
Transforming Public Health Law: The Turning Point Model State Public Health Act

*James G. Hodge, Jr., Lawrence O. Gostin, Kristine Gebbie, and
Deborah L. Erickson*

Protecting the public's health has recently regained prominence in political and public discussions. Threats of bioterrorism following September 11, 2001 and the deliberate dissemination of anthrax later that fall, the reemergence of novel or resurgent infectious diseases, (such as the West Nile Virus, SARS, influenza, avian flu) and rapid increases in diseases associated with sedentary lifestyles, poor diets, and smoking (e.g., heart disease, diabetes, cancer) have all raised the profile of public health. The U.S. government has responded with increased funding, reorganization, and new policies for the population's health, safety, and security. Politicians and the public more clearly understand the importance of law in improving the public's health. Recognizing that many public health laws have not been meaningfully reformed in decades, law- and policy-makers and public health practitioners have focused on the legal foundations for public health. Laws provide the mission, functions, and powers of public health agencies, set standards for their (and their partners') actions, and safeguard individual rights.

Constitutionally vested with broad powers, states have incrementally crafted over decades public health laws that authorize a broad range of public health activities or address specific public health problems. The breadth and specificity of public health laws vary significantly across states given differences in political

and legal environments. Yet when viewed collectively across the nation, state public health laws are often antiquated, fragmented, inconsistent, and incomplete. For most policy makers, the question is not whether to reform public health law, but *how* to do so. To address this inquiry, the Turning Point Public Health Statute Modernization National Collaborative, a partnership of public health practitioners and representatives from federal, tribal, state, and local agencies, and national public health organizations, developed model state public health legal provisions. The Collaborative's three-year effort culminated in the production of the Turning Point Model State Public Health Act (the "Turning Point Act").¹

The Turning Point Act is the most comprehensive model public health law ever drafted in the United States. Its provisions include constitutionally and ethically sound bases for state and local public health agency infrastructure, power, practice, and safeguards. Rather than presenting strict mandates, the Act offers a menu of provisions for state and local officials to use voluntarily to assess their existing statutory and regulatory public health laws. In this article we explain how law (principally statutory law) can be a tool for improving public health infrastructure and outcomes, and demonstrate existing needs for public health reform. We then describe the provisions of the Turning Point Act, demonstrate why they are important, and

James G. Hodge, Jr., J.D., LL.M., is an Associate Professor, Johns Hopkins Bloomberg School of Public Health; Adjunct Professor of Law, Georgetown University Law Center; and Executive Director, Center for Law and the Public's Health. **Lawrence O. Gostin, J.D., LL.D., (Hon.)**, is Associate Dean and Professor, Georgetown University Law Center; Professor, Johns Hopkins University; and Director, World Health Organization Collaborating Center on Public Health Law and Human Rights. Dean Gostin is Adjunct Professor and Fellow at Oxford University and a lifetime Member of the Institute of Medicine. **Kristine Gebbie, Dr.P.H., R.N.**, is Professor, Columbia University School of Nursing, and Director of the Center for Health Policy, Columbia University School of Nursing. **Deborah L. Erickson, B.S.**, is Deputy Director, Alaska Division of Public Health, and former Chair, Turning Point Public Health Statute Modernization National Collaborative.

assess how the model law can and is actively being used by public health practitioners.

Public Health Law as a Tool for Practitioners

Legal interventions and structural supports are important tools for public health practitioners even when education, intervention, and popular opinion combine to effectively change or influence individual behaviors in ways that are conducive to the public's health. Law is a critical component to each of the three key elements of the national public health infrastructure: (1) health data and other factual information; (2) a competent workforce; and (3) systems and relationships.² Data about the health status of individuals, threats to communal health, and available resources are used to identify outbreaks, evaluate improvements or diminutions in health status, and assess the impact of program changes. Laws support and protect data acquisitions, uses, and disclosures, and authorize fact-based activities.³ A competent workforce is also essential to accomplishing virtually any public health objective. Practitioners need the authority to gather, analyze, produce, disseminate, and act upon public health information. Legal competency is essential to establishing professional capacities and criteria for workforce competency.⁴

Unlike the other two elements, application of law to systems and relationships seems fuzzy. The informal systems and relationships that develop within a public health agency and across communities are vague to practitioners who may be used to analyzing and applying statistical information. However, systems and relationships within public health infrastructures are amenable to legal analysis. Inter-agency and mutual aid agreements between state, local, and tribal governments form the framework supporting public health programs, and further allow communities to adequately respond to emergencies.⁵ Laws underlie the organization of a public health agency (or a community public health system) and help identify key relationships, data flows, and performance expectations.⁶ Though informally supplemented, formal relationships and structures (often set forth in law) may determine success or failure, especially in critical situations.⁷

Viewing public health activities as if they were all part of a quest for universal acceptance of a set of behaviors that educated citizens will follow simply because they make sense seemingly diminishes the role of law. This narrow view, however, is misguided. Legal interventions are important even when education, intervention, and popular opinion combine to change or influence individual behaviors in ways that are conducive to the

public's health. Non-legal approaches that devalue the role of laws in community policy decision-making are inherently limited, as seen nationally through recent experiences concerning tobacco control, vaccine promotion, and diet/exercise. In the first two cases, strong legal actions were necessary to achieve or at least move toward a preferred public health goal. In the latter, the

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obesity epidemic in the United States suggests that new solutions to change behaviors, products, and environments are needed, which in turn may require new laws.

Individuals use or implement the law in two principal ways: (1) they do what they are explicitly told to do, putting everything else aside; or (2) they do anything they have not explicitly been told not to do until someone stops them. Choices of actions or interventions depend on the degree of risk a health official is willing to take, community governance, and prior successes or failures. These and other factors help explain the diversity of existing state public health laws. No matter the choices, it is essential to know what the laws mean, to appreciate why they exist, and to understand historical and modern applications.

The Need for Public Health Law Reform

The law is a critical tool for developing public health infrastructure, building relationships, and authorizing practice, but the existing framework for public health laws is insufficient.⁸ While federal law-making authority is an important component in public health, it is constitutionally limited in scope, and thus incapable of completely preempting most fields. Unlike the federal government, states (as well as local and tribal governments) can widely legislate to protect the public's health through the exercise of their expansive police powers.⁹ State public health laws can create a mission for public health authorities, assign their functions, and specify their execution.¹⁰ Still, problems of obsolescence, inconsistency, and inadequacy may render older state laws ineffective or counterproductive.¹¹

The need for public health statutory reform was highlighted by the Institute of Medicine (IOM) in its 1988 report on the future of public health.¹² Finding that state public health laws are in many cases badly

outdated, the IOM recommended that states review and revise their public health statutes to (1) clearly delineate basic authority and responsibility of public health authorities, and (2) support modern disease control measures for contemporary health problems. In response, some states have updated and revised their public health laws. Texas, North Dakota, West Virginia, New Jersey, Michigan, and others have passed public health reorganization acts since 1990.¹³ Washington used its general health reform law in 1993 to develop its Public Health Improvement Plan that set minimum performance standards.¹⁴ Executive agencies in other states (such as Connecticut¹⁵ and Illinois¹⁶) also drafted comprehensive state public health plans. In 2003, however, the IOM continued to note that “public health law at the federal, state and local levels is often outdated and internally inconsistent.”¹⁷ It recommended further action, including the development of the Turning Point Act, to stimulate state public health law reform.

Public health laws may need to be reformed for many reasons. Built in layers over the last century in response to new diseases or other threats,¹⁸ state public health laws often reflect outdated scientific understandings of disease, public health interventions, or legal norms for protection of individual rights. Legal expressions of public health powers differ widely across various disease threats, sometimes authorizing dissimilar responses to very similar conditions. A South Dakota statute passed in the late 1800s, last amended in 1977, forbids anyone infected with a “contagious disease” to “intentionally [expose] himself...in any public place or thoroughfare.” As defined, “contagious disease” may include highly contagious, airborne conditions, like tuberculosis, and blood-borne diseases, like HIV.¹⁹ New Jersey statutes separately address communicable diseases, venereal diseases, typhoid, tuberculosis, and “communicable diseases [introduced] by vessels.”²⁰ These and other statutes do not reflect modern strategies for controlling the spread of different contagious conditions.

Many public health laws pre-date modern developments in constitutional (e.g., equal protection and due process) and statutory (e.g., disability discrimination) laws. As drafted, these statutes may allow unfettered use of public health powers without due process protections, fail to respect individual freedoms, or prescribe unfair measures. In Montana, for instance, no due process procedures accompany a health officer’s statutory power to “isolate or quarantine persons who refuse examination or treatment” for sexually transmitted diseases. Examinations can be made whenever the officer deems it “advisable or desirable.”²¹ Vermont features even broader statutory authority: “The com-

missioner of health shall have the power to quarantine a person diagnosed or suspected of having a disease dangerous to the public health.”²² Laws like these are susceptible to constitutional or other legal challenges because they authorize intrusive actions under broad standards or without adequate protections. Even if unchallenged, these laws do not assimilate current public health practices, raising fundamental questions as to the legal authority to act.²³

Non-uniformity pervades state and territorial public health laws. Their independent evolution has led to profound variations in structure, substance, and procedures for detecting, controlling, and preventing disease. Differing approaches can be appropriate for legal responses to public health dilemmas that are not prevalent in every (or even most) states.²⁴ However, variations can inhibit efficient responses in cases where coordinated, collaborative efforts are critical (e.g., multi-state public health emergencies).²⁵ Fragmentation in public health laws leads to other problems. Essential public health powers may be critically lacking for a given disease or condition. Such deficiencies surfaced in state responses to SARS.²⁶ For example, Alaska public health authorities and legislators were required to move quickly to add a new law to authorize reporting and quarantine for persons with SARS after legal advisors indicated that the State lacked legal authority to quarantine exposed persons.²⁷

Some state laws are so complicated, ambiguous, and inconsistent that they confuse health practitioners and their attorneys.²⁸ Though legal variation can be a strength, many existing public health laws need substantial reform. They fail to achieve fundamental aspects of public health preparedness: mission and functions of agencies, stable sources of funding, active surveillance and data evaluation, and adequate powers over persons and property. Public health statutes should: (1) provide adequate, modern powers to deal with the full range of health threats; (2) clarify standards and fair procedures concerning coercive and other public health powers; and (3) develop a stronger public health infrastructure.

The Turning Point Model State Public Health Act

Funded by the Robert Wood Johnson Foundation, the Public Health Statute Modernization National Collaborative sought to transform and strengthen the public health legal framework. With representatives from five states (Arkansas, Colorado, Nebraska, Oregon, Wisconsin), multiple national organizations (such as APHA, ASTHO, NACCHO, NALBOH, NCSL, NGA), and government agencies (e.g., CDC, HRSA, IHB, IOM), the Collaborative developed the Turning Point

Figure 1

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Act to serve as a tool for state and local governments to assess their existing public health laws and consider potential reforms.²⁹ The Turning Point Act is the most comprehensive model state public health law introduced in the United States (see Figure 1, below, for a listing of its substantive articles and sections).

The Act's provisions reflect modern constitutional, statutory, and case-based law at the national and state levels, as well as current scientific and ethical principles of modern public health practice. States are not mandated to use the Act. Neither the Collaborative nor its partners lobby for its introduction or passage in legislative or administrative bodies. Nor are the Act's provisions intended to be adopted wholesale without refinement. Instead, the Act provides a flexible template of language and policy choices for states considering major or minor public health law reforms.

Scope

Based on IOM's conception of an intersectoral public health system, the Turning Point Act incorporates a systematic approach to the implementation of public health responsibilities and authorities. It focuses on what the Collaborative has judged to be sound principles of essential public health services and functions

based on their definition in *Public Health in America*.³⁰ Unlike most state statutory codes, the Act presents a broad mission for state and local public health agencies (and their partners)³¹ (see Figure 2).

Statutory recognition of the comprehensive functions of public health agencies supports their essential roles and responsibilities, clarifies a systems-based approach for accomplishing public health goals, and helps sustain ongoing resource commitments.

Often missing from states' public health laws are provisions to strengthen the public health infrastructure. In response, the Turning Point Act encourages state/local public health agencies and their partners to:³²

- Identify and provide leadership for the provision of essential public health services and functions;
- Develop and support an information infrastructure that supports these services and functions;
- Develop and provide certification, credentialing, or effective training for the public health workforce;
- Create performance management standards for the public health system that are tied to improve-

Figure 2:

Article II. Missions and Functions

Section 2-101. Mission Statement

A. It is the policy of this [State] that the health of the public be protected and promoted to the greatest extent possible through the public health system while respecting individual rights to dignity, health information privacy, nondiscrimination, due process, and other legally-protected interests.

B. The mission of state and local public health agencies is to provide leadership and protect and promote the public's health by:

1. Assuring the conditions in which people can be healthy;
2. Providing or assuring the provision of essential public health services and functions (as defined in § 2-102) that are culturally and linguistically appropriate for the populations being served;
3. Encouraging collaboration among public and private sector partners in the public health system; and
4. Seeking adequate funding and other sources to provide essential public health services and functions or accomplish public health goals through public or private sources.

This Act shall not be construed to require an individual or agency within the public health system to provide specific health services or to mandate state and local public health agencies to implement unfunded programs.

ments in public health outcomes or other measures;

- Consider voluntary accreditation programs for state or local public health agencies;
- Provide incentives for and evaluation of workforce development efforts, performance management, and accreditation standards; and
- Comprehensively plan and set priorities for the accomplishment of essential public health services and functions.

The Collaborative viewed relationships among public and private sector partners as key to improving public health outcomes. The Act promotes relationship building through formal agreements, use of public health districts or partnerships, authorization to privatize some services or functions, and options for enhancing communication and collaboration.³³

Substantive provisions of the Act provide modern language on traditional state and local public health powers (e.g., surveillance, testing, screening, vaccination, partner counseling and referral, isolation, quarantine, nuisance abatement, and inspections).³⁴ The Collaborative focused on these core powers because

they are among the most outdated provisions in existing state laws. The intent was to articulate existing powers within a framework that balances the protection of the public's health with respect for individual and communal rights.

These powers are not classified based on specific diseases (as commonly found in many state laws). Instead, the Act links core public health powers and duties to (1) providing essential public health services and functions,³⁵ and (2) responding to "conditions of public health importance" (defined as "a disease, syndrome, symptom, injury, or other threat to health that is identifiable on an individual or community level and can reasonably be expected to lead to adverse health effects in the community").³⁶ This non-disease-specific framework allows practitioners considerable flexibility in responding to new and emerging threats without resorting to last-minute legal updates as problems emerge. It also helps to apply public health powers more uniformly across similar conditions, avoiding more stringent or harsh measures for diseases or conditions that may be politically or societally unpopular or non-favored.

To further prevent the potential for injustices or abuses, the Act subjects the exercise of public health powers to a unique series of guiding principles that reflect modern public health practices and balance communal and individual interests (see Figure 3).³⁷

Additional provisions stress the need to seek advance voluntary compliance among individuals concerning compulsory powers, such as isolation and quarantine.³⁸ Through these provisions, the Turning Point Act equips existing and future public health practitioners (and the communities they serve) with clear statutory guidance for legally and ethically sound practices.

Additional articles of the Act address public health emergencies³⁹ and public health information privacy.⁴⁰ Provisions concerning public health emergencies mimic the Model State Emergency Health Powers Act (MSEHPA), drafted in 2001 by the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities (and supported in part by the Collaborative).⁴¹ These provisions provide for advance preparedness through planning and enhanced surveillance, specify the definition and manner of declaring public health emergencies, and list various powers and duties of public health agencies for emergency responses. Public health information privacy protections in the Turning Point Act are adapted from a 1999 model act drafted by Lawrence Gostin and James Hodge under the auspices of the CDC that established a "gold standard" for protecting identifiable public health data.⁴² Because the HIPAA Privacy Rule largely exempts public health authorities from its coverage,⁴³ the Act pro-

Figure 3:

Article V. Missions and Functions**Section 5-101. Prevention and Control of Conditions of Public Health Importance**

B. Guiding Principles. In carrying out these authorities or powers, the state or local public health agency is guided by the following principles:

1. Public health purpose. The exercise of any public health authority or power shall further or support improving or sustaining the public's health by accomplishing essential public health services and functions.
2. Scientifically-sound practices. Whenever possible, a state or local public health agency shall exercise its authorities or powers through procedures, practices, or programs that are based on modern, scientifically-sound principles and evidence.
- 3 Well-targeted intervention. A state or local public health agency shall strive to design and implement interventions that are well-targeted to accomplishing essential public health services and functions. An agency should avoid using compulsory power in a manner that is over-broad (applying to more individuals than is necessary for the public's health).
- 4 Least restrictive alternative. A state or local public health agency shall employ the least restrictive alternative in the exercise of its authorities or powers, especially compulsory powers. This means that where the agency may exercise one or more of its authorities or powers to accomplish essential public health services and functions, it shall, to the extent possible, employ the policy or practice that least infringes on the rights or interests of individuals. Employing the least restrictive alternative does not require the agency to adopt policies or programs that are less effective in protecting the public's health or safety.
5. Nondiscrimination. State and local public health agencies shall not discriminate in an unlawful manner against individuals on the basis of their race, ethnicity, nationality, religious beliefs, sex, sexual orientation, or disability status.
6. Respect for dignity. State and local public health agencies shall respect the dignity of each individual under their jurisdiction, regardless of their nationality, citizenship, or residency status.
7. Community involvement. Protecting the public's health requires ongoing public health education and outreach to encourage, facilitate, and promote community participation in accomplishing public health goals.

vides meaningful provisions that allow legitimate acquisitions, uses, and disclosures of identifiable health data by public health agencies while respecting individual privacy expectations.

Limits

Though comprehensive, the Turning Point Act has limits. It does not cover some distinct areas of law (e.g., environmental health services, mental health) despite their strong public health relevance. The Act does not include model provisions for all existing laws that impact the public's health (such as seat belt provi-

sions and tobacco control regulations) or specific program areas. It does not address legal areas traditionally found elsewhere in state statutes (e.g., disabilities protections), nor provide a model approach for financing essential services and functions (initial drafts of finance provisions were not included in the final Act due to the potential for political objections). Most importantly, while the Act includes sections on public health infrastructure, it does not attempt to design a model public health department or an ideal state/local organizational structure. The Collaborative found that significant variations in the structure and organization of state and local public health systems preclude a standardized systems approach.⁴⁴ Instead, the Turning Point Act frames provisions for improving infrastructure (as noted above) that may be useful in any type of public health system.

Legal and Regulatory Uses

Together with the Center for Law and the Public's Health, the Collaborative has monitored state public health legislative activity to assess the potential impact of the Act. Between January 2003 and June 2005, they found that thirty-two states introduced over seventy-five bills or resolutions (thirty of which have passed) on public health subjects addressed in the Act, though not all of these reform measures can be linked to the Act.⁴⁵ The Center will continue to track relevant state (and select local) public health laws through at least May, 2007 with additional support of the Robert Wood Johnson Foundation. Some states have introduced legislative bills that are directly based on the Act. An initial bill introduced in 2003 in North Carolina legislature restated large portions of the Act concerning mission, infrastructure, and relationships, but did not pass.⁴⁶ Alaska's Turning Point reform legislation, supported by the Governor and passed on June, 27, 2005, modernizes many core public health powers of the state's Department of Health and Social Services consistent with Turning Point provisions.⁴⁷ It includes new provisions relating to surveillance reporting, medical treatment, isolation, and quarantine for the prevention and management of conditions of public health importance, as well as health information privacy and public health emergencies.

In addition to legislative activity, many states (such as Arkansas, Colorado, Delaware, Kansas, Missouri, Montana, Nebraska, New Jersey, North Carolina, Oregon, Tennessee, and Wisconsin) have specifically used (or are considering using) the Act to review and potentially reform their laws.⁴⁸ Other states have opened discussions on the Act, (such as New Mexico and South Carolina) only to close them for the time. Multiple factors (e.g., politics, organization, budgets) affect the

level of use and review of the Turning Point Act among states, tribal authorities, and localities. Practitioners or policymakers may be comfortable with their existing laws, or feel that they already have modern public health statutes, and thus disfavor comprehensive reform. They may still, however, draw specific language from the Act concerning certain powers or functions and tailor it to fit their own state's needs. These and other factors affecting state public health law reforms will be the subject of several case studies in 2006-2007 through an RWJ project led by Kris Gebbie.

Many public health agencies have organized committees to conduct comprehensive reviews of their state public health laws. Some jurisdictions have not assessed their public health law for decades, if ever. Committee representation may include public health agencies, legislative members, offices of Attorneys General, other state agencies (e.g., environmental protection, natural resources, emergency management, law enforcement), and private-sector entities (health care associations, civil rights groups). Public health law reform committees in states like Arkansas, Delaware, Missouri, Montana, Nebraska, and Oregon correlate the sections of the Act (see Figure 1) to existing state laws, identify distinctions, or gaps, and prioritize potential areas for reform.

Above all, these committees understand that the purpose of the Act is not to stimulate legislative activity merely for the sake of reform. Reforming public health laws is a delicate process that involves good timing, political will, and willingness to compromise. Consideration of the Turning Point Act provides opportunities for building relationships among public health practitioners, legislators, and other partners that may lead to incremental or comprehensive changes in state public health laws in the future. What may be more important than comprehensive reform is the value of reviewing and analyzing state public health laws, of seeking to better understand respective roles and functions, of asking what improvements can be made, of pursuing those improvements in measured steps, and of building relationships among key players. Though its provisions and policy choices are not timeless, the Turning Point Act's potential to stimulate public health legal reform is.

Conclusion

State public health laws in the United States are ripe for reform. Laws are an essential tool for improving public health infrastructure and outcomes. Even when state and local practitioners understand the importance of law to accomplish public health objectives, they often find that existing statutes are obsolete, inconsistent, and confusing. Layered over time, these

laws accumulate to provide widely divergent and antiquated standards (both inter- and intra-state) for responding to a host of conditions, some of which share epidemiological traits.

To address the need for state public health law reform, the Turning Point Collaborative produced a comprehensive array of scientifically, ethically, and legally sound provisions supporting state and local public health agency infrastructure, powers, duties, practice, and protections. An increasing number of jurisdictions have chosen to review their laws and initiate changes consistent with the Act and their unique needs. This is the essence of state public health law reform in the twenty-first century: public health practitioners and partners making their own choices based on model provisions developed by and for public health practitioners.

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