so-called "*open-fields*" doctrine, inspectors may search a public place (e.g., an eating area of a restaurant) or test pollutants emitted into the open air.

Generally speaking, courts issue warrants in criminal investigations only on evidence of probable cause to believe that a person has committed an offense. However, courts issue warrants for health and safety inspections on grounds that are far less stringent than in criminal investigations. To obtain a warrant for an administrative search, public health agencies need only demonstrate specific evidence of an existing violation of a health and safety standard, or a reasonable plan supported by a valid public interest.

The courts have carved out a major exception to the general rule that agencies must obtain a warrant for an inspection. Courts permit reasonable inspections of pervasively regulated businesses without a warrant. In *New York v. Burger*, the Supreme Court held that an inspection without a warrant of a pervasively

regulated industry is reasonable if (1) there is a substantial public interest for the regulatory scheme; (2) the search is necessary to achieve the objective; and (3) the enabling statute gives notice to owners and limits the discretion of inspectors.(115)

The courts permit inspections without warrants for a wide range of heavily regulated (and often hazardous) businesses such as mining, firearms, alcoholic beverages, and transport. They also permit inspections without warrants for licensed businesses with substantial public health significance such as nursing homes and health care facilities. Finally, the courts allow health inspectors to conduct routine audits of data (e.g., medical or pharmacy records), which, by statute, they have a legal right to search. The judiciary permits administrative searches of pervasively regulated businesses without a warrant because of the importance of routine inspections in enforcing health and safety standards (warrants may afford owners time to conceal hazards) and the reduced expectation of privacy in highly regulated commercial activities.

Nuisance Abatement

Private and public nuisances are distinctly different doctrines. A private nuisance is an unreasonable interference with the possessor's use and enjoyment of land (e.g., flooding or contaminating adjoining land). Private nuisances principally are part of the common law and are redressed through the tort system. A public nuisance is an unreasonable interference with the community's use and enjoyment of a public place or harm to common interests in health, safety, and welfare.(116) Public nuisances need not necessarily involve interference with interests in land but all activities that harm common pool resources such as silence, clean air or water, or species diversity. Public nuisances are principally legislative and enforced by public health agencies; private citizens lack standing to bring public nuisance actions unless they suffer an interference with their enjoyment of land distinct from the general public interest.

Public nuisances are usually defined by the legislature or public health agencies. The legislative or administrative definition is often broad and virtually co-terminus with the police power; e.g., "anything which is injurious to health, or indecent or offensive to the senses, or to an obstruction to the free use of property, so as to interfere with the comfortable enjoyment of life or property."(117) Legislatures or agencies also specify particular conditions as public nuisances such as "a breeding place for flies, rodents, mosquitoes,"(118) or a place that is conducive to "high risk sexual activity."(119)

The modern courts have sustained a wide spectrum of traditional nuisance abatements, including noxious odors, diseased crops, hazardous waste, pollution, unsanitary or dangerous buildings, and fire hazards. The courts have also sustained nuisance abatements in response to public health problems of more recent origin such as unsafe health care practitioners, public meeting places that increase risks of STDs (e.g., adult entertainment), and violence by abortion protesters. For example, in several cities public health agencies have used nuisance laws to close down bathhouses in response to the HIV epidemic, believing that they create opportunities for anonymous sex.(120)

Courts possess broad equitable powers to alleviate nuisances. These powers include issuing injunctions to abate nuisances (e.g., order cleanup, repair, discontinuance of hazardous activity, or closure), damages to the injured parties, or destruction of property. If abatement is the remedy, public policy suggests that, where there is no emergency, the person should be given reasonable time and opportunity to rectify the hazardous condition. If the public health agency does have to intervene, it should avoid unnecessary property damage.

In summary, public health agencies have ample methods to regulate commercial activities including licenses, inspections, and nuisance abatements. At the same time, these regulatory techniques, if applied in an arbitrary or discriminatory manner, can be unjust and trample constitutional protection of liberty and property interests as the following discussion suggests.

Economic Liberty and the Pursuit of Public Health

The regulatory techniques used by public health authorities (e.g., licensing, inspection, and nuisance abatement), while protecting the public's health and safety, undoubtedly interfere with economic liberties. The Framers clearly intended to protect economic liberties as evidenced by several constitutional provisions. Notably, the Constitution forbids the state from depriving persons of property (or life or liberty) without due process of law (economic due process),(121) impairing the obligations of contracts (freedom of contract),(122) and taking private property for public use without just compensation ("takings").(123)

Economic Due Process

Conservative scholars argue that economic liberties are important in the constitutional design and observe that the Supreme Court has, at times, strongly protected commercial relationships. However, on more careful reflection, the Court has more often seen public health regulation as a sufficient justification for government infringement of economic freedom. During the early 20th century (the so-called Lochner era, named after a famous Supreme Court case),(124) the Court most prized economic freedoms and aggressively invalidated numerous attempts at social and economic regulation. Certainly, the Court struck down a great deal of legislation designed to protect the public's health such as minimum wages, consumer protection and licensing. Nevertheless, as evidenced by its seminal decision in *Jacobson v. Massachusetts*,(125) the Court conceded, at least nominally, that the state could exercise its police power even if it interfered with liberty. Since Roosevelt's New Deal, the Court has granted police power regulation a strong presumption of validity even if it interferes with economic and commercial life.

Freedom of Contract

While some scholars espouse a belief in free economic relationships, the contracts clause has become a relatively unimportant limitation on public health powers. The clause applies only to the states; challenges to federal restrictions on contractual freedom must be brought under the due process clause. Moreover, the clause applies only to existing contracts; states are free to limit the terms of future contracts.(126) While most public health regulation affects

future economic relationships, it sometimes can affect existing contracts. The Supreme Court, however, has emphasized that the police power "is an exercise of the sovereign right of government to protect the lives, health, morals, comfort, and general welfare of the people, and is paramount to any rights under contracts between individuals."(127)

Regulatory "Takings"

The federal government and the states have the power of eminent domain, which is the authority to confiscate private property for a governmental activity. However, the Fifth Amendment imposes a significant constraint on this power by requiring "just compensation" for private property taken for a public use. The theory behind the takings clause is that individuals should not have to bear public burdens that should be borne by the community as a whole. Consequently, the takings clause is about government spreading loss when pursuing the public interest.

Despite its just purposes, an expansive interpretation of the takings clause would shackle public health agencies by requiring them to provide compensation whenever regulation significantly reduced the value of private property. Since public health regulation, by definition, restricts commercial uses of property, it has become a focal point for a sustained conservative critique of social action itself.

Government confiscation or physical occupation of property is a "possessory" taking that certainly requires compensation. The Supreme Court, however, has held that government *regulation* that "reaches a certain magnitude" also is a taking requiring compensation(128). This idea of "regulatory" takings is problematic for public health agencies because when they strictly regulate land use they cannot be certain whether they will be compelled to compensate property owners. The Supreme Court has been bitterly divided about have far to extend the regulatory takings doctrine. However, lower courts have used the "property rights" tenor of the Supreme Court's opinions to strike down important public health regulation, particularly in the environmental area.(129)

Takings litigation can penetrate deeply into core public health concerns. Consider the decision of the First Circuit Court of Appeals holding that Philip Morris was likely to succeed in its claim that a state law requiring manufacturers to disclose the ingredients in cigarettes was a regulatory taking.(130)

Conclusion: The Comparative Value of Personal and Economic Liberty

Government regulation for the public's health, as we have seen throughout this *Resource Guide*, inevitably interferes with personal or economic liberties. The Court usually grants the legislature deference in the exercise of police powers. A permissive approach to government regulation is justified, in part, by democratic values; citizens elect representatives to enable them to make complex policy choices. A legislative choice to prefer collective health and well-being over individual interests deserves respect and insulation from aggressive judicial scrutiny. This is broadly the judicial approach to public health regulation

affecting personal autonomy. Certainly, public health regulation that intrudes on fundamental rights and interests such as total deprivation of liberty deserves more stringent judicial review. Government may not, without good reason, invade on deeply valued personal interests in liberty, free expression, and privacy.

The normative issue is whether there is something in the nature of economic liberty that warrants a departure from the normal deference to public health regulation. Put another way, how important is unbridled freedom in property uses, financial relationships, and the pursuit of occupations? The diminution of economic liberties is no more important than the many deprivations of personal autonomy that routinely occur with public health regulation (e.g., vaccination, reporting, and contact tracing). Courts generally understand that some loss of individual freedom is necessary for the common welfare.

The same logic ought to apply to economic regulation for the common welfare. The reason for the governmental intervention is to prevent owners from using their private property in ways that are harmful to the public interest. Thus, the state's aim is not to deny economic opportunity per se, but only to foreclose commercial activities that are detrimental to public health and safety. The creation of private wealth, moreover, cannot be regarded as a fundamental interest akin to total loss of personal liberty or economic freedom, for private wealth creation it is not essential to the achievement of a healthy and fulfilling life. Rarely does economic regulation affect an individual's basic ability to obtain the necessities of life such as food, shelter, and medical care. It appears reasonable for a legislature to make a social choice that favors immediate health and safety benefits over future wealth creation. A community cannot benefit from increased prosperity if it experiences excess morbidity and mortality from hazardous commercial activity.

Government, to be sure, ought not carelessly or gratuitously interfere with either economic or personal freedoms. But if government has a reason, based on averting a significant risk to the public's health, and the intervention is likely to achieve its purpose, then the decisions of public health authorities deserve respect in a democratic society.

Chapter 7: Guidelines for Public Health Law Reform*

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

Create Modern, Consistent, and Uniform Public Health Laws

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

Problem of Antiquity

The most striking characteristic of state public health law, and the one that underlies many of its defects, is its overall antiquity. Certainly, some statutes are relatively recent in origin, such as those relating to health threats that became salient in the latter part of the 20th century (e.g., such as environmental law). However, a great deal of public health law was framed in the late 19th and early-to-mid 20th centuries and contains elements that are forty to one hundred years old such as infectious disease law. Certainly, old laws are not necessarily bad laws. A well-written statute may remain useful, effective, and constitutional for many decades.

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* This chapter is based on previously published work: Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *Improving State Law to Prevent and Treat Infectious Disease* (Milbank Memorial Fund 1998); Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States, 99 Colum. L. Rev. 59* (1999).

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

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

Problem of Multiple Layers of Law

Related to the problem of antiquity is the problem of multiple layers of law. The law in most states consists of successive layers of statutes and amendments, built up in some cases over one hundred years or more in response to existing or perceived health threats. This is particularly troublesome in the area of infectious diseases, which forms a substantial part of state health codes. Because communicable disease laws have been passed piecemeal, in response to specific epidemics, they tell the history of disease control in the United States (e.g., smallpox, yellow fever, cholera, tuberculosis, venereal diseases, polio, and AIDS). Through a process of accretion, the majority of states have come to have several classes of communicable disease law, each with different powers and protections of individual rights: those aimed at traditional STDs (or venereal diseases), including gonorrhea, syphilis, chlamydia, and herpes; those targeted at specific currently or historically pressing diseases, such as tuberculosis and HIV; and those applicable to "communicable" or "contagious" diseases, a residual class of conditions ranging from measles to malaria, whose control does not usually seem to raise problematic political or social issues. There are, of course, legitimate reasons to treat some diseases separately. Nevertheless, affording health officials substantially different powers, under different criteria and procedures, for different diseases is more an accident of history than a rational approach to prevention and control.

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

Problem of Inconsistency Among the States and Territories

Public health laws remain fragmented not only within states but among them. Health codes within the fifty states and four territories have evolved independently, leading to profound variation in the structure, substance, and procedures for detecting, controlling, and preventing injury and disease. In fact, statutes and regulations among American jurisdictions vary so significantly in definitions, methods, age, and scope that they defy orderly categorization. Ordinarily a different approach among the states is not a problem and is often perceived as a virtue; an important value of federalism is that states can become laboratories for innovative solutions to challenging health problems. Nevertheless, there may be good reason for greater uniformity among the states in matters of public health. Health threats are rarely confined to single jurisdictions, but instead pose risks within whole regions or the nation itself. For example, geographic boundaries are largely irrelevant to issues of air or water pollution, disposal of toxic waste, or the spread of infectious diseases.

Public health law, therefore, should be reformed so that it conforms with modern scientific and legal standards, is more consistent within and among states, and is more uniform in its approach to different health threats. Rather than making artificial distinctions among diseases, public health interventions should be based primarily on the degree of risk, the cost and efficacy of the response, and the burdens on human rights. A single set of standards and procedures would add needed clarity and coherence to legal regulation, and would reduce the opportunity for politically motivated disputes about how to classify newly emergent health threats.

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

State public health statutes should define a cogent mission for the health department and identify a full set of essential public health functions that it should, or must, perform. Broad, and well-considered, mission statements in state public health statutes are important because they establish the purposes or goals of public health agencies.(131) By doing so, they inform and influence the activities of government and, perhaps ultimately, the expectations of society about the scope of public health. Mission statements also demonstrate a legislative commitment to public health. They provide a measure of the kinds of activities that are politically sanctioned. When it is acting under a broad mission statement, a public health agency can better justify its decisions to legislators, the governor, and the public. Further, legislative language that explains that public health agencies exist to assure the conditions for population health can provide a mandate for the health department to take the lead within the executive branch in devising strategies for reducing injury and disease. Courts often pay deference to statements of legislative intent and may permit a broad range of activities consistent with mission statements. Thus, even if the aspirational qualities of mission statements do not produce the desired results, they can help support agency action in courts of law.

Public health statutes that hold agencies responsible for providing essential public health functions support good practice for many of the same reasons. By creating agency duties, the legislature can ensure that the full range of

public health services will be available to the population in a given geopolitical area. Researchers, and the agency itself, can also use these essential functions as a way to monitor and evaluate agency performance.(132)

Provide a Full Range of Public Health Powers

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

Public health authorities need a more *flexible* set of tools, ranging from incentives and minimally coercive interventions to highly restrictive measures. Reformed public health statutes should expressly grant agencies the authority to employ a broad variety of measures to encourage and, if necessary assure, safer behaviors: traditional prevention strategies (e.g., counseling, education, and health communication campaigns); incentives for behavior change (e.g., tax breaks, cash allowances, food, transportation, or child care); means for behavior change (e.g., condoms or sterile drug injection equipment); mandatory attendance for counseling, education, testing, or treatment; directly observed therapy; out-patient care or treatment in a clinic for STDs, TB, or drug dependency. These less restrictive powers would enable public health authorities to encourage, supervise and/or control persons who pose a significant health risk without full deprivation of liberty.

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

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

Statutes that fail to provide clear criteria hamper public health work in a variety of ways. Paradoxically, a lack of statutory guidance may lead public health officials either to over-use or to under-use coercive powers. Without clear criteria, public health officials may restrict an individual's liberty without valid public health grounds or may be so unsure of their authority to act that they do

not use these measures to respond to actual threats. Broad discretion and the absence of criteria also invite abuse of compulsory powers, their discriminatory use against stigmatized or marginalized groups, or create the perception of such abuse against the vulnerable even when health officials have no malevolent intentions.

Effective and constitutionally sound public health statutes should set out a rational and reliable way to assess risk to ensure the health measure is necessary for public protection. Chapter Three of the *Resource Guide* proposes criteria to govern the regulation of public health threats. Most importantly, public health authorities should be empowered to employ a compulsory intervention only to avert a significant risk based on objective and reliable scientific evidence and made on an individualized (case by case) basis.

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

Impose Procedural Limits on Powers: Procedural Due Process

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

Provide Strong Protection Against Discrimination

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

A great deal of protection against discrimination is already found in disability discrimination law and, to a lesser extent, in disease-specific statutes. Public health statutes should have non-discrimination provisions that are as strong as those in disability discrimination law. At the very least, public health statutes should not have provisions that are inconsistent with, or undercut, the safeguards afforded in disability discrimination and disease-specific statutes. There exist strong reasons, moreover, for public health statutes to have anti-discrimination provisions that are even stronger than those found in many disability laws. The federal courts have narrowed the scope of the Americans with Disabilities Act; state anti-discrimination protection, therefore, takes on renewed importance.

Provide Strong Protection for Privacy and Security of Public Health Information

Privacy and security of public health data are highly important both from the perspective of the individual and the public at large. Individuals seek protection of privacy so that they can control intimate health information. They have an interest in avoiding the embarrassment and stigma of unauthorized disclosures to family or friends. They similarly have an interest in avoiding discrimination that could result from unauthorized disclosures to employers, insurers, or landlords. At the same time, privacy and security protection can advance the public's health. Privacy assurances can facilitate individual participation in public health programs and promote trust between health authorities and the community. Public health laws, therefore, should have strong safeguards of privacy to protect these individual and societal interests.

Public health legislation, however, should not grant individuals absolute privacy. Authorities need reasonable access to data and the power to use those data for important public health purposes such as surveillance and response to health threats. If privacy rules become overly strict, legislatures risk impeding important public health functions and harming the public interest.

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

State legislatures should enact the following standards for collection, use, storage, and disclosure of personally identifiable information: require agencies to justify collection of data for an important public health purpose; provide information for persons and populations about the legitimate uses of personal information; proscribe secret data systems; assure access by individuals to their personal records; mandate the technology necessary to secure health data; and institute an independent review of privacy and security arrangements within health agencies.(133)

The Process of Law Reform as a Public Health Activity

The methods and goals of public health are often misunderstood and undervalued within government and society.(134) Health departments receive modest funding, particularly in comparison to resources allocated to medical services. The fact that public health often polices the commons and champions population-based risk reduction through behavior change (e.g., smoking cessation, designated drivers, exercise and diet modification) deprives it of specific beneficiaries who are motivated to form political constituencies. The prevalence of an individualistic, market ideology in political circles makes it difficult even to speak of public health in the vocabulary of contemporary politics.(135) Public health needs opportunities to draw attention to its resource requirements and achievements, and to develop constituencies for programs.

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

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

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

The Future of Public Health Law

This *Resource Guide* and, in a more systematic way, the book, *American Public Health Law* (University of California Press, 2000), seek to provide a fuller understanding of the varied roles of law in advancing the public's health. The field of public health is purposive and interventionist. It does not settle for existing conditions of health, but actively seeks effective techniques for identifying and reducing health threats. Law is a very important, but perennially neglected, tool in furthering the public's health. Public health law should not be seen as an arcane, indecipherable set of technical rules buried deep within state health codes. Rather, public health law should be seen broadly as the authority and responsibility of government to assure the conditions for the population's health. As such, public health law has transcending importance in how we think about government, politics, and policy in America.

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