Why and How States are Updating Their Public Health Laws

Susan M. Allan, Benjamin Mason Meier, Joan Miles, Gregg Underheim, and Anne C. Haddix (Moderator)

Anne C. Haddix

There are four speakers here today. Mr. Benjamin Meier, from the Center for Health Policy at Columbia University, will talk about the Alaska public health law reform pursuant to the Turning Point Model State Public Health Act. He will discuss turning national collaboration into state legislation. Our second speaker, Joan Miles, directs the Montana Department of Health and Human Services and will talk about Montana's public health statute modernization and putting the pieces together. The third speaker, Dr. Susan Allan, director of the Oregon state health department, will talk about the differences between updating public health laws in Virginia and Oregon. Gregg Underheim is a member of the Wisconsin legislature and will discuss shepherding public health bills through state legislatures.

Benjamin Mason Meier

This presentation will assess how the *Turning Point Model State Public Health Act (TPA)* is currently being used by state policy makers in public health legislative reforms. Both, the Center for Law & the Public's Health at Georgetown and Johns Hopkins Universities and the Center for Health Policy at Columbia University have invested years in researching public health law modernization, and it is a pleasure to represent both these centers in speaking to you on this topic. The TPA, published in September 2003, provides a comprehensive template for states interested in public health law reform and modernization. Our current Alaska study is the first in a series of case studies designed to examine the political and policy efforts undertaken by states following the development of the TPA. Through this project, we are comparing four states that have considered reforming their public health authority pursuant to the TPA and, by analyzing this comparative case study, we are investigating how the TPA is codified into state law and how these modernized state laws can change public health practice. Conclusions based on this analysis are intended to provide the public health practice community with information to facilitate successful modernization of public health statutes across the country and inform scholarship on public health infrastructure.

Examining the events that took place in Alaska following publication of the TPA, statutory attempts to reform Alaskan public health law were made in two consecutive legislative sessions, with only the latter leading to statutory reform. The first of these efforts, HB369/SB304 – *An Act Related to Public Health*, came in the form of minority-sponsored bills reproducing the entire TPA, neither of which received a committee hearing, allegedly due to the incumbent administration's concern that an bill that was unlikely to pass for partisan reasons bill could stymie support for future public health modernization efforts.

This subsequent effort, a "Governor's Bill" sponsored by the administration, was later introduced by the Governor as HB95/SB75 – *An Act Relating to the Duties of the DHSS*. This bill incorporated (or created functionally equivalent provisions of) many of the major facets of the TPA, deviating from the TPA where it was felt to be either (a) inapplicable to the public health needs of Alaska or (b) unpassable given apparently resistance in the legislature.

Even among those sections of the TPA reflected in the Governor's Bill, the drafters often pared down the language of the TPA, finding that the length of the Act's language would pose political problems in achieving legislative consensus. Particularly in TPA Sections 5 and 7 (as noted in the examples in the adjacent table),

Table
Governor's Bill vs. Turning Point Act

Subject	HB 95/SB 75 Governor's bill	Turning Point Act
Mandatory Testing or Examination	§18.15.375 Epidemiological investigation (c)(2) pursuant to an epidemiological investigation, the department may "require testing, examination or screening of a non consenting individual only upon a finding that the individual has or may have been exposed to contagious disease that poses significant risk to the public health."	§5-106[c] "Mandatory Testing and Examination" The state or local public health agency may require testing or medical examination of any individual who has or may have been exposed to a contagious disease that poses a significant risk or danger to others or the public's health.
Medical Treatment	§18.15.380 "Medical Treatment" A health care practitioner or a public health agent who examines or treats an individual who has or may have been exposed to a contagious disease shall instruct the individual about the measures for preventing transmission of the disease and the need for treatment."	§5-107 Compulsory Medical treatments. Any health care provider or public health agent who examines or treats an individual who has a contagious disease shall instruct the individual about: (1) Measures for preventing re-infection and spread of the disease; and (2) The need for treatment until the individual is no longer infected.
Information Security	§18.15.365 Confidential Security Safeguards. The department shall " acquire, use disclose and store identifiable health information in a confidential manner that safeguards the security of the information and maintain the information in a physically and technologically secure environment."	§7-104 Security safeguards. State and local public health agencies have a duty to acquire, use, disclose, and store identifiable health information in a confidential manner that safeguards the security of the information.

the drafters made use of summary language, viewing that approach as less likely to provoke legislative amendments.

The bill ultimately passed unanimously in both houses on May 8, 2005 and was signed into law on June 23, 2005. Despite changes to provisions regarding (1) definitions of public health, (2) an individual's right to redress, and (3) penalties for unlawful quarantine, *An Act Relating to the Duties of the DHSS* was enacted largely as the Governor's Bill was first introduced.

In analyzing the divergent underlying conditions that caused these different policymaking results and generalizing beyond the present case study, this second Alaskan effort was predisposed to success on the basis of (1) the Turning Point experience, (2) the politicization of public health, and (3) the top-down policy effort. First, many actors noted that the TPA was "a good place to start" in reforming state public health laws, acquainting them with statutory language and the means to effect change through law, giving legitimacy to Alaskan actors' drafting of state law, and providing carefully considered and tested language of the nation's best practices for public health. Second, in considering the political contentiousness of public health law reform, political resistance to the scope of the state's public health authority was overcome in part due to support stimulated by the SARS outbreak and concerns with bioterrorism. Also important was the Governor's support for the 2005 legislation.

In sum, enactment of the 2005 legislation was the culmination of over a decade's efforts by Alaskan public health actors, who - working with academics, the Robert Wood Johnson Foundation, and other states - changed opinions on the need to reform Alaska's public health statutes and translated the Turning Point Act into modernized state law.

Joan Miles

Montana has a decentralized public health system. There are 56 counties. Many public health laws in Montana have not changed since the 1930s and 1940s. Some of the laws are still archaic and language such as, "...local boards shall guard against the introduction of communicable diseases," still permeate Montana laws. There is a need to modernize public health statutes because public health threats and practices have changed. We do not practice public health or medicine with outdated science; therefore, we should not practice with antiquated legal authorities. Modernization will provide unambiguous authorities and responsibilities and delineate between state and local entities as well as support modern disease control measures that address contemporary health problems and threats.

The current status of public health in Montana is encouraging. There have been no cases of measles since 1990; there were 8,500 cases in 1962. There have been no cases of congenital rubella since 1990. There were 220 cases of tuberculosis (TB) in 1960 but only 15 in 2004. Infant mortality rates decreased from 21.5 per 1,000 live births in 1970 to 5.8 per 1,000 live births in 2000. Youth smoking rates have been declining since 1999.

A coalition was formed in order to determine the areas of law that needed to be updated in Montana. This group included medical, legal, public health professionals, legislators, and others. The coalition used model legislation as a guide. For example, the coalition reviewed *the Model State Emergency Health Powers Act* and *the Turning Point Model State Public Health Act*. The group also consulted with experts from the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities.

The Montana coalition determined that the key areas for modernization included:

- Development of a mission statement for the public health system
- Major public health powers of state and local agencies
- Defined standards for conditions of public health importance
- Procedural due process protections, and
- Planning and preparation for public health emergencies.

There were significant differences between the existing, old public health laws and the model laws. For example, with respect to legal issues in public health emergencies, the old law did not provide powers to obtain facilities and supplies during an emergency or natural disaster. It is hoped that in the new standard the state and local public health agencies may acquire and use materials and facilities; control and close roads and public health areas; and, enforce measures to dispose of infectious waste, human remains, or other threats to health. The next steps in Montana are to continue deliberations and refinement of the current law, reach out to county attorneys, hold sessions and conferences, and finalize proposed legislation for the next session.[1]

Susan M. Allan

This presentation will compare experiences in updating public health laws in Virginia and Oregon. Over the past five years, the Virginia legislature reviewed its laws on quarantine and isolation. Oregon has not completed this process.

The five distinguishing factors between the two states are:

Current public health laws in the two states: Virginia is a state which has traditionally had strong public health laws. It provides both broad and sweeping public health powers, and also addresses specific issues like quarantine and isolation. Conversely, Oregon's public health laws are not focused and the general public health and emergency authorities are not clear.

Political context: In Virginia, the governor's office was actively involved and very supportive in updating public health laws. Additionally, public health is a high priority topic in Virginia by virtue of proximity to Washington D.C. and the presence of many military facilities in the state. The state receives federal funding for public health activities. However, in Oregon, public health has a low visibility and does not garner the same level of federal funds for public health activities.

History of public health in the state: The Virginia public health system is one of the most centralized in the country and has a long history of visibility and authority. The staff of most of the local health departments are state employees (32 out of 35 county health departments). In contrast, in the Oregon public health system the local health departments have considerable power and relative autonomy. Until 2005, for five years, Oregon had no senior public health official with authority over all the state-level public health programs.

Experience with emergencies: The Pentagon is located in Northern Virginia. The state has experienced major emergencies. including the attack on the Pentagon and the anthrax attacks in 2001, the Beltway sniper, hurricanes, and SARS cases. Oregon has not had comparable major public health emergencies.

Oregon focuses more on emergencies related to wildfires, tsunamis, and other natural disasters.

Who is driving and managing the process: Virginia passed a major revision of quarantine and isolation laws three years ago, with significant leadership from private practice health law attorneys, who were very effective in strategically managing the process. In Oregon, while many parties participate in the review and development of proposed revision of the public health emergencies laws (including the American Civil Liberties Union, the Governor's office, county attorneys, and local health departments), the process was convened and managed by the state public health director.

Gregg Underheim

Legislators pass laws as the products of a particular process. It is critical for public health practitioners to understand this process. Here are some things to know about legislators. They like to get re-elected. They do not care about the deep details, as they need to see the big picture. They get their ideas from a wide range of people. They introduce legislation in response to the efforts of interests groups. Lastly, there are only a small number of public policy wonks among them.

In order to work effectively with legislators, public health practitioners need to:

(1) Decide what the agenda is and talk with one voice. (2) Be willing to talk to legislators in the language that legislators understand. (3) Always bring evidence with you, for example, give the legislator something to take to the drafting attorney. (4) Identify the legislator you want to champion your cause. You want to pick a committee chair, bulldog legislator, or one who is facing electoral trouble. Generally, most legislators want to do the right thing to advance the public health agenda.

References

1. *Postscript:* Montana successfully updated public health statutes during the 2007 legislative session although the proposed new language for public health emergencies was separated out in a different bill that was defeated. Therefore, Montana has updated general public health statutes but still needs to work on the specifics of emergency powers.