# Law and the Public's Health

# CONTRASTING EXPERIENCES OF STATE PUBLIC HEALTH LAW REFORM PURSUANT TO THE TURNING POINT MODEL STATE PUBLIC HEALTH ACT

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One of the great challenges in public health policy is ensuring that state and local agencies possess the legal authority necessary for health promotion and disease prevention efforts. Laws in many jurisdictions reflect dated health problems and anachronistic responses, lack functionality and coherence, and contradict modern constitutional or scientific norms. Many public and private-sector policy makers, scholars, and public health officials have long argued that state public health laws throughout the country are ripe for reform.<sup>1</sup> This call for reform was answered in the Turning Point Model State Public Health Act (Turning Point Act),<sup>2</sup> a template developed to spur state public health law modernization. In this article, we explore the lessons learned from the Turning Point Act—comparing the subsequent public health law modernization efforts of two states, South Carolina and Alaska-to inform future state reform initiatives.

# TRANSFORMING MODEL LANGUAGE INTO STATE LEGISLATION

## Alaska and South Carolina

In 2000, the Turning Point Collaborative brought together representatives from several states and other public health partners to develop model state statutory provisions for public health.<sup>3</sup> Released in September 2003, the Turning Point Act presents model legislative language for states interested in public health law reform and modernization. Since its completion, 33 states have introduced 125 bills or resolutions (and passed 44) based on the subject matter of the Turning Point Act.<sup>4</sup> This comparative case study examines the actions of Alaska and South Carolina actors prior, concurrent, and subsequent to the development of the Turning Point Act.

Following the Institute of Medicine's (IOM's) 1988 report, *The Future of Public Health*,<sup>5</sup> which criticized states for failures to modernize their public health

laws, public health actors in Alaska and South Carolina began to consider legal reforms as a needed step in public health modernization. Initial efforts were undertaken in Alaska to consider specific weaknesses in state statutory authority for public health. Motivated by the prospect of public health law reform, Alaskan state actors joined and later became the lead state for the Turning Point Collaborative. South Carolina actors chose to participate in other Turning Point Collaboratives, feeling that they already had "very strong public health laws" even if they did not reflect contemporary concepts of essential public health services. To

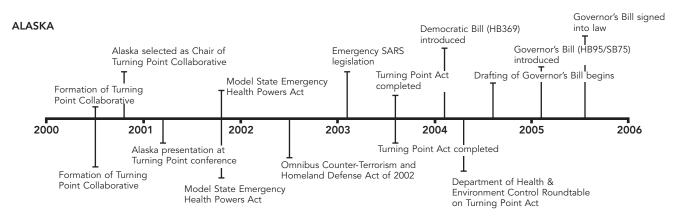
Both states considered public health law reform anew following the terrorist attacks and anthrax dispersals in the fall of 2001. In rapid response to these events, the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities engaged in a national process<sup>8</sup> to develop and prepare the Model State Emergency Health Powers Act (MSEHPA), later incorporated in Article VII of the Turning Point Act.<sup>9</sup> Officials in both South Carolina and Alaska worked immediately with state legislators to prepare legislation based on the MSEHPA, and within the year, both states' bills had received unanimous legislative support without significant amendment.

Having changed state public health emergency law in line with a national model, however, Alaska and South Carolina diverged in their consideration of the Turning Point Act. Based on our comprehensive case studies in each of these jurisdictions—involving extensive, confidential interviews and legal reviews—this article explores this divergence (Figure 1).

#### Alaska

Attempts to reform Alaskan public health law consistent with the Turning Point Act were made in two consecutive sessions of the Alaska legislature, with the latter leading to reform. In the first effort, the President of the Alaska Public Health Association took the Turning Point Act to a sympathetic minority legislator, who introduced in the House of Representatives HB369, An Act Related to Public Health, largely reproducing the entire Turning Point Act. Neither that bill nor a companion minority bill in the Senate received a committee hearing, and both expired without any action at the end of the legislative session. Because the Alaska Department of Health and Social Services (DHSS) was working to draft its own bill based on the Turning Point Act, the Department acted to assure that

Figure 1. Timeline of state public health law reform



#### **SOUTH CAROLINA**

SARS = Severe Acute Respiratory Syndrome

these bills were scuttled, believing that debate on an "unpassable" minority bill would stymie support for future modernization efforts.

In the second effort, the DHSS prepared its own bill based on the Turning Point Act during 2004, capitalizing on the Severe Acute Respiratory Syndrome (SARS) epidemic to present the legislature with an act for public health law modernization on an expedited time frame. The Division of Public Health partnered with the Alaska Attorney General's Office to prepare a gap analysis—a legal review of Alaskan public health law in comparison with the provisions of the Turning Point Act. Working with the encouragement of the Alaska Commissioner of Health and Social Services, public health actors understood that the eventual bill would go to the legislature with Administration support.

On January 21, 2005, the Governor introduced HB95 in the House and SB75 in the Senate (referred to collectively as "the Governor's Bill"). The Governor's Bill incorporated (or created functionally equivalent provisions of) many major facets of the Turning Point Act, deviating from the Turning Point Act only where it was felt to be either (1) inapplicable to the public health needs of Alaska or (2) unpassable given the legislature's resistance to certain government programs.

In hearings on the Governor's Bill, the Executive Director of the Division of Public Health drew on Alaska's experience with SARS to argue for comprehensive modernization. Providing only public health and medical expertise (lobbying is prohibited to state actors), the Executive Director encouraged advocacy groups (including the Alaska Public Health Association) to mobilize support for the bill. While there

was opposition from some legislators and advocacy groups on issues of quarantine, isolation, and surveillance, ongoing meetings helped limit the degree of opposition. The Executive Director of the Division of Public Health and the Governor's health liaison to the legislature assuaged the concerns of key committee chairs. Although two large organizations (Christian Scientists and the Alaska Civil Liberties Union) testified in opposition, early outreach efforts by the Executive Director of the Division of Public Health led these and other opposition organizations to feel that many of their concerns were addressed, even if not fully accommodated.

The Governor's Bill passed unanimously in both houses on May 8, 2005, and was signed into law on June 23, 2005. Despite changes to the 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.  $^{11}$ 

## South Carolina

Though not participating in the Turning Point Model Law Collaborative, South Carolina actors expressed interest and stayed apprised of the Turning Point Act through their affiliation with other Turning Point collaboratives. During this time, several South Carolina Department of Health and Environmental Control (DHEC) staff met with state academics and policy makers to assess how public health law reform might take shape. However, key DHEC representatives immediately questioned the need for public health law reform and the application of the Turning Point Act to South Caro-

lina. DHEC's Chief Counsel for Health Services had concluded that "it was not in the best interest of our state and our agency to push through an overhaul of the public health laws," believing that potential attempts to seek significant public health law reforms in South Carolina's conservative political environment had the potential for damage to the structure and functions of DHEC through legislative "backsliding."

Following DHEC's Chief Counsel, who noted repeatedly that "public health law [in South Carolina] was in pretty good shape," DHEC representatives deferred to her skepticism of the benefits of the Turning Point Act. Despite strong support from academics at the University of South Carolina Arnold School of Public Health and others for considering public health law reform, no substantial reform efforts were undertaken. To date, South Carolina has not engaged in any fur-

ther efforts to consider comprehensive changes to its public health laws.

# Leadership for public health law reform

In both states, the state agency—the DHSS in Alaska and the DHEC in South Carolina—was the key actor in deciding whether or not to transform public health law (Figure 2). A state's health department can be pivotal in generating the initiative and gathering the expertise to pursue public health law modernization, including recognition of the need for reform, examination of model public health laws, development of gap analyses, and drafting of proposed bills. Even legislators who support reform will be hard pressed to push state legislation without the detailed analyses and strong support of the state public health bureaucracy. Despite apparent similarities between South Carolina

Figure 2. A comparative process model for state public health law reforma

Stage I: The emer	gence and utilization of the Turning Point Act	
	Alaska	South Carolina
Dominant actors	Turning Point Collaborative Division of Public Health	<ul> <li>Division of Health and Environmental Control</li> <li>Public health academics</li> <li>Turning Point Collaborative</li> </ul>
Key forces	Agenda setting	<ul> <li>Lack of an external galvanizing force for public health law reform</li> <li>Preference for vague statutory authority</li> <li>Lack of commitment from state legal staff</li> </ul>
Result	Model for discussion of issue	Decision not to pursue modernization
Stage II: The deve	elopment of state law	
	Alaska	South Carolina
Dominant actors	Division of Public Health Office of Attorney General	NA
Key forces	Necessities of public health Political considerations	NA
Result	Law specific to state needs and circumstances	NA
Stage III: Legislati	ve action	
	Alaska	South Carolina
Dominant actors	Division of Public Health Executive branch Advocacy groups	NA
Key forces	Turning Point experience Politicization of public health Executive prerogative	NA
Result	Reformed state law	NA

<sup>&</sup>lt;sup>a</sup>Adapted from Gebbie KM. Washington State reorganization: more of the story. J Public Health Policy 1997;18:188–218. NA = not applicable

and Alaska in political climate, rural health imperatives, and state control over the public health system, public health leadership differentiated their respective abilities to enact modernization.

In South Carolina, the "underwhelming" response from the DHEC Office of the Legal Counsel blunted any subsequent attempts to develop a draft law or pursue legislative action. The Office of the Legal Counsel perceived South Carolina's public health laws as comprehensive and satisfactory, and never performed a gap analysis comparing South Carolina laws with Turning Point Act provisions. Believing South Carolina "had never been confronted with a public health issue that couldn't be dealt with [under] existing public health law," DHEC's Chief Counsel preferred to craft small tailored policy changes as threats arose. This approach has led to the sort of "disease-specific" statutory and regulatory laws that have proliferated within many states (an approach that was rejected, in part, by the Turning Point Act).<sup>1</sup>

Because of this lack of perceived need, DHEC legal officials declined to take on a project that they believed would overwhelm an office already taxed by excessive litigation responsibilities. Without the support of legal staff, other DHEC actors did not seek to intervene in matters of legal concern. Although some outside of DHEC considered enlisting support beyond the agency, it was determined that any legislation drafted without collaboration from DHEC's Office of the Legal Counsel "would be the worst possible thing."

In Alaska, statutory reform was buttressed by Alaskan officials' longstanding commitment to public health law modernization and participation in the Turning Point Collaborative. Alaska public health officials embraced the need for and process of public health law modernization and considered the applicability of the Turning Point Act to the specific public health needs and political climate of Alaska. Given Alaska's extended participation in the Turning Point Collaborative, the Administration's public health spokespeople were able to bring legislative perceptions of an abusive public health authority in line with the reality of their legislative mandate, marshaling universal support for an initially unpopular initiative to reform public health law.

As a top-down approach to public health law reform, the Governor's introduction of the bill changed the legislative calculus, giving it credibility and momentum. Framed as a Democratic bill introduced by a Republican Governor, there was little reason or opportunity for either Democratic or Republican legislators to oppose the bill. With the Republicans in the majority in both legislative houses, the Governor's Bill received pref-

erential treatment in committee. Government actors proved invaluable in shepherding the Governor's Bill through committees, with the Commissioner of Health and Social Services acting behind the scenes to assure reluctant legislators that reform was necessary and not adverse to their interests, and the Executive Director of the Division of Public Health acting in committee hearings to share his expertise as a physician and public health practitioner. In doing so, the Division of Public Health was able to work independently of the Governor's Office in moving the bill forward, allowing the Governor to sponsor a successful bill without becoming personally involved in legislative wrangling.

#### CONCLUSION

The Turning Point Act has been a catalyst for consideration of state public health law reforms. However, consideration leads to different responses depending on the underlying circumstances in each state. This comparative case study has shown that the level of public health agency leadership—including recognition of legislative need, participation in multistate initiatives, creation of formal gap analyses, and development of public health partnerships—is critical to law reform. Assuming that the mere presence of model legislation is sufficient to stimulate change is erroneous, as would be assuming that other voices are sufficient to carry the process.

Additional case studies and ongoing legislative tracking of the Turning Point Act will provide further information on how these and other factors can be used by the public health community to facilitate successful modernization of public health statutes across the country and inform scholarship on the role of policy in building enhanced public health systems through law reform.

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