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Transitions in State Public Health Law: Comparative Analysis of State Public Health Law Reform Following the Turning Point Model State Public Health Act

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Given the public health importance of law modernization, we undertook a comparative analysis of policy efforts in 4 states (Alaska, South Carolina, Wisconsin, and Nebraska) that have considered public health law reform based on the Turning Point Model State Public Health Act.

Through national legislative tracking and state case studies, we investigated how the Turning Point Act's model legal language has been considered for incorporation into state law and analyzed key facilitating and inhibiting factors for public health law reform.

Our findings provide the practice community with a research base to facilitate further law reform and inform

future scholarship on the role of law as a determinant of the public's health. (*Am J Public Health.* 2009;99:423–430. doi: 10.2105/AJPH.2008.140913)

POLICYMAKERS, SCHOLARS,

and public health officials have argued that state-based public health laws are ripe for reform.^{1,2} Despite a burgeoning research agenda on the effect of law on the public's health,^{3,4} few studies have examined the enabling statutes that create state and local public health agencies and empower them to prevent disease and promote health.^{5–7} This gap in legal analysis was recognized in 2 recent Institute of Medicine reports,^{8,9} increasing the interest of state public health

officials in modernizing the statutory basis of their practice.

Beginning in 2000, the Turning Point Public Health Statute Modernization Collaborative (Turning Point Collaborative)—part of a larger Robert Wood Johnson Foundation effort to strengthen public health infrastructures¹⁰—brought together state representatives with federal, tribal, and local public health partners and private sector actors (e.g., health professionals and institutions) to “transform and strengthen the legal framework for the public health system through a collaborative process to develop a model public health law.”¹¹ After 3 years of development, the Turning Point Collaborative released the final version of the Turning Point Model

State Public Health Act (Turning Point Act) in September 2003,¹² proposing it as a template of key public health powers for state, tribal, and local governments considering public health law modernization. The effectiveness of the Turning Point Act as a catalyst for law reform has not yet been determined.¹³

With the Turning Point Act serving as a basis for several state public health law reform efforts, we hypothesized that consideration of the act led to varied reform initiatives and responses according to distinct underlying policy conditions in each state. We believed that a comparative analysis would elucidate the approaches most likely to support modernization efforts and assist public health advocates and



officials in framing future law reforms.

METHODS

With the Turning Point Act as our frame of analysis, we conducted case studies in 4 states (Alaska, South Carolina, Wisconsin, and Nebraska) that have considered reform of state public health laws subsequent to the completion of the Turning Point Act. We assessed how state participants employed or did not employ the Turning Point Act to modernize their public health laws. Moving beyond individual state case studies, we then compared state reform efforts to analyze generalizable variables for public health law modernization, draw lessons from public health law reforms, and identify inhibitors to statutory modernization.

The comparative case study method is ideal for assessing the process of state public health law reform efforts. Such a methodology allows researchers to (1) draw conclusions through an examination of varied responses to the same model act,¹⁴ with each individual case study confirming or refuting the general hypothesis that state factors determine legislative outcomes, and (2) formulate more specific questions for future consideration.¹⁵ Given the impracticability of experimental or statistical methods, this comparative analysis provides guidance for future legislative action and hypotheses for further study.

To select representative case studies of state public health law reform efforts, we first identified states with divergent preexisting

public health laws, enacted amendments, and subsequent changes in practice. Because our analysis required a variety of underlying policy conditions and outcomes, we sought states that offered significant variable divergence among a limited number of case studies. In addition to the 5 states that led the Turning Point Collaborative,¹² we considered (guided by state legislative tracking tables developed by the Centers for Law and the Public's Health) states known to have considered the Turning Point Act as a tool for modernizing public health laws.¹⁶ Our selection of states for this study was based on a preference for differentiations in (1) the number of public health bills introduced (at least one), (2) the diversity of legislative sponsors (both parties, or both houses), (3) the range of Turning Point Act provisions introduced or adopted (many or few), (4) the successes and failures in bill passage, and (5) the breadth of geographic region, public health system configuration, and government institutional structure. Applying these criteria, complemented by consultations with individuals interested in state public health law reform, we selected to study public health law reform efforts in Alaska, South Carolina, Wisconsin, and Nebraska.

As part of each case study, we employed process tracing to examine the chain of events and decision-making processes by which underlying policy conditions determined the enactment or failure of state public health law reform.¹⁷ This method involved 3 steps: (1) identifying key actors, (2) interviewing these actors, and (3)

acquiring documentation. State case studies were based on a minimum of 10 qualitative interviews with informants from public health agencies at the state and local levels, public health advocacy groups, and state executive and legislative offices. The semistructured interviews focused on (1) the role of the informant in the statutory or regulatory reforms, (2) public health issues addressed by those reforms, (3) obstacles to state law reform and strategies used to overcome those obstacles, (4) subsequent changes in public health regulations and programs, and (5) expected changes in public health performance and outcomes. By collecting corresponding documentation—such as draft legislation, correspondence among actors, and activist materials—we were able to verify interview findings, construct a case timeline, and identify state-specific dynamics of law reform.

Based on a content analysis of interview transcripts and collected documents, we then drafted a narrative description of the law reform process for each assessed state. By examining evidence from specific points throughout the law reform process, we identified a plausible causal chain of actions that contributed to, or detracted from, the enactment of modernized public health laws, describing these findings in 4 individual case studies of state public health law reform.¹⁸

Through the comparative case study analysis, we assessed thematic results across states, examining (based on the general hypothesis) the congruity or incongruity between expected and observed processes and outcomes

in each state.¹⁹ Our analysis was framed around the 3 stages found to be critical in statutory change: emergence and utilization of the Turning Point Act, development of draft bills, and regulatory action (Table 1).²⁰ Where an underlying policy condition (or similar conditions) appeared dispositive in 2 or more cases (especially where the policy outcome varied), we identified this factor as a key variable associated with successful or unsuccessful public health law reform.

RESULTS AND DISCUSSION

The examined public health law initiatives featured successes and failures in employing the Turning Point Act to enact state law reform. Although no single causal linchpin could be identified, our comparison of reform processes among these diverse states revealed that the variables outlined in Table 1 predisposed each state's reform efforts to their respective conclusions. Through this comparative process model, it was possible to compare across states the dominant actors, key forces, and results at critical stages of statutory change.²⁰

In comparing these state results, we found the following key variables to be critical underlying policy conditions in either facilitating or inhibiting public health law reform.

Facilitators

Gap analysis. The preparation of a jurisdiction-specific gap analysis—directly comparing side-by-side the elements of the Turning Point Act with corresponding elements of state law—clarifies the



TABLE 1—Comparative Process Model Analysis of Legal, Political, and Policy Efforts for Public Health Law Reform Based on the 2003 Turning Point Model State Public Health Act: Alaska, South Carolina, Wisconsin, and Nebraska, 2003–2008

	Alaska	South Carolina	Wisconsin	Nebraska
Stage 1: Utilization of the Turning Point Act				
Dominant actors	Turning Point Collaborative; Division of Public Health	Division of Health and Environmental Control; public health academics; Turning Point Collaborative	Turning Point Collaborative; steering committee; contributing partners	Turning Point Collaborative; Department of Health and Human Services; Public Health Law Committee
Key forces	Agenda setting	Lack of an external galvanizing force or gap analysis; lack of partnerships or leadership; fear of backsliding	Agenda setting; partnership development	Agenda setting; partnership development
Result	Model developed for discussion of issue	Decision not to pursue public health law modernization	Model developed for discussion of issue; Public Health Law conference	Model developed for discussion of issue; public health system reorganization
Stage 2: Development of draft law				
Dominant actors	Division of Public Health; Office of the Attorney General	...	Strategic planning retreat participants; chair of the Assembly Committee on Public Health; Wisconsin Legislative Council	Department of Health and Human Services, Legal Division; Public Health Law Committee
Key forces	Necessities of public health modernization; gap analysis	...	Gap analysis; necessities of public health; political considerations or tradeoffs	Gap analysis; necessities of public health and bioterrorism funding; political considerations or tradeoffs
Result	Law developed pursuant to Turning Point Act but specific to state needs and political circumstances	...	Law developed pursuant to Turning Point Act but specific to state needs and political circumstances	Regulation on quarantine and isolation developed pursuant to Turning Point Act but specific to state needs and political circumstances
Stage 3: Regulatory action				
Dominant actors	Legislators; Division of Public Health; executive branch; advocacy groups	...	Legislative Committee Chairs; Joint Public Affairs Committee of WPHA and WALHDAB	Department of Health and Human Services; local health departments; Public Health Association of Nebraska
Key forces	The Turning Point experience; politicization of public health; executive prerogative	...	The Turning Point experience; politicization of public health; grassroots advocacy	Directed Health Measures Handbook; grassroots advocacy
Result	Reformed state public health law	...	Reformed state public health law	Local adoption of quarantine and isolation regulations

Note. WPHA = Wisconsin Public Health Association; WALHDAB = Wisconsin Association of Local Health Departments and Boards.

need for modernization and assists the drafting of state law based on model legislation. After

widespread attention was given to a series of public health emergencies, a legislative imperative arose

to resolve weaknesses in state public health legal authority.²¹ In this policy context, a gap analysis

may legitimate legislative weakness and want, proving critical to passage of reform legislation.



In Wisconsin, for example, the chair of the Assembly Committee on Public Health requested a gap analysis as soon as the Turning Point Act was released. To compare Wisconsin law to the model, each section of this state-specific gap analysis enumerated the language of the Turning Point Act, the then-current language of Wisconsin law, and options for amending Wisconsin law to conform with the Turning Point Act.²² For those unacquainted with the legislative authorities of Wisconsin's public health system, this gap analysis was a productive way to frame the necessity of public health law reform, focusing actors on the crucial elements of the Turning Point Act and delineating each element to be balanced against political feasibility and other countervailing factors.

By contrast, some South Carolina state actors viewed the non-emergency aspects of the Turning Point Act as merely a matter of public health "housekeeping" that streamlined statutory authorities but provided little perceived public health benefit over current law.²³ Because of this preconception, no gap analysis was conducted to compare the Turning Point Act with South Carolina public health laws. Although several academics in the state expressed support for the Turning Point Act, state public health officials—without an analysis of specific gaps in state law—believed their public health laws to be sufficiently comprehensive. As a result, there was little incentive among these actors to seek comprehensive statutory reforms for what they viewed as incremental practical gains, suggesting that as

the perceived policy distance between the status quo and model law decreases, a state is less likely to scrutinize its laws through a gap analysis.

Agenda setting. For those states that successfully reformed public health laws, the process of translating the Turning Point Act into state legislation was often achieved with advance organization and planning. These preparatory activities occurred well before any legislative effort began—in some cases, even before the completion of the Turning Point Act—through years of coordinated, calculated, and supportive agenda setting across the public health system. State public health law reform proponents were able to draw on this robust agenda setting to inspire grassroots dedication to public health law modernization, enlist support from the public health system, and ensure the prioritization of public health law reform on the policy agenda. Figure 1 presents the various states' agenda-setting timeframes, highlighting the time spent developing consensus legislation and cultivating legislative momentum.

In some cases, participation in the Turning Point Collaborative itself galvanized state actors to consider public health law modernization, whereas states that did not participate in the collaborative experienced delays in setting the agenda necessary to pursue law reform. During the Turning Point Collaborative process, Nebraska collaborative members met with a Public Health Law Committee to consider the application of model legislation to state law. It was this,

the Turning Point process, rather than the Act's model language, that inspired the organization of the state public health community and the reorganization of the state public health system in Nebraska.^{24,25} Likewise, Alaska's experience as the lead state for the Turning Point Collaborative familiarized state actors with the need for and the process of public health law modernization, strengthening the ability of public health leaders to work for change and focusing actors on the applicability of the Turning Point Act to the specific public health needs of the state.

Key partnerships. Pursuant to this three-phase timeframe for reform, partnerships developed before legislative drafting became crucial in building support for legal changes. Collaborations between state officials and public health associations in many states bolstered efforts to reorganize the public health system, to draft bills or regulations, and to embolden law modernization efforts. These partnerships developed, depending on state political dynamics, in a process that was either top-down, bottom-up, or accomplished through equal power sharing between governmental and nongovernmental actors.

In Alaska, a top-down effort led by the Division of Public Health of the state Department of Health and Social Services was instrumental to success. Earlier minority (Democratic) party bills failed in Alaska because although these bills had the support of many public health advocates, they lacked the backing of those with the political capital necessary to

advance these ideas into law.^{26,27} When proposed as a governor-supported bill, however, the drafters were able to confer outside the political process to finalize a bill for introduction. This allowed the resulting "Governor's Bill"²⁸ to avoid media and legislative scrutiny during its drafting and minimize contentiousness as it moved through legislative committees.

In Wisconsin, a bottom-up consideration and adaptation of the Turning Point Act by the local public health community improved the specificity of the resulting state legislation, framing the bill²⁹ as a genuine product of in-state, organic development rather than a model imposed by out-of-state actors. Contributing partner meetings brought nongovernmental agencies into the early decision-making processes, allowing local actors and academics from across the public health system to study the policy implications of the Turning Point Act. By giving nongovernmental actors this opportunity to resolve internal conflicts and coordinate positions before legislative action, these contributing partner meetings ensured consensus in the final bill, prevented politically damaging amendments, and developed the "grassroots effort" necessary to sway recalcitrant legislators.

In Nebraska, nongovernmental actors cooperated with governmental actors through a hybrid process that was neither top-down nor bottom-up. When the state first considered public health law reform, governmental actors turned to public health associations, getting feedback and "buy-in" from nongovernmental partners and

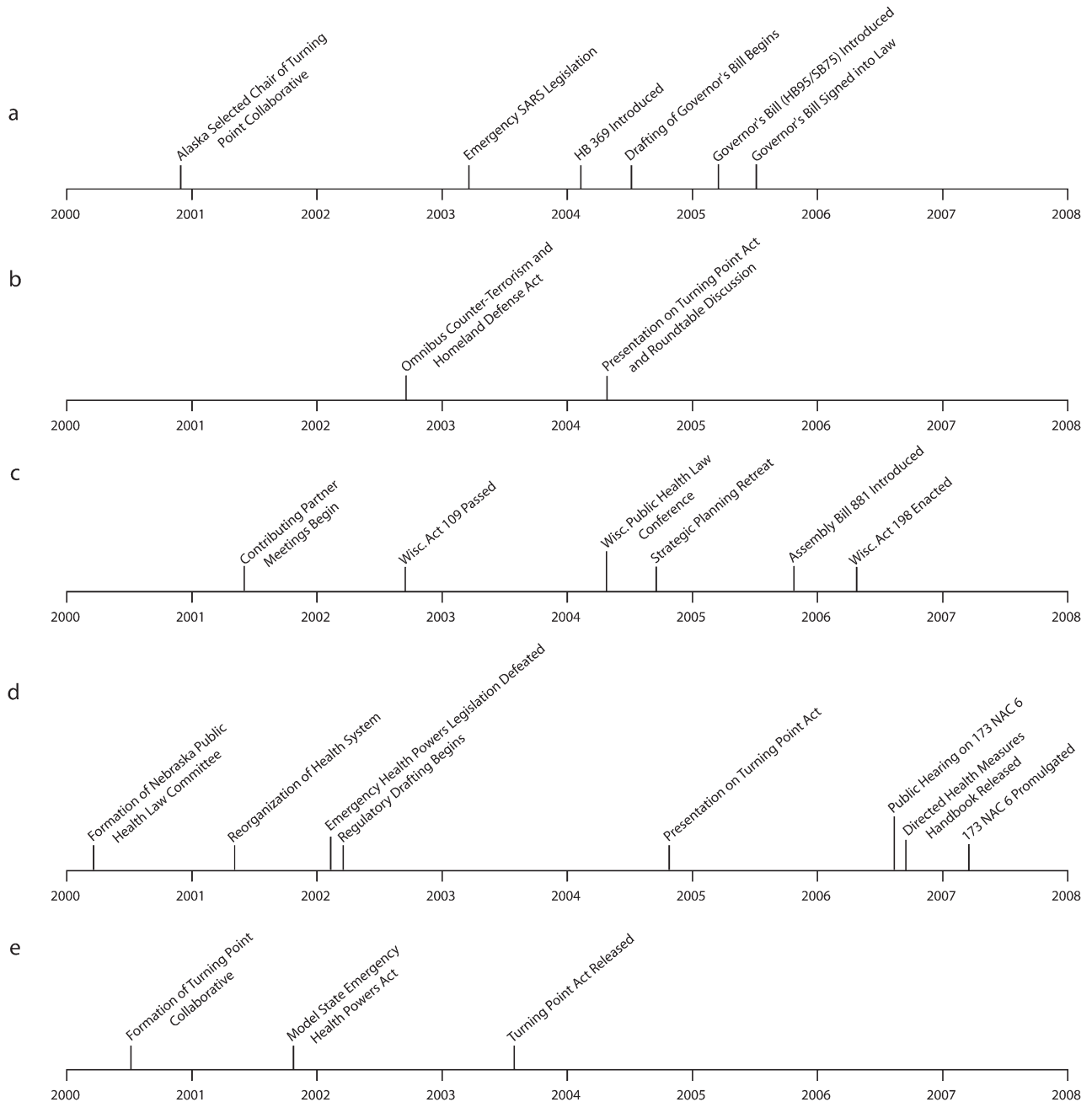


FIGURE 1—Timeline of state public health law reform efforts in: (a) Alaska, (b) South Carolina, (c) Wisconsin, (d) Nebraska, and (e) nationally: 2003–2008.

deciding collaboratively which group would spearhead the modernization initiative. With

governmental actors facing cumbersome bureaucratic approval processes to sponsor a legislative

initiative, an informal Public Health Law Committee allowed these state actors to forward to

nongovernmental partners any initiatives that could not be organized exclusively through the state



bureaucracy. In doing so, non-governmental actors were able to work with their governmental colleagues to incorporate local actors into the public health system (particularly following the reorganization of the state public health system to create local health departments²⁴), and the state health department was able to work with its nongovernmental partners to provide the detailed legal analyses necessary to support public health law reform.³⁰

Legislative champions. Among key partners, legislative champions within the executive or legislative branches were vital to shepherding public health law reform efforts through the legislative process. In Alaska, the governor (and, by extension, the governor's office) became a key proponent of public health law reform,³¹ which (1) gave the resulting bill instant credibility and momentum, (2) obviated the need for extended nongovernmental or legislative partnerships, (3) compelled committee hearings in which the bill received preferential treatment, and (4) blunted legislators' attempts to stall or block action.²⁷ Similarly, the introduction of Wisconsin's bill²⁹ by the legislative chair of the Assembly Committee on Public Health changed the legislative calculus in supporting public health modernization, with many legislators, largely ignorant of public health issues, simply deferring to the chair's expertise and judgment in health matters. The generalizability of this theme is reinforced by the experiences of South Carolina, where no champion arose among elected officials and legislative initiatives faltered, and Nebraska,

where, absent a legislative champion, public health actors opted to pursue regulatory rather than legislative reform.³⁰

Inhibitors

Unaltered model legislative language. Although no successful law reform effort simply replicated the language of the Turning Point Act, each took guidance from its structure and provisions, employing its language as a template in framing public health legislation and regulation. Where the provisions of the Turning Point Act were copied verbatim as a proposed statute, however, the resulting bills found little support in the legislature. For example, previous minority-sponsored bills in Alaska that largely reproduced the entire Turning Point Act did not gain the legislative momentum needed to advance into law.²⁶ This contrasts with the subsequent successful modernization effort in Alaska, wherein the drafters enlisted the governor's support and deviated from the Turning Point Act where it was thought to be either inapplicable to the public health needs of Alaska or not passable given political resistance to government programs. To stymie legislative and nongovernmental opposition to controversial elements of the Turning Point Act, the Alaska drafters opted for brief, general language that could withstand legislative scrutiny and then met with the Alaska Civil Liberties Union to consider discordant but influential viewpoints on the language.

Similarly, many state public health officials in Nebraska felt that the language of the Turning

Point Act was more specific than was necessary for their state. Like some South Carolina actors, Nebraska informants noted that many of their legislators preferred less specific legislation than other states, opting to delegate authority to executive agencies to specify law through administrative regulations. Further, many Nebraska actors believed that the legislature would have been resistant to national models, particularly models introduced in their entirety. Given these obstacles to comprehensive statutory reform, public health actors selected those provisions of the Turning Point Act deemed most pressing—quarantine and isolation authority—and addressed remaining gaps in state public health law through regulation rather than legislation.³⁰

Lack of impetus for public health reform. To overcome political resistance to reform, many modernization supporters mobilized a "politics of fear," exploiting specific disease threats to generate support for comprehensive changes in public health law. This mobilization around health threats was grounded in many actors' familiarity with promulgating legislation based on the 2001 Model State Emergency Health Powers Act, developed by the Centers for Law and the Public's Health in the aftermath of the terrorist attacks of September 11, 2001 and ensuing anthrax dispersals.^{32,33}

To focus legislative attention on the dangers of Alaska's antiquated public health authority, public health administrators capitalized on legislators' concerns regarding the state's inability to respond to

infectious disease outbreaks. Highlighting Alaska's limited response to the threat of SARS (severe acute respiratory syndrome),³⁴ these actors could demonstrate that the legislative status quo was not commensurate with modern public health threats, necessitating some type of law reform. Even after the global threat of SARS had passed, enduring legislative fears over emerging epidemics, compounded by a heightened threat of bioterrorism, added a security imperative to modernizing the state's public health authority.

South Carolina showed contrasting underlying policy conditions, with the state lacking any compelling public health threat or media attention to increase pressure for public health law reform. Much of the current focus of South Carolina's public health authority is framed by the state's emergency response to the HIV/AIDS epidemic³⁵ and consideration of the Model State Emergency Health Powers Act.³⁶ When the nonemergency provisions of the Turning Point Act were considered, many governmental actors expressed satisfaction with the comprehensiveness of their existing public health laws, finding any potential limits in South Carolina's legal authority to be acceptable given a preference for small, narrowly tailored policy changes as threats arise.³⁷

Fear of backsliding. In all states that considered the Turning Point Act, proposed changes in public health laws led to fears of "legislative backsliding."² Because any attempt to consider new public health laws might bring unwanted attention to existing laws, exposing



TABLE 2—Principal Actors and Decisive Forces at Each Stage of Public Health Law Reform

	Utilization of the Turning Point Act	Development of draft law	Regulatory action
Actors	Public health partners	Legal counsel	Legislative champions
Forces	Agenda setting	Gap analysis; leadership	Advocacy

the entire public health system to potentially damaging amendments, both public health proponents and opponents of modernization concerned themselves with the risk of legislative retrenchment in the state's public health authority.

These fears manifested themselves in state-specific ways. In Wisconsin, concerns over the civil liberties implications and financing of Turning Point Act provisions forced anticipatory compromises and fiscal neutrality in the bill's language; although the feared objections were never raised, actors felt that their preemptive changes averted subversive amendments to the resulting legislation. In Nebraska, regulatory changes were believed to protect the public's health sufficiently while posing comparatively less risk of backsliding in existing statutory authorities.³⁸ Finally, in South Carolina, concerns about legislative backsliding and attendant fears of reorganization of the public health system contributed to the abandonment of comprehensive public health law modernization.

Lack of legal leadership. In considering the need for and approach to public health law reform, legal experts within the state health department can be pivotal in initiating reform efforts, constructing appropriate regulatory language, and gathering expertise necessary to pursue law modernization. Often the legal office may

recognize the need for change as it interprets existing laws, crafts enforcement actions, or responds to challenges to anachronistic statutes. In Alaska, a legal determination of the inadequacy of prior law in the face of a modern SARS epidemic provided a key stimulus for reform. Further, once a legal gap is identified, legal counsel must be enlisted to scrutinize model laws, conduct gap analyses, and even draft proposed bills for introduction by supportive legislators. In South Carolina, state public health actors deferred to the health department's legal office, which, for the reasons discussed earlier, did not support comprehensive statutory changes. Although law reform could stem from active legislative delegations or enterprising public health actors—as was the case in South Carolina's experience with public health emergency legislation³⁶—public health actors will be hard-pressed to advance such reforms where the legal office opposes them.

Conclusion

As additional public health actors examine their legal authority and advocate law modernization, model legislative language will continue to be valued as a tool for statutory reform and, correspondingly, for improvements in the foundation of the public health system. Based on this comparative case study, Table 2 presents a

series of stages correlated in our analysis with successful public health law modernization.

These stages highlight common forces present in state consideration of public health law reform based on the Turning Point Act, with public health partners, legal counsel, and legislative champions serving crucial roles in agenda setting, gap analysis, leadership, and advocacy. With these actors performing complementary tasks during overlapping stages of a successful law reform process, it is necessary for modernization proponents to coordinate their efforts well in advance of any proposed legislation, working across agencies and sectors to reform law for the public's health. ■

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Contributors

B.M. Meier carried out the case study research, collaborated in the analysis, and led the writing. J.G. Hodge collaborated in the research, analysis, and writing.

K.M. Gebbie originated the study, supervised its implementation, and collaborated in the analysis and writing.

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Human Participant Protection

This study was found to be exempt from review by the Columbia University institutional review board.

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Competing Initiatives: A New Tobacco Industry Strategy to Oppose Statewide Clean Indoor Air Ballot Measures

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To describe how the tobacco and gaming industries opposed clean indoor air voter initiatives in 2006, we analyzed media records and government and other publicly available documents and conducted interviews with knowledgeable individuals. In an attempt to avoid strict “smoke free” regulations pursued by health groups via voter initiatives in Arizona, Ohio, and Nevada, in

2006, the tobacco and gaming industries sponsored competing voter initiatives for alternative laws.

Health groups succeeded in defeating the pro-tobacco competing initiatives because they were able to dispel confusion and create a head-to-head competition by associating each campaign with its respective backer and instructing voters to vote “no”

on the pro-tobacco initiative in addition to voting “yes” on the health group initiative. (*Am J Public Health.* 2009;99:430–439. doi:10.2105/AJPH.2008.138461)

CLEAN INDOOR AIR LAWS, designed to protect nonsmokers from secondhand tobacco smoke, also decrease smoking prevalence and cigarette consumption.^{1–3} In

2006, health groups passed statewide clean indoor air laws through the ballot initiative process (enacting a law by direct popular vote) in 3 states: Arizona, Ohio, and Nevada. In response to these public health efforts, the tobacco and gaming industries organized competing pro-tobacco ballot initiatives in an attempt to implement pro-tobacco laws and avoid the strict regulations proposed by health