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THE PUBLIC'S HEALTH

AND

THE LAW

IN THE

21ST CENTURY:

Second Annual Partnership Conference

on

Public Health Law

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Founded in 1911 as the Massachusetts Society of Examining Physicians and Incorporated as the American Society of Law & Medicine in 1972.

Fall 2003

Dear Society Members and Journal Subscribers:

On June 16-18, 2003, the American Society of Law, Medicine & Ethics, in partnership with the Centers for Disease Control and Prevention and the Department of Health and Human Services, convened a major conference entitled "The Public's Health and the Law in the 21st Century: Second Annual Partnership Conference on Public Health Law." More than 500 individuals from all of the 50 states assembled in Atlanta, Georgia, to engage in both plenary and concurrent sessions devoted to all aspects of public health and the role that law plays in promoting and sustaining a healthier population. The audience was truly multidisciplinary—and included lawyers, members of the judiciary, physicians, state legislative members, public health officers, nurses, bioethicists, and academics. This supplement seeks to capture the essence of the plenary and concurrent sessions of the program.

The conference collaborators wish to acknowledge the generous unrestricted funding from the Alfred P. Sloan Foundation, the Robert Wood Johnson Foundation, the Milbank Memorial Fund, and the Greenwall Foundation. The American Society of Law, Medicine & Ethics acknowledges the creative work of the program planning committee, the authors of the articles included in this supplement, and the dedication of the extraordinary conference faculty.

We also extend our special thanks to each of the following for their exceptional support for the conference and the conference proceedings: Julie Gerberding, MD, MPH, Director of the CDC; William H. Gimson, MBA; Ed Thompson, MD, MPH; Kathy Cahill, MPH; Deborah Jones; James Marks, MD, MPH; and other colleagues at CDC for their financial and technical support for planning the conference. Finally, we thank Sherry Everett Jones for serving as Editor-in-Chief of the proceedings and for her enthusiastic support for the proceedings and the conference.

Sincerely,

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Preface

Sherry Everett Jones

This supplement to the Journal of Law, Medicine & Ethics is the proceedings of the conference *The Public's Health and the Law in the 21st Century: Second Annual Partnership Conference on Public Health Law* held in Atlanta, Georgia on June 16–18, 2003. The conference was co-sponsored by the American Society of Law, Medicine & Ethics and the Centers for Disease Control and Prevention. In addition, the conference planning committee (see Appendix A) and the many funding and collaborating organizations (see Appendix B) were critical to the success of this conference.

After a resoundingly successful first annual conference in June 2001, the conference planning committee and collaborating organizations were convinced of the value of a conference that brings together participants with a wide range of expertise in public health, the law, and related disciplines. More than 500 participants came to this second annual national conference, including state and local public health leaders and practitioners, elected and appointed public policy makers, law enforcement officials, members of the judiciary, physicians and attorneys working in public health, and researchers and educators in public health law.

The primary goals of the conference were fourfold: 1) to improve the understanding of the critical role law plays in protecting the health of the public and in the public health system's emergency preparedness; 2) to explore new perspectives on the intersection of public health and law; 3) to apply scientific information about law to public health policies and practice; 4) and to improve partnerships and the legal tools used to improved public health.

These proceedings capture both the spirit and the substance of the meeting. These proceedings first present papers from the plenary sessions. The plenary sessions explored issues that are both cross-cutting and central to all those who shape, implement, and interpret public health laws and policies. Following the plenary papers are summaries of each of the concurrent sessions. The concurrent sessions addressed important and specific areas of public health law, including for example, the Health Insurance Portability and Accountability Act (HIPAA), the effect of the *Olmstead* decision on the Americans With Disabilities Act, public health preparedness in communities of color and across the nation, the use of science-based guidelines to shape public health law, school-based policies affecting nutrition and physical activity, public health law and ethics, and emerging issues in public health and law. The third section of the proceedings is the result of a call for full paper submissions from conference presenters. Two papers were accepted for publication and are published here as full articles.

These proceedings would not have been possible without the hard work and dedication of many individuals. In particular, I would like to thank Ben Moulton, Executive Director of the American

Society of Law, Medicine & Ethics, Anthony D. Moulton and Richard A. Goodman, Co-Directors of the CDC Public Health Law Program, Montrece Ransom, Attorney Analyst with the CDC Public Health Law Program, and the entire CDC Public Health Law Team. In addition, I would like to thank each of the proceedings authors who made the commitment to share their expertise with conference participants and subsequently with readers of these proceedings. I would like to add special thanks to the Robert Wood Johnson Foundation, the Milbank Memorial Fund, The Greenwall Foundation, the Alfred P. Sloan Foundation, and Healthcare Georgia Foundation for their generous grants which made the conference and these proceedings possible. Finally, I would like to thank the many Centers for Disease Control and Prevention programs that provided financial and technical support for sessions throughout the conference.

My hope is that these proceedings memorialize the breadth of practice areas falling under the public health law umbrella and capture the immeasurable practical expertise that each conference participant brought to this partnership conference on public health and the law. The conference and these proceedings provide a means for leaders in public health and the law to strengthen public health practices.

Sherry Everett Jones, PhD, MPH, JD, the Proceedings Editor in Chief, is with the Division of Adolescent and School Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention.

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Conference Welcoming Remarks

Ed Thompson, Deputy Director for Public Health Services,
Centers for Disease Control and Prevention

It is a real privilege to be able to welcome you to Atlanta to the second public health law conference. This has become one of the most exciting activities that the Centers for Disease Control and Prevention (CDC) sponsors and helps to facilitate. It is growing each year. The fact that so many of you have chosen to take time to come here testifies very eloquently to the importance that law has in public health and that we are now increasingly recognizing.

It is a common greeting for people who meet each other on the street to say, "what have you been doing?" In public health, for the last few weeks and months, we have been doing viruses, lots of viruses. We started with a bacterium, that was anthrax, but we addressed that problem. All the white powders, we hope, are behind us for the time being. No doubt we all have our white powder stories—the different kinds of things that people thought might be dangerous but were not.

And then we began a parade of viruses. We dealt with the West Nile Virus last year, and we will deal with it again this year. Last summer, when the West Nile Virus was at its height, as a state health director, our office dealt with it in many ways. One of those ways involved occasionally having to require an individual to clean up property that contained hazards where mosquitoes might breed. Most people did it voluntarily; however, a few refused. In those cases, we had to turn to the legal profession to assist us in carrying out our public health responsibility.

Then we moved to new viruses. Right after the West Nile crisis of last summer, we moved to a virus that we hope we never see again: the smallpox virus. We are combating smallpox with another virus, the vaccinia virus that makes up the smallpox vaccine. As we attempted, and continue to attempt, to prepare some of our health care workers and some of our emergency workers to respond to a smallpox attack, we found ourselves utterly dependent on the legal profession to help us work through some of the issues involved in protecting people against smallpox using the smallpox vaccine. A number of legal issues came to the fore and became dominating themes.

And then we found a new virus and a great way to make people pay attention to a virus. If we had named the virus that came out of china, "the virus that causes pneumonia," or something of that nature, it would never have captured public attention the way it did when we gave it the ominous-sounding acronym SARS. That virus, too, has brought to the fore the need to deal with public health issues through legal means, because our primary weapons for dealing with it have included old-fashioned public health tools like isolation and quarantine, usually done voluntarily, but on occasion requiring legal intervention. Once again, public health law became an important public health protective tool.

In the midst of all of these things we had yet another virus—or at least some call it a virus—it is called the HIPAA virus. This spring, the

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implementation of the HIPAA privacy rule (Health Insurance Portability and Accountability Act) has demanded a great deal of attention from us. There is an enormous amount of legal advice being given concerning HIPAA, and some of it is good. Importantly, HIPAA was crafted very carefully not to interfere with the public health functions that we all carry out in the exchange of information in public health circles. Because of the confusion around sharing information for public health purposes, this sharing remains an important legal issue.

And then finally, most recently, we find ourselves dealing with the monkeypox virus, and once again, in yet a different way, legal issues come to the fore because we have found ourselves in the position this time of controlling the transfer of property, of the movement of animals from one place to another, in an attempt to reduce the likelihood that human beings will get a disease. That has required legal intervention and has required legal actions. Throughout all of this, the theme remains that doctors do not protect the public's health alone, nurses do not protect the public's health alone, and sanitarians do not protect the public's health alone. From the very beginning of our public health activities, the law has been part of our activities, and public health law is as fundamental a public health discipline as any other discipline within public health. So thank you for coming and helping us make public health law a stronger discipline.

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From Smallpox to SARS: Is the Past Prologue?

John J. Hamre, James G. Young, and Mark Shurtleff

John J. Hamre

I am really quite honored to have a chance to be here. Also let me say how much I appreciate what all of you public health professionals do. One of the unfortunate dimensions of modern American life is that we have chosen to privatize all aspects of life. People do not live on their front porches anymore and watch their neighbors in the evening. They go out back in their wall-enclosed backyards. And we have done the same with medicine.

Medicine has been privatized in America. We have lost a sense of the public obligations of health and hygiene and sanitation. So I thank you for keeping the flame alive on what we clearly now know is the far bigger issue of health care in modern society.

About 4 years ago I became president of the Center for Strategic and International Studies. One of the first things that we did when I got there was to run an exercise called "dark winter." It was a simulated National Security Council meeting dealing with smallpox in America. I had thought that the exercise would be about the mechanical challenges of consequence management after a terrorist incident. Instead it turned out to be an exercise about saving constitutional democracy in America, because we failed. We failed in that exercise to cope with a problem we did not understand. We came to realize that something far bigger is at stake with how well we deal with a bioterrorist incident—democracy. Public health workers all serve on the front lines. We may send troops off to places like Iraq, but it is public health that will be on the front lines of saving democracy if we ever have a bioterrorism attack in America.

During this last year, we have been dealing with a series of very important developments—SARS, monkeypox, and of course, anthrax. So what we have is an anomaly. We have had enormously challenging developments in public health that involve all the same attributes of bioterrorism at the same time that the public is now becoming deeply skeptical whether or not bioterrorism is really a problem. I think this is going to be a challenge for all of us.

I would like to discuss these new developments and consider the underlying themes about how we organize the government to deal with these problems, and the challenges that stand before us. First, we are dealing with a government that is organizing homeland security too narrowly around the experiences of September 11th. It would be great if we would all pause and breathe deeply for a couple of months rather than to design a whole new construct for the federal government that is a bit artificial.

What is the attribute of public health care that distinguishes between SARS and a bioterrorism attack? Why is one of them in a Department of Homeland Security and the other one not? By creating this Department, we have taken the rare and unusual, we hope very rare and unusual, event and we have made it the premier organizing principle for the government. Ripping out of the rest of the government, from the connective tissue that makes sense of public health, we have pulled bioterrorism away from public health, as though bioterrorism and public health are separate, free-standing activities. That is unfortunately the challenge that we have created for ourselves by creating this new department of homeland security.

Now we need to reconnect the severed missions. We are learning several things. Public health is a national security issue. Two and one-half years ago, when the Bush administration came to town, they did not really believe that. They eliminated public health positions that were

on the National Security Council staff. They are now quietly bringing those positions back. We are living in a world where the patterns of tourism and transportation will, within days or hours, bring a hypercarrier from Hong Kong, from the Metropole hotel, to Toronto, and all of a sudden create a disease that now has cost the Canadian government $700 million. It is the kind of day and age that we are living in. We cannot treat health as though it is a private matter, which tends to be the public philosophy that informs so much of our thinking, at least in the United States.

Public health is a national security issue. Having said that, most national security experts do not know how to think through the basic issues in public health. The experience that we had when we ran "dark winter" was that the people who decide national security issues do not even know how to ask the right questions when it comes to public health. I think we saw that in real life with how we dealt with the anthrax problem. Everybody in Washington was preoccupied with the question, "Who did this?" What the public really wants to know is, "What can I do to protect myself?" Fortunately, public health professionals at the local level stepped in and kept people calm during the anthrax crisis. I was amazed at how ineptly the federal government dealt with the anthrax crisis at the national level and how well it was handled at the local level. At the local level, people could get up in front of a local television station, explain that anthrax is not infectious, and that there are some basic hygiene techniques the public can use to protect itself. That was exactly what the public needed to hear at a time when, in Washington, we really did not know what to say.

I worry that the public health advocates of homeland security are creating the impression that we can provide a sterile environment that protects us against all hazards. Whereas, everybody knows that such protection is not possible. I believe our goal should be to restore normal life as quickly as possible, not simply protecting against anything that could possibly happen or go wrong.

A second worry I have about our approach to homeland security is that it rests on such a narrow base of internationalism. The whole concept of homeland security has this very flawed premise that we can protect this little enclave called North America. Consequently, we ignore the fact that we have to deal with the underlying pathologies in society that are the cause of so many problems. If you ask, who in the United States government is responsible for a failing health care system in Africa that cannot contain an infectious disease, you find there is nobody in the government that has that responsibility. Yet failing to deal with the causes of infectious disease globally means we treat symptoms, not causes.

I believe the starting point of homeland security should be a very robust concept of internationalism. Partnering internationally with entities and organizations is important because the causes of public health problems will require international efforts at the source, not simply dealing with the attributes of failure once they come to America's airports or to its shores. Currently, we do not approach the problem this way because of the way we have thought about this problem of homeland security; we have misdirected or misapplied the lessons of September 11th into too narrow a formulation.

The entire federal government has to be in the business of homeland security, and homeland security starts in the smallest village in Africa, or the smallest village in China. It does not begin only in New York City. It does not begin just at the airports. Unless we uncover this much deeper sense of internationalism to inform our homeland security, I fear ultimately we will fail.

Finally, I think the great challenge of this decade, especially for the national security community, is to come to grips with the question, what do we do about truly dangerous conditions that exist outside the sovereign reach of our government's control? That really was the question at hand when we had to go into Iraq, or go into Afghanistan. A failing or incompetent government became a reservoir for al Qaeda terrorists. What do we do about the condition that spawns international terrorism? I think we have come to realize, especially after the Iraq experience, that simply overthrowing governments

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does not solve the problem. We have got to have a much richer portfolio of tools, especially when you look at what we have learned from SARS.

We cannot accept another government, especially one as large as China's, that chooses to hide a major public health problem because it is embarrassing. We have got to insist on more competence and more objectivity than we have in the past. To do so, it means we have to start by avoiding dividing the world into either "you are for us" or "you are against us." Doing so becomes a barrier for cooperation, especially in time such as these when we need to be working with governments that we do not agree with. It does not help if we do not talk with them. We are going to have to become far more creative and interactive in this world, in insisting on solving problems.

Yes, there will be times when we have to use force, but we need a far richer set of tools to deal with these pathological conditions in other countries than just simply using muscle every time a problem comes up. That brings me back to why it is so important to have public health professionals involved in homeland security. We have not made adequate progress in Washington dealing with homeland security. Thank goodness we have made enormous progress in the field. That is what all of you are doing. I would like to close by saying how grateful I am that all of you have seen the true experience and lessons learned from September 11th; that is, homeland security is not produced by creating separate departments. Homeland security is produced by your creative work as health care professionals every day. Every American needs to understand that public health is a national security issue.

James G. Young

During the SARS outbreak, it was important to know we had support from the Centers for Disease Control and Prevention and others and that at least some people understood what we were going through. Critics might say, "you should have got this [SARS] stopped" or "you should have been able to do this or that," but the support helped us realize that there were people who understood what we were doing and understood the directions we were taking. Frankly, with almost every decision we have had to make, I heard one person whispering in one ear saying, "do more," and I had someone else whispering in the other ear saying, "do less." I had no road map because it was a disease we knew so little about. We made a lot of correct decisions, but obviously, you learn as you go.

SARS, clearly for us, is a health care emergency because at the beginning when we were dealing with it, we knew virtually nothing about it; we had no cause and we had no idea how it was being spread. We certainly recognized that it was infectious. We had no cure, we had no test, and these remain. The testing for SARS, while improving, is less than ideal.

SARS is truly a difficult illness with which to deal. It can be characterized as the great pretender. When you are trying to sort out who has SARS in a hospital setting from the people who do not, you are trying to deal with people who are either in a hospital or come to hospital with headache and malaise, going on to fever, and then starting a mild cough. Then a week or two later, it might develop into an atypical pneumonia. That probably represents half of the people in a hospital at any given time. If you are running, as we are, several hundred hospitals in the province and you are trying to find one patient here and there within a system who may have SARS, and figure out from there who may have spread it, it becomes a very difficult job.

What we have learned is that SARS particularly strikes elderly people. Elderly people (above 60–65) with multiple medical problems, especially diabetes, do very poorly with SARS. It especially strikes health care workers; health care workers because of the proximity they are working with patients who are affected. Over 50% of our affected people are health care workers. We have been extremely fortunate that, to date, none of our health care workers have died.

Our problems began, as did Hong Kong's and Vietnam's problems, in the Metropole hotel. There was a doctor from Guangdong province visiting Hong Kong, staying at the Metropole, on the seventh floor. The doctor who named SARS and eventually died treating it in Vietnam was staying on the seventh floor, as was an elderly Chinese couple from Toronto. The husband and wife returned to Toronto and both had SARS.

The wife visited her family doctor, received some antibiotics but did not improve. She had multiple medical conditions, deteriorated, and died in late February. The infection was missed, or the fact that she had died of an infection was missed. Her son became ill and went to hospital on the March 8. The dates are very important. He was recognized within 16 hours as having a serious infectious chest condition. It was thought, in fact, that he might have tuberculosis. At that point, he was isolated in the hospital. He got worse and deteriorated and died on the March 13. Five of his family members became ill that day as well. All five were immediately put in isolation on March 13.

One could say we did a good job of discovering an infectious agent once it was recognized and isolated relatively early. In fact, SARS had first been described by the World Health Organization (WHO) the day before, on March 12.

The problem for us was that although the son had been protected after 16 hours and although all of his relatives had been protected, all of those in the hospital and the patients near him in the emergency department had not been protected. Bear in mind, even if we had known about SARS, if he had gone into a hospital and someone had asked him whether or not he had traveled, his answer would have been no. It was his mother who had traveled. The son infected several other patients and they in turn infected several other patients and medical staff within the hospital setting. Nearly the entire cluster and everything we are working on to this day arises out of those cases.

We decided fairly early on that we had a serious problem and that it involved multiple layers of government. We made a decision to call a "provincial emergency" in order to mobilize the full resources of the Ontario government. The Ontario government represents 40% of the Canadian population. We organized such that the provincial government was working in concert with the municipal government. The city of Toronto, the region of York (just outside of Toronto), and the Province worked together with a great deal of assistance and advice, and constant contact with Health Canada in trying to manage this.

My instructions from the Premier were to "fix it," and do whatever was necessary to fix it. That was the extent of the political interference. If anyone is drawing up a model, try to draw up a model where you have the authority. We had the authority under the Emergency Act and under the Health Protection Act. Also, we had instructions from our politicians to fix it, but with no interference.

We used multiple professions, and this being a law conference, I might comment on the important role that lawyers played. We were ordering people to do things and we were moving mountains in a hurry. We literally closed our health care system down one night. When we called the emergency, we met from 7:00 p.m. until 3:00 a.m. We compiled a set of directives, not guidelines. They did not say to hospitals and doctors' offices "we would like you to do this." They said, "you must do these things." They were absolutely the new way that medicine would be practiced in the province.

It was good to have the legal advice when we were making decisions. Bold, rapid actions and literally closing the health care system down, while we put infection control and proper surveillance in place, was key. We went after consistency and coordination, working together on a Province-wide basis. We issued orders not just in the northeast corner of Toronto where we had one affected hospital, but also we went after the 300 hospitals in the Province and we made them all do certain measures in order to prevent the spread of SARS.

We made our decisions based on science. When we heard new science, we waited to see whether or not it fit our pattern of behavior before we leapt from solution to solution. So when there was all the debate about it being airborne, we did not suddenly decide it was airborne and switch

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because we were seeing a pattern of spread that was droplet. Also, we saw 10 days as being a proper isolation period. We were not seeing people becoming infected from objects, so we did not go to major measures cleansing everything in sight. Of course we encouraged hand-washing, but we tried to be consistent.

In addition, we tried for transparency. My partner, the Commissioner of Public Health, and I co-led the effort along with a huge team across the Province. Every day at 3:00 p.m. we had a press conference for an hour to an hour and a half. People stopped us in the streets and said, "it is very reassuring to know what is happening, how it is happening, and how you are doing it."

In hospitals, we literally closed the hospital system down. We stopped entry of people in because we realized they could move it around. We stopped volunteers. We paid attention to transfers because we quickly learned there is a lot of movement within health care systems and patients going from facility to facility. It is really easy to move SARS when you are moving patients. We put gloves, gowns, and masks on everyone. We had to re-educate our medical people that everybody that had a fever had SARS until proven otherwise, and that included them.

One of our big challenges was, and remains, getting health care people to stay home when they are sick. It is a huge problem because they are very dedicated, but they also can spread disease just like the rest of us. For awhile, we cancelled all of our elective surgery while we put all of this in place, then we put it back up and got it running again.

In public health, we paid a huge amount of attention to case management and contact tracing. We followed who met whom very vigorously. We also made SARS a reportable disease on March 21. That meant that we could quarantine and we could take all of the other necessary measures. In all, in the first part of our cluster, we had over 1,100 cases investigated. Now we are closer to 2,000 cases that we have looked at in order to find something like 300 cases. We had 12,000 quarantined in the first phase and about 8,000 in the second phase.

A very important step we made was to put public health people in every hospital to work with the hospitals. Isolation or quarantine was our mainstay. Good infection control, good contact tracing, and isolation are exactly what works. We have put people in quarantine for 10 full days. With one exception—we had one medical student who appeared to have gotten sick on the 12th day—everyone else does fit within the 10 days. It is challenging to go back and take a very careful history and help people to remember the headache or the malaise they had a day or so earlier but which they did not think much of at the time.

We made twice daily symptom checks. One of the mistakes we made was to call the quarantine "voluntary quarantine." It was not voluntary. What we should have said was verbal mandatory quarantine. If we found that people were not doing it, then we went to written measures; there were provisions within our act that allowed us to serve people with a notice to stay home. If they did not abide by that, they were taken by police to a hospital and hospitalized for 10 days.

In fact, during the outbreak, we changed the law in Ontario. We do not have to take people to the hospital now; we can take them anywhere we want. That offers an interesting range of options for someone not behaving. We found it worked, but we had to follow up very closely. Our problems were one of two things: 1) people either both broke isolation and lied to us or they misunderstood and 2) health care workers and others went out when they were sick.

Something else we learned, and with which the CDC assisted us, is that when you are doing intubations on SARS patients, it is phenomenally infectious. People have to be in stryker suits and few people should be in the room. In one incident, we had workers in gowns, gloves, and masks doing an intubation and still eight people got SARS from the one intubation. So in the hospital setting, SARS is deadly.

In the community, SARS does not seem to pose as much risk. We found we had to do the contact tracing and find the cases, but we did not get a community outbreak and we never had

random community cases. There has never been a random case in Toronto that we cannot track back to—whether it is somebody who is the son or daughter of someone or someone who came in contact with a patient—there are no random cases. Thus, there are no risks in the community such as walking on the streets. This was very disappointing to the press because no one was wearing masks and no one was panicked—the public understood what was going on.

We are battling a second smaller group of cases now. What happened to us was, everything went quiet and we had missed one case in an elderly person who had congestive heart failure and was not recognized as having SARS. We learned that the person had SARS with serology later. The patient's health care worker relative carried it into a hospital and a 97-year-old man recovering from a hip replacement (or a hip fracture) got it next. He developed no fevers and a little post-op pneumonia. It sat dormant and undetected for another week or two. Consequently, it got into the system again and spread, the lesson from which is, you are never finished with it and you have to look for it. We are building a new surveillance system.

The reported cost of $700,000 for SARS is only the health care cost. The cost to our economy, to our trade, to business, and to tourism, puts the cost in the billions of dollars already.

There are two lessons on which I will concentrate. First, we have recognized that public health has a very important role. Public health has to pay attention to hospital infections, doctors' offices, long-term facilities, and community simultaneously. The linkages have to be much stronger. Second, it is in all of our interests to address these outbreaks when they form and when they begin, whatever country they begin in. I was recently in China and my conversation with both the mayor of Beijing and one of the senior health officials was to the effect that it is far more economically viable, and it makes far more sense, for the countries of the world to work together and find these outbreaks at the beginning. We must learn to manage them before they go from Guangdong or any other province in China or India or any other third world country to North America or Europe or any other place. There is much work to be done.

Mark Shurtleff

What are we going to do? In this country, we are constantly in a love-hate relationship with our government. As a lawyer, I am very familiar with the love-hate relationship. People have a lot of strong attitudes about lawyers, but when you are in trouble, what is the first thing you do? You pick up the phone and call your lawyer. It is the same with government. In this country, we are proud of our heritage. I am going to talk about the rights of people and what we expect of government, and when government does not do what we expect, that is, when government goes too far, what do we say?

As we go forward with the law and public health law into the 21st century, as we go forward and plan, we have to collaborate. The partnerships represented at this conference are wonderful. As we go forward in this country, in order to be successful, we have to recognize and remember the rule of law and the principles that founded this country. I think we can turn it to our advantage.

People have recognized that one of the most important responsibilities of government is protection of public safety. As this country's jurisprudence developed, people were willing to give up certain rights in order to protect individuals—in order to find, catch, and prosecute those who have committed crimes against us. What we have done through our 200 years of American jurisprudence in basing what we do on the law and the constitution, and the principle of individual freedom, individual rights, the principle of less government, and the principle that government should be closest to the people, is end up with a country with a lot of rules.

As we move forward interpreting and creating laws, we should find some way of trying to handle and prepare for the future; that is, find balance in our system of government. On one side, you have individual rights and liberties; on

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the other side you have what needs to be done in order to protect the public. When it comes to public safety, we have to be able to recognize that even if someone is accused of a crime, they have certain rights. Society gives up certain rights such as under the Fourth Amendment right to search and seizure or the right to use of deadly force. We give to our law enforcement officers the ability to take a life. People do not complain about that power as long as it is kept in balance.

I'm urging us to remember that this country is based on those principles of "we the people." Remember that our founding fathers decided to move away from monarchy, from a system of government that said, "Hey, do not worry about it, we will take care of all your needs. And we will dole out rights to you depending on what we think you ought to have." In this country, our founding fathers said that government does not give rights, we have certain inalienable rights—life, liberty, the pursuit of happiness, property, equality—these are certain rights that the government cannot grant or take away. But government is instituted among men in order to protect and preserve those rights. So it behooves all those of us working in government in the public sector to remember that whatever we do, it is in order to protect those rights of individuals.

Understand that a threat to our health is as great if not greater than what we are facing in this war on terrorism. With the war on terrorism, even though it is a unique new war and it is harder to identify our enemies, we have been very successful so far in going out there and doing it. The federal government can do this; they are very familiar with the military and there is a way we can go out and plan this. When it comes to protecting us here at home, again, we are going forward and spending a lot of money, diverting all our attention towards terrorism and trying to catch someone. We forget that if there is something like a microbe that is brought here, the terrorists, so to speak, the people who are going to hurt us, do not even know that they are terrorists. They do not even know that they are carrying something that could become a huge disaster.

So we need to understand and let people know that when it comes to public health, when it comes to all our efforts to try and protect the public, we are acting in much the same way as law enforcement. It is important to start changing the attitudes of legislators and others so that they understand that this is extremely important. Our actions must be not only from the top down. It needs to be from the bottom up. It needs to be from all of you.

I really congratulate CDC and others for bringing together this group, this partnership, and this collaboration. I think we need to bring in more of the private sector as well. They are going to be very important in preparing for the future. So that is what I am asking us to do; I am asking lawyers, doctors, public health workers, private sector persons, law enforcement, and everybody else to come together and to be included in this. To that end, the President put together his advisory council. They submitted the statewide template initiative to the President. The statewide template initiative is just that, a template. It is a good guide for us to consider as we move forward.

Let me share a few things that the committee recommended to the President. The guiding principles are important to understand. First, we need to ensure that the efforts are state-based, but locally focused and driven so that they are flexible and adaptable. Recognize that our enemy is networked and can only be defeated by a network system. The template goes not only to the traditional forms of terrorism, but also it includes concerns about bioterrorism. We must ensure that our homeland security efforts do not result in a significant alteration of our federalist form of government. We must enable government and the private sector at all levels to carry out its homeland security responsibilities. We must promote citizen participation in state, local, private sector, and regional homeland security efforts. We must also ensure that funding follows the policy. The bottom line is that the homeland will be secure when hometowns are secure. We in the state government and in federal government need to provide the support, the funding, the training, the communications, the systems, and also a framework of law

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so that when a bioterrorism attack happens, we are not scurrying about.

Unfortunately, in this country, because of our system of government, were we to have the terrible outbreak of SARS or some other type of attack, either intentional or unintentional, people cannot turn to the government. We cannot turn to a local health director and say, "You have unlimited power. Do whatever it takes." The people in this country will not accept that. But they will accept it if we use a reasoned approach where we have the protocols established and in place; where we take a look at the existing laws and change them so that we are protecting the rights of individuals.

I look forward to working with you. I ask that you consider as we go forward and plan for the future with model acts, protocols, and templates, that we consider the laws in this country. I ask that we all remember we are a country that believes in the rule of law and it is through the law that we can ensure that everything is in place in the event of a disaster.

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From Public Health to Population Health: How Law Can Redefine the Playing Field

Daniel M. Fox, Mary Kramer, and Marion Standish

Daniel M. Fox

Today's panel is about the expanding boundary of population health policy, what that expanding boundary has to do with law, and what kinds of challenges and opportunities come out of it. What I want to do for the next few minutes is talk to you about the notion of population health as it exists where law and policy are made, rather than where it exists in a spectacular international theoretical literature. Then I want to introduce our panelists. In the process, I will explain why the Honorable John Nilson, is not with us, which tells you a great deal about not only the real world of the politics of population health, but also about the kind of trouble you can get into if you are a first class lawyer involved in population health.

First, some questions. What is population health? How does it relate to public health? Is there a law of population health, and how does that law relate to public health law? And how do the politics of population health inform the law of population health? These are big questions. A few years ago I began to feel some dissonance between what my good friends around the world, who were writing the international theory of population health, were doing and what I was hearing from my good friends who run for office, meet payrolls, and make policy to take care of huge batches of patients. I realized that the definition of population health had expanded over the past 10 or so years in the minds of people who run for office, meet payrolls, and take care of bunches of patients. I began to wonder about asking my friends who made policy what they thought about when they use the phrase "population health" and how they related it to public health. Here, in summary, is the answer that I received.

Population health is what the people say it is. The people in any jurisdiction or any country know what they prioritize and what they believe to be population health. The people who are most exquisitely positioned to know what the people think population health is are the people whom the people send to public office. If the people do not like what they do, the people send them home.

I began to ask my friends who run for office and meet payrolls in the public and private sector how the people who could send them home, whether they are voters, stockholders, or directors, were defining population health. As I wandered around the United States, into Canada, into various countries in Europe, and then into a few developing countries, I began to hear a whole bunch of issues being described as population health. What was on that list?

- Health care and access and quality of that health care.
- Income: do I have enough to meet my needs and the needs of the persons close to me?
- Food: can I trust that it is safe?
- Air: can I breathe it?
- Land: is it oozing with toxics and is it appreciating in value in my neighborhood?
- Water: is there enough of it? Is it clean enough? Can I drink it? Can I play in it?
- Long-term care: the progressive, intermittent frailty that afflicts 100% of the population, or almost 100%. Some people die quickly and do not have that experience, but it is a population issue.
- And yes, public health, the people who do surveillance, who do epidemiology, who do health education. That is very important. It is on the list, somewhere.

I saw policy makers taking that combination of themes and out of them in each jurisdiction

creating a set of population health policies that include public health and its glorious tradition.

In late August of 2001, the Reforming States Group (RSG), the National Association of State Budget Officers (NASBO), and the Milbank Memorial Fund began to review the survey instrument used for the third biennial survey of state spending for health care. The first two surveys, the first bottoms-up count of spending for health care in the United States, had been done by NASBO, the RSG, and the Fund beginning in 1997. I persuaded my colleagues in planning these surveys not to get too grandiose at first and to just count the money spent for health care because nobody had ever counted the money that states spend for health care from the bottom-up.

Some of you may know that the survey, when placed alongside the National Health Accounts published by the federal government, revealed that about 60% of health care spending in this country is public; federal, state and local government funds. The notion that we have a predominantly private health care system turned out to be wrong by 25%.

By the time we got to August in 2001, we had decided to do an empirical, "What do the people say population health is?" count of population health spending by the states. A group of budget officers and state legislators had gone through the accounting system that is used in common by many states and came up with an empirical, practical definition by which to count the money. In August 2001, there were even people who wondered whether disaster preparedness and disaster spending were population health categories.

I remember vividly the day that the incoming president of ASTHO [American Society of State Health Officials], Dr. Georges Benjamin, who is now the Executive Director of the American Public Health Association, told ASTHO staff that as soon as he took the presidency, around Labor Day, he was going to join the NASBO/RSG committee and work on improving the survey instrument. How do I remember that day? I got 70 emails from people I know and admire who were state and local health officers. Like a lot of emails in politics, they had a certain verbal similarity. All of them said, "Dan, we thought you were a friend of public health. Why are you going to let the budget officers and the legislators count the money? We in public health know how to count the money." Because they were form letters, I decided to write a form reply. I wrote that I have been around government for almost four decades, and a lot of people have a lot of opinions about what got spent, but only one opinion counts.

Population health is a broad, ever-changing concept related to the politics of life and living in every jurisdiction. It relates to public health not because it is better, different, or something else. Public health is part of population health. Is there a law of population health? You bet. It is broader than public health law. If you read Justice Stevens' decision for the U.S. Supreme Court in the *Maine Rx* case two weeks ago, you will have learned that the Medicaid benefits that a state may provide are justified by the state's public health powers: in that decision, prescription benefits, tomorrow perhaps long-term care.

How do the politics of population health inform the law of public health? That is the subject of our conversation this morning. We have three panelists. Let me first describe John Nilson, QC, who is not here. I will explain why he is not here because it has everything to do with population health. John has that rare experience in North America of being a member of the Legislative and Executive Branches at the same time. He was, as the AGs [Attorneys General] among us know, AG and Minister of Justice for Saskatchewan for a number of years before his colleagues decided that having dealt with a small piece of the budget, he ought to deal with 45% of the provincial budget and become Minister of Health.

Saskatchewan is the home of the New Democratic Party, which is the party that brought Canada its health system in the early 1960s. Legendarily, it took a doctors' strike in 1962. Planeloads of volunteer physicians were flown in for three weeks, at the end of which Saskatchewan had universal health care. Two years later, Canada had that system. John spent yesterday on the front

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bench in the Legislative Assembly using notes and a Blackberry and the telephone to run the Ministry while maintaining the one-vote majority of the New Democratic Party in the run-up to the provincial election. The polls say it is too close to call.

When I got here about midnight last night, I had a message to call John. I called him at home. His wife answered, it was 10:00 P.M. Regina time. She said, "John just walked in. He's been out there since early this morning." And then John came to the phone and said, "I'm sorry I can't be there, I had written such terrific remarks." So I am going to miss John, and I hope Gene Matthews and Tony Moulton and the other members of the planning committee for this conference will invite him next year whether or not he is a Minister. If he is not a Minister, he will for sure be here. The polls say his seat is safe, although nothing is safe in politics.

Mary Kramer

It is great to be here because my learning curve is as important as I hope any of yours. It is a wonderful opportunity. I enjoy being the President of the Senate in Iowa. I must tell you, though, that being a legislative leader, as some have said, is sort of like being the groundskeeper at a cemetery. There are lots of people under you, but nobody listens.

This morning I would like to touch on about five points that I think are important. I will try to illustrate with some examples of each and then end with what I think is the relationship between the law and the issues around public health. I would begin with what Dan referred to as the new definition of population health or public health. From a legislative standpoint, I try to embrace all of that under the fiat called "quality of life." I do that because that is a politically astute way to deal with it and to allocate resources to things that political officials think are important.

Quality of life relates to economic development. What can be more important than that? In that broad definition then, you talk about the quality of your air and water, the safety and desirability of your food supply. You mean the public health, meaning a high level of performance, not just the absence of illness or pain. These kinds of quality of life issues lead to improved success in education, in the productivity of the workforce, and in the potential income of the citizens of your jurisdiction or enterprise. In our case, of our state. What is a higher order than that?

The quality of life of the citizens is its highest order. Let me give you one example. A few years ago we decided that early childhood was not well cared for or did not have enough attention given to it. We had the usual preschool stuff, some interesting childcare programs dotting the state. There was not, however, any universal idea or institution that deals with early childhood. There is the health part, the education part, the family support part, and the childcare part, but nobody has responsibility for it. So how do you make that come together?

We created a pot of money that we called Empowerment Fund. Any county that would come together and pool the resources of the educators, the United Way, the public health officials, and in many cases the medical providers, would be entitled to carry out the strategic plan they created with a pot of state money. We only asked for a measure of how many children arrive at school ready to learn. There is a pretty universal definition of ready to learn. It includes having all the appropriate preventive health care in place before you arrive at kindergarten. That has been a remarkable effort. Even if we have not yet reached every child, we have certainly educated the state about what arriving at school ready to learn means. That it is a failing component if we have children arriving at school who do not meet that measure.

My second point is that reactions and relationships around new knowledge are not suited to be assimilated or dissimulated by our current government structures. I have heard Secretary of Education Paige say we are now more interested in how children perform than we are in how systems perform. Now, is that not a statement that we could take to heart in what we are talking about today? Last night at the reception one of my colleagues from Oklahoma said, "In politics we have some data and we have some stories." You need both. You also need good stories about the

successes and bad stores about the failures. For instance, how did we react when the information became broadly available about the importance of development of children in infancy, the brain knowledge and the brain development? All of that kind of new information exploded on the scene. What did we do about that? Nobody was really in charge of doing anything, were they? We all had a finger in that, but who was really responsible? For one thing, the media in Iowa at that point looked at some infant mortality issues; they were a disgrace. Iowans were furious that we had such a poor tracking system and demanded we do something about it.

Another senator and I called together a group of people in central Iowa who provide services to young pregnant women. The room was not big enough for all the people that wanted to provide services to that group. We were shocked. What began the conversation was people saying, "Well, I don't know what you're doing in my neighborhood. I do a better job than you, and I should have the money. So why don't you just go out of business and give me the money so that I can do this?" It was a classic example of "we love the programs more than we love the customer." That conversation, however, led to the creation of what we call the "State Child Death Review Team" through our medical school. Every death is reviewed for its preventability and its cause. I will talk a little bit about Medicaid later, but what we learned from Medicaid data is that that low birth weight babies are our highest cost. We have not solved the problem yet.

To respond to that we did create a program which I still believe has great merit, and it is a win-win deal. The hospitals agreed that they would, at the birth of every child, announce to the mother and share a video that explains what are the assets of a successful family. And then, as part of discharge planning, talk to that mother about where she might have gaps in that, and would she be interested in being connected with community resources who could help her fill those gaps. It has been remarkable what has happened. The hardest part now is keeping the community resource network updated in the software. In Iowa, we are such a rural state that very few births occur in the community where people live. The hospital is not in the same community as where people live. So those networks become more and more important.

Next I would like to talk to you about Iowa's models of community knowledge. The foundation that I was fortunate enough to lead had data that showed which claims the major insurance carriers experienced. That gave us insight into what was going on in the community. Let me give you one example. In one small community, diabetics were not receiving retinal exams. It was a paid benefit but they were not getting it. What was going on there? We went into that community—our model was to invite elected officials, physicians, hospitals, school people, and faith-based leaders to lunch and say, "Here is the data for your community." The doctors in that community said, "That is not right. You've made a mistake here." They paid to have their own records searched and found that in fact it was right. They even worked with optometrists. In the end, the disgrace of those exams not occurring and not providing appropriate health care when it is available was overcome because the partnership works.

In one county, when the physicians recognized a child with asthma, with the family's permission, they connected to the public health officers. The public health officers, with the permission of the family, went into the home and did a consultation about asthma and asthma triggers. Inhalers were donated. Part of the consulting was to teach the family how to help the child use the inhaler and to help the child recognize the onset of the symptoms. We reduced emergency visits due to pediatric asthma to zero in that county. Zero. The stories about the improved quality of life for those children and those families are remarkable.

A combination of community-wide data and the engagement in problem solving is fabulous. My next point is that sometimes a terrible thing presents a great opportunity. I believe that the opportunity for improvement of population-wide health is through the new partnership with public health, emergency management, and law enforcement.

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There are huge opportunities to build those bridges and understand what is going on with one another. In our state, law enforcement is delighted to be able to turn to public health to use their credibility in making the public pronouncements, for example, how we would approach the smallpox vaccination, how we approach West Nile, or what we are doing about monkeypox. Those sorts of things, where these new partnerships exist, are tremendously powerful, and they add so much credibility for the public.

One other issue I would like to raise is that of biotechnology, that is, the issues around genetically altered crops. This issue, I believe, will become a food safety issue. One of the heroes of our state, a man named Norman Borlaug who has probably prevented starvation in more people than any other man in the world, has said, "No one who opposes biotechnology has ever been hungry." We do not understand the potential impact of genetically engineered crops in famine and starvation. That is going to become a public health issue.

I also want to thank Dan and the Milbank Fund because what we are doing with our Medicaid transformation is a very exciting thing. I have nothing to report to you that has actually happened except a bunch of meetings. The important development, however, is that we are going to approach the problem using an insurance model. I am not interested in privatization, so take that off the table. I am interested in using insurance techniques to manage the separate populations of Medicaid, the early childhood, the mothers, and the families. How do we manage that with a kind of a spending account that helps educate them about what the emergency room costs and what the importance of having a medical home is? You have someone who coaches and counsels about the children's health, someone you can relate to—that would be especially true in minority populations and immigrant populations. In Iowa, with the agricultural workers and the agricultural economy, we have many small towns who have full classes of only children who speak Spanish and no teachers in that community that speak Spanish. We have a large Hispanic population, and they are incredibly important to our workforce. We are a microcosm of what goes on in the rest of the world. One of the beauties of our problems is they should be solvable because they are of a manageable size. And that is how we are approaching it.

Finally, I would like to talk a minute about three issues in the law. The first is the challenge of confidentiality. Here is my concern about confidentiality: I sense public anger with what many people see as silly rules. For instance, the church members go to the hospital to provide comfort and care to their friends. The hospital now cannot tell them where that person is or how they can reach them or how they can visit. This diminishes credibility and says we are doing silly things. In my perception, the public perceives these acts as heavy handed and unnecessary. In our state, at least, it diminishes the credibility of government and the law.

The second issue is that there is a need for clarity around the law in public health purposes. Public health continues to plow new ground. There will always be decisions that have to be reached. Let us say Iowa has some fabulous regional groups that are prepared to deal with emergencies. We have storms and floods, and now we are in the bioterrorism mode. We have teams of people, so sometimes we are called by other states to provide that team of people. But how does that state know that when they arrive, they are appropriately credentialed, the people that they say they are, or have the skills and the licenses that they say they do? What are the issues around that problem that have to do with the law?

Finally, the current systems of state government, and probably local government, too, in my view, do not function in today's world. Having spent a lot of my career working with continuous improvement, process management, and documenting how things should work to serve the customer at the end, the silos currently in state government are not functioning. Public health is separated from other functions of government. You just heard Dan talk about the new Supreme Court decision that says now Medicaid can use public health law. Medicaid is in Human Services.

There does not seem to be a visible bridge between human services and public health in many states. So whose job is it? I will leave you with that thought. Whose job is it?

Marion Standish

Mary mentioned that there were communities in Iowa where there were no Spanish-speaking teachers. I began to think about the fact that in California, we are trying to close a $35 billion state budget deficit, and we have many, many teachers who are losing their jobs. The Iowa State Department of Education might want to come to California for some active recruitment. It is one of the most powerful lessons of the convergence of policy and politics, and that is, context is everything.

As all of us know in all of the states, but I think for us in California particularly, the budget deficit does drive much of our most immediate thinking. That is unfortunate for those of us in public health who tend to look ahead and see a lot of what is coming down the pike, rather than only what is right in front of us.

I want to send warm regards and thank-yous from the President and Chief Executive Officer of the California Endowment, Dr. Robert Ross, for inviting us. He really wanted to be with us today, but as the former Health and Welfare Agency Director of San Diego County, he was reluctant to be in a room with so many lawyers. He said to me that in his previous role, he was often quoted as saying, "Make me do the right thing," which I think is what many people in public office say to their colleagues out in the lawyering and advocacy world. Now as the CEO of a large foundation, I am not so sure that he was as anxious to get the same sort of exposure. As for myself, it really is a privilege to be here.

When I graduated from law school in 1976, I wanted to work in what we called Public Interest Law. I found my way as a relative newcomer to California and to the federally funded legal services program called California Rural Legal Assistance. For the next almost 20 years, I worked to improve the lives of California's farm workers. Our work ranged from representing migrant children in schools, to helping farm worker women escape sexual assault from employers, to ensuring that emergency room doctors recognized symptoms of pesticide poisoning.

Our practice was equally wide-ranging. From the schoolhouse, to the courthouse, to the State Capitol, and to Congress, we represented farm workers wherever and however decisions were made that affected their lives. It really is this approach to what you call public health law that has provided a lens for my comments today and for the three points that I want to cover.

I want to discuss with you today what public health law needs to do and how it ought to redefine itself if it is going to be effective in redefining the playing field. The three points I want to make, I will come back to them in more detail, are: 1) we need to be about enforcing existing laws that affect population health; 2) we need to be about the development of new policies and laws that address the emerging issues for population health; and, 3) perhaps most importantly, we ought to focus on the creation of a legal framework that establishes tools and standards for what population health ought to be and how we get there. I am going to come back and speak about those issues specifically, but let me explain for a moment a little bit about the California Endowment and how, in my role as a Program Officer at the Endowment, we arrived at this.

The California Endowment is a health conversion foundation. We were created by the Blue Cross of California when it converted from a non-profit to a for-profit, now called Well Point. The proceeds of that conversion resulted in the establishment of two foundations, the California Endowment is the largest of them. It now has assets, the last we checked, of nearly $3 billion, all of which are dedicated to the people of California. Half of our grant-making is in what we call community generated grant proposals. People apply, and we review and approve or deny those grant applications. Half of our grant-making is developed by foundation program officers basically

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out of a review of those community grants and an assessment of what are the most pressing issues for a community that might benefit from a more strategic approach to grant making.

Our mission is to increase access to health care for the under-served and improve the health status of all Californians. That part of our mission, to improve the health status of all Californians, of course led us to consider the issues of population health. Our focus on population health, in turn, led us to a close examination of health outcomes and how they were distributed across the state and between different communities and groups of people. Ultimately we were faced with a very fundamental question and that is, why is it that some people in some places are consistently less healthy than others? This question, for us, translates into a comprehensive effort to reduce health disparities.

Our commitment to health disparities is grounded in a belief that the health care system, that is health treatment, cannot treat away health disparities. We know that health disparities are not the result of specific populations experiencing a different set of illnesses than those affecting the general population. We know that only about 2% of deaths in the U.S. are attributable to purely genetic factors. Most importantly, and one of our biggest challenges in this country, is that the lack of access to quality medical care, while core to reducing health disparities, does not account for them. In fact, the CDC estimates that shortfalls in medical care account for only 10% of early deaths in the U.S. We know that the overall susceptibility to disease is greater and illness rates are higher due to a broad range of social, economic, and environmental conditions. According to some, nearly 60% to 70% of early deaths in the U.S. are attributable to those factors.

Spending in the medical care system as contrasted to the public health or the prevention arena is very disproportionate to the causes of death. When we think about this issue and we drill down further into the communities in which we work, we understand that the conditions that exist in the most disadvantaged communities limit individual knowledge about health, constrict choices about health behaviors, expose people to multiple risks that directly produce ill health over time, and hinder any effort to treat diseases once they have occurred.

Consider, for example, the health prospect of a young African American or Latina girl growing up in South or East Los Angeles in a very low-income community with tremendous concentrated poverty. Over a million people live just in those two communities and we call them communities of Los Angeles. Compare that to a similarly situated girl who has health insurance growing up in a more prosperous neighborhood in the same county. We know that we can predict virtually without fail that they will have different downstream health consequences, just by virtue of the fact of who they are and where they live. Why? I think most of us know why. But let me just give you a couple of the whys.

There is little availability in South or East Los Angeles to relevant or culturally competent health information. There are pollutants, toxins, and microbial agents in the air, in the water, in the soil, in the homes that people live in, the schools they attend, and the parks they play in. Many communities in our poorest communities have inadequate neighborhood access to health-encouraging environments, including grocery stores with affordable nutritious food, safe places to play and exercise, or effective transportation to even get to their health care provider.

These very same places that have inadequate access to health-encouraging behavior also have excessive outlets for unhealthy products, whether it is cigarettes, alcohol, or fast food. They often have high crime rates and violence, which limits the availability to move safely within the neighborhood, that increases psychological stress, and impedes community development and community economic opportunity. Joblessness, poor working conditions, and low wages are generally the norm in those very same communities. Not that I want to complicate the world of public health any more than it is already complicated, but especially in the current context, we have to say the solution to improving population health is in reducing health disparities. It is in ensuring that there is an

opportunity for health for all. It is a complex and multifaceted challenge. It is not, as we are currently organized for the most part, easily framed by a single disease or a single set of services.

In my mind, within this broad arena, and a very messy arena, public health lawyers and public health law can really redefine opportunities for population health in the 21st century. So what will it take? Here come my three points. First, I want to talk about these three areas and give you a couple of examples of where I think we can move the ball down the court on population health. To repeat those three points: 1) we need to focus on the enforcement of existing laws and regulations at all levels and across a broad range of disciplines; 2) we need to focus as public health lawyers and in public health law on the development of public policy laws and regulations that address new and emerging threats to the public health; and 3) our biggest challenge, we need to begin to develop a comprehensive legal framework that defines a goal of health for all and establishes legal standards and tools for achieving it.

Let me turn for a quick moment to the enforcement of existing law. This should be a no-brainer. There are thousands of laws covering virtually every aspect of our life. I think of them almost as talmudic in scope. Many of these laws, if properly enforced and monitored, would make an enormous difference in the health circumstances of populations. They are not necessarily easy targets, but based on community interest, data, public awareness, and a scientific base of cause and effect, we can move this issue.

Let us take housing code enforcement, for example. We know that even the best asthma medication will not solve the problem of a moldy, dilapidated home that triggers a child's asthma attacks. Yet most states or localities have housing codes that require landlords, both public and private, to maintain their homes in a habitable manner. Few tenants have the resources or courage to demand compliance with these standards. It is an arena where litigation, threats of litigation, can make a difference not just in individual compliance but if focused on a particular community, a much broader triggering of compliance among landlords.

Take another example, physical education in schools. Obesity is epidemic in California, it is epidemic throughout the country, especially among low income children. State law in California requires physical education every day in school. Many school sites, however, have no teacher dedicated to the program and few resources to create a program. When I say "resources," I mean basketballs, footballs, tennis balls, any of the basics. Often they are challenged by safety and facility issues that make it impossible to participate in a physical education program. Few students or parents are even aware that state law mandates physical education in their schools. This is another example where public health lawyering can let people know that someone's watching and that enforcement is out there.

Let me turn to the second area of involvement, the development of new public policies. Public health is the perfect arena for the development of public policy in law-making. Here is where the health issues are identified at the broadest level. Like the canary in the mine, public health professionals can virtually forecast a health problem and identify early interventions to stop it before it becomes a crisis. Prevention of asthma, diabetes, and obesity are good examples of what you knew before anyone else really knew it. What can we do about it? The "soda out of schools" campaign in California is a good example of policy-making. Schools throughout the state, and probably the nation, have exclusive pouring contracts with soda companies. Vending machines that promote high sugar content beverages are open and available to kids as young as the fourth grade. Legislation proposing to eliminate sodas from elementary school campuses, to set nutrition standards for foods, and to require healthy alternative foods sold in school, passed the California legislature last year with public health people at the forefront. New legislation was proposed this year to ban sodas throughout high school, and I think it stands a good chance of passing.

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Land use planning, I know, is a subject that we have had more experience with, but it is an excellent example of public policy-making for health. Using alcohol control as a model, lawyers can play a role in developing model land-use control ordinances to control the density and location of fast food outlets or conversely to develop language for general plans to increase parks, playgrounds, parks, and walking trails.

Health and habitability standards for schools are a third example of policy-making that will make a difference. Even if kids with asthma have the right medication, their homes are in good condition, and they have had a community health outreach worker visit their home to make sure they have mattress covers, pillow covers, and hepa-air filters, they often go to schools that are run down with poor ventilation, old carpets, and windows that will not open. A measure to develop indoor air quality standards for schools was introduced last year in California. While I do not think it will pass this year, it stands a good chance of passing in the future. These are just a few of the examples of what we can do both in the enforcement of existing laws and the creation of new policies.

The third area, I will be brief here because this is the toughest one I would propose for public health law, involves the creation of a legal framework that establishes a core set of rights and responsibilities relative to health, and what I would characterize as the opportunity to be healthy. We have laws and legal strategies that can be applied to address specific diseases or injuries and we have legal tools to support public health decision-making regarding health threats. What we do not have is a comprehensive framework for what resources, services, and environments must be in place for an individual community and population to be healthy and stay healthy. To support this legal framework, we need standards, we need tools, and we need legal handles for getting at what it takes to ensure population health. The standards and tools must cut across multiple disciplines, must be comprehensive in scope, and must involve partnerships with many players across the field. Perhaps the most important tool is recasting ourselves.

This takes me back to my experience at California rural legal assistance, and that is, we must begin to see our role not so much as public health lawyers but more in the nature of corporate counsel, except that our client is the community. Like a corporate law firm, we must strive to ensure the success, that is, the health of our client and the community. It will require representation on many issues, in many forums, and with many partners. If we are able to work in that manner, to enforce existing laws, to create new policies where they are appropriate, and develop this legal framework, we will have redefined the playing field and have the opportunity to change population health and improve population health in the 21st century.

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Public Health Law: The Values of Global Collaboration

Myongsei Sohn

I would like to extend my appreciation to the planning committee of this outstanding conference, the Centers for Disease Control and Prevention (CDC) and the American Society of Law, Medicine & Ethics (ASLME) for allowing me to have this great opportunity to share my experience in teaching and studying medical and public health law and ethics with my U.S. colleagues. This morning, *USA Today* is reporting that Brundtland, the Director General of the World Health Organization (WHO), finally declared that the aggressive control measures have stopped SARS. I think it is a special achievement on her part as she departs the WHO in less than two weeks. The new Director General of the WHO, JW Lee, is a close friend of mine. The good news for us is that he has a great interest in Public Health Law and wants to encourage greater understanding and development of this particular field. During the global struggle with SARS, the revision of the International Health Regulation has gained a great deal of attention around the world. The greater role of Public Health Law is urgently needed with global collaborations with fluid and effective networking.

To begin, I must mention my personal ties with the city of Atlanta. About twenty-some years ago I met Dr. Nicholas Fotion, who came to Yonsei University as a visiting scholar in Philosophy from Emory University. At that time, the field of Medical Ethics was nearly an uncharted area of study in Korea. No one from the field of Public Health and the Korean government recognized the possibility of interdisciplinary study of Medicine and Ethics and Law. My experience with Dr. Fotion has inspired me to see beyond the conventional frame of medicine. I began with the perspective that the study of medicine must be integrated with a more complex understanding of the social, cultural, and philosophical background of the healing processes. I began to explore a new field of interdisciplinary effort where the practice of medicine would be examined and encouraged through efforts designed to foster public health. With that in mind, I would like to mention Dr. Fotion and Atlanta with appreciation and gratification.

Last year, when I saw the conference advertisement on the ASLME web site, it was thrilling to me to know that this particular conference was to be held in Atlanta. Then, I informed Professor Park, my friend and colleague at the law school, and asked him to join me in Atlanta for this conference in 2002. Our experience and the participation in the conference enhanced our understanding of how we can successfully integrate law and medicine into an interdisciplinary curriculum. Soon after our return from the conference, my friend Professor Park was appointed as the Dean of the Law School. Now I often joke with him that the charm of Atlanta somehow worked in his favor.

I also want to mention that it was at this conference last year that we procured a great gift from Larry Gostin, his own book, *Public Health Law: Power, Duty, Restraint*. On the way back home to Korea, I could not put down the book. Then I decided to use this book for class reading with my graduate students. The course was a great success. I and my students have a new enriched perspective and understanding of public health law. And we all had been convinced that our own nation needed a perspective of our own into public health law.

I am again here in Atlanta and I became a charter member of the American Public Health Law Association launched at this conference. I

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would like to stand next to you so that we can enhance our understanding of the field with variations, but I also would like to become an active participant so that I can contribute with some unique understanding. In addition, I believe that the gathering of people in this room can be extended to the global expansion of public health law. In this regard, I would like to make several suggestions to you. It is certain that the United States is the leading country in health law and especially in public health law. You are the pioneers. I could see the real power of America in witnessing that people from various fields try to analyze, study, and find solutions to common issues overlapping their fields. Now I wish that you as a leader use this power to communicate and encourage the scholars in other countries to exercise the power of organization for the health of the public worldwide.

If you turn your eyes just a little bit outside of the United States, you will see many more people struggling to protect the health and safety of their own peoples. Now is the time to share your valuable experiences and keen wisdoms to advance the knowledge of others. As we discussed and learned at this conference in relation to SARS, public health law is a very large concern for all nations. The public health problems of one country can transmit to others as easily and rapidly as the virus. The issues however will be more complex since the variables relating to a region's social, economic, and cultural environment would make it so. However, the experiences of one country or region can provide much needed insights, potentially avoiding other outbreaks. I am sure that your experiences will be a great help to other nations, as the experiences in SARS in Canada and China would give you better understanding of effectiveness of public health law. This is why we must emphasize international collaboration and communication.

For the last 10 years, my Korean colleagues and I tried to develop not only domestic collaborations to solve Korean problems, but also Asian collaborative efforts and communications. In 1995, when I was a Policy Advisor to Ministry of Health and Welfare, with the Korean government, I tried to prevent its fragmentation of health care law. I initiated the enactment of Fundamental Law for Health Care Services, which included not only services and confidentiality, but also health promotion, including fees for hazardous materials such as tobacco. Since 1995, I have worked to design and implement various projects, such as the enactment of Bioethics and Law, Organ Transplantation Law, the Cancer Control and the Chronic Disease Control Law, and the revision of the Emergency Medical Services Act and Communicable Diseases Prevention Act.

I would like to take this opportunity to introduce you to our future plan for the contribution to international collaboration in this field. On July 4, 2003 Yonsei University is going to hold a review symposium on the WHO International Health Regulation sponsored by the World Health Organization. The symposium will focus on the implementation of such regulations in nations that require specific applications. At this symposium, we plan to present what we have learned and experienced at this Atlanta conference. We would like to provide our comparative studies on the public health law movement of the United States to our participants and audience. At this time, we expect the experience of CDC and ASLME would provide good references to the Korean situation.

In 2005, Yonsei University will co-host the International Congress on Medical Law with the World Association for Medical Law. As we were watching the founding of the Public Health Law Association on Monday evening in Atlanta, I hoped that the 2005 Seoul Congress could serve as an avenue in which the World Association for Public Health Law and Ethics would be founded. We can include some aspects of public health law and ethics in Seoul at this 2005 meeting. At the end of August is our 10th Annual Meeting of the Board of Governors in the World Association for Medical Law in Gent, Belgium, and I will propose that, if you agree.

As I extend our warm invitation to all of you to the 2005 International Congress in Seoul, I would like to remind you that your experience and

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expertise in your field make you a leader in the global community. Despite our differences, I believe that the shared challenge in public health law does constitute a significant area of universal cooperation.

Lastly, as a member of a populous Asia, I would like to initiate a greater effort to make a greater number of Asian scholars and professionals participate in this field of study. I am deeply grateful that this Atlanta conference provides tools for all of us to clearly identify our own challenges and apply appropriate solutions to them. I believe that as long as we share the same academic interests and concerns, we are not strangers to each other, despite a long distance separated by the Pacific Ocean. What I most liked about this conference was your warm and welcoming hearts to us. Thank you very much. Kamsahamnida.

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Are We Prepared for Tomorrow's Health Challenges?

Angela Z. Monson, George E. Hardy, Jr., and Ed Thompson

Angela Z. Monson

Thank you so much for the invitation to be here with you. It is always a pleasure to be with people who understand, believe in, and know the importance of public health. Those of us who work in the legislative arena know how infrequent it is to have dialogue and conversation with people who really have a good, tangible, hands-on working knowledge of health care, and particularly of public health.

The notion of public health is an interesting one. It will range—if you talk to people in the legislature or out of the legislature—from just complete ignorance to total unawareness of what we mean by the words "public health." When you talk to individuals like us in this room, we find a mixture of definitions, a mixture of understandings, and a mixture of appreciation as to what public health really is. This is great deal like the legislative process itself where we bring together a group of people who bring different ideas and backgrounds to the table. So we do have great challenges and great opportunities before us.

We are partners as we move forward in developing and establishing good health policy, and developing solutions to problems that exist. The challenge is to decide what we do as advocates, as individuals who understand and who are engaged on a daily basis in public health? What do we believe is going to be the future of public health and how does it fit? How does it fit in the big scheme of things?

The picture and definition of public health have been painted by many different individuals, some who know, and some who do not know what public health really is and can be. The media plays a huge role in defining what the public believes are public health issues and what the public believes to be the appropriate response by public health professionals and agencies. If you ask right now, the public will talk about SARS of course. They understand SARS because the media has painted an impressive picture of SARS as a major public health issue. But when you talk about death from pneumonia and other conditions that far exceed the deaths and complications caused by SARS, the reaction is, "Oh! We didn't know that."

So, sometimes the media can be a friend. But sometimes the media does not paint an accurate picture. The question we should ask ourselves is, are *we* painting the correct picture? Are *we* doing the right things to make sure the media and the public have a clear understanding and an appropriate awareness of what public health is? Within our own professional associations, what kind of dialogue and discourse and questions are *we* asking and what kinds of strategies are we developing that will bring some clarity within our own professions as to what is public health? I am not convinced we are, although I am convinced that we can do so.

The second question is this: Have we lost the true notion of or focus on public health? Has it gotten lost in the larger debate over health care? This debate includes the uninsured and how we are going to provide coverage and access to health care for the uninsured—this debate about Medicaid reform and Medicare reform. These issues are in the press and we talk about them all the time, but we never really talk about them as it relates to public health. The public certainly does not view these issues of benefits and mandated coverage and prescription drug coverage as public health issues. The issue of health care facility development is one of my concerns at home. Not the old certificate of need policies. I try to avoid

the usage of that phrase because it has such terrible political connotations. But how the health care infrastructure develops, how systems are created, is a big issue. What facilities are going to be allowed? Take the ambulatory surgery centers and these niche hospitals and specialty hospitals. If you carve out the more lucrative services, do they take away from our old tertiary care hospitals, trauma facilities, and emergency care and the lack thereof? This whole debate is very current in political and legislative arenas.

Does the notion of public health ever creep into these discussions about malpractice reform, medical errors, and the use of evidence-based medicine? These are hot topics on the legislative agenda and in the media and around the kitchen tables of the people I represent. But do we see the connection? Is the connection made between these health care issues and public health? Have we really worked hard enough—this is the third question I would like to pose—in making the connection between public health and one's own health status? In all the issues I talked about earlier, we can clearly make the connection with one's well-being, but have we made the connection between these issues and public health? What does that mean? We are advancing this notion that public health and the law ought to be married and that there is a relationship between them. And certainly, the good things that have occurred in public health policy have happened because of changes in the law. There is a clear connection between the law and public health. But, mind you, laws are created through a political process. Laws are not always based upon good, clear, practical, reasonable, and rational information. How dare I say that? It is true; laws are created as a result of the political process.

So the next question I would like to pose to you is this: How effective are we as advocates, as experts, as people who work in public health? How effective are we in the political process? Do we do all that is necessary to make sure that people understand what we do? And, do we, as advocates, as people who work in our own little arenas, in our own little houses, really understand the political process?

Let me pose a question to you: Who are policy makers? Who are the folk that look like me? Well, there are not a whole lot of women, and for public health issues, that does change the dynamics and the discussion on the issues. What drives us to run for office? In many states, it is certainly not the salary because it is about $400 a year for some. Fortunately, I am from a state where you can make a livable wage. That is important because it changes the diversity of the legislative body. If it is $400 a year, who is going to run for office? Retirees and people who work for corporate America. It is in corporate America's best interests to have those folk in the legislature. There is nothing wrong with that, but we need to understand who it is we are working with in the political process.

We also need to understand better the political institution. What are the rules of the legislative game? The rules are extraordinarily important for those of us who are right there because they may mean either we win this bill or we do not. In the session earlier, someone talked about losing a bill on a reconsideration motion by simply one vote. Well, that happens. And, if we do not know what reconsideration motions are and what those rules are, sometimes we as advocates will lose. We almost lost our clean air legislation in Oklahoma, but we used those rules and we got it back on the agenda through the reconsideration process. We worked really hard.

As advocates, how much do we really understand the political institution? And as advocates, how much do we really understand this political environment? Many of you in this audience worked hard on a model bill, or a template, that we routinely refer to as the Catastrophic Health Protections Act. I had a little to do with that in Oklahoma. Little did I know, as I moved the bill in the Oklahoma Senate, that my good friends on the Democrat side, who are a little left of center, would be some of my biggest adversaries. Little did I know that my good friends who are a little to the right of center would be my biggest adversaries. When we thought we were putting together a very good and appropriate public policy to address what could be a tremendous public health

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crisis in our state, little did we know that individuals from both sides of the aisle would come together to argue against what we thought was good policy.

The adversaries used this whole notion of protection of personal liberties and protection of personal rights and properties. It was a different debate than I have ever engaged in during my 20-plus years around the Capitol. The debate went so far as to say, "I'm going to protect my personal rights even if it kills me." And I guarantee you, without some better understanding of this environment within which we work, and the mindset of both legislators and the public, we will lose our fights.

So how do we educate? How do we inform? Someone said, "legislators are looking for immediate results." If we provide some of the information that has been presented at this conference, I really do not know how persuasive it would be in the legislative arena. It is excellent information for us who work in the health field but we have to figure out a way to provide it in a manner that is persuasive and that moves public policy makers to take action now. Term limits and their implementation in state legislatures also significantly change the dynamics in those bodies. People are looking for immediate results because they only have two times to run for re-election, or they only have, as in my state, twelve years to be in this legislative body. So term limits also change the dynamics. We must be aware of these circumstances and situations because they have a bearing on how we behave and on the strategies we develop.

How well do we engage others in our efforts? By "others" I mean educators and the business community. I think about all the issues on this agenda. I think about the work of the Oklahoma state public health agency and about our county health departments. It is not hard for me to see a reason why the business community, teachers, and other educators would want to be engaged in this fight with us. It is clear to me, but it may not be clear to them. What are we doing to find new partners? I guarantee you, if this issue of public health, however we define it, is to percolate to the top, if it is to be given the kind of attention that it really merits, then we are going to have to find partners. Not just our traditional partners, but nontraditional partners, too.

When we talk to legislators about these issues, how well do we quantify the issues? I am not talking about how many people are affected. I am talking about dollars. I have heard some very compelling information about cost savings if we do things that we know, as public health advocates, are good for the whole society through prevention and education. There is compelling, quantitative information about what it costs if we do not do these kinds of things, but do we use this information? We have talked about business as a partner in public health. So as we think about screenings and other approaches that save money because they prevent very expensive health care treatment, then we should talk about the financial benefit that accrues to businesses that provide health insurance. As a business owner, I would want to know this. We have to package this information in an accurate and convincing way because we have some other folks out there who are going to oppose us every step of the way on these issues and say, "No, the cost right now far outweighs or far exceeds the benefit that we would gain in the long run."

There are many challenges ahead of us. The world really is changing and we must change as least as fast. The idea of public health must change as well. We have to learn to use technology and the media. We have to learn to use the law in a way that moves our cause and that moves this issue of public health forward. We have to bridge gaps of knowledge, information, and understanding. We have to identify new approaches and new responses to new problems. We have to develop truly strategic approaches for public policy change. We cannot believe that just by presenting the most accurate information people will be convinced that our position is best. We need to clearly define our goals and have a central focus that makes sense to the public, to our traditional and nontraditional partners, and, yes, to the skeptics who are looking only at the short term.

Let me close by saying that we must never lose sight of that ultimate vision, that ultimate goal. The ultimate goal for me, in terms of health care and in terms of public health is to create a healthier population with a better quality of life and health status. That is what we are about. To do that we will have to make sure that the tenets and the premise and the foundation of public health are included in virtually every aspect of our lives and virtually every aspect of the law. We have to see the big picture and realize there is a role for public health in virtually everything that we do. It is to our advantage, all of us, to redefine the challenges and the responses of public health. It is our business to do that. There is no one else better than we who are here today to do that. If we do not do it, if we do not identify and meet these challenges—and they are numerous—then someone else will do it for us. If we allow someone outside to do that for us, without us, then it is very likely that one of these days we will find ourselves out of business. The knowledge base, the information base, will not be there. The understanding will not be there.

We have lots of work to do, so my final charge and challenge to you all is simply to go forth and do good.

George E. Hardy, Jr.

Let me say to this audience that I agree totally with what Senator Monson has said. As the Senator indicated, so much of what we do is about perception.

I do want to respond to a couple of the Senator's questions. First, if anything positive came out of September 11th, anthrax, and the bio-preparedness efforts, it is that at least people are beginning to talk about public health. As someone said in one of our sessions today, there is a public health story on the front page of every paper every day now. That is a real blessing and it is a real negative because two things have happened. One is that the public now talks about public health. The President of the United States has talked about public health infrastructure. I was always taught infrastructure was a four-letter word and you certainly would not use it around the legislature. Now the public's perception of public health is smallpox and SARS. These are important issues that we have to address and be responsible for, but they are not all of public health. Public health is about prevention, about promotion, and about protection. And, protection means the environment, protection against other diseases and injury, not just bio-terrorism.

We have some real challenges and opportunities before us. Senator Monson asked, "Have we been effective advocates?" Unfortunately, we know the answer to that. A poll done before September 11 found that 82% of American adults do not believe they have ever used or benefited from a public health service. Well, do you have a birth certificate? Do you breathe the air? Are there epidemics in your communities? Are your kids vaccinated? Yet, the public's perception is that they have not benefited from public health. And while legislators debate how many policemen we need, how many firemen we need, and how many schoolteachers we need, they do not debate whether they are needed at all. In some communities, there are debates about why we even need public health. I think the answer is we have not been particularly effective in our advocacy. There is a lot more we can do. We have an opportunity now, but we have to make very clear that advocacy is more than just protection and it is more than just smallpox or we lose that opportunity.

In this country, we have a system of governmental public health—federal, state, and local. No one part of that system can work without the other two. We all like to think that we can from time to time, and we all get aggravated with one another from time to time, but no one part of this system can protect the public without the other two. We have to be advocates for all of that and be clear that all of those efforts are needed. When you get down to that and to how we are going to respond to the challenges, it really does come to infrastructure. We have to come up with a better term and we have to be able to explain in better ways what infrastructure means and what it does.

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I have always thought about infrastructure, from my local public health days, as money, material, and manpower. It was the three M's. We do not say that anymore. It is money, material, and people or workforce. We are starting to see some money, although it is all targeted toward bio-terrorism, and it is certainly true that every single state now is having budget deficits. And we are starting to see some materials, at least in the form of laboratory preparedness.

What I would challenge us all to think about is that, from my perspective, the real crisis in public health right now is the workforce. If you look at the state public health workforce in this country, 25% to 30% is either eligible now for retirement or will be within five years. When I was in the state of Alaska a few weeks ago, I was told 38% of their public health nurses are eligible to retire now. There is nobody coming along behind these people. We have artificial expectations. The bio-terrorism money said here is money for labs, epidemiology, communications experts, and leaders. That is great; we need that money, but the people are not there. As I have said, there are a lot of people who are unemployed sitting in a park outside of my office, but none of them are PhD lab directors. We have to get together the academic community, the practice community, and the policy makers, and recognize this problem and do something about it. Five years is not a very long period of time.

There are two other challenges I would like to raise, which Senator Monson raised as well. Have we defined public health? What is public health? What are we going to do? In this context, the challenge and opportunity before us is to recognize that there are a lot of problems on which public health can bring some expertise to bear; however, we cannot lose sight of the core responsibilities of public health. The nation is focused on access issues, the uninsured, and the underinsured and it should be. These are critical issues. Medicaid is ruining the states' budgets, and that is going to demand people's attention. We have to help in whatever way we can, but we cannot let those issues subsume and overtake everything that public health has to do. The other challenge is the counter to preparedness. We have to prevent preparedness from becoming all of public health. We have to somehow incorporate preparedness into public health and use those resources and that expertise in the dual-use capacity in which they were proposed.

As you go out of this meeting, please continue to think of ways that the law and the legal profession and the policy makers, many of whom are lawyers or listen to lawyers as we do, can use these resources as advocacy tools to help us address the real issues. And the real issues are protection, promotion, and prevention. Thank you very much.

Ed Thompson

I must confess that although I am supposed to present the federal perspective in this conversation, I am not totally capable of doing that, because I have determined that I will never stop thinking and speaking as a state health official, no matter where I actually work. I look at this from both directions.

I want to bring some points that I have gleaned both from today's discussion, from much of what has gone on during the course of the week, and from what has gone on "back at the office" for all of us for the last couple years.

Someone asked me this morning if CDC is prepared for the next public health emergency. I answered, "No, we are not. And neither is state public health, and neither is local public health." The reasons is that even if we have the best possible public health system in our city, in our state, or at the national level, we still will not be perfectly prepared for the next specific thing that is going to happen, because we do not know what it is going to be. We are never going to know what it is going to be, because nature is always going to be ahead of us. The best that we can do is be prepared for whatever comes in the best way that we can, recognizing that we will inevitably be thrown curves. We will always be trying to reach to swing at them. That is important in public health.

There are three things that I want you to think about. George Hardy and Senator Monson both have alluded to these. In the late 19th century, the

so-called sanitary movement removed the sewage from the streets, brought clean water through pipes into people's homes or near them, and disposed of trash and human waste properly. That movement did more to improve human health, lengthen life spans, and improve overall health than all of the medical advances of the entire 20th and, what has so far passed, 21st century. Think about that— it's true. All of the medical things that we do, such as the miracle surgeries and the antibiotics, which have contributed enormously to our health, do not begin to touch the basic environmental health activities that came to fruition over a century ago. Some of those were pipes, and some of them were things that were physically engineered, but much of it was environmental health law, requiring that certain things be done, requiring certain standards for food preparation, and on and on.

Environmental health remains a fundamental part of public health, and it is not about getting the minute traces of 2-4 di-nitro chickenwire out of whatever it is you are concerned with. It is about the basic things: separating humans from microbes and seriously dangerous toxic substances. The other things are important, too, but that is an important part of what we do. What I talked about at the beginning of this meeting and what you talked about in various sessions throughout this conference is the new challenges public health has faced during the last two years, such as SARS, West Nile Virus, and monkeypox.

All of these new public health challenges exemplify things against which people cannot protect themselves. We are used to saying to the patient in the chair or to the population to whom we are speaking, eat more of this and less of that. Exercise and you can protect your heart. If you do not want to get the flu, get yourself a flu shot. If you want to avoid lung cancer and emphysema, do not smoke, do not start, or give it up. People can do these things for themselves. At least three of the last four public health crises, however, have been things that people cannot protect themselves against. *We* have to do it—state public health, local public health, and national public health. We have to do it for them, and we have to be capable of doing that for them, very much like environmental protection. That is why it is so important that we be prepared for the next challenges.

Finally, I want to pick up on something that Senator Monson said, "We have to learn to use the law." I agree. This old public health doctor just said something surprising, because I have quarantined dozens of patients, and I have impounded animals. I have done all these things we are doing now with isolation and quarantine and control of animals' movements and things that we do in the case of bio-terrorism. These are old hat. Public health has been using these techniques for years and years.

We have done it before, but please take note, we have not done it in today's society. We have not used the law in these ways with today's people, with today's expectations, with today's consciousness of individual liberties, with today's large numbers of individuals who use the law for public good, but an almost equally large number of individuals who use the law for private gain. We have to learn to use the law in a new way. Someone once defined insanity as doing the same thing over and over again and expecting to get different results. Well, with public health law, if we do the same things repeatedly, we are likely to get different results.

Those are three of the big challenges for being ready for the future of the public's health. I talked earlier this week with someone about a concern that we in public health have, that is this tendency to focus on the science and consider it a nuisance that we have to deal with the politics of things. I said, "You can't take the public out of public health." Public health doctors are not scientists; we are as much politicians as we are anything else. We deal with people; we deal with legislators, governors, presidents, Congress, and local law enforcement officials. We have to integrate science and ordinary dealings with people, which is what politics is really all about. There is nothing wrong with that. Most of you are from disciplines that understand this because it is the bulk of what you do. You have to help us public health doctors realize that we cannot sit back here hiding in our white coats and say, "Oh, no, we are scientists, we don't do politics." We all do politics.

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Workshop on Smallpox Legal Preparedness: What Have We Learned from Smallpox Legal Preparedness?

Gene W. Matthews, Anne M. Murphy, Wilfredo Lopez, and Walter A. Orenstein (Moderator)

Walter A. Orenstein

The strategy used to eradicate smallpox included surveillance and containment. Cases of smallpox were identified and isolated to prevent further transmission. Contacts of the cases and contacts of the contacts were identified and vaccinated which terminated natural transmission. A smallpox attack would require both surveillance and containment as well as mass vaccination of the population. Bioterrorism preparedness has focused on pre-attack vaccination of response teams who would implement a post-attack response. Groups being considered for response teams include public health and hospital workers. In addition, responders could include security staff, emergency medical service personnel, and other health-care workers. In the event of smallpox-related terrorist event, public health authorities would not know the magnitude, mode, and duration of the attack, so it is likely there would be a rapid decision to vaccinate the whole population.

There is a very effective smallpox vaccine but it has some side effects. Thus far, none of the life-threatening adverse events previously attributed to smallpox vaccine have been reported among those vaccinated. However, there have been 21 unexpected cases of inflammation of heart and/or membranes surrounding the heart. There also have been five heart attacks, which is within the statistical range of potential chance occurrence, but a possible connection to smallpox vaccinations cannot be ruled out. Thus, policies have to balance the threat of a smallpox attack with the potential side effects of the vaccine.

The Association of State and Territorial Health Officials surveyed its members to measure acceptance of the smallpox vaccine as an integrated part of an overall bioterrorism plan. Factors affecting acceptance were the ending of the Iraq war, perceived risks, and perceived reduced threat levels. Members had concerns about liability and compensation and adverse cardiac events.

Gene W. Matthews

At the turn of the 20th century, many state emergency health powers laws were encapsulated in just one sentence: "The health officer shall take such action as deemed necessary to prevent the spread of communicable diseases." In 1954, the Salk polio vaccine ended the era of community-wide emergency public health control measures, while *Brown v. Board of Education* was the beginning of procedural protections of individual liberties against government actions. Today because of smallpox, SARS, and monkeypox, we have to balance collective action for the common good against individual liberties.

Courts will review quarantine and isolation orders in light of due process. Common elements of due process include adequate notice, the right to be heard, access to legal counsel, and a final decision that a court can review.

The smallpox vaccination legislation covers four categories of individuals: health care workers who monitor or treat persons with smallpox, members of a smallpox response team, public safety personnel assisting smallpox response teams, and personnel associated with certain U.S.

facilities abroad.

In the monkeypox experience, public health authorities had three important issues to address: 1) how to "trace back/trace out" (i.e., identify where the infection came from and to where it has been transmitted); 2) use of the smallpox vaccine for protection against monkeypox; and 3) importation embargos and shipment bans for the sale and distribution of all African rodents and prairie dogs.

Anne M. Murphy

Illinois recently implemented Phase I of the federal pre-event smallpox plan [described above]. Initially, local health departments and hospitals were resistant because of concerns over informed consent, liability protection, and injury compensation. Additional consent forms and written disclosures were developed in collaboration with the CDC. Disclosures included a recommendation that those with diabetes, those over 65, and those with a chronic medical condition do not get the vaccine.

To prepare for the implementation of Phase I of the pre-event smallpox plan, Illinois public health officials determined what information was most important for those giving and getting the vaccine, including a recommendation that those interested in the vaccine consult with a physician, that secondary contacts of vaccinees be given information about possible transmission risks, that those with HIV and those who are pregnant be informed about the risks of vaccination, that privacy rights are explained, that those who experience an adverse reaction are entitled to compensation, and that those getting the vaccine are aware of the risks associated with vaccination. The priorities were to highlight the risks for specific groups and acknowledge that not all risks associated with the vaccine are known, to be clear about compensation gaps, and to create additional categories of individuals for whom receipt of the vaccine is not recommended.

Wilfredo Lopez

To prepare for the smallpox vaccination program in New York City (NYC), health officials reviewed Centers for Disease Control and Prevention (CDC) materials and the NYC Phase 1 plan for consistency, commented on CDC's consent process and form, and finally drafted a consent addendum. A pre-vaccination education program was conducted with hospital staff. In October 2002, city health officials raised concerns about the need for liability protection for state and local health departments in light of the current budget crises.

After a minor smallpox scare, NYC health officials helped draft joint city and state guidelines for hospital management of possible cases of smallpox. They reviewed existing laws regarding isolation and quarantine and drafted amendments to the NYC health code regarding the removal and detention of suspected cases. It was decided that those in contact with people with smallpox had to be detained, even though they were not infectious. More flexibility and due process were added to the statutes, including the provision of lawyers to represent the detained and an opportunity to be heard.

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Symposium on Public Health Law Surveillance: The Nexus of Information Technology and Public Health Law

Angela McGowan, Michael Schooley, Helen Narvasa, Jocelyn Rankin, and Daniel M. Sosin (Moderator)

Angela McGowan

The Centers for Disease Control and Prevention's (CDC) goal is to develop a surveillance system of public health laws that would both support research and analysis among policymakers and legislators, and support the scientific basis for public health law. This session was convened, in part, to discuss the value of creating an electronic system to track public health legal information. Public health surveillance is the "ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve health. Data disseminated by a public health surveillance system can be used for immediate public health action, program planning and evaluation, and formulating research hypotheses."[1] There is currently no system available that meets the goals of this definition of "surveillance" for public health laws.

To develop such a system, many issues must be considered. For example, this system should clearly define the purpose of such a system, identify the stakeholders, identify the gaps, describe the uses of the data and analysis, and determine what actions will be taken as a result of the information gathered. In addition, data sources must be identified, case definitions must be agreed upon, and procedures to analyze and disseminate the data must be considered. Finally, resources must be found, unintended consequences and threats considered, impediments identified, and a timeline established.

Michael Schooley

In 1994, the Office on Smoking and Health started tracking tobacco laws including those addressing advertising, excise taxes, licensure, preemption, smoke-free indoor air, and youth access, all of which influence health behaviors and could affect tobacco use rates. CDC put the results of these law-tracking activities into an on-line system called the State Tobacco Activities Tracking and Evaluation System (STATE).

The purpose of STATE was to provide summary information on a breadth of tobacco-related issues for program managers, decision makers, and health researchers. STATE provides information about planning, monitoring, and evaluating a tobacco use prevention program. The system summarizes information about tobacco-related behaviors, the economic burden of tobacco use, the health consequences of tobacco use, tobacco-related legislative information, and funding sources for tobacco programs. The focus of STATE is on state-level information and laws. Local level information is available on the Internet and from tobacco control advocates, but it is collected passively rather than proactively.

STATE includes both the enacted date and the effective date of tobacco-related laws in order to associate the law with outcomes and consequences, as well as attitudes and behavior changes. The surveillance activities made possible by STATE can indicate progress toward health improvement, such as preventing initiation among young people, and eliminating exposure to environmental tobacco smoke. Looking at public health law data is a critical part of assessing the

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impact of interventions because often such impacts are associated with changing laws and policies.

Helen Narvasa

The Health Policy Tracking Service (HPTS) is a non-partisan web resource that systematically collects, tracks, and analyzes state health care legislation on behavioral health, health insurance, managed care, Medicaid, pharmaceuticals, health care providers and facilities, long-term care, tobacco, nutrition and physical exercise, public health preparedness, and state health budgets.

Many lessons were learned in creating the HPTS system. Having qualified research staff to identify, analyze, and interpret the data is crucial to HPTS' success. It also is important to consider the audience when developing aspects of or making changes in the system (i.e., keep it simple, but also suit a variety of information needs and user levels). E-mail alerts help remind users of the resources available to them. It also is vital to solicit regular internal and external feedback, disseminate information beyond the website, and monitor other available resources to ensure relevancy of the system.

Jocelyn Rankin

Reference librarians get a wide range of questions from public health practitioners, researchers, lawyers, clinicians, policy makers, legislators, and public health and law school faculty and students. A library serves as a collaborative learning space, communication center, quality filtering device, value-added service center, and locus for information tools development and knowledge creation. A library is not a place to provide legal advice or interpretation or to provide medical diagnosis, treatment, or other health advice.

CDC's new Information Center will be the locus of CDC's outreach programs and collaborations with both the public health community and the broader public, and a bridge between the public side of CDC and the more secure laboratory functions. A needs assessment will determine whether there should be a public health law and health policy information service.

Libraries are moving toward more virtual services, with electronic resources, desktop access to library resources, electronic delivery between libraries, customized products and services, and systems that hyperlink and reflect cognitive mapping. There will be new tools for organizing web-based resources, new publishing paradigms with more open access, prototypes for institutional repositories for information, systems to insert knowledge at the point of need, meta-search engines, more options for full-text searching, and federated searching capability.

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Legal Preparedness for Public Health Emergencies: TOPOFF 2 and Other Lessons

John A. Heaton, Anne M. Murphy, Susan Allan, and Harald Pietz (Moderator)

John A. Heaton

There is a fine balance between civil liberties and protection of the public's health.

Legislators, especially those in the western United States, are concerned about selling the Model State Act ("Act") because of the loss of civil liberties. State constitutions give governors broad powers, such as declaring martial law and giving public health leaders the authority to act. State laws should consider issues such as property rights; taking of businesses and supplies; quarantine and isolation; due process; coordination among states, counties and cities; communication systems; conscription of doctors and nurses; and compensation. When two mock emergency response drills were held in New Mexico, concerns arose regarding opening records associated with dams, national laboratories, waste repositories, and three air force bases.

When the Act was first developed, it did not have due process or a prescriptive methodology for quarantine, isolation, or taking of property, which apply in a true emergency. New Mexico was able to overcome the complaints about basic aspects of civil liberties by conducting statewide hearings and by educating citizens about the Act.

The Act includes elements to protect civil liberties. There must be clear and convincing evidence for all decisions regarding isolation or quarantine and persons may request a hearing at any time, which must be held within five days. Only the least restrictive means can be used, and health conditions must be monitored. Food, clothing, shelter, and sanitary conditions are all part of isolation and quarantine, as well as mental and medical health services, religious worship, and communication with legal advocates and the media. People have the right to refuse medical treatment, testing, and vaccination.

Anne M. Murphy

TOPOFF 2, a congressionally mandated terrorism preparedness exercise, took place in Seattle and Chicago during the week of May 12, 2003. In Chicago the premise was an intentional release of pneumonic plague in three sites. Emergency operations centers were set up and participants followed scripts that had both very detailed planned and unknown elements. New information and situations came into the centers continuously.

In exercising the deployment of state and local emergency systems, there were major transportation and other logistical challenges because the event simulated a widespread geographic bioterrorist event designed to tax existing resources. Federal, state and local government officials and hospital workers all responded.

In Illinois, a legal team was developed among federal, state, and local attorneys in order to address legal issues associated with the TOPOFF 2 exercise. The legal team anticipated many legal issues, cutting across many disciplines, and prepared accordingly. Strong working relationships among all participating agencies were extremely important, especially with legal offices of the City of Chicago. Attorneys from border states were also involved in the exercise and worked through a special working group on interstate legal issues. There was tremendous media coverage.

The formal objectives of the TOPOFF 2 legal team were to: report medical information to departments of public health and others consistent with federal and state privacy laws; use licensed and non-licensed personnel in and out of Illinois to distribute medicines and supplies from the National Pharmaceutical Stockpile (NPS); and ensure communication among attorneys and their clients during the exercise.

Many lessons were learned from the TOPOFF 2 legal team. First, it was important to start bridging communication gaps before an emergency occurred. Having a list of emergency communication mechanisms proved critical and invaluable. Second, it was important to persevere in bridging gaps (whether substantive or geographic) between public health, law enforcement, emergency management, federal, state, and local officials, and attorneys and their clients. Third, it was important to get comfortable shifting the response paradigm and remain flexible.

Susan Allan

Federal law is an integral part of a local response to terrorism. For example, relevant federal laws might include those addressing international borders, interstate issues, primacy laws (where a federal agency can step in if a state agency is not effective), and issues related to having federal agencies and the military residing in affected communities. Likewise, a local response must consider the potentially overlapping jurisdictions of state laws, state agencies (public health, emergency management), local ordinances and entities (fire, police, etc), and regional environmental, airport, and park authorities.

In the event of a terrorism event, messages must be coordinated among adjacent jurisdictions, states, and military and federal authorities, as agencies have different planning and preparedness plans. In the middle of an emergency public health authorities might have to ask for legal advice from the state attorney general, the county attorney, the commonwealth's attorney, local boards of health, and federal legal advisors—and the advice may differ.

Quarantine and isolation bring up some particularly interesting and challenging issues around restriction of movement, compulsory vaccination and treatment, the right to counsel, least restrictive alternatives, and how to manage when little is known about a particular disease (i.e., protection of the public while protecting individual rights). Even when the legal authority is clear, there are questions around whether the enforcer is prepared and has enough staff, what level of force they are willing to use, where detainees will be kept, and who will pay.

Likewise, a number of issues must be considered if during an emergency, there must be a taking of property including, lost wages, restricted access to facilities or businesses, the redirection of resources, or the disruption of other activities and events.

Another important issue includes both the rights and responsibilities of government and private workers. Will they show up for work if they are infected, and if so, what is needed? In planning for an emergency, compensation and liability to patients and those not served must be considered. Similarly, if public health authorities take advantage of volunteers, issues such as credentialing, training and supervision, responsibility for their own actions and liability should be considered.

Finally, public health authorities must consider what to do if there are inadequate resources to address an emergency and maintain normal government operations. The legal responsibilities and potential liability for redirecting resources to emergency preparedness are an important element of resource management.

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Public Health Preparedness and the Law in Communities of Color

Vernellia R. Randall, Glen Safford, and Walter W. Williams (Moderator)

Vernellia R. Randall

Public health preparedness must use a comprehensive approach that includes both communities and public health systems. There are three basic questions that should be asked when evaluating public health preparedness in communities of color: 1) Is the community basically healthy?; 2) Does the community have access to necessary information, resources and services?; and 3) Are the information, resources and services available and provided to the community in a nondiscriminatory manner?

Racial-based health disparities is a well documented fact for many communities of color. Individuals from these communities tend to have more morbidity and higher mortality. This health disparity is race based and not just a function of social class. Similarly, access to basic goods and health care is racialized and class based. For instance, 50% of non-white women have financial difficulty in obtaining food and more blacks than whites are in temporary and emergency shelters. Similarly access to health care resources is also impacted by race. For instance, more blacks than whites are without adequate health insurance. Most hospital and physicians offices are outside minority communities. In fact, since the 1960's as many as 70% of hospital closures are in minority communities. Finally, access to first responders is affected by race. While access is generally inequitable, it is further handicapped by lack of trust between first responders. This lack of trust is often caused by instances of racial profiling.

The bottom line is that institutional racism in basic goods, in health care, and in first responders impacts the ability of communities of color to be adequately prepared for a public health emergency. Institutional racism is a system of procedures, practices, and patterns that perpetuate and maintain the power, and influence the well-being of one group over another. A comprehensive public health law approach to preparedness would eliminate health disparities, increase health care utilization, ensure quality health care, enhance data collection in minority communities, eliminate discrimination, and increase first response effectiveness.

Glen Safford

Tribal sovereignty is based on the concept of nationhood. The Indian Self-Determination Act recognized that American Indian people needed to develop leadership skills crucial to the realization of self-governance, and a voice in the planning and implementation of programs.

Tribal health care systems are operated by tribes, under contract with federal and state governments and private entities. Staff must answer to tribal councils and health boards as well as the Great Lakes Boards. The level of collaboration varies, but most tribal health care systems report communicable diseases and collaborate during outbreak investigations and prophylaxis. Tribal health care systems also receive and use free vaccines from the state and other programs.

The Great Lakes Inter-Tribal Counsel's (GLITC) mission is to expand self-determination efforts, with deep respect for tribal sovereignty and reservation community values. There are three levels and functions to the system: provide technical assistance and support; provide input, ideas, and model procedures; and provide assistance with policy and planning approval with tribes. GLITC does not do anything the tribes want to

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reserve for themselves. True community public health is provided through a mixture of professional and consumer perspectives, with bottom-up strategic planning, with an emphasis on prevention and education, and using a broad definition of health care.

Many lessons have been learned through working with tribal communities. For example, it is important to stress tribal sovereignty. To work together, strong and innovative systems, model approaches, and strong technical capabilities are essential. In addition, it is critical to develop informed, trusting relationships, and broaden mutually beneficial alliances. Most importantly, when working with tribal communities, partners need to have open attitudes, and learn from each other.

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Approaches to Implementing the Olmstead ADA (Americans with Disabilities Act) Ruling

Shelley R. Jackson, Gayle Hafner, Daniel O'Brien, and Georges Benjamin (Moderator)

Shelley R. Jackson

The Department of Health and Human Services, Office for Civil Rights (OCR) enforces Section 504 of the 1973 Rehabilitation Act and Title II of the Americans with Disabilities Act. OCR works through complaint investigations and compliance reviews, as well as outreach, technical assistance, and public education to promote voluntary compliance. In the *Olmstead* decision of June 1999, the Supreme Court held that the *ADA's* "integration regulation" requires state and local government to administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities. The decision changed the focus from whether a right to more integrated services exists, to under what circumstances and how services will be provided. The New Freedom Initiative announced by President Bush in February 2001 is a broad-based initiative to remove barriers to community living for people with disabilities and promote swift implementation of the *Olmstead* decision. The President signed an Executive Order concerning community integration of people with disabilities in June 2001, and federal agencies are taking action in response to that Order. OCR plays a significant role in carrying out the New Freedom Initiative, the Executive Order, and *Olmstead* implementation.

When OCR receives a complaint, it asks three questions: 1) Have treating professionals determined that services are being offered in the most appropriate and integrated setting possible?; 2) Does the complainant oppose more integrated services?; and 3) Can more integrated services be reasonably accommodated? The third question involves the cost of providing services, the resources available to the state, and the impact of relief for the complainant on the ability to serve others. For example, in San Francisco, the U.S. Department of Justice and OCR found that some individuals in a nursing home did not need institutional care, did not oppose community placement, and the city could meet their needs by expanding existing services. OCR is implementing a pilot alternative dispute resolution program to resolve complaints voluntarily, and will expand dissemination of information about voluntary compliance with *Olmstead* and integration regulation.

Gayle Hafner

Public policy makers have an opportunity to improve quality of life and reduce Medicaid spending by evaluating the most appropriate and preferred placement of elderly and disabled individuals. As much as 25% of states' Medicaid money goes to keeping people where they do not want to be. Not everyone needs 24-hour care. When given a choice about their long-term care, often people will choose community care and when individuals have more control, they participate more in their community.

After the *Olmstead* decision, it became increasingly clear that many people in nursing homes did not need to be there. In Texas, 1300 people over age 65 left institutional care when given the choice. Texas introduced legislation to let people take their Medicaid money with them, from institutional care to community care. A small percentage of people needed more money in order to live in the community, but on average living in the community costs two-thirds of the costs of an institution. Texas saved millions of dollars. Thus,

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states that are facing Medicaid cutbacks should reevaluate their programs under the *Olmstead* obligations. Nationally 46 billion dollars goes to nursing homes, and relatively little goes for waivers, personal care, and home health; 70% of those dollars go to long term care in institutional settings and only 30% goes to community care. The reverse ratio is true for the people who need care; 80% of the people who need long term care are struggling in the community fighting against going into costly nursing facility care, at least 25% of the people in nursing facilities want to go home, and soon far more people will be in need of long term care. Shifting money from institutions to people serves more people with less money.

Daniel O'Brien

For state governments, Medicaid often serves as the key source of funding for *Olmstead* initiatives. Current funding levels are not insignificant. Annual expenditures for both Medicare and Medicaid total $260 billion—an amount that approaches $1,000 from every U.S citizen. Despite this investment, many proposals remain unfunded. This is true even though some initiatives could actually reduce outlays over the long term.

The Supreme Court's analysis in *Olmstead* clearly supports state efforts to expand community based treatment for persons with disabilities. States are required to provide this treatment "… when the State's treatment professionals determine [this] is appropriate, the affected persons do not oppose such treatment, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

As described in a recent study by the National Conference of State Legislators, states are struggling to meet *Olmstead* objectives in the face of severe budgetary limitations. The present budgetary objective is to contain costs rather than to expand services. At the same time, many jurisdictions have sought to advance community integration plans. Forty-two states have formed *Olmstead* "task forces". Ten states have enacted *Olmstead*-related legislation.

Given the current fiscal climate, states have three basic means of enhancing *Olmstead*-compliance efforts. First, they can reformulate current programs to advance community treatment goals. Second, a jurisdiction can expand available resources. State user fees, institutional property sales and federal grants can be used to support *Olmstead* initiatives. Third, a state may minimize its legal exposure by diverting institutional admissions, privatizing certain operations and seeking to access private insurance coverage where appropriate.

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The Challenge of For-Profit Health Care Conversions

Marion R. Fremont-Smith, Mark Urban, and Sandy Praeger (Moderator)

Marion R. Fremont-Smith

Most hospitals are considered charities under common law because they were established for the benefit of the public. The law granted them benefits, but also imposed duties. Under the *cy-pres* doctrine, if a charitable purpose becomes obsolete or incapable of being carried out, the court could modify those purposes to meet current needs of the organization and the community. Modern laws attempt to find a purpose as near as possible to original purposes set up by donors. In the case of hospital conversion, some regulators say assets must be used to support hospital health care, while others say they can be used in the broad sense of health care. That has been a continuing conflict between communities and regulators.

Since 1996, 30 conversion statutes have been enacted, covering hospitals, HMOs, and insurers. A conversion statute is one under which a state official or the court oversees the sale or transfer of control of an organization so that public assets are protected. State attorneys general regulate charities, but many have no time or resources to investigate conversions, and therefore, often, they have been unaware when sellers or states keep proceeds. Defining the respective roles of state officials is important because there are often conflicts between the attorney general's duties (protect public assets) and those of the commissioner of insurance (protect subscribers) and public health officials (protect communities).

Most statutes require advance review of proposed conversions, assurance of fair market value price, and assurance that the successor organization will be charitable (i.e., exempt from taxes). These statutes also may require an assessment of the impact on access to health care and the quality of the system. In some statutes, post-conversion oversight is required.

Mark Urban

There have been 15–20 hospital conversions in California. There was concern that community benefits of non-profits would be lost because in some cases, boards were acting in their own interest rather than in the community interest. Charitable trust doctrines were not well suited to deal with those concerns. As a result of these concerns, California passed legislation setting up a system of mandatory Attorney General consent for sale of non-profit hospitals to for-profit and non-profit entities.

In California, when a hospital wants to transfer control, it has to file a detailed application with the Attorney General, which triggers a 60-day review period. One public meeting is required, usually at the end of the process, which includes local leaders, community groups, elected officials, advocacy groups, consumers, and employees unions. Issues considered as part of the Attorney General's review include the effect on availability and accessibility of health care in local communities, how to use sales proceeds as part of a conversion foundation, and fair market value, if any. The applicability of the Ethical and Religious Directives is an issue in transactions involving Catholic hospitals.

Most conversions are approved with conditions that have to do with maintaining healthcare, such as: a) continuation of the most important hospital programs (e.g., emergency rooms and intensive care units), continuation of levels of charity care (i.e., based on cost rather than billing

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rates), and continuation of major community benefit programs (e.g., outpatient services, diabetes programs); b) including a local governing or advisory board that is reflective of the community; and c) using the proceeds of hospital sales in ways consistent with the historical hospital services, usually in-patient services. Compliance issues include ensuring that conversion funds are properly used and managed, monitoring to ensure compliance with conversion conditions, and monitoring complaints from advocacy groups.

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The Role of Law in Health Services Delivery: Diabetes and State-Mandated Benefits

DeKeely Hartsfield
and Frank Vinicor (Moderator)

DeKeely Hartsfield

Diabetes is a chronic and systemic disease that has reached epidemic proportions. An estimated 17 million Americans have diabetes (5.9 million of which are undiagnosed), and an additional 16 million individuals are considered to have pre-diabetes. Studies have shown that timely screening and referral are necessary to maintain healthy blood glucose levels and slow the progression of diabetes-related complications. Furthermore, lifestyle changes (i.e., altered diet and physical activity) can prevent or delay the onset of Type 2 diabetes for high-risk individuals.

The Division of Diabetes Translation at the Centers for Disease Control and Prevention undertook an analysis of diabetes-related legislation across the nation. More specifically, state laws, rules and regulations mandating health insurance coverage for diabetes-related supplies and services were examined according to *Sample Purchasing Specifications for Services Related to Diabetes*—an evidence-based model of standards of care for persons with diabetes. Lastly, the Division evaluated the number of individuals with diabetes that would potentially benefit from the mandated coverage of preventive measures, laboratory examinations, medical management services (i.e., self-management education, nutrition therapy, periodic eye and foot exams, therapeutic footwear, and case management), medications, devices, and supplies related to diabetes.

The study found that 46 states and the District of Columbia have diabetes-related legislation. Although existing, the legislation varies in content and rarely mandates comprehensive coverage. Of the insured U.S. population with diabetes, 26%–41% are covered by state regulated plans, and 55%–73% are insured by non-state regulated plans (range was dependent upon the variation in regulation of state and local government-sponsored insurance plans). Future research will examine the effect of legislation on the provision of care and what services are covered by self-insured plans, Medicare, and Medicaid.

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New Pressures/New Partnerships: Public Health and Law Enforcement

Cliff Karchmer, Pam Tully, Leah Devlin, Frank Whitney, and Michael Sage (Moderator)

Cliff Karchmer

The Police Executive Research Forum is completing a major initiative that encourages police chiefs to formalize working relationships with emergency medical personnel. The effort is sponsored by the U.S. Department of Justice, Bureau of Justice Assistance as a demonstration with the goal of preventing recurring violence that eventually leads to homicide. The initiative originally involved a consortium of emergency room clinicians, emergency medical service (EMS) personnel, as well as police executives. The collaboration initially focused on arguably preventable dimensions of domestic violence and homicide. However, after "9/11" and the ensuing anthrax crisis, the project developed into a three-step draft interactive protocol for earlier police intervention in situations involving possible deaths and mass casualties. With this shift in the project, Police Executive Research Forum's (PERF) principal collaborators shifted from emergency clinicians to public health practitioners. The basic three-step protocol is as follows: 1) the police chief contacts the local public health official, college, or medical school; 2) the nature of the problem is identified and basic data is collected and presented by each core participant; and 3) relevant staff meet to develop a coordinated, preventive action plan, and to identify steps to implement that plan.

Police outreach to public health is relatively new, but learning from practice drills such as those used in TOPOFF 2 could make responses more effective. Public health officials should take the initiative to invite police into public health preparedness meetings. To date, much of the work on public health preparedness has lacked contributions from the police who will have to enforce relevant laws. The recent quarantine discussion is a case in point: police have been conspicuously uninvolved in determining policy and in identifying potential options short of quarantine.

Finally, what is needed is a means of storing documentation on the lessons learned from TOPOFF 2 and other drills and exercises (e.g., an interdisciplinary clearinghouse of action plans, exercises, and tabletop and real drills of various types). At present, no such database of after-action reports exists, and the lack of this database severely impedes the ability to learn from practice exercise.

Pam Tully

New techniques, partnerships, and languages used in intelligence gathering and communication are evidence that this field is changing dramatically. These changes can be referred to by using the acronym BASICS (Building America's Strength Through Information and Communication Sharing). Partnerships between federal, state, and local public health officials are critical. For example, the North Carolina State Bureau of Investigation, Federal Bureau of Investigation, North Carolina Public Health, and the Department of Agriculture have partnered to discuss concerns surrounding eco- and bioterrorism. The challenges to using the BASICS model and communication strategy have included language barriers, (e.g., clarity of terms—a "case" used in the public health profession means something different than a "case" in the legal and law enforcement profession), funding problems, and predominantly, politics. However,

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working together to develop a mutual understanding **can** be achieved and basic differences **can** be overcome. There is strength and success in these new partnerships.

Leah Devlin

The North Carolina Bureau of Investigation has partnered with many other state agencies to address issues such as communicable disease containment and prevention, environmental hazard protection, natural disaster response, and healthcare for the incarcerated. Some define collaboration as an "unnatural act between non-consenting adults," but the overriding goal of forming partnerships for public health preparedness is to protect communities.

Over the past 18 months, the North Carolina Department of Health and Human Services' strategy has been to develop joint interagency training; to share their expertise to identify and address gaps in policy, law, or emergency response protocols; to strengthen the legal infrastructure of public health laws (e.g., to extend due process procedures in quarantine and isolation laws and to create a research registry); to partner with others who will be called upon to respond to public health emergencies; and to provide leadership support (e.g., identify liaisons within other relevant agencies, conduct daily risk assessment sharing, and establish a memoranda of agreement for an emergency alert communication system).

Frank Whitney

Public health officials and attorneys working in the area of criminal law often are unfamiliar with each other's processes (e.g., due process issues, collection of evidence, and chain of evidence requirements for court proceedings). Chapel Hill hosted four public health forensic epidemiology courses for leaders in law enforcement and public health. One week after a forensic epidemiology course, a rash-like illness of a visiting Israeli national prompted immediate communication between the state, its Response Coordinator for Weapons of Mass Destruction, the Centers for Disease Control and Prevention, the Federal Bureau of Investigation (FBI), and the Bureau of Immigrations and Customs Enforcement (formerly INS). The rash was not smallpox, but it demonstrated the success of the training and how extraordinary federal resources can help public health. The federal government provides intelligence, money, and national connectivity. A Joint Terrorism Task Force, lead by the FBI, serves as the contact point for all major law enforcement databases nationally. Its intelligence is accessible to states through the U.S. Attorneys' office.

The processes of public health and law enforcement are complementary but involve different legal issues. Public health uses an inductive process to collect evidence and develop hypotheses, while law enforcement uses a deductive process to steadily develop a case. The goals of finding and controlling an outbreak, and finding law breakers and collecting admissible evidence to prevent future attacks, could conflict. The anthrax attacks, in fact, provided our country the time to learn vital lessons that would not have been possible in an infectious disease attack.

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When Public Health Meets the Judiciary

Michael J. Murphy, Anne M. Murphy, Maureen E. Conner, and Linda Chezem (Moderator)

Michael J. Murphy

The conflict between courts and medicine is best shown in the mental health cases requiring judgment of whether a person should be confined, and whether they should be medicated or left free to decide for themselves. In such cases, deprivation of liberty for noncriminal offenders is at question, but if they are released, they may be exposed to injury or injure others. "Clear and convincing" evidence is hard to prove in such cases.

The TOPOFF 2 terrorism preparedness exercise was two years in planning, but the courts were involved only seven days before the exercise (because quarantine issues were added to that exercise only two weeks beforehand). Judge Murphy was put in charge of the Circuit Court building and was asked to stop all court proceedings to stop people from going into a building that might have been contaminated. Two important lessons were learned: at least one court should have been left open to provide a forum of appeal, and the courts should have been involved in TOPOFF 2 early in the planning process. Currently, those charged with a crime in Illinois must appear before a judge within 24 hours. Due process is threatened when no court is available.

Experts are needed to educate judges, particularly on issues of detention. Generally, courts prohibit *ex parte* communication (communication with a judge that includes only one party) because if only one side communicates with the judge, there is a risk of biasing a case. Thus, education about the legal issues pertaining to public health emergencies, such as quarantine and isolation, is needed before an emergency arises. In the event of a case involving a public health emergency, expert information can be provided to both sides (i.e., the person being detained and the detainer). An *amicus* brief (friend of the court brief) should be filed as soon as possible and must be made available to any and all interested parties. Bench books (i.e., a brief submitted to the judge explaining the legal issues involved in the case) provided to a presiding court are very helpful and also must be made available to any and all interested parties.

Anne M. Murphy

Police powers have historically been the legal cornerstone for state and local public health regulation: reporting and regulation of communicable disease, enforced isolation and quarantine, regulation of health facilities (involving significant issues of patient and worker safety), and food, drug, and dairies regulation (e.g., food embargo, involving complex jurisdictional issues). Public health regulation also covers laboratory testing and health data collection. The Health Insurance Portability and Accountability Act (HIPAA) provides the authority for the health data collection, but there is increasing concern about the release of such information.

Sooner or later, the judiciary will weigh in on the legal authorities of public health. Dialogue with the judiciary is needed to address antiquated judicial processes that are affected by bioterrorism preparedness and response. Public health legal issues are unique because they involve complex medical and clinical issues, multiple jurisdictions, state and local regulations, and multiple disciplines (e.g., medicine, epidemiology, environmental health, emergency response, law enforcement), and all are overlaid by state and local police

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powers. Specific challenges include the multiple jurisdictions involved in emerging disease outbreaks (e.g., monkeypox), escalating health facility insolvency (particularly as related to an increased emphasis on patient safety), increased demand for health data paralleling greater legal regulation of confidentiality, and vaccination and research initiatives involving civil liberties aspects.

In Illinois, TOPOFF 2's interdisciplinary and interjurisdictional planning teams evolved into a standing workgroup of all stakeholders. This will be the forum to reach consensus on the state's proposal on public health emergency powers; updating state isolation regulations to include forensic epidemiology, legal, and judicial issues; addressing the scope of public health emergency powers and disaster powers; and issues of access to data by public health officials.

Ideas of how to address public health emergency issues include inviting the judiciary to participate (without *ex parte* communication) in task forces and workgroups, educational forums (including, perhaps, customized education for the judiciary), creating bench books, and in approaching the leadership of judicial organizations about their preferences for involvement.

Maureen E. Conner

Every state has a judicial branch education organization supervised by the state supreme court or administrative office, or run by law schools, universities, or nonprofit groups. All organizations work with the trial and appellate courts to identify the state's needs.

The involvement of JERITT (The Judicial Education Reference, Information and Technical Transfer Project) can help reduce the time and cost of developing new education programs, report on timely issues or emerging trends in judicial branch education, and disseminate important information (e.g., through publications, electronic communications, and technical assistance offerings). JERITT conducts annual and biennial surveys related to education and training to develop a snapshot of what is happening across the country. Among other services, JERITT's website (http://jeritt.msu.edu) offers free access to databases, online grant products, specialized research, and information for managing judicial branch education. A new electronic communications capacity includes listserves, threaded discussions, and chat rooms for use by judicial branch education organizations.

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Health Care and Public Health Lawyers: Reclaiming the Historical Role

Maureen Mudron, Cynthia Honssinger, Rod G. Meadows, and Lori Spencer (Moderator)

Maureen Mudron

Traditionally, hospital emergency readiness plans primarily addressed natural disasters, but because of preparations for year 2000, the arrival of terrorism in the United States, and the potential for mass casualties, hospitals were prompted to bring together new partners and create new emergency readiness plans. These new plans, however, give rise to a number of important issues hospitals must consider. First, hospitals must consider legal liability that might arise during an emergency. For example, what liability might arise when decision are made regarding the provision of individual treatment versus mass triage? Second, hospitals must be cognizant of relevant privacy rules, such as the Health Insurance Portability and Accountability Act (HIPAA), as they apply to public health emergencies activities. Third, hospitals must be aware of the Emergency Medical Treatment and Active Labor Act (EMTALA) which requires Medicare-funded hospitals to screen patients for emergency medical conditions and prohibits their transfer until they are stabilized.

Cynthia Honssinger

The model State Emergency Home Powers Act codifies police powers that have been vested in public health officials since the days of plague and TB. If adopted by a state, the Act gives public health officials the authority to address known diseases and other public health issues often not considered in modern public health laws. Since the arrival of terrorism in the United States, public health officials have had to judge the risk of losing the significant legal powers currently held under existing laws when encouraging those laws be scrutinized and debated by the legislature.

Rather than approach the legislature seeking broad new powers to address twenty-first century threats, Colorado incorporated bioterrorism emergency response under the existing state law addressing natural disasters and emergencies. In the event of an epidemic or bioterrorism event, an advisory group will convene to advise the governor. The governor has the authority to draft 30-day executive orders for healthcare delivery system activity, based on specific advice from this advisory group. The emergency would have to be restated after 30 days and all associated activities re-instituted (e.g., suspending pharmacy rules and licensing rules to allow physicians and nurses from other states to enter and treat patients in Colorado).

Colorado has chosen an approach that expands on existing public health powers to offer flexibility and discretion in the face of an emergency. In this way, state and local health officials have reclaimed and updated the role of public health as a guardian of the community.

Rod G. Meadows

The role of public health lawyers has not generally been recognized or understood within the healthcare law bar until recently. Most healthcare lawyers have traditionally identified only three or four segments of healthcare law: 1) Litigation—which generally involves medical malpractice or contract disputes; 2) Regulatory—which involves numerous sub-specialties including state certificate of need work and federal fraud and anti-kickback; 3) Transactional—which

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includes mergers and acquisitions, physician-institution joint ventures, and payor contracts; and 4) General Counsel/Corporate Governance—which includes a broad spectrum of legal advice and guidance, including many parts of the previously enumerated sub-specialties.

The events of September 11, 2001 and the war on terrorism have been the primary reasons that the healthcare bar in general has come to a greater understanding and appreciation of the role of public health and those relatively few lawyers who provide representation in that area. Primarily as a result of the leadership of Lori Spencer, a member of the Executive Committee of the Health Law Section of the State Bar of Georgia, a one day program on the role of public health in healthcare, co-sponsored by the Center for Disease Control and Prevention, significantly raised the knowledge base of lawyers in Georgia on this topic. This initial conference has led to supplemental programming through a variety of programs sponsored by the Section. Public health lawyers throughout the nation should recognize the influence that a single, dedicated healthcare law leader, such as Ms. Spencer, can exert in individual states by promoting attention and education on the issues of public health law.

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Should Your State Have A Public Health Law Center?

Jill Moore, Marice Ashe, Patricia Gray, and Doug Blanke (Moderator)

Doug Blanke

The Tobacco Control Legal Consortium is a national "network" designed to tap expertise about tobacco control legislation and to leverage existing resources. Based at the William Mitchell College of Law in St. Paul, Minnesota, the Consortium supports local counsel with research, strategic advice, sample materials and pleadings, and *amicus* briefs. The Consortium's priorities are to support capacity nationally, to offer education, and to perform outreach activities to a variety of audiences.

The Consortium seeks to advance policy change by making legal expertise more readily available to the tobacco control community. Legal issues are inevitably involved in policy change. The Consortium does not provide legal representation, but conducts analysis and research. They publish on important and emerging legal issues as well as on specific cases, assist in the development of legislation, and train public health practitioners and policy makers on recurring legal issues. The Consortium serves health departments, advocates, public attorneys and local counsel, and they fill the gap in states that provide no legal resources for tobacco control.

Jill Moore

The University of North Carolina-Chapel Hill School of Government is comprised of an Institute of Government and a Master of Public Administration program. The Institute is a non-partisan, non-advocacy organization. In 2001-02, Institute faculty taught 236 courses for 14,000 public officials, conducted research, published 26 books and hundreds of articles, advised public officials on long- and short-term projects, and responded to more than 100,000 telephone inquiries. The faculty has expertise in judicial branch law and education, public administration and finance, governance and public leadership, and many areas of public law, including public health law. Strictly speaking, the Institute of Government is not a public health law center, as public health law is only one small part of its work. Nevertheless, the Institute does provide a great deal of legal support to public health practitioners in North Carolina, principally through two full-time and two part-time faculty members who specialize in different areas of public health law. The public health law faculty provide education and technical assistance to county managers, county attorneys, local health directors and health department staff, and judges, among others. Special topic seminars and the Institute's website (www.iog.unc.edu) supplements annual legal conferences and courses for these client groups.

A University-based public health law center, such as the Institute, offers several advantages. Tenure-track faculty appointments provide protection for faculty members who must sometimes dispense unpopular advice. In addition, the academic environment allows Institute faculty members to specialize in specific areas, while simultaneously forging links to the practice community.

Marice Ashe

The California Technical Assistance Legal Center (TALC) helps public health practitioners understand the scope of local police powers, design state and local health codes, and

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engage in rulemaking and administering regulations. Their constituents are primarily tobacco control advocates at local health departments and community-based organizations, but also include government attorneys, elected officials, and community and state agencies and organizations. TALC answers legal questions for public health officials such as when a public health official has a legal *duty* to act, what a public health official's legal *power* to act is, and what must be done to *protect* liberty and property interests. TALC helps to answer these questions by building capacity within the community to understand legal issues, providing analysis, interpreting and developing model ordinances, and enhancing collaboration. TALC assists communities with strategic planning, promotes policy development, and provides consultation on litigation strategy from a very practical point of view.

Patricia Gray

The Houston Law Center founded the Health Law and Policy Institute in 1978. The Institute educates law students, policy makers, researchers, and the public about developments in health care and the legal and ethical implications of those developments. It is funded by grants for specific research and by a $400,000 state budget line item. Because the Institute is supported by an academic institution, it is prevented from conducting advocacy work. Instead, it educates legislators on a variety of timely health care policy issues and conducts health care-related research to support state agency activities. It also produces user-friendly publications for both lawyers and lay readers. Its Website has links to both federal and state regulations and court decisions that impact health care.

Many issues impact the development of states' health care-related regulatory schemes, including advances in bench and medical science and technology, occupational and product safety issues, and the expansion of social programs (e.g., the Americans With Disabilities Act, the Family and Medical Leave Act, and the Health Insurance Portability and Accountability Act [HIPAA]). The Institute helps state legislators and agency officials wrestle with the underlying related practical and ethical aspects of new laws and regulatory schemes. A public health law institute, such as the Health Law and Policy Institute in Texas, can help states address a variety of timely issues such as privacy, security of and access to information in the post-9/11 world, health provider licensing issues, reproductive technology, immunization, genetic testing, cellular cloning, and end of life planning concerns.

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New Directions in Health Insurance Design: Implications for Public Policy and Practice

Karen Pollitz, Donna Imhoff, Charles Scott, and Sara Rosenbaum (Moderator)

Sara Rosenbaum

This is a volatile time for health insurance policy. Medicare and Medicaid are in turmoil, as is the private health insurance market. Public and private health insurance costs constitute eighty percent of healthcare spending in the United States. Public health professionals depend on the insurance system to behave in ways that are responsive to public health in prevention and crisis management.

Karen Pollitz

Seventy-five percent of the American population, excluding the elderly, has coverage through the private health insurance system. Ninety percent of this group receives their insurance through employer-sponsored programs, and the remaining ten percent buy their own coverage. Approximately ten percent of the non-elderly population has insurance through a government program, and fifteen percent of the non-elderly population, almost forty-one million Americans, is uninsured.

The increase in the uninsured is due to a decline in employer-sponsored coverage. Almost ninety-nine percent of extremely large companies offer health benefits to their workers, though only two-thirds of small employers offer coverage, and that number is declining. The Medicaid program has expanded, particularly with the creation of the Children's Health Insurance Program in the late 1990s. However, states are experiencing record fiscal crises, and many Medicaid programs are seeing reductions in funding at the state level.

Trends in the content of coverage also are disturbing. In recent years there has been an aggressive shifting of costs to employees and a decline in what employer-sponsored benefit plans include. The decline is driven in large part to increased cost-sharing requirements. Consequently, deductibles are increasing and co-pays are rapidly being replaced by co-insurance, where a percentage of the cost of a service is paid by the insured. In the case of expensive prescription drugs, the burden to the insured could be devastating.

New products are emerging which are designed to increase consumer awareness of health care services. This trend, called Consumer Driven Health Plans or Consumer Directed Health Plans, is an attempt to educate the consumer based on the theory that wiser, more educated shoppers will inherently help to control costs in the healthcare system. However, there is disagreement as to the benefit of such plans. Healthcare is often delivered poorly and consumers may not be in a position to do anything about it. These plans have very high deductibles in place, and offer a small cash account, in some cases $1,000 for a $5,000 deductible, to be applied toward deductible costs. High cost sharing causes consumers to delay healthcare. Once an individual is seriously ill, however, and has no choice other than to do what the doctors says, the consumer will end up paying more for care, while their insurance companies pay less.

Donna Imhoff

To understand new directions for the design of health insurance, and the implications for public policy, it is useful to review the impact of public policy on the environment in which health insurance markets exist today. Historically,

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state laws have governed the insurance business. However, over the last several decades, Congressional action has eroded state authority. For example, the Employee Retirement Income Security Act (ERISA) removes state authority to govern the activity of self-funded companies. As a result, the Maryland Insurance Administration (MIA) has no jurisdiction to investigate a complaint from someone enrolled in a self-funded plan. Other exceptions to the general rule include federal oversight of Medicare supplemental insurance, the Health Insurance Portability and Accountability Act (HIPAA), and a whole series of requirements imposed on state regulators by the Gramm-Leach-Bliley Act (GLB) that mandate procedures for licensing insurance agents and brokers, or, as they have been renamed by GLB, "producers." As a result of the exceptions, the dynamics have changed in the historic relationship between health insurers and regulators.

The goal of insurance regulation is to oversee and support competitive, stable, and viable insurance markets and to ensure that consumers are treated fairly. In Maryland, as in most other states, regulators oversee the business of insurance through: 1) licensing (insurers, health maintenance organizations, private review agents, etc); 2) solvency regulation; 3) rate and form review; 4) market examination; and 5) investigation and resolution of consumer complaints.

Regulatory oversight occurs at both the company level and the product level. At the company level, the state monitors and examines for solvency compliance by assessing the financial conditions of companies and their ability to pay claims. At the product level for health benefits plans, rates, forms, and contracts are reviewed and must be approved by the MIA. Business practices are regulated by a thorough examination of companies.

States vary in the regulatory effort expended on handling consumer complaints. In Maryland, in 2001, the MIA closed 29,000 consumer complaints. For investigating complaints about payment for health care services, the MIA employs nurses and contracts with peer review organizations. Those health professionals comprise a peer review system that allows the insurance regulator to review the decision of a health plan when the plan determines that the service is not medically necessary and that, therefore, the plan will not pay for the service. When the peer reviewer determines that a service was medically necessary, the Commissioner has authority to use the determination as the basis to issue an order for the plan to pay for the health care service. In some cases, during the course of an investigation, companies reverse their initial decision and agree to pay for health care services without the need for formal regulatory action in the form of an order to do so. Other states use similar processes to review the payment decisions of health plans when the decisions are based on medical necessity.

Regulation has an impact on health policy. Because Maryland is a highly regulated market, data are available to assist policy makers that otherwise would not be captured. For example, an entity that produces data on the small employer group market is the Maryland Health Care Commission. The Commission was established as part of the Maryland Health Insurance Reform Act of 1993, and its website contains a wealth of information about the health coverage. The Commission posts various reports on their website (www.mhcc.state.md.us). Maryland also regulates hospital rates and has a rate determining system that is unique among states. The rate formula includes uncompensated care costs, thus providing a system for everyone who pays for hospital services equally to share the burden of uncompensated care. All payors for hospital services at Maryland hospitals pay the same rate for the same service in any particular hospital. The system is referred to as the "all payor hospital payment system."

Charles Scott

Wyoming does not regulate insurance rates except for rate bans in the small group market. The state has few mandated benefits. Wyoming, however, regulates insurance companies for financial solvency and regulates

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policy forms essentially seeking to prevent complaints. Like all states, Wyoming investigates and resolves consumer complaints. In the small group market, insurers in Wyoming set a rate for their company. Rates for individual small groups may be no more than thirty-five percent above or below that index rate. The purpose of this limitation is to keep insurers from defeating the guarantee issue provisions by pricing high risk groups out of the market.

There is a national medical inflation rate of eight percent to ten percent which translates in Wyoming to a twelve to twenty percent increase in premiums for large groups. Wyoming's small group premiums increased an average of twenty-seven percent in 2001. For Wyoming, small employers' health insurance costs will add thirty to fifty percent to the cost of wages.

As a cause of medical inflation, hospital costs are the most important factor, beating out second-place prescription drug costs. The cause of hospital cost increases include rising professional wages, new technology, and new construction. Hospital wages must be competitive for skilled professionals, like nurses, who have many other options in today's economy. Defensive medicine, a direct result of the malpractice system, also contributes to rising costs. Defensive medicine may be responsible for up to twenty percent of the total U.S. health care costs.

In Wyoming, cost shifting adds thirty percent to the cost of health coverage, with the Medicare program responsible for half of this cost shift. Adverse selection is a major factor in the high cost increases in the small group market. In that case, healthy groups drop coverage due to high costs, and consequently sick or at-risk people are more heavily concentrated among those insured, driving up premiums.

To solve rising health coverage costs, society must address cost shifting and adverse selection as well as the underlying causes of medical inflation. Repealing mandated benefits may be useful in states with many mandated benefits. Most states are currently in a budget crisis and cannot afford new or expanded programs.

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Quarantine in Severe Acute Respiratory Syndrome (SARS) and Other Emerging Infectious Diseases

Jane Speakman, Fernando González-Martín, and Tony Perez (Moderator)

Tony Perez

SARS and monkeypox have given the public health community a unique opportunity to examine the use of quarantine measures. Until recently, the word "quarantine" was not used in polite conversation, and evoked unsavory images. The recent SARS epidemic illustrated the important role of quarantine and isolation as a public health response to communicable disease.

Jane Speakman

As public health officials in Toronto began to take control of the SARS epidemic, a second wave of the disease (SARS II) emerged. In the first SARS epidemic, approximately 8,200 individuals were isolated. There were approximately 82 probable cases, 66 suspect cases, and 24 deaths. On May 22, 2003, SARS II emerged. In total, approximately 13,000 people were quarantined. SARS II saw the onset of difficult questions being asked about the control and spread of SARS.

The province of Ontario establishes the public health policies and legislative framework for the entire province. Within the province there are 37 health units, each with a Medical Officer of Health. The Medical Officer of Health and the health unit ensure that all prescribed policies and legislation are carried out. During the SARS crisis, the health units in Toronto and York region were heavily involved in controlling the outbreak. They played a critical role in informing the public, risk management, case management, and disease surveillance.

The primary piece of legislation that allowed for a timely and effective response to the outbreak was the Health Protection and Promotion Act. This legislation provided the working framework for the Toronto response to SARS. Section 22 of the legislation is a significant provision in the law that allows the involuntary isolation of the population.

Public health authorities initially required people go into voluntary home isolation when medically indicated. People were cooperative, but among other things, the voluntary isolation presented financial hardships for families with one income earner who was suddenly placed under home isolation. The situation became extraordinarily difficult, and public health authorities found that a few circumstances required legal intervention. Section 22 orders were drafted. Section 22 orders can be served if a communicable disease exists, if that communicable disease presents a risk to the population served by the Officer of Health, and if the requirements in the order serve to eliminate or decrease that risk. It is important to remember that the legislation allowed people to appeal Section 22 orders.

Fernando González-Martín

In the *Blacks Law Dictionary*, isolation and quarantine are considered to have equal meaning. However, in public health, "quarantine" is distinguished as being applied to well persons, whereas "isolation" is the separation for the period of communicability of an infected person.

The World Health Organization (WHO) is revising the International Health Regulations (IHR), originally adopted in 1969. In the mid 1990s, these regulations were considered out of date; however, many developing states look to these principles for guidance to prevent the spread

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of disease. The purpose of the current IHR is to ensure the maximum security against the international spread of diseases with minimal interference in world traffic. In the revised version, the purpose will be maintained while the scope and role of the IHR will be changed. The scope of the current IHR is extremely narrow and only applies to three diseases: cholera, plague, and yellow fever. The revised IHR will replace this disease list and introduce the broader concept of a "public health emergency of international concern." Isolation under the current IHR directly relates to specific time periods for each of the three listed diseases.

2001 saw a shift in the way the WHO viewed its responsibility to respond to disease outbreaks. WHO's Department of Communicable Disease Surveillance and Response began to implement its "global health security" strategy whose goals are to contain known risks, respond to the unexpected and improve preparedness. In the future, WHO's efforts will be guided by the revised IHR that provide the legal framework for its global alert and response activities and operations.

Once the revised IHR come into force, states will be required to notify WHO of all events consistent with a "public health emergency of international concern". A decision instrument has been developed in conjunction with the Department of Health and Human Services (DHHS) and other Ministries of Health to assist Member States in the notification process. In order to respond better to emerging international health concerns, WHO seeks to expand its ability to make recommendations on an event-specific basis. Every public health event is different and the measures required must be adapted to the particular circumstances surrounding each event.

During the SARS outbreak, countries with "areas of recent local transmission" quickly amended their laws and regulations to allow for the implementation of isolation and quarantine measures. At the same time, WHO provided states with timely recommendations on the specific measures required in the area of infection control, including isolation procedures. This information was posted on the WHO website which received up to 10 million hits per day at the height of the outbreak, highlighting the importance of communications capability at WHO for the future.

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Using Science-Based Guidelines to Shape Public Health Law

Stephanie Zaza, John Clymer, Linda Upmeyer, and Stephen B. Thacker (Moderator)

Stephanie Zaza

Compared to evidence-based public health, evidence-based medicine is a more familiar phrase. Evidence-based medicine has become increasingly popular in the past decade, due in large part to the emergence of computerized database search technology and advanced statistical tools which allow researchers to quickly identify and summarize vast amounts of scientific information.

Today, the concept of evidence-based public health is gaining momentum and has grown in popularity. However, the term "evidence-based" lacks clarification and is subject to a variety of interpretations. The evidence that supports evidence-based medicine or public health may include individual experience, anecdotal information, the content of a single scientific article, or the results of a sophisticated systematic review of scientific literature. The imprecise language used to describe evidence leads to confusion over what types of evidence are most appropriate in answering different types of questions.

Evidence-based decision making in medicine and public health is often criticized for limiting the ability of seasoned clinicians and public health professionals to bring their practical experience to the problem solving process. Clinical practice guidelines, in particular, have been characterized as dangerous to decision making at the individual level. In addition, the extreme positions of those who advocate for evidenced-based decision making compound the problem, suggesting that no decision should be made without a strong, scientific evidence base, or that decisions should not be informed by experience or other factors.

An assumption is often made that only one type of evidence is used for all decisions. This assumption stems from the use of the term "evidence-based" as a synonym for "best practices," "guidelines," or "practice guidelines." If evidence-based decision making relied only on these narrow categories of evidence, the critics of the process would be correct. The term "evidence-based", however, can be broadened to allow for different kinds of evidence to support different kinds of decisions. Public health officials must contemplate the types of decisions they are required to make and ensure they have the right types of evidence to make and support those decisions.

Asking for evidence-based decision making in public health requires a shift in thinking. Evidence-based decision making has the potential to reap numerous rewards, including better performance, improved health outcomes, and a more efficient use of resources. In order to be effective, however, evidence-based procedures must permeate all levels of the public health infrastructure. The principles of evidence-based public health should be incorporated into academic coursework in schools of public health, policy, and administration. It is important to demand that public health organizations and agencies develop tools for evidence-based decision making, and that efforts to develop frameworks that recognize the importance of all types of evidence in decision making continue.

John Clymer

The primary goals of the Partnership for Prevention are to translate science for policy makers and assist them in evaluating the merits of competing demands for limited health resources. The Partnership unites disparate interests to

advance the health of populations, conducts scientifically sound policy analysis, and develops evidence-based policy recommendations.

Evidence—the science surrounding public health, disease, and medicine—leads to conclusions about disease burdens, economic burdens, policy effectiveness, and cost effectiveness, all important factors in policy decision-making. Many prevention policies require an initial investment for the purpose of generating long-term benefits. However, policy-makers cannot afford to wait out these benefits; they are constrained by political and financial pressures to produce quick results. Thus, additional factors are also important for policy decision-making, such as ability to demonstrate short-term health and economic benefits, ease and cost of implementation, and community interest and buy-in.

The Partnership has demonstrated that policy priorities do not follow best evidence. For example, we ranked recommended clinical preventive services based on their health benefits and cost effectiveness. The study concluded that some of the highest impact, highest value services are grossly under-utilized, including tobacco cessation counseling and vision screening for older adults. In an examination of health insurance mandates at the state level, the Partnership found that most state legislatures do not employ evidence-based recommendations when determining which services must be covered.

Many opportunities to improve the health of populations are available if we go beneath the surface to identify health benefits or repercussions in policies that do not appear initially to be related to health. What we choose to grow and market for consumption, for example, has a direct impact on health. The Partnership has recently examined several existing policies outside the traditional health sector to determine their impacts on health. For example, California Proposition 49, or funding for after-school programs designed to improve education and physical activity and to reduce crime, substance abuse and pregnancy, revealed that any health benefits would be modest at best.

Policy makers should use science to filter out noise. Much of the information policy makers receive comes from the media or lobbyists who often have questionable agendas. Evidence-based policy making helps distinguish between special interest rhetoric, or junk science, and real science.

Linda Upmeyer

Many times, legislators shy away from science simply because they have a problem understanding the scientific terms. Also, some legislators are technologically challenged and do not realize the merits of technology as a tool. In such cases, asking a legislator to visit a website for information and resources will not be productive. Their ability to actually use technology can be an issue, and scientifically minded public health officials run the risk of overloading legislators with what is, to legislators, indiscernible technical information. Science is often like a foreign language and understanding is required to make lay people comfortable.

After knowledge, credibility of data is the largest barrier to the acceptance of evidence-based public health policy and decision making in legislative bodies. Every lobbyist has an agenda, and everyone is "a special interest group" to some extent. Thus, it is important that those who educate legislators are honest, have integrity, and are diligent in methodology and approach. Lawmakers often lack confidence in the actual health benefits and effectiveness of a proposed intervention. Public health officials must examine all of the intended and unintended consequences of their proposed actions.

Civil liberties play their part in legislative thinking also. For example, despite support from Mothers Against Drunk Diving and federal incentives to pass a lower alcohol blood level standard (the .08 Legislation), a debate ensued on the validity of the bill when ABATE members protested a perceived infringement on their civil liberties. Legislation mandating screening of newborns for hearing deficits was passed only after it was amended to allow parents obtain waivers if they

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objected to the testing. The issue of parental choice also impeded the enactment of child seat-belt legislation. Costs, especially in the current economic climate, are an extremely important consideration for legislators, and public health officials should always take this into consideration. Any new policy must be based on sound science that attempts to strike a balance with issues of civil liberty.

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Applying the Regulatory Powers of Public Health

Angela Z. Monson, Jake Pauls, and Michelle Leverett (Moderator)

Angela Z. Monson

The advent of sales over the Internet has led to interesting developments in sales tax policy as states attempt to monitor, control, and collect revenue from illusive Internet tobacco vendors. Tobacco sales have been successfully monitored and regulated, to some extent, in convenience stores, grocery stores, and smoke shops, and in most cases sales taxes are collected. The Internet, however, is extremely difficult to regulate. States could use their regulatory powers to ban the sale of products such as tobacco and alcohol over the Internet, but enforcement would be nearly impossible.

The issue of enforcement of Internet sales is extremely difficult. Keeping the products out of the wrong hands, under aged children for example, is difficult. Also, it is difficult in terms of tax policy. Because Internet tobacco vendors are not, for the most part, legitimate retailers, a large, coordinated effort among cooperating states is essential to their identification. Websites can be changed; domain names can be moved.

Many states are cooperating to create a uniform process in their tax collection methods by implementing the Streamline Sales Tax Initiative. State legislators, tax administrators, private individuals, and large companies have come together and created a collective agreement, resulting in uniform definitions, standards, accounting, and auditing procedures for the collection of sales tax from Internet commerce. The effort will soon move to the Congressional level. Several large companies, fearing retroactive tax assessments, have volunteered to begin paying sales tax for their products sold over the Internet in exchange for a promise from the states not to collect back taxes. Ultimately, the collection of sales tax on the sale of products over the Internet will assist states in regulating commerce, as it creates a new system for identifying and tracking sales.

Jake Pauls

Concerns have arisen especially since the World Trade Center disaster and the recent nightclub incidents in Chicago and Rhode Island regarding the safety of places of assembly, high-rise buildings, and homes. Universal Design, a concept promoted by the Committee on Trauma Research, states that the most successful injury prevention involves improved product design and changes in the man-made environment. Achieving improvements in product design through laws and regulations is highly effective. In the United States, builders encounter local codes and national model codes, and the extent to which codes for buildings function depends on their development, their adoption, and their enforcement.

Unlike many industrialized nations, model building codes in the United States are developed by the private sector. Codes are ratified by government officials, but the adoption process is often complicated by constitutional issues. In the United States, 44,000 jurisdictions are able to adopt building regulations; this reflects constitutional issues including state's rights.

Difficulty in the enforcement of building codes entail conflicts of interest issues, political compromise, and ethical challenges. Even if a perfect building code was agreed upon, it is doubtful that it would be adopted unchanged, and it would most likely remain unenforceable.

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The U.S. building codes' approach to high-rise evacuation stems from the belief that, in a high-rise fire, a 100% evacuation will simply not occur. This is a bad assumption and is being critically reexamined. The emergence of consumer advocacy groups has affected high-rise safety research and may affect future construction. The Skyscraper Safety Campaign, led by surviving family members of victims of the World Trade Center and Pentagon disasters, has successfully initiated litigation to compel the Port Authority of New York and New Jersey to build in accordance with local building codes.

Homes provide the greatest challenges in terms of maintaining the public's health. Falls are the leading cause of injury, and environmentally triggered falls have been inadequately addressed in safety requirements. The incidents of stair related injuries have risen dramatically, doubling in the past 25 years. Fire related injuries have significantly decreased in this time period. Stair-related injury costs in 1995 are estimated at $49.9 billion. It is unclear whether public health officials will become leaders in this arena. Problems surrounding home safety and usability codes will increase as people prefer to age in place, making this a legitimate issue for government intervention through regulation. The key to progress would be attention to legal issues including the legitimate role of government, and attention to ethics within the public safety regulation field.

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The HIPAA Privacy Rule: Reviewing the Post-Compliance Impact on Public Health Practice and Research

Lora Kutkat, James G. Hodge, Jr., Thomas Jeffry, Jr., and Diana M. Bontá (Moderator)

Diana M. Bontá

Current economic conditions have coincided with the implementation of the Health Insurance Portability and Accountability Act (HIPAA) and forced public health officials to consider how to ethically incorporate compliance into their already strained budgets, while maintaining the integrity and intent of the legislation.

Lora Kutkat

As of April 14, 2003, the HIPAA Privacy Rule provides a new federal floor of protections for personal health information. The Privacy Rule establishes standards for the protection of health information held by many physicians' offices, health plans, and health care clearinghouses. The Rule protects personal health information by establishing conditions regulating the use and disclosure of individually identifiable health information by these entities, also referred to as covered entities. The Rule does not prevent the daily operations of health care establishments (i.e., the treatment of patients and the collection of payment). These activities are considered routine, expected operations in health care establishments, and as such, an individual's permission is not required under the Privacy Rule when personal health information is used for these, and limited other, purposes.

The Privacy Rule applies only to those organizations and individuals that qualify as covered entities. The Privacy Rule's application to research is determined by whether a covered entity is conducting the research. If research is being conducted by a covered entity, then the HIPAA regulations generally apply to that covered entity's uses and disclosures of protected health information for research. On the other hand, many researchers who collect and release personal health information will not have to comply with the Privacy Rule because they will not be covered entities.

Most individually identifiable health information held by covered entities, referred to as protected health information (PHI), is protected by the Privacy Rule. PHI exists only when three elements occur simultaneously: when health information with an identifier (e.g., name, address, social security number, date of birth, or other knowledge that the health information is individually identifiable) is held or maintained by a covered entity. The Privacy Rule does not apply when one or more of these elements is missing.

Under the Privacy Rule, research conducted by a covered entity must generally be conducted with an individual's authorization. There are several exceptions to this rule, however. For example, the Privacy Rule sets standards to de-identify health information and create a limited dataset. A limited dataset is protected health information minus direct identifiers and may be used or disclosed for research and public health activities when a data use agreement is in effect between the covered entity and the recipient of the information. In addition, an Institutional Review Board (IRB) or a privacy board may waive the authorization requirement, a process slightly different from waiving informed consent. IRBs and privacy boards can waive authorization when it

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determines that the research meets the waiver criteria, which include, among other things, an assessment that the research poses minimal privacy risk to the individual, contains a plan to protect identifiers, and the information will not be improperly used or disclosed. Researchers who work for covered entities can perform certain activities in preparation for research if the covered entity collects from the researcher a written or oral statement verifying that the protected information will be used only to prepare protocol, that the health information will not leave the covered entity, and that the health information is necessary for research purposes.

James G. Hodge, Jr.

Concerning the impact of the Privacy Rule on public health, it is important to note one fundamental maxim: public health agencies performing public health functions that include the acquisition, use, or disclosure of protected health information (PHI) are not covered by the Rule. In this capacity, public health agencies are not covered entities, and thus are not required to adhere to the provisions of the Privacy Rule. Beyond this fundamental, however, are external and internal impacts of the Rule on public health practice and research.

Externally, the Rule may impact public health practice by limiting the flow of PHI from covered entities to public health authorities. Concerning disclosures, in general PHI should not be disclosed by covered entities without individual written authorization. Exceptions to this anti-disclosure provision, specifically outlined in the Rule, deal with law enforcement, judicial proceedings, limited commercial marketing opportunities, and minors. An additional limited exception, discussed earlier, concerns disclosures for health research. The most relevant exception, however, relates to disclosures for public health purposes. Covered entities can disclose PHI to public health authorities without specific individual authorization.

Public health authorities are authorized in other federal, state, and local laws to collect PHI to prevent and control disease, injury, or disability. The Privacy Rule is not meant to impede public health authorities' access to the information that has always been available. A public health authority is broadly defined as an "agency or authority of any level of government, federal, tribal, state, local, as well as anyone acting under contract or grant of authority from that state, local, tribal, federal agency, responsible for public health matters as part of its official mandate."

Internally, the most profound potential impact of the Rule concerns those activities of public health authorities that resemble the functions of covered entities, like the provisions of healthcare. One interpretation suggests that those public health authorities that provide health services to disadvantaged or other individuals are acting in the interest of public health and are, therefore, exempt from the Rule. This interpretation embodies the intention of the Rule not to interfere with public health activities. However, the prevailing interpretation maintains that these public health authorities are hybrid entities, or multi-functional entities with covered entity components. Under this interpretation public health authorities are covered under the Rule to the extent to which they perform covered functions.

The Rule states that hybrid entity status also applies to a healthcare provider performing activities not typically related to the provision of care, such as a hospital running a cancer registry. The Department of Health and Human Services clarified this issue of hybrid entity status, stating that a public health authority performing healthcare activities is performing covered functions and must adhere to the Privacy Rule. To date, most public health authorities have elected hybrid status. This requires them to adhere to the Rule concerning its covered functions, but not with regards to its non-covered, public health functions. States that have not elected this status must generally adhere to the Privacy Rule regarding all of their information exchanges.

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Thomas Jeffry, Jr.

Public health authorities are not covered entities, and HIPAA only applies to covered entities. However, the physicians, hospitals, and individuals that partner with public health authorities are covered entities. For covered entities, there are administrative penalties in place for violations of the Rule. The Office for Civil Rights recently published administrative regulations outlining the process of bringing action against non-compliant, covered entities. Public health authorities must remember that their potential partners may carry liability under the provisions of the Rule.

In order to protect itself, a covered entity must identify disclosures that are for treatment, payment, and healthcare operations and which, therefore, do not require individual authorization. Also, they must identify disclosures that are subject to certain exceptions required by law. The Rule permits, for example, for a physician to report patients treated for gunshot wounds to local authorities as required by law. Covered entities must identify those disclosures specifically associated with health oversight activities, including oversight activities of the Department of Health and Human Services, and disclosures related to fraud and abuse or intended to thwart a serious threat to public safety. Public health authorities must take into consideration the approaches of the private sector to gray areas in the Rule. Traditional disclosures that have been provided to public health authorities for public health purposes are relatively safe for covered entities, but expansions of traditional public health duties and authority in light of the current social climate suggest increased power to collect information that may not be covered by an exception under the Rule.

Covered entities that have federal assurances to perform research have an obligation to protect human subjects. Part of that protection entails a thorough understanding of "downstream" usage of the information disclosed. Covered entities must discern the ways in which disclosed information will be subsequently used by the public entity.

The concept of a community health record is an example of a gray area. Some communities are examining the implementation of a public health record to facilitate the sharing of information with healthcare providers to expedite treatment. This is an area to watch, because the Privacy Rule does not specifically address the acquisition of public health information for this specific purpose. Covered entities must determine when to rely on the threat to public safety or disaster relief provisions to disclose information.

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School-Based Policies: Nutrition and Physical Activity

Dexter Louie, Eduardo J. Sanchez, Sean Faircloth, and William A. Dietz (Moderator)

Dexter Louie

In spite of laws in many states regulating the nutritional content of foods and the availability of "junk food" and soda, a 2001 Surgeon General's Report indicated that 15% to 20% of the nation's children are overweight or obese. In areas that are predominately Hispanic and African American, the numbers rise to between 40% and 50%. Although there are continuing efforts to educate the adult population, many school systems and public health jurisdictions have had little impact on the rising numbers of overweight and obese children. This session described the process of initiating a student-based, student driven approach to obesity, junk food, and diabetes and disease prevention.

A need existed for a grassroots approach at the student level to raise awareness of increasing obesity rates and diabetes and other related diseases in the adolescent population. Dr. Louie developed a program at the Joaquin Moraga Intermediate School using one group of students, a "leadership class." Initially, Dr. Louie spent a brief amount of time with the students, holding one meeting to discuss the medical realities of obesity and diabetes. He then challenged the students to conduct their own research. The students made the connection between the national epidemic and conditions in their school and created a plan for their school and community. The student buy-in was essential and complemented existing laws to combat adolescent obesity. The students' plan included product sampling among the student body, surveys of the student body, telephone interviews with vendors to find out what, nutritionally, they were being sold through on campus vending machines, school bulletins and announcements, and incremental changes in the snack bar. Students requested and were granted vegetarian options on the school meal plan, in addition to a "Milk-Chug" machine offering nutritional alternatives to sodas. One of two soda machines was removed altogether, and the students organized a Health Awareness Week to foster student education at the peer level.

As an unintended result of the students' fact finding and brainstorming, the students implemented several plans to increase activity. One such plan, "Girls on the Run," involved students in a non-competitive program of games for girls. The non-competitive aspect was an important feature of the plan because only 5% to 10% of high school students participate in competitive athletics.

The program was successful because it involved students in proactive leadership and decision making. It is an adaptable model that can find success in all socioeconomic, cultural, and academic environments. Importantly, the program is sustainable year to year because there are no budgetary requirements. What the program requires is volunteer time on the part of a knowledgeable adult professional, student buy-in, and support from key adult sponsors at each school.

Eduardo J. Sanchez

Often the role of a public health official is to "carry out the will of the legislature," but state public health officials can be actively involved in the legislative process. The adolescent obesity epidemic underscores a threat to the nation's fiscal future as well as its physical future. For example, the San Marcos Consolidated School District in Texas found that 55% of fourth

graders were at risk of being overweight or overweight. This finding suggests obesity is rapidly advancing since the San Marcos data eclipses the 40% of all fourth graders in the state of Texas (2 out of every 5 children) that are at risk of being overweight or overweight. The rising rate of obesity represents a threat to a medical delivery system that will be unable to cope with the increasing number of individuals who will suffer from cardiovascular disease, diabetes, strokes, some forms of cancer, arthritis, and the mental health issues associated with being obese.

The Texas Department of Health addressed and continues to address the epidemic directly and in several ways. Two years ago, the 77th Legislature enacted Senate Bill 19, which returned the curriculum of physical education to public schools in Texas. Many school districts have adopted school-based health programs like the Coordinated Approach to Child Health (CATCH), which teaches children about nutrition and engages them in physical activity. In addition, the programs provide for the education of parents, school administrators, teachers, cafeteria workers, and physical education teachers so that a clear understanding is reached concerning what constitutes comprehensive fitness promotion in children.

In Texas, the efforts of one legislator to enact legislation opened the debate on school nutrition and obesity. The legislation established a 12-member statewide advisory counsel charged with the study of nutrition consumption and presented the opportunity for legislators to engage in the information gathering process. Perhaps the legislators will be able to develop good public policy based on the information they gather and their continued education.

There is opportunity for government involvement without limiting personal freedom if existing federal nutritional programs undergo more interaction and coordination specifically targeted at childhood obesity. Of the 1,000 babies born each day in Texas, almost half qualify for Medicaid. Under the umbrella of this and other subsidizing programs, there may be opportunity for education and prevention. A uniform and unifying approach to common health threats is what defines good public health. In Texas, four state agencies have created a memorandum of understanding to work together on the issue of overweight children and adults: The Texas Department of Health, the Texas Department of Agriculture, the Texas Department of Education, and the Department of Human Services. The fight against obesity is "a fight on behalf of our fiscal and physical future."

Sean Faircloth

Obesity is an issue that should be addressed in terms of health and public policy. In Maine, the government has played both the role of encouraging the obesity epidemic and finding of solutions to combat the disease. The federal government has played an active role in encouraging obesity in the United States by subsidizing the automobile and fossil fuel industry. When John F. Kennedy was President, 61% of children in the U.S. walked to school. That number has now dropped to 14%. In the same era, 20% of Americans' food dollar was spent outside the home in restaurants, while today that figure approaches 50%. In addition, the government has chosen not to provide consumers with basic nutritional information in fast food and chain restaurants, even though that information is easily and readily accessible in the food industry. Government has also strangled the public school system, forcing them to seek additional support from large corporations who, in turn, use the schools as marketing and advertising tools for their high sugar and high fat content products. Finally, due to Federal Communications Commission decisions, the early seventies saw a significant increase in advertising of high sugar and high fat content food targeted specifically at children.

Maine has a population of 1.2 million. The state's Chief Public Health Officer estimates that the epidemic of obesity costs the state close to one billion dollars each year. In such a small state, that amount of money has a huge impact on society. In order to avert this human tragedy, with the government's track record in promoting behavior

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and policies leading to obesity, the argument should be changed from "let's get government involved" to "let's get government out of the obesity promoting business." The state of Maine has embarked on a long and arduous process of regulation based on the principals of freedom of choice in transportation, of information, and from exploitation for children in public schools.

A dedicated amount of state gas tax revenues should be devoted to the creation of walking trails and biking trails, so that citizens have a freedom of choice when it comes to their preferred methods of transportation. Freedom of information would include the accessibility of ingredient lists and nutritional values at all chain restaurants, to allow citizens to make fully informed dietary choices.

Children are exposed to advertising on television, at convenience stores, and through a proliferation of other sources. Public schools are not the proper environment for the advertising of foods high in fat and sugar. The concept of freedom from exploitation for children in public schools embodies this philosophy. The issue of individual's right to choose to have a snack or beverage high in sugar and fat content is not a balanced argument because at most points of sale near public school campuses, the choice of purchasing a 100% juice product does not exist. In most cases, students are not currently offered choices, other than choices between high fat and sugar content products. True freedom of choice would mandate that healthy items also be made available.

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The Role of Non-Governmental Organizations (NGOs) in Public Health Law

Suzi Ruhl, Mari Stephens, and Paul Locke (Moderator)

Paul Locke

NGOs can play an important role in the development, implementation, and reform of public health laws. To be effective, NGOs must recognize the critical role law plays in protecting the health of the public and in the public health system's emergency preparedness. They must be ready to work with federal, state, and local leaders to advance the goals that public health laws were enacted to achieve. NGOs also have technical expertise, which they can utilize to help translate highly complex scientific concepts into public health action steps that regulators, legislators, and members of the public can readily understand.

Suzi Ruhl

Those who are most often affected by pollution tend to be low income people, the working class, Native Americans, and people of color. Those most affected by pollution issues, however, usually have the least input in the creation of policy. NGOs can use the law to try to prevent and abate pollution, and public health can fill in the gaps where the laws are inadequate. The law is a toolbox, and within that toolbox are a variety of tools available to NGOs. Administrative tools include permit challenges and petitions for rule making; legislative tools may include preparing model laws, critiquing existing bills, and engaging the served community.

Two effective tools used by NGOs in shaping public health law are advocacy and the use of the legal process. Advocacy is defined as participation and decision making in a non-adjudicatory process. Advocacy is used in the administrative and legislative arenas. The importance of advocacy, especially from a community-based perspective, is three fold: identifying gaps in the scope of legal authority, raising awareness of needs not addressed through theoretical solutions, and providing an opportunity to rectify problems with the practical application of theoretical models.

Use of the legal process usually involves an adjudicatory proceeding that can be presented before the courts or before an administrative agency. Legal action is important because it can focus attention on a neglected issue, and it can encourage performance of a non-discretionary duty. Although legal action is a tool of last resort, it is important to have the capacity to take action when necessary. The capacity for using legal action can be used as a catalyst for cooperative problem-solving and collaboration. Fundamentally, NGOs play a vital role in the development and implementation of public health law. It is important to recognize national NGOs, but grassroots efforts and community-based organizations bring an important additional perspective to what is required to improve public health.

Mari Stephens

The March of Dimes is a non-profit organization dedicated to improving the health of babies by preventing birth defects and infant mortality, a mission the organization carries out through programs of research, community service, education, and advocacy. The March of Dimes is a volunteer led organization. Volunteers develop the goals and objectives of the March of Dimes and carry out its mission. Some volunteers work as activists in the state legislature; their status as volunteers has a significant and positive

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impact on lawmakers. By maintaining its status as a non-profit organization and an organization led by volunteers, the March of Dimes ensures its deference to a variety of stake holders in the community, from parents and business owners to state legislators.

The March of Dimes holds an annual legislative event during and out of session to ensure that its voice is heard and to identify which legislators respond with the most enthusiasm to the issues championed by the organization. Advocacy priorities are determined annually by the March of Dimes' Office of Government affairs in Washington, D.C. The State Public Affairs Committee in the state of Georgia, which receives and creates strategies for the implementation of these priorities, is also comprised of volunteers, with a permanent staff in place to serve their needs. An example of a successful campaign, where diligent advocacy resulted in successful policy revision and funding for this NGO, was the Folic Acid Campaign.

In 2001, the March of Dimes in Georgia evaluated existing efforts to educate parents on the importance of folic acid in the prevention of birth defects. They discovered that Georgia had some of the highest numbers of reported cases of spina bifida in the nation. The March of Dimes partnered with Emory University to educate legislators and solicit funds for its Folic Acid Campaign, aimed at behavior modification in women of childbearing age. Working in and outside the legislative session, lobbyists visited legislators' offices, researched legislative committees, and even visited the capital with constituents, some of whom were mothers of children suffering from spina bifida. These active lobbying efforts, and the press that resulted from them, all but ensured that the March of Dimes agenda was included in the state budget. They were awarded $125,000 annually, and with roll over and enhancements. Creative, persistent, and flexible lobbying efforts are critical elements of the March of Dimes' successful advocacy programs.

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Land Use and Zoning for the Public's Health

Bruce Bragg, Thomas Galloway, Doug B. Spohn, and Donne E. Trotter (Moderator)

Bruce Bragg

It is important to re-engage public health professionals, after an absence of almost a half a century, in the issues of land development and community design. Resources should be devoted to processes that directly engaged diverse communities in defining their idea of good public health. In Michigan, within demographic communities, the idea or definition is slightly different, but an agreement was reached that activities should be developed around four basic environmental areas: food, air, water, and land use. Resource teams were developed around each of these areas, and an attempt was made to describe the current status of environmental conditions and identify major health problems. The community was engaged in a dialogue and a strategy for improvements was developed. The Michigan Land Use Resource Team identified land trends, described water and air quality, and even mapped automobile injuries, including pedestrian injuries and deaths.

The Land Use Team includes members of public health, the regional planning commission, and several community organizations representing minority neighborhoods. Architects, city planners, and land developers work with the team, and the University of Michigan has involved its departments of urban affairs, resource planning, and criminal justice. The regional planning agency recently completed a growth study engaging the larger community in a dialogue concerning the impact of different scenarios for growth.

From a public health point of view, it is important to understand the importance of time and cost to land developers. Developers sometimes work within narrow windows of opportunity, and this does not always allow for community influence in land use and design. Development will occur along the least costly trajectory. With efficiency and cost effectiveness as priorities, developers will rarely include frills without guidance from the community. Without regulatory control or control over zoning, public health's primary influence on developing trends is the active engagement of the community. The goal should be movement toward an enlightened community that can clearly express what is desired and needed and transform those needs/desires into zoning regulations and other community policies.

Thomas Galloway

Zoning in the United States began in 1916 in New York City. Using the rationale of public health, safety, and welfare, New York became the first city to adopt a comprehensive zoning ordinance to protect the quality of its light and air. Height and bulk regulations and building set backs stemmed from this concept and were inaugurated with public health effects being one of the most important of the several rationales for public intervention in local land markets.

In 1926, *The Village of Euclid v. Ambler Realty Company* became the first Supreme Court level test of the constitutionality of zoning, or restricting uses of privately held land. In that case, landowners contended that zoning constituted a taking of value and that, if restrictions were imposed, they must be compensated for the value taken from the potential use of their properties. The Supreme Court ruled that takings were legitimate in this case under the broad public interest criteria for governmental intervention. During the

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next eighty years, the assault on the takings issue has continued, but the legitimacy of this public intervention has prevailed. However, over this same period, the role of public health in land use virtually disappeared. Today, we no longer think in terms of the health effects of land use, except in regard to abatement, animal control, or most recently, air quality. However, this is changing.

As zoning practices emerged at the turn of the last century, the concept of separate use evolved. Every use has its place, and those places should be kept separate. It is this idea that led to our modern culture of getting in a car to buy a loaf of bread. The "mom and pop" corner stores and, in most areas, the pedestrian-friendly gridiron street layout have virtually disappeared. New urbanism seeks to re-establish mixed use communities, where services are located in residential areas and there is a facilitation of physical activity and community interaction. A rebirth of these mixed-use communities, sometimes labeled "smart growth," has as its central idea in the development of livable spaces where people can work, play, and shop without depending on automobiles.

Today, we are coming to the conclusion that current local ordinances for zoning and subdivision development are inappropriate for the 21st century. We recognize that smart growth can contribute to the improvement of the public's health in more meaningful ways and that the public health profession has much to offer in designing smart growth policies. Key barriers on which we must focus include current public policy or regulations (zoning, subdivision regulations, traffic, highway and road standards), the private financing of smart development, private and public development, and community and citizen opposition (NIMBYism [not in my back yard]) to alternative development schemes.

Doug B. Spohn

There are several definitions of smart growth resulting in a misunderstanding on the part of the public, who in large part believe that smart growth implies high density. There are several problems inherent in the zoning process, which produce barriers to smart growth. The zoning process is political and creates a clear separation of commercial and residential use. Zoning takes a great deal of time to implement, sometimes keeping property owners waiting for a year or more before their property can be purchased, which increases the cost of that property. Regulations in zoning ordinances are outdated and based on what developers can do as opposed to what they should do.

Other barriers to smart growth include society's attachment to its automobiles. Smart growth offers a solution to this dilemma by attempting to build services that are closer to homes and communities. Developers are faced with issues of time and money. Often unable to wait, developers will chose the methods and practices already in place and predetermined by most municipalities rather than wrestling with the many variances required in the development of an innovative, smart community.

A lack of knowledge of what constitutes physical and economic wellness prohibits some communities from realizing their smart growth potential. Many times, communities make decisions that exclude certain social or economic groups and inadvertently decrease revenues and gains to the community. For example, one Georgia community issued an ordinance restricting new home construction of houses valued under $150,000.00. An unforeseen side effect of this policy was that teachers and other service professionals were no longer able to live in the community they served, and many opted to serve different communities. The exclusionary decision resulted in a negative impact on the overall health in terms of revenue potential and quality of service in the community.

In Duluth, Georgia the city agreed to incorporate a town green and bring in mixed use, including residential buildings, to revitalize the heart of the city. The plan included stimulating and soothing architecture, and the addition of an amphitheater designed to handle 4,000 people. The addition of the amphitheater alone has given rise to events that bring people out of their homes and into a strong, community environment. An interactive water fountain successfully contributes to a stimulating,

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comforting destination for citizens. Other cities that form Metropolitan Atlanta are currently considering the implementation of smart growth concepts. Perhaps those cities will implement the kind of practices and planning that have revitalized the City of Duluth.

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Who Will Keep the Public Healthy? Assuring a Legally Prepared Workforce

Mary Anne Viverette, Jennifer Leaning, Susan K. Steeg, Kristine M. Gebbie, and Maureen Litchveld (Moderator)

Mary Anne Viverette

The Commission on the Accreditation of Law Enforcement (CALEA) employs rigorous evaluation techniques. Objective accreditation, such as made possible by CALEA, is important from the public's perspective and in the national community of law enforcement.

To counteract a general distrust of law enforcement agencies, the Law Enforcement Assistance Administration (LEAA) developed a grant to develop standards by which the quality and performance of law enforcement could be measured. LEAA developed 107 standards and, though well received by the law enforcement community, no single group or agency took the initiative to begin a program to evaluate and implement the standards. In 1979, the Department of Justice established an additional grant that effectively organized the four major law enforcement groups: the International Association of Chiefs of Police, the National Sheriff's Association, the National Organization of Black Law Enforcement Executives, and the Police Executive Research Forum. With input from the Department of Justice, these four groups came together to form the Commission on Accreditation, a non-profit, private organization that established a voluntary accreditation program for law enforcement agencies.

The Commission on Accreditation established three main objectives, including the establishment of voluntary standards particular to professional law enforcement agencies, the creation of a process for compliance to those standards, and the recognition of professional excellence among law enforcement peers. The overall goal of the program is to improve law enforcement. The Commission includes 21 members made up of police chiefs, judges, senators, and members of the public and private sectors. Members from outside law enforcement are able to provide an objective, community perspective on the evaluation process. Approximately every five years, the standards are reviewed for relevance.

There are several benefits for law enforcement agencies that comply with the Commission's standards, including a reduction in liability, better defense in lawsuits, and increased community support. In addition, accreditation is recognition of excellence in the larger law enforcement community. Currently there are approximately 600 accredited law enforcement agencies. Because it is a long-term commitment and expense, and because agencies are inviting other officials and members from the community to evaluate their processes, many agencies have not chosen to attempt accreditation. However, 1,800 agencies are in the review process. The standards set by the Commission also ensure the promotion of individuals based on an evaluation of skills and competencies.

Jennifer Leaning

From the perspective of the human infrastructure, the networks in place to deal with bioterrorism in urban environments provide particular challenges. Urban environments are comprised of large numbers of people woven throughout already existing networks, which require massive efforts of coordination and communication in order to function properly in disaster scenarios. The issue of overlapping jurisdiction is a danger in urban settings and underscores

people's preconceptions or misconceptions about the nature of their responsibilities.

A thorough planning process is invaluable, including establishing clear communication channels and levels of authority. Strong leadership skills should be imbedded in public health training programs so that public health leaders can withstand the "visible, hot light." The traits of good, strong leadership are critical in maintaining public confidence in the event of a bioterrorism attack, but are too often overlooked in the public health profession.

The ethical obligations of public health must be understood in order to ensure the public's understanding of actions that may be required during an urban bioterrorist attack. In the context of a mass casualty event, when it is very clear that leaders did everything in their power to save the entire population, the public accepts the fact that there is a greater good for the greatest number of people.

Public health law has become increasingly complex and legal issues that warrant public health actions are not well understood within the public health community. Expanded public health powers are the result of delegated authority through representative government. They are not a dictatorial imposition of technical expertise, but rather the result of a democratic process that has allowed the infusion of technical expertise.

Public health officials must encourage community participation, mold senior leaders, and develop competent management systems to interface with a range of different key players. There will be challenges in the law to the draconian measures that may have to be imposed in difficult times. The primary mission of public health is the protection of the population; however, individual liberties must be respected.

Susan K. Steeg

Public health law can have an important impact on the workforce. For example, in the State of Texas, federal smallpox legislation was important to public health workers. In 2002, President Bush announced his desire for a smallpox vaccination plan for the country, and he called for the immediate vaccination of the military. The President requested that states develop plans to vaccinate their hospital workers and public health workers. The proposed Phase I plan involved vaccinating an estimated half-million people. Section 304 of the Homeland Security Act, enacted on January 24, 2003, provided liability protection for manufacturers and hospitals, but did not provide rights or protection for vaccinated workers. The day Section 304 was enacted, the Secretary of the Department of Health and Human Services issued the following declaration: "To achieve a successful vaccination program, and because it is impractical to have counter measures administered at every healthcare entity, it is critical that the healthcare entities participate and that their personnel be protected while acting within the scope of their employment." The phrase "acting within the scope of their employment," was critical. This is the same language that appears in workers' compensation laws that are a basis for determining eligibility for compensation. The Homeland Security Act failed to address the workers' compensation issues that might arise from the smallpox vaccination, and hospitals were concerned because of the additional costs of potential claims.

On January 31, 2003, the Texas Nurses Association refused to participate in the vaccination program. Taking the lead from their national organization, they cited the lack of compensation for medical care and lost wages resulting from adverse effects from the vaccine. There was no clear direction as to whether workers' compensation carriers for public and private employers would uniformly cover claims for adverse effects. The Texas Department of Health was fielding questions from its own public health nurses as to whether or not the state's carrier had taken a position on this. It became apparent that a plan must be developed to deal with these issues.

The Office of General Counsel of the Texas Department of Health convened four state agencies: the Office of the Attorney General; the Texas Workers' Compensation Commission; the

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Texas Department of Insurance; and the State Office of Risk Management. The agencies worked together to interpret Section 304 of the Homeland Security Act and deliver a unified response to workers' concerns. The Office of the Attorney General issued an informal opinion citing Texas case law and concluded that a health care worker who voluntary participated in the smallpox vaccination program was eligible to apply for workers' compensation. The Texas Department of Health developed an employee participation statement affirming that the employee's voluntary participation was within the course and scope of employment.

By the end of April of 2003, Congress passed the Smallpox Emergency Personnel Protection Act, which established a compensation fund to provide secondary coverage for medical expenses and lost wages.

Kristine M. Gebbie

Public health organizations have committed a great deal of energy to developing both worker competencies and organizational capacity. To be clear, capacity is an organizational measure including: material resources (physical plant, supplies, and equipment); defined policies, procedures, and systems; an effective communication system; and competent workforce. Competency, on the other hand, is an individual measure of whether an individual possesses both the knowledge and skills required to perform the task or objective. Competency-based programs are becoming the norm in both education and practice settings.

Who Will Keep The Public Healthy?[1] is the most recent Institute of Medicine report on education of public health professionals, those educated in public health, or a related discipline, who are employed to improve health through a population focus. The report suggests that education of these professionals (both basic and continuing education) should cover the eight domains of core public health competencies including analytic and assessment skills, basic public health science, cultural competency, communication, community dimensions of practice, financial planning and management, leadership and systems thinking, and program development and program planning.

The report further identifies that in addition to these core public health competencies, there are eight emerging areas important to the public health field: informatics, genomics, communication, cultural competency, community-based participatory research, global health policy, law, and ethics.

In addition to basic competencies, public health law competencies are important to attorneys working with public health organizations; leaders of public health organizations; professionals in key program areas such as surveillance and reporting, control of diseases, licensing, or certification programs; and for all staff involved with record-keeping and public communications. These competencies can be included in professional curricula, specific continuing education, or specialized education such as exercises in emergency preparedness.

There are a number of key partnerships and collaborations already working on further development of the workforce, including the Public Health Workforce Collaborative, the Council on Linkages between Public Health Practice and Academia, the Health Resources and Services Administration-funded Public Health Training Centers and Centers for Disease Control and Prevention-funded Centers for Public Health Preparedness. All are necessary because society needs well-educated professionals in public health and related disciplines to effectively shape the programs and policies that will improve population health. If society loses sight of who will keep the public healthy, society will have lost an opportunity to improve the public's health during the 21st century.

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Preemption in Public Health: The Dynamics of Clean Indoor Air Laws

Elva Yañez, Gary Cox, Mike Cooney, and Robert Eadie (Moderator)

Elva Yañez

Preemption is a powerful strategy used by special interest groups to undermine strong, local public health standards. Currently, 20 states in the U.S. have preemption ordinances in place related to clean indoor air initiatives. These preemption laws are the direct result of an ongoing and aggressive campaign of tobacco companies to thwart clean indoor air initiatives, which ultimately, according to tobacco industry internal documents, cause significant reductions in their annual revenues. Clean indoor air policies have arisen from a greater understanding of the documented health risks associated with exposure to secondhand smoke and action by local government (city councils, county commissions, and boards of health) to protect the public from these hazards. The efforts of the tobacco industry undermine local authority and seek to shift policy action to the state and federal levels, where the industry has greater political influence. In the mid-1990's, in response to a dramatic increase in the number of states with preemption legislation, tobacco control activists and national organizations realized that increased and strategic advocacy action was required to counter the threat posed by preemption.

By 1994, advocacy groups took action, securing resources for a focused and coordinated national response. The response included the funding of research and the creation of a national Preemption Task Force. Lessons from victories and defeats were analyzed and centralized so that advocacy groups could determine the most effective responses to preemption. A handbook of background and campaign materials was developed in a further attempt to centralize the groups' activities. "Stone Soup" conferences, in which attendees paid their own travel and lodging expenses, were held with great success and provided a forum for tobacco control organizations to educate their lobbyists on the subject of preemption. It was necessary to educate the entire tobacco control field about the negative impact of preemption. Locally, with the assistance of a solid knowledge base and a pool of expertise, scores of proposed preemption bills were defeated across the U.S. in the 1990s. Specific elements of successful campaigns to fight preemption were identified and implemented to counter the significant resources and influence of the tobacco industry. Where the tobacco companies rely on limitless money and influence, the tobacco control movement has successfully countered preemption through a mobilization of authentic grassroots bases of support, highly organized and effective counter strategies and tactics, and increased capacity and expertise within the field. Local control provides the opportunity to build authentic, viable support to defend public health from detrimental special interest action, which is the key to moving forward.

Gary Cox

Tobacco, along with diet and exercise, is responsible for up to 65% of premature death and disability. It follows that tobacco cessation is an extremely important issue for public health on the national, state, and local level. Oklahoma was one of the first states to have a preemption law passed. In 1987, the board of health in Tulsa passed a strict clean indoor air ordinance and recommended it to the city commission. One week later, a lobbyist for a major tobacco company introduced a preemption law in the state legislature. The preemption law passed, and the city of Tulsa never had the opportunity to enact its local clean indoor

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air ordinance. The state's law was one of the weakest in the U.S. and only during the current legislative session did the Governor of Oklahoma sign SJR21, a 100% statewide law regulating the use of tobacco products in public buildings. In effect, the citizens of Oklahoma were without protection from the dangers of secondhand smoke for the last sixteen years.

The passage of preemption laws surrounding clean air ordinances in Oklahoma gave rise to preemption laws in daycare centers, nursing homes, environmental regulation, and in restaurant inspection. This resulted in the deterioration of local control in these areas. Preemption is like a cancer. Once started they can spread and can hinder efforts to protect local populations. In Oklahoma, the tobacco companies actively utilize front groups (e.g., The Oklahoma Restaurant Association) and stalwart lobbyist to further their efforts. In Oklahoma, special interest groups control the general will of the public and the public health through preemption efforts. Often, state laws are not as stringent as they should be, and local authorities are left with little or no power to protect the public's health. However, public health needs arise at the local level and must always be responded to at the local level. Oklahoma has unsuccessfully attempted to repeal preemption on several occasions. Arguments for preemption in Oklahoma include uniformity, economic development, and the right of businesses to control their own affairs, independent of government interference.

It is important to keep grassroots efforts alive in the battle against preemption. Grass Roots activity builds awareness of tobacco related issues and encourages the critical involvement of youth and students in issues involving the public's health. Advocacy efforts that come from community partnerships can be invaluable and even if a state is stuck with preemption, encouraging grassroots efforts will ultimately lead to increased opportunities to repeal preemption.

Mike Cooney

The constitution of Montana guarantees the citizens of Montana the right to a clean and healthful environment and the opportunity to self govern. If the legislature takes action with which the citizens disagree, citizens can amend, overturn, or suspend an act of the legislature through the initiative and referendum process. The citizens have this right at the state and local level and, therefore, play an active role in the government.

In 2001, the Helena City Commission passed a clean air ordinance, but shortly after the passage of the ordinance, the opponents of the clean indoor air initiative began gathering signatures in an effort to suspend the effective date of the ordinance until a public referendum could occur. Just one day before the effective date of the ordinance, the opponents certified enough signatures to suspend the ordinance and place it before the voters.

The referendum involving the smoking ordinance was placed on the ballot in a special election Almost two thirds of voters (62%) voted to support the Smoking Ordinance. Once enacted, however, the opponents filed a complaint in State District Court naming the City of Helena, the City-County Board of Health, and the City-County Health Department as defendants. The count, alleging a takings (i.e., that something was taken from these businesses), has yet to be decided. A city judge in Helena found the smoking ordinance to be unconstitutional because violations are "municipal infractions" and are, therefore, civil matters rather than criminal. Currently the issue is under consideration by the State District Court.

In the opening session of the 2003 legislature, a bill was introduced to preempt local ordinances. Although the bill was initially defeated, it reemerged. It was revised by another legislator to include a one-time, $10 fee on gaming machines, turning the bill into a revenue bill and became law. The opponents ignored health considerations and successfully changed the debate to one of property rights and economic impact. In the end the opponents of the initiative were unable to convince local health officials, the city council, or the local voters that the ordinance was detrimental, and thus, had to turn to the legislature to find success.

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New Developments in Public Health Case Law

Karen Smith Thiel

Karen Smith Thiel

In recent years, public health law has seen some important court decisions. Those are presented below.

In *Pelman v. McDonald's Corporation*,[1] the court dismissed a complaint filed by three children who claimed that McDonald's practices in making and selling its products were deceptive. This deception, the children alleged, caused them to consume McDonald's products with great frequency and become obese, thereby injuring their health. The plaintiffs pled five causes of action against McDonald's, alleging that McDonald's: 1) failed to adequately disclose the ingredients and health effects of its products and described their food as nutritious without disclosing detrimental health effects; 2) engaged in marketing techniques geared toward inducing children to consume their products; 3) acted negligently in selling foods high in fat, cholesterol, salt, and sugar when studies show that foods containing these ingredients cause obesity and detrimental health effects; 4) failed to warn consumers of the quantity and qualities of levels of fat, cholesterol, salt, and sugar in its products or of the detrimental health effects of such foods; and 5) acted negligently in marketing foods that were physically and psychologically addictive.

The Court's analysis of this case focused on questions of personal responsibility, common knowledge, and public health and the role of society and the courts in addressing the issues raised in the complaint. The Court ruled that the plaintiffs failed to show that McDonald's violated the New York Consumer Protection Act and failed to identify a single instance of deceptive acts; failed to demonstrate that information regarding the nutritional content of McDonald's food was solely within the possession of McDonald's, or that a consumer could not reasonably obtain such information; and failed to identify a single advertisement, promotion, or statement directed at infant consumers, and dismissed the claim that McDonald's targeted children.

Although the Court dismissed the plaintiffs' complaint in its entirety, the court clearly went out of its way to discuss the elements of a cause of action for each claim that might have helped the plaintiffs survive McDonald's motion to dismiss. The Court presented the argument that overconsumption of McDonald's products differs in kind from what one would expect from other restaurants if ingredients specific only to McDonald's products are present. The court noted that McDonald's has a duty to plaintiffs who have an "allergic sensitivity" to their food, and a case could have been made that eating McDonald's food with high frequency is a misuse of the product of which McDonald's is aware.

In *State of Rhode Island v. Lead Industries Association*,[2] Rhode Island attempted to recover expenses incurred by the state because of the defendants' production and distribution of lead. The state alleged that an extensive history of conduct existed consisting of misrepresentations and the concealment of evidence regarding the hazards of lead. As a result, the state suffered substantial damages, including the cost of discovering and abating the lead and other expenditures related to medical care for exposed children. Costs also were incurred for educational programs for children suffering as a result of lead exposure, and for programs designed to educate the public on the presence of lead in the state.

The state pled the following causes of action: public nuisance, violation of the Rhode Island Unfair Trade Practice and Consumer Protection Act (UTPA), strict liability, negligence, misrepre-

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sentations and omissions, civil conspiracy, unjust enrichment, indemnity, and equitable relief to protect children.

Only the State's tort claims and equitable relief to protect children failed. However, even though the Court refused to dismiss the other counts, ultimately only the issue of public nuisance was submitted to a jury trial. A mistrial was declared when the jury could not reach a unanimous decision on whether lead in paint constituted a public nuisance.

In *Philip Morris v. Reilly*,[3] the First Circuit Court of Appeals held that the Massachusetts Disclosure Act was invalid because it created an unconstitutional taking of companies' products. In 1996, the state of Massachusetts attempted to pass a Disclosure Act, which required tobacco companies to submit to the state the ingredient list of all cigarettes, snuffs, and chewing tobacco products sold in the state. The state held that previous disclosure requirements did not adequately allow it to investigate public health concerns. Massachusetts desired to publicize the ingredient lists to create a greater public awareness of potential health effects of tobacco additives.

In this case, tobacco companies claimed that the statute constituted an unconstitutional taking based on the consideration of its ingredients as trade secrets, granting the ingredients protection under the Takings Clause. The companies held that public disclosure of these ingredients destroyed their value, thereby effecting a taking. The court agreed that trade secrets are property protected by the Takings Clause and applied the three-part factual inquiry to evaluate whether a taking has occurred: 1) Whether the government action interferes with investor-backed expectations; 2) What is the economic impact of the regulation?; and 3) What is the character of the government action?

In its analysis, the court concluded that the companies had reasonable investor-backed expectations to maintain the integrity of their trade secrets. The disclosure would have a "potentially tremendous" economic impact. Finally, the court was not convinced that the regulation was tailored to promote public health.

In *Souvannarath v. Hadden*,[4] the court ordered an issuance of writ of mandate directing Fresno County, California, to desist from placing non-compliant tuberculosis (TB) patients in the county jail. Souvannarath was a Laotian woman residing in Fresno County who spoke little English. In January 1998, she was diagnosed with multi-drug resistant TB and it was determined that she should be treated with intravenous administration of medication and treatment at a chest clinic. In July 1998, Fresno County concluded that Souvannarath was not complying with the treatment program and served her with a notice, written in English, ordering her to appear at the chest clinic. When she failed to appear, the county health director issued an order for her quarantine and isolation, directing that she be detained in the county jail until she completed the prescribed course of treatment.

The Fresno Superior Court ordered the issuance of the writ after finding that section 121358 of the State Health and Safety Code precluded the use of the jail as a detention facility for non-compliant TB patients. The Court determined that there was no evidence that the County had complied with the statute's procedural requirements. The appellants contended that section 121358 did not prohibit the use of the jail when fiscal considerations were taken into account and that, because the county used no state funds in carrying out its policy, it had preserved the intention of the statute. The Court concluded the Legislature unmistakably intended to prohibit the use of jails at TB detention facilities, even though the restriction might place a burden on a particular county to identify and fund different housing options.

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Using the Turning Point Model State Public Health Law

Lawrence O. Gostin, Glen Safford, and Deborah Erickson (Moderator)

Deborah Erickson

The Turning Point Initiative is an initiative for which the Robert Wood Johnson (RWJ) and W.K. Kellogg foundations partnered in order to fund a group of states and a number of communities within each of those states to work through a planning process to look at ways to strengthen their public health systems at the state and local levels. Out of that process, the states and communities would come together at the national level to talk about what they had been learning and what the issues were. There were a number of issues that resonated with all of the states. As part of a second phase of the Turning Point Initiative, RWJ funded what they termed "National Excellence Collaboratives," five workgroups which were formed to address the five issues that they thought were the most significant that needed to be addressed (e.g., the modernization of public health law, performance management and public health, information management in public health, promoting social marketing techniques in public health, and leadership development in public health).

The Public Health Statute Modernization National Collaborative is a partnership of representatives from five states (Alaska, Colorado, Nebraska, Oregon, and Wisconsin) and nine national organizations. It first met in 2000 and decided to develop a model law that could be used as a tool (e.g., to provide a checklist for states to determine whether they have sufficient legal authorities in which to act, as well as sample statutory language). First, the collaborative conducted an assessment of the current state of public health law in the U.S. Then, the Collaborative worked to define the framework of what the public health law model should include. A draft model law was available for public comment during the winter and spring of 2003. A final version of the model law is expected by early fall 2003.

The collaborative identified some issues that would not be addressed in the model act even though they have strong relevance to public health. These included mental health, substance abuse, and regulation of the healthcare industry. Also, the model act does not include extensive language concerning areas of law that are traditionally covered in elsewhere in state statutes, such as tax provisions and administrative procedures. Moreover, the act tried to avoid specifying regulatory details in the law, leaving that to administrative law.

Lawrence O. Gostin

There is need for public health modernization. Several models or processes have been ongoing for a number of years. First, with support from the Centers for Disease Control and Prevention (CDC) and from the Council of State and Territorial Epidemiologists, a model public health privacy law was developed. That model law included standards states could consider adopting to protect privacy. Protection of privacy has become especially important because HIPAA (the Health Insurance Portability and Accountability Act) carves out state public health privacy.

Second, there was the Emergency Health Powers Act, which has been highly controversial. Despite the controversy, the Act has been supported in the New York Times, the Washington Post, and USA Today. That law was written at the request of CDC, and approximately 25 states have adopted the law in whole or in part. The law was never intended to be adopted in whole; it was intended to

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be a checklist for states to use. It has been very successful. As controversial, important, and helpful as that law has been, it was never intended to be the kind of day-to-day public health law and modernization that the Turning Point Project is.

Like many other kinds of public health preparedness, public health has been ill prepared in relation to legal powers because many of the laws that provide the foundation for public health authority in the U.S date back to the late 19th and early 20th Centuries. They have been amended in layers with every new infectious disease epidemic (e.g., plague, cholera, smallpox, tuberculosis, polio, HIV/AIDS, West Nile Virus, and now SARS). As a result of amendments, two kinds of errors have occurred: 1) the amendments do not provide the kinds of powers that are often needed in public health; and 2) almost an opposite error, many of the amendments are unconstitutional or of arguable constitutionality because they predate the modern Constitution era of Due Process. The Turning Point Project goes well beyond power and Constitutional rights. It also tries to bring the legal authority for public health agencies into the early 21st Century by providing a mission, essential services, and powers and authorities for public health. The program encourages stable streams of funding that do not put public health into silos, and is interested in surveillance planning, workforce issues, and various other issues that modern public health has been requesting support in for such a long time.

Old laws are not necessarily bad simply because they are old, nor are they necessarily bad simply because they are highly inconsistent, but in the U.S., society has failed to pay close attention to public health until recently. This can be seen in the funding of public health agencies, in lack of laboratory capacity, in lack of surveillance capacity, and in the lack of the public's understanding of what public health does. Most people think public health is simply public healthcare for the poor. Neglected until very recently is the lack of understanding of the need for modern legal functions (e.g., law as a tool to promote the public's health).

Glen Safford

The Great Lakes Inter-Tribal Council (GLITC) is a consortium of eleven Tribal Governments in Wisconsin and Michigan. Typically, tribal healthcare is tribally operated and, therefore, directly accountable to tribal councils and health boards. Tribal healthcare systems take their philosophical cue from the concept of Tribal Sovereignty, the assertion that tribes are nations unto themselves. This concept is reinforced by the "self-determination" efforts of the tribes. According to Public Law 93-638 Section 2, "the prolonged Federal domination of Indian service programs has served to retard rather than enhance the progress of Indian people and their communities by depriving Indians of the full opportunity to develop leadership skills crucial to the realization of self-government and has denied to the Indian people an effective voice in the planning and implementation of programs for the benefit of Indians which are responsive to the true needs of Indian communities."

The mission of the GLITC is to expand tribal self-determination efforts by providing enhanced services and assistance and advocating the improvement and unity of tribal governments, communities, and individuals. The GLITC maintains a deep respect for tribal sovereignty and reservation community values. The level of tribal collaboration in public health varies and most often includes tribes reporting communicable diseases, collaboration for outbreak investigations and prophylaxis, state run vaccination programs, prenatal care coordination, and WIC participation.

More recently, collaborative relationships are expanding into new areas such as health research with university systems, health data collection through epidemiological programming, student health career development through a growing relationship with colleges and the Wisconsin Indian Education Association, and emergency preparedness response. Because of their sovereignty, tribes may decide it is in their individual or inter-tribal interest to collaborate in new functional areas such as these.

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Workshop on Public Health Law and Ethics I & II: The Challenge of Public/Private Partnerships (PPPs)

Michael R. Reich, Jody Henry Hershey, George E. Hardy, Jr., James F. Childress, and Ruth Gaare Bernheim (Moderator)

Ruth Gaare Bernheim

The issue of public health ethics has received much attention in recent years and is seen as a new field, distinct from medical ethics. Faculty from the University of Virginia, Johns Hopkins School of Public Health, Georgetown University, the University of Minnesota, and others received a grant from the Greenwall Foundation to examine this new field of public health ethics and identify the unique principles that distinguish it from the study of medical ethics. In the course of that study, which included exploring the field with public health practitioners, a number of distinguishing ethical principles emerged. The moral principles appropriate for public health officials included producing benefits; avoiding, preventing and removing harms; producing a maximum balance of benefits over harms; and distributing benefits and burdens fairly. Ensuring public participation also emerged as a key principle in public health ethics, as did respecting autonomous choices and actions, and protecting privacy and confidentiality. Transparency and building and maintaining trust were also key moral considerations for practitioners. The values emerging from the practice of public health provide a different perspective than that expressed in traditional medical ethics.

Focus groups involving members of the National Association of County and City Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), and the Centers for Disease Control and Prevention (CDC) were included in the exploration of practitioners' views. In the focus groups, ethical needs were assessed and key ethical challenges were identified. The focus groups revealed a need perceived by practitioners for more assistance with ethical issues, both in substance and in process. Practitioners wanted to know how to determine and balance ethical principles, as well as to whom to turn when performing ethical analysis.

Ethical issues surrounding public/private partnerships (PPPs) were particularly confusing and unclear, and practitioners often asked the question, "With whom do we partner?" Some wondered if they should actively seek PPPs when addressing the challenge of dealing with scarce resources. Given scarce resources and the opportunities that PPPs often create for more funding, the groups requested guidance in partnership and allocation decisions. Existing public health law could not adequately answer these questions. Many public health practitioners felt that scarce resources were pushing them into PPPs without the opportunity to address or understand issues arising from the different cultures, different values, and different governance structures of potential partners in the private sphere. Some practitioners felt that the potential partners were more powerful, in a sense, than their public health organizations, and this created tension. Most were not opposed to PPPs but felt they lacked ethical guidelines for their formation.

Michael R. Reich

There has been a proliferation of PPPs in international health in recent years, with one list citing more than fifty different PPP organizations. One reason for the proliferation of PPPs in

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international health is that both private sector and public sector organizations have recognized that they do not have adequate resources to deal with the complex problems they confront. Private companies and non-governmental organizations have recognized the need to become engaged in public health, and are increasingly interested in partnerships with the public sector to achieve this engagement. In addition, a flow of money from private foundations (especially the Bill and Melinda Gates Foundation) has promoted the establishment of new relationships.

Three factors can help define a PPP: 1) there must be at least one private, for-profit organization and one not-for-profit organization; 2) these groups must have a shared objective for creating something of social value; and 3) there must be a group of core actors who agree to share the costs and the benefits of the partnership.

While PPPs are proliferating in international health, there are many differences in numbers of partners, types of organizations, funding levels, objectives, evaluation, and effectiveness. Partnerships work when four criteria are met: 1) creation of something of social value; 2) a relationship of trust among partners; 3) a commitment to partnership; and 4) the existence of a broader sense of social legitimacy. Partnerships are often created outside of existing regulatory frameworks, however, and, therefore, raise potential risks as well as benefits.

Three broad views define responses to the issues raised by PPPs. Public Sector Protectionists say they do not want partnerships because they infringe on areas of responsibility that traditionally fall to the public sector. Partnership Optimists promote PPPs because they believe that partnerships provide resources for problems that could not otherwise be resolved. Conditional Positivists feel that partnerships are good, but that they should meet predetermined conditions in order to ensure their social responsibility and effectiveness. Since partnerships are appearing throughout international health activities, public health professionals need to consider the ethical, technical, and political issues that may result from them. Some of the lessons from the experiences with PPPs in international health may be relevant for PPPs in the US domestic public health context.

Jody Henry Hershey

Market driven changes in health care, combined with the changing role of government, has forced public health officials to focus on the issue of partnerships. Increasingly, consumers demand accountability. Policy makers and grantors expect multidisciplinary collaborations. Grantors often see applications as strengthened when multiple partners exist, and they actively seek proof of sustainability. All of these factors have led to a "Devolution Revolution," where more and more responsibilities are shifted to the local level.

In an environment of tremendous community needs, limited resources, and extreme competition among health and human service agencies for limited resources, the question of public-private-nonprofit partnerships becomes compelling. If the public health agency has rock solid support from influential leaders in the community, and if staff includes specialists from all areas of human services, and if there are no other competing health systems in the area, and if there are unlimited resources, public health might survive in the short-term without significant contributions from partners, but they will not innovate, learn, or be ready for the time when the base of support is at risk. The financial and programmatic constraints of government and industries at all levels require public health agencies to seek partnerships and coalitions aggressively.

A local public health agency and its public health officer are faced with difficult issues regarding public-private partnerships. These include: 1) Congruency of mission and goals—Are the missions and goals of the partnership consistent with that of the local public health agency?; 2) Conflicts of Interest—Is there a perceived or real conflict of interest in the partnership?; 3) Conflicts of Obligation/Accountability—To whom and to what are local public health agencies

accountable?; 4) Balancing Ethical Rules and Values—What ethical rules and values are local public health agencies balancing? Who's rules and values should they protect? What is the role of the public health professional?; and 5) Allocation Issues—Who decides what gets funded? In situations where money is available, the agenda may already be established and set by others. Ultimately, local public health agencies and public health officers need more guidelines—an organized framework for evaluating and decision-making—on public-private partnership issues.

Specific scenarios, providing examples of the issues that local public health agencies face in establishing public-private partnerships, were discussed, as well as NACCHO's Corporate Funding Policy that provides guidance to the organization when collaborating with other partners including the private sector.

George E. Hardy, Jr.

There is clearly a financial need for partnerships. A benefit exists for the not for profit and public sectors in the movement of many public health officials into the corporate sector. Federal, state, and local public health organizations are an interconnected system. Health officials must consider a number of specific obligations when considering private partnerships. Public health officials are charged to protect the public confidence and the credibility of the public health system. First and foremost, they are obligated to uphold the law.

Public health officials have an obligation to work with partners to examine the strength and validity of existing laws. There is the obligation to protect the public's health. In issues of partnerships, the most important role of the public health official lies in protecting the public trust and confidence. When a private company desires to sponsor a public health event or partner with public health, the health officials have the option of expanding that partnership to include a series sponsors. Although public health agencies must be aware that while broadening the scope of the partnership, there is a risk that the original sponsor, perhaps desiring to be the only sponsor, will withdraw its offer of support.

James F. Childress

Ethics is too important to be left to ethicists. It requires interdisciplinary and practical conversation. In the context of public health ethics, the language of "good and evil" or "right and wrong" is rarely applicable. More often it is a matter of what is appropriate or not appropriate, or what is ethically justifiable or unjustifiable. In their ethical arguments, pubic health officials should engage in the process of deliberation, defined by John Dewey as an "imaginative rehearsal of various courses of action." Imagination enables us to envision possibilities and we can then engage in a process of critically analyzing the reasons for or against potential partnerships. There are many kinds of important relationships between the public and private sector and not all merit the label of partnership. When evaluating the need for a partnership, public health officials should consider who is affected and what is at stake. Questions of practical limits exist; these may be political or legal. We use both our imagination and our reason in determining which course of action would be best, all things considered.

There are unmet health needs, and PPPs provide a means of addressing them; however, important to consider all possible outcomes and to think about the net balance of benefits in relation to costs, where costs might include missed opportunities. Other questions are also important. Can limited accountability be adequately addressed? A distortion in public health priorities, for example, in order to further the interests of the corporate partner, is not what most adequately addresses the concerns of injustice and equity in healthcare. Is uncertain sustainability an issue in PPPs? Though the corporation may give; the corporation can also take away.

Collaboration and cooperation may give rise to the problem of dirty hands. There may be a sense of a loss of purity on the part of the public health

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sector if it involves itself deeply with corporate interests. In a possible collaboration with tobacco, for instance, actions may symbolize approval. This potentially links the public health organization to a social agenda that is problematic. Criteria must be established to make the broad values of transparency and trust more concrete in order to more adequately address cases that will emerge. NACCHO uses the term "prudence," which suggests caution as well as choosing the appropriate or right course of action.

A conflict of interest is a condition or state of affairs in which an agent (an individual, a profession, an institution, or an organization) has a motive or incentive based on the pursuit of his, her, or its interest to breach a moral obligation. Conflicts of interest may be real or apparent, but that may not matter from a standpoint of trust. If, for example, members of a community perceive a conflict of interest in spite of a public health official's confidence that one does not exist, the public's trust may be compromised. There are actions that can be taken to address conflicts of interest, including, if possible, avoiding them; however, this may involve sacrificing other important values. It is important to ensure transparency in relationships to avoid a conflict of interest being hidden, which may further damage the public's trust.

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New Directions for Health Insurance Design: Implications for Public Health Policy and Practice

Sara Rosenbaum

ABSTRACT

National attention on issues of public health preparedness necessarily brings into sharp focus the question of how to assure adequate, community-wide health care financing for preventive, acute care, and long-term medical care responses to public health threats. In the U.S., public and private health insurance represents the principal means by which medical care is financed. Beyond the threshold challenge of the many persons without any, or a stable form of, coverage lie challenges related to the structure and characteristics of health insurance itself, particularly the commercial industry and its newly emerging market of consumer-driven health plans. States vary significantly in how they approach the regulation of insurance and in their willingness to support various types of insurance markets. This variation is attributable to the size and robustness of the insurance market, the political environment, and regulatory tradition and custom. Reconciling health insurance markets with public health-related health care financing needs arising from public health threats should be viewed as a major dimension of national health reform.

Introduction

In a speech at *The Public's Health and the Law in the 21st Century: Second Annual Partnership Conference on Public Health Law*[1] the Honorable John H. Hamre, President of Center for Strategic and International Studies, remarked that a fundamental goal of public health is to ensure that population-wide health crises do not turn into crises of government. This remark aptly captures the underlying rationale for addressing one of the nation's most stubborn public policy paradoxes, namely, the relationship between public health and health insurance, the principal means of financing medical care in the U.S. These two systems traditionally have maintained an uneasy coexistence. State regulators historically have struggled with how to balance the need to regulate the scope and reach of health insurance with the need to maintain a viable health insurance market. With the exception of Medicare and Medicaid (which themselves were a response to market failure), the federal approach to reform can be characterized as one of general avoidance interspersed with a combination of tentative and marginal reforms and large-scale failures.

When they have occurred, national reform efforts have been driven by evidence of large and growing gaps in access to affordable coverage. Even comprehensive reform plans such as that proposed by the Clinton Administration have relied at least to a significant degree on traditional insurance principles in terms of benefit design and coverage. The public health implications of insurance reform have received considerably less attention, other than perhaps improving coverage of specific clinical preventive services.

Profound issues regarding the adequacy of health care in relation to public health threats are found at the intersection of health insurance and public health. While these issues have been evident for decades, events of the past several years have

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underscored the need for a more in-depth focus on the challenges that arise from the nature and structure of health insurance itself. In this regard, the large number of Americans without any form of coverage represents the best understood, but by no means the only, challenge.

This article explores the nature of the relationship between health insurance and public health in a context of public health threats and preparedness. The timing for such a review may appear less than propitious, given the pressures under which the current health insurance system is operating, in terms of both escalating costs and declining coverage. Yet as greater attention is given to matters of population health in relation to public health threats, policymakers and leading public health officials have grown increasingly aware of the need for fundamental improvements in how the nation finances access to essential health services, both in preparation for, as well as response to, a public health emergency.[2] The need for attention to the public health/health insurance intersection is equally true, regardless of whether such a public health crisis emanates from an act of bioterrorism or the naturally occurring spread of a deadly disease such as Severe Acute Respiratory Syndrome (SARS).

Beginning with a general overview of the relationship between health care, health insurance, and public health, the article explores possible approaches for addressing the issue of adapting insurance to public health financing needs and examines relevant precedent.

Background and Overview

How to assure the availability of accessible, timely and quality medical care in the face of terrorism and other public health emergencies represents an enormous public health challenge. Over the past generation, public health threats have grown, but at the same time, health care has become both increasingly costly and market-driven. In most communities, public health agency involvement in the direct provision of health care is extremely limited, and in many communities' public health authorities as sources of even basic medical care have virtually disappeared.[3]

Overwhelmingly, public health agencies depend on the private sector not only to furnish necessary health care, but more importantly, to pay for it. In 2000, government administered public health activities represented 3.4 percent of total national health expenditures, up from 2.7 percent in 1980.[4,5] Like the individuals they serve, public health agencies depend on a vast, complex, and highly decentralized web of public and private health insurance arrangements to finance nearly all medically necessary health care, whether acute, preventive, or long term in nature. In 2000, out-of-pocket payments accounted for less than 20 percent of all personal health care expenditures; in contrast, three quarters of all personal health spending derived from public and private health insurance.[4]

Workers (whether employed by private industry or in the public sector) secure coverage for themselves and their families through employer-sponsored plans, which number literally in the thousands. Employer plans are governed by myriad state and federal health laws, including both state insurance laws, as well as various federal laws governing particular classes of coverage (e.g, the Employee Retirement Income Security Act (ERISA) for private employer health plans; the Federal Employee Health Benefits Act governing plans sponsored by the federal government, and separate laws governing coverage for military workers and their dependents).[6]

Each separate body of law governing private insurance has its own distinct structure. Requirements, and variation can be significant, ranging from state laws establishing comprehensive benefit content and design requirements to the deregulatory nature of ERISA, which applies to self-insured plans and contains virtually no content standards beyond isolated coverage rules (e.g., reconstructive surgery following breast cancer) and principles of continuation and portability. Regardless of whether regulation is relatively extensive or minimal, however, health insurance as it has come to be understood in this country is driven by principles of risk, narrowly conceived concepts of what constitutes covered and necessary health care, and

rigorous adherence to a contractually rigorous medical model that vests in the industry broad powers to define coverage.[6,7]

Public insurance is similarly pluralistic in its legal structure. Approximately 40 percent of all children and adults with family incomes at or below the federal poverty level secure coverage through Medicaid (and in the case of children, Medicaid's companion State Children's Health Insurance Program (SCHIP)).[8] Both laws confer considerable design and coverage discretion on state agencies. Medicare offers a unified insurance scheme for elderly persons and persons with severe disabilities that prevent work, but Medicare, and to some degree Medicaid, both rest on certain principles linked to traditional notions of health insurance.

The nation's voluntary and pluralistic insurance scheme thus operates in accordance with a constrained picture of what constitutes "medically necessary" health care, with dramatic results. The most obvious is a widespread lack of coverage among working-age persons and their families. Some 40 million Americans are uninsured on a full-year basis, a number that rises to 60 million if a point-in-time measurement system is used.[9] Additionally, as discussed in more detail below, enormous gaps in financing are evident, and these gaps carry major implications for public health policy and practice.

The ability of public health agencies to ensure basic medical care essential to public health protection is routinely tested even under normal conditions. In the face of a public health emergency that triggers the need for both population-wide planning as well as an immediate and sustained population-level response, the consequences of coverage gaps and limits become clear. The very lack of coverage for so many persons amounts to a public health threat in and of itself given the well documented relationship between coverage on one hand and health care access and outcome on the other.[10,11]

Furthermore, the coverage that is available falls well short of the range and level of intervention needed to finance health care related to a widespread public health threat. Public health emergencies call for aggressive prophylaxis where feasible, as well as a rapid response using health care protocols that not only treat specific covered patients but also protect against the externalities that threats trigger. Notification of exposed persons, further prophylaxis, and community-wide tracking become essential. A public emergency also can compel substantial flexibility in the types of settings in which health interventions take place and the types of personnel who are deployed. Finally, public health authorities need access to sufficient resources not only to respond during the acute phase of an emergency but over the long term as well, and to both physical and mental health sequelae.

Even a generous private insurance plan is not designed to address this range of preventive, acute, long-term, and patient management services. Certain consequences flow from the conventions of traditional health insurance policies: limited coverage for prophylaxis, exclusions and restrictions related to coverage for chronic and long-term physical and mental health conditions arising from an acute episode of illness, exclusions of certain conditions entirely, restrictive standards of medical necessity, differentiation between physical and mental health conditions, and restrictions on the range and types of health professionals and providers who can be compensated and the service settings in which payment will be made. These limitations on payment are particularly evident in the individual and small group insurance markets, where the risks are highest and the exclusionary practices of insurers at their most aggressive.

In sum, health insurance may limit the ability of public health authorities to plan for health care linked to public health threats and emergencies in two respects. First, the sheer number of persons excluded from the insurance system creates a fundamental management problem. Second, the constraints on coverage and payment that are intrinsic to health insurance have the potential to significantly limit public health agencies' ability to plan for and ensure an appropriate level of medical care response to a public health emergency.

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Over the past decade, public health agencies have increased the level and intensity of their "conversation" with the health insurance market serving both public and private purchasers. For example, the CDC has launched collaborative efforts with the Washington Business Group on Health and the National Committee for Quality Assurance to promote more robust coverage and utilization of preventive health services in employer-sponsored health plans, and collaboration with the Centers on Medicare and Medicaid Services around clinical prevention also has grown. But despite this increased emphasis on formal interaction between the worlds of public health and health insurance, the worlds of public health and health insurance stand in fundamental contrast to one another, and their interaction is complicated, to say the least. Differences can be found both in the underlying policy imperatives for their existence and the policy and legal frameworks within which they operate. These differences inevitably make common accommodation difficult, despite the imperative to do so.

At their core, public health agencies are bounded by little more than the geographic areas they serve. The very concept of public health is vast, covering what the Institute of Medicine has characterized as everything that a society does "collectively to assure the conditions for people to be healthy."[12] Public health agencies operate under constitutional and statutory authority, and their legal duties run to the community as a whole.[13] The task of public health agencies is to identify and measure risk and assure necessary, community-wide responses to risk until such time as the risk is contained.

Health insurers, on the other hand, derive their powers chiefly from the risk contracts they negotiate with both public and private individual and group purchasers and in an environment relatively free of content and structure design and regulatory constraint.[14] There are those who see a population dimension to health insurance. This is because from a technical standpoint, the task of coverage design itself bears certain shallow similarities to public health, since insurers consider evidence of medical efficacy in the context of utilization by a covered group as a whole.

But considerations of group risk for medical care use (defined strictly to exclude persons, health conditions, and services classified as beyond the furthest reaches of actuarial risk concepts) are a far cry from the broadly framed mission of public health practice. Compared with public health, the business of health insurance is exceedingly narrow. Health insurance entails the provision of financial protection for specifically framed medical risks, effectuated through payments on behalf of covered persons to a relatively narrowly drawn class of medical care vendors. To conduct their business, health insurers engage in a process termed "fair discrimination," a form of risk selectivity sanctioned by law.[6] Unlike public health, whose mission must be highly elastic and responsive to community risk, health insurance, whether sold in the individual or group market, whether purchased by public or private buyers, and whether fully insured or self insured, is a remarkably *inelastic* product structured to recognize and accept legal responsibility only for carefully defined risks.

Inelasticity is achieved in several ways. First, to the extent that the law permits, insurers avoid enrolling "bad risks" or charge exceedingly high premiums for the privilege of enrollment. Second, insurers structure their contracts to avoid certain categories of health risks altogether (for example, marketing only to employee groups). Third, insurers employ strict contractual definitions of what they will pay for in order to keep payments and coverage within the four corners of the contract of coverage they write.[15] In particular, insurers avoid risks that are either social or external and community-wide in nature, and therefore uninsurable, as opposed to the risk of specified illness or injury in a specific covered person. These structural considerations are perfectly logical if the fundamental purpose of insurance is the protection against certain individual "medical losses." But the protection of individuals against specified medical risks is a vastly different proposition from the protection of a community before, during, and after a community health threat.

To some degree, Medicare and Medicaid (especially Medicaid) depart from these principles, although Medicare has its roots in commercial insurance.[16] Both programs were established to cover persons excluded from traditional forms of health insurance because of a lack of attachment to the workforce as a result of deprivation, age, or disability. Medicaid in particular extends a type and depth of coverage not found in Medicare or the commercial market.[16] Yet in recent years, even Medicaid has become increasingly privatized, as Medicaid as moved toward a managed care purchasing approach, which by 2002 resulted in more than half of all beneficiaries enrolled in health plans operating according to commercial insurance principles. Broader Medicaid coverage remains available through residual benefits,[17] but the necesity of these benefits is unclear. Medicare managed care contracts, on the other hand, are coextensive with Medicare, while the same is essentially true for separately administered SCHIP programs.

In sum, reliance on commercial norms and techniques creates obvious areas of potential conflict between public health and health insurance. Public health entities want the maximum possible elasticity in resources available to find, treat, and manage community health risks. Insurers want to avoid unanticipated risks whenever possible and minimize their risk exposure even for contractual treatments. Public health agencies need to ensure access for the uninsured, while health insurers focus on averting the impact of non-coverage on their policy holders.

The result is the potential for serious gaps between what public health needs and health insurance financing, not only in terms of who has access to coverage at all, but also the range, depth, and extent of coverage, the settings in which coverage will be recognized, the professionals who can be paid for the covered services they furnish, and the protocols used to guide coverage decision-making. Even for those who are insured through public or private health plans, coverage may be extremely constrained. Exclusions and coverage limits for preexisting conditions, particularly in the commercial market, can have major consequences during emergencies. Health insurers may also exclude reimbursement for any treatments related to acts of war or declared public health emergencies, both of which are community-wide threats. Indeed, common forms of coverage limitations unrelated to public health threats may loom large if one occurs. For example, a 24-year-old with hay fever who acquires individual coverage would, in many markets, hold a policy that excludes or limits coverage of *upper respiratory infection*s. This exclusion would trigger regardless of whether the condition is the result of allergies or an anthrax attack.

Commercial contracts may place strict limits on the coverage of preventive benefits (including prophylactic treatments), narrow the classes of benefits they cover, and offer only partial coverage for certain benefits (for example, covering only selected immunizations recommended by the Centers for Disease Control and Prevention).[18] These limitations and exclusions are especially prevalent in the case of plans purchased in the individual market, where the need for risk avoidance is crucial to the preserving of any market driven system at all. Such exclusions can result in the absence of coverage for entire classes of treatment, even where the preexisting individual condition that triggers the exclusion is relatively benign (e.g., hay fever).[19] Contracts also tend to impose strict limitations on how medical necessity is defined and applied, which in turn may curb the availability of long-term aftercare, when the need is to minimize the effects of a disability or chronic condition rather than "restore normal functioning."[15]

As part of their duty to manage utilization, insurers and their networks reserve the right to determine the practice guidelines they will follow, the approach to health care they will use, and the patient management techniques to which they will adhere. This autonomy over practice style is, in the view of insurers, essential to managing health and financial risk. Such autonomy over care and costs, coupled with its use of financial incentives to achieve certain cost restrictions, may raise a host of serious issues where public health agencies have

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attempted to set practice standards that are considerably more comprehensive, aggressive, or sustained.[14,20] Insurance contracts also contain numerous limitations and exclusions. Benefits that are considered "free" or related to "public health" concerns would be excluded. Costs related to the collection of information from patients and their families (i.e., surveillance) would not be considered part of the allowable cost of care.

The link between coverage and receipt of covered benefits through a company's network, which is the hallmark of the modern managed care product, has added a further layer of complexity to the public health/health insurance intersection. Even when coverage is not conditioned entirely on use of a company's network, the cost consequences of going "out of network" for care can be enormous to patients and providers. Although the United States Supreme Court's 2003 decision in *Kentucky Association of Health Plans v Miller*[21] affirms states' powers to regulate insurance networks, state laws actually are relatively limited in this regard; indeed, most state "any willing provider" laws apply only to pharmacies.[22] Furthermore, although states might regulate networks, they have not chosen to prohibit "tiered coverage arrangements" that allow insurers to condition full coverage on use of designated providers.

A new generation of insurance plans may further increase the potential for payment denial, exclusion, and coverage limits, even in the face of major public health events where treatment is indisputably required. Known by various names (e.g., consumer-driven plans, defined contribution plans), these products offer a design that combines extremely high deductibles (potentially in the thousands of dollars) and restricted coverage with linked spending accounts that provide consumers with a defined level of cash subsidy to assist in the purchasing uncovered health care.[23] Frequently the terms of coverage are unclear, with ambiguity around which types of services will count toward coverage at all.

The underlying theory of this new and even leaner form of coverage is its potential to reduce the high cost of insurance and to make consumers more cost conscious about health spending. This approach to insurance has been termed a "skin in the game" approach to insurance design, aimed at exposing consumers to greater health costs and making them to more accountable for care choices.[19] The ability of such plans to gain in popularity from their current modest levels is unclear. A 2002 study suggests an enrollment of approximately 1.5 million Americans, but also found significant interest among employers.[23]

The Policy Response

Policy reforms enacted in the wake of the September 11 attacks offer potential approaches for adapting health insurance to larger systemic health care needs arising from public health emergencies.

One model may be expansion of public insurance to fill coverage gaps and finance non-insurable risks during declared public health emergencies. This is the model pursued by New York, with assistance from the federal government. The sheer magnitude of the New York City disaster kept to a minimum the potential for clashes regarding how to finance emergency health care; death so totally dominated the World Trade Center attacks that remarkably few people required treatment, at least at the height of the events. But in order to ensure adequate financing to address the physical and mental health needs of potentially millions of persons, New York temporarily lifted all eligibility restrictions on Medicaid with the help of the federal government. This temporary extension of Medicaid to virtually any member of the population in need of coverage was essential to the stabilization of the health system and its ability to respond to the emergency.

A second model is legislation aimed at stabilizing and supporting the insurance industry in order to prevent its withdrawal from, or restrictions on, certain aspects of the market. This approach is illustrated by the Terrorism Risk Insurance Act of 2002.[24] In the aftermath of September 11th, the property and casualty industry threatened to withdraw all coverage through their use of "terrorism" exclusions. Individual states began to approve these coverage exclusions in order to avoid losing the

industry entirely within their borders. So great was the perceived risk of economic collapse as a result of the loss of property and casualty insurance, that within a year of the attacks Congress enacted the Terrorism Risk Insurance Act of 2002. Enacted to protect and stabilize property ownership, the Act effectively limits state regulatory discretion over insurance, as well as insurers' discretion not to protect against particular risks related to acts of terrorism. For insurable events connected to an act of terrorism, the federal government acts as a risk sharer and reinsurer thereby ensuring market stability. In effect, the Act combines regulatory intervention with risk sharing to maintain certain events as insurable while protecting the industry against unmanageable loss.

The model offered by the Terrorism Risk Insurance Act could be adapted to health care through legislation that combines broadened coverage with federal reinsurance guarantees. Such an approach might apply federal standards for broadened benefit and payment levels during declared periods of public health emergencies. This broader coverage could be financed through a combination of special premium fees and stop-loss coverage guaranteed by the federal government.

A third model would be direct financing of public health agency activities during periods of declared public health emergencies. Agencies could receive special payments on a mandated expenditure basis to underwrite the cost of identification, tracking, payment for treatment and aftercare, deployment of health professionals, and other activities related to a response to public health emergencies. Such an approach, combined with increased payments toward public health preparedness, could bridge gaps not filled by health insurance.

Mandated spending for public health emergency activities could be pursued as revisions to the Public Health Security and Bioterrorism Preparedness and Response Act of 2002.[25] This Act amended the Public Health Service Act to authorize a federal legal framework for planning and executing public health and medical care activities during public health emergencies. But the Act did not specify provisions for funding reforms on a mandatory basis. As a result, financing is contingent on discretionary Congressional financing decisions; given the slow and speculative nature of the federal appropriations process, this poses a serious problem. Mandating funding, up to at least some aggregate upper limit, could bridge the period between the first sign of emergency, when immediate response is critical, and an ultimate appropriation of funds. It is important to note that the legislation does permit the Secretary of HHS to waive certain payment rules, sanctions, and conditions of participation under Medicare and Medicaid during emergencies in order to avert payment denials because of technical compliance failures. But the Act contains no provisions related to broad modification of program eligibility and coverage standards of the sort that New York pursued.

In sum, events over the past several years offer various models for financing public health emergencies. Two are insurance based, one relying on modification of public insurance, and the other, regulation of private insurers along with government reinsurance. A third model entails direct financing for certain services. Conceivably all three approaches could be combined in a layered format that would extend public coverage to uninsured persons, broaden coverage for persons with private insurance through reinsurance, lift otherwise applicable coverage limits in the case of public coverage, and provide mandatory direct financing for certain public health agency activities. This combination approach could be designed so that it becomes effective upon formal declaration of a public health emergency.

Why a National Response is Necessary

A national response to this problem is an imperative in light of the cost of stabilizing health care during a public health emergency, as well as the constraints under which individual state officials operate where regulation of the insurance industry is concerned. Indeed these constraints are illustrated by the speed with which they granted broad exclusions to the property and casualty industry in order to avert loss of the products within their borders.

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Wyoming and Maryland offer contrasting cases in point. In the case of Wyoming,[26] medical care cost inflation and its tremendous impact on the price of health insurance are officials' chief considerations. Of concern is the decline of managed care (a potentially effective means of controlling costs), pharmaceutical price increases, and hospital and physician costs. Of particular concern is the impact of medical malpractice on the cost of health care, given medical liability's potential to directly and indirectly affect health costs (e.g., higher premiums as actuaries respond to the threat of litigation through escalation in premium pricing, the large payouts for both economic and noneconomic damages that can flow from litigation, and defensive practice of medicine that may develop in the context of growing medical liability exposure).

In Wyoming as elsewhere, higher private insurance costs are attributed to cost shifting from public insurers and uninsured patients to private insurers, inadequate payments made by public insurers, and of bad debt and charity care emanating from both uninsured and underinsured patients. Other causes include government regulations and mandates, insurance company losses on their investment earnings, the insurance cycle, and adverse selection. While mandates are viewed as a factor, state officials see the state's role in mandates as modest and the essential design of the market and its interaction with the medical care system as a greater problem. Even where all mandates repealed and bare bones policies encouraged, lawmakers view the impact on cost as modest (between 10 and 15 percent). Taken together, these complex problems mean that state officials' overarching priority is keeping the population insured at all. Issues related to the quality, breadth, and depth of coverage, as well as its interface with public health priorities, are secondary to this fundamental aim, a reality shared by many states.

Although Maryland is a state with a stronger regulatory tradition and a far larger and more robust private market, regulators face similar challenges.[27] With a mission of assuring a stable and competitive insurance market and ensuring fair treatment for consumers, Maryland's Insurance Commission uses a range of regulatory tools aimed at ensuring the proper design and integrity of insurance. These tools span licensure, solvency regulation, rate and form review, market conduct examination, and complaint investigation and resolution. Negotiation over all phases of insurer practices also constitutes a critical aspect of market oversight as well as offering the state an opportunity to balance competing needs related to coverage *at all* with an assurance that the coverage that is available meets essential community needs. Thus the state's ability to manage insurance policy is constrained.

Conclusion

Integrating public health priorities into an insurance market has become an imperative in health policy. Indeed, in a recent article in *Clinical Infectious Diseases* Ruth Faden and colleagues note that the nation still has not resolved the issue of compensation for those injured as a result of mandatory vaccination program in the context of an attack. The authors argue that "there should be no financial or insurance barriers to such treatment" and that this problem should be resolved through the insurance system rather than by creating "special structures."[28]

Insurance governed by commercial norms represents the principal means for financing medical care. As a consequence, there is an enormous need to reconcile this health care financing model with the broader population-level considerations that stem from emergencies. Recent developments offer promising approaches, and the experiences of states in their efforts to attract and retain a stable insurance market suggest that a federal response is necessary. Combining the approaches that have been attempted merits careful exploration and analysis.

What is evident is that doing nothing is not an option. The nation has entered an era when no health care policy can be said to be truly adequate unless it has achieved a level of public health accountability commensurate with the age in

which we live. Reaching the point at which the public's health and medical care financing are in sync inevitably will require law and policy interventions at all levels of government, and the active collaboration of experts in health insurance, health care, and public health policy and practice.

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Public Health Ethics: The Voices of Practitioners

Ruth Gaare Bernheim

ABSTRACT

Public health ethics is emerging as a new field of inquiry, distinct not only from public health law, but also from traditional medical ethics and research ethics. Public health professional and scholarly attention is focusing on ways that ethical analysis and a new public health code of ethics can be a resource for health professionals working in the field. This article provides a preliminary exploration of the ethical issues faced by public health professionals in day-to-day practice and of the type of ethics education and support they believe may be helpful.

Public health law and public health ethics have been the focus of much scholarly and professional attention in recent years, beginning well before but certainly fueled by the bioterrorist and infectious disease threats arising with 9/11 and Severe Acute Respiratory Syndrome (SARS). While legal interventions in public health have been accepted as legitimate throughout history, the current debates about law are driven by the felt need to update antiquated, fragmented, and inconsistent public health statutes. Public health ethics, on the other hand, is emerging as a new field of inquiry, distinct not only from public health law, but also from traditional medical and research ethics.[1]

Whereas public health officials have always looked to the law to establish their authority, funding, and obligations, particularly in emergencies, many now also recognize the need to turn to the field of ethics for answers to questions that law cannot provide. To take one example: When confronted with a case about whether to detain or isolate a person who has an infectious disease which may pose a threat to others, the difficult question is not, "Does one have the legal authority to do so?" but rather "When and how *should* a public health official intervene ethically in this situation?" In short, there is growing recognition in public health that, given our pluralistic society where consensus about social norms is often lacking, explicit ethical analysis can help to "elucidate and interpret applicable law and provide additional justification and legitimacy for public health authority and action in a particular situation where more than one alternative course of action is legally permissible."[2]

To address the ethical dimensions of public health, scholars in ethics and related fields have been exploring the theoretical foundations of public health ethics, to enrich our ideas about the common good and to offer frameworks that enumerate and balance communal values with the individual interests that seem to dominate our political and legal systems.[3,4,5] At the same time, public health practitioners have been actively engaged through professional associations in formulating a Code of Ethics that sets out basic public health values to serve as a resource for practitioners facing ethical questions in their day-to-day jobs.[6]

Much of this work is at an early stage of development, with some ethical concepts and methods still "largely undefined",[1] and public health values unspecified. Complicating the analyses is the fact that public health is an "enormously complex phenomenon."[8] Furthermore, as elaborated by Wendy E. Parmet, public health professionals not only possess specialized skills, such as their abilities to use biostatistics and

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epidemiology, they also share a common language and values and a world view that may differ significantly from those in another profession such as the law.[7] Governmental public health officials, who generally are either elected directly or appointed by democratically elected officials, also have additional professional roles, obligations and values growing out of their accountability to citizens — the public—and other government officials to ensure that "the government is able to monitor the population's health and intervene when necessary…."[8]

To provide a preliminary understanding of the language, values and perceived ethical needs of public health officials in practice and a general inventory of some of the major ethical issues encountered in governmental public health agencies, faculty from the Institute for Practical Ethics and Public Life and the Center for Survey Research at the University of Virginia convened three focus groups of between 9 and 12 public health practitioners each (one at each level of government practice) in March and April, 2001 in Washington, D.C. and Atlanta, Georgia. Participants were recruited through publicity and subsequent self-selection from members of the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), and from among staff of the Centers for Disease Control and Prevention. The questions raised in the focus groups were exploratory, rather than quantifiable, and included: 1) What are the ethical challenges that emerge most often in the practice of public health? 2) What are the principles or values that animate the practice of public health? 3) How well are practitioners in the field equipped to deal with the ethical dilemmas they encounter? and 4) What education or support would be useful to assist them?

This article presents a summary of the major ethical issues and types of cases described by the public health professionals, as well as a brief account of the ethical values or principles the groups highlighted and of their perceived needs for ethics training and support. It should be noted, however, that focus group findings generate only limited information and impressions and are designed to stimulate new ideas and further study. The article concludes with a few observations about the profession of public health and the fields of public health law and ethics.

Ethical Issues and Cases

Public health practitioners at all levels of practice reported that they must confront numerous ethical choices, both explicitly and implicitly, in their professional roles every day. They often feel ill-prepared to make the "ethical trade-offs" and percieve a need for more education and support to make these decisions.

The major ethical issues raised by practitioners can be grouped under four headings: 1) Public – private partnerships and collaboration in general; 2) The allocation of scarce resources, setting priorities, and choosing among different groups and health needs; 3) The collection and use of data and information; and 4) Politics and relationships with other government officials and legislative bodies.

With whom do we partner and collaborate?

Public health practitioners, particularly at the local and state levels, emphasized the ethical concerns arising from a strong current commitment in public health to partner and collaborate with many sectors in the community, including businesses, faith-based organizations, consumers' rights and advocacy groups, and non-profit agencies. Their ethical concerns involved real and perceived conflicts of interest and conflicts of obligation that arise with these relationships: Do we accept money from private organizations in order to carry out our programs? What about funds from pharmaceutical companies and the tobacco industry? These questions ignited lively discussions about cases and the roles of public health professionals.

The following scenario presented by one participant led to a lengthy discussion and analysis of relevant considerations: If I can solve my community's dental problems because a drug company says it will give my department this

amount of money for educational materials and for a dental program, and in return the company asks that its name be listed on the educational material and that it be allowed to publicize the program, what do you do? Other participants responded with numerous questions and concerns: Would it matter if the health department frequently purchased products from that company? Would it matter what the public perception of that company was, or what the company's employee policies were, and if so, how much time and energy should public health professional spend to investigate these questions? Also, did it matter what kind of product the company produced so long as it was not purchased by the public health agency, e.g. what about fast-food companies? Other questions speculated about different potential relationship conflicts. For example, what if a business that was regulated by the public health agency, such as a restaurant, offered funding to the health department?

One participant summed up the sentiments expressed during a group discussion: "Clearly the public-private partnership, as we move into the future, is a huge issue, and as we can see, there's just a gazillion issues, none of which have been worked out, none of the criteria, as you say for analyzing…." Among the major ethical concerns voiced by public health officials was the potential loss of trust with community members, as well as the danger of being coopted by more powerful organizations with greater financial resources.

How do we allocate scarce resources?

The difficult ethical challenges of priority-setting and allocating scarce funds also permeated all of the focus group discussions. Public health officials noted that assessments of their particular community health needs should be the main factor in priority-setting. However, they voiced concerns that community allocation decisions were influenced by other factors, such as the need to fund programs "mandated" by other authorities and by pressure to devote time and energy to programs that could be funded by private organizations, such as a program funding education about and drugs for a particular disease, such as hepatitis C. Participants asked: Was it an ethical breach to allow an outside party to direct public health attention to a particular problem? Even if the funding had a positive impact on health in the community, did it matter that it diverted resources from other greater community health needs

Another case highlighted the traditional public health tension between individual good and population benefit. One participant presented an illustrative case: One of the issues we wrestle with regularly with the Medicaid program is transplants. Where do you deny transplants and where do you provide transplants? It's almost strictly a fiscal issue. If I spend huge bucks on a transplant with a relatively low chance for success, I'm spending money that I could be better using on primary care somewhere else, that may save a number of lives in the long term. We have wrestled with this question, trying to devise some kind of formula, such as, if it gets to be 40% probability of success we'll do it. Or is 45% the right number? Or do you couch the question in terms of what the cost is going to be as well? Does it make a difference if the cost is $100,000 versus a half a million? We wrestle with this all of the time, trying to figure out some kind of way to make this decision "scientific." It is clear, however, that this is an ethical decision.

Ethical issues related to the collection and use of data and information

Numerous ethical issues relating to the collection, use, and dissemination of data emerged during focus group discussions. One concern focused on the potential risk for imprecision and inaccuracy in data assessment and reporting, particularly given the power of data to secure funding, drive agendas, and appear in publications.

Another cluster of ethical issues revolved around the collection, reporting and use of data about particular subgroups in the population that are identified on the basis of ethnicity, race, geographic location, or socioeconomic status (SES). While targeting a population can be beneficial,

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the potential long-term harms of stigmatization were a great concern. One participant raised lead poisoning as a good example because, while it crosses racial categories "it is geographically located and still causes a stigma to attach with the SES." Related concerns addressed the effect of the data on the subgroup itself, raising individuals' frustration (because often there is inadequate funding for follow-up) and panic, given the repeated messages that they are more likely to be "carriers of every single bug in the whole wide world." On the other hand, one participant pointed out that to have effective interventions for smoking cessation among women, for instance, "one size doesn't fit all" because the type of tobacco use, the motivations for use, and the cultural contexts differ among subpopulations. The ethical trade-off was characterized as benefit versus potential stigmatization, and without either the data to quantify the benefit or harm or general agreement about explicit overriding ethical principles to rely on, it was not clear to participants how to analyze such ethical trade-offs.

The dissemination of more general health information also raises complex ethical issues for public health officials. While public health officials expressed strong commitments to be truthful and build trust with their communities, they were concerned that the release of some information was counterproductive and served only to create fear in the community or inappropriate behavior. Information about the risk of infectious disease outbreaks was an example. Genetics was another, as described by one participant: "I'm actually more concerned that in the enthusiasm about genetics we're racing to everybody with information without establishing a public understanding that this doesn't mean you necessarily are going to develop a disease. This doesn't mean that your child will have it. I think that is an ethical problem – that we're just putting all this information out there without qualifying it…."

Ethical issues related to political and intergovernmental relationships

Participants in all three groups described ethical issues that arise because they felt constrained by governmental relationships and politics. As public health officials they are government employees and therefore must operate within a system in which local, state, and federal politicians make decisions and generate publicity about public health funding, goals and strategies. At all three levels, public health professionals described the need at times to compromise public health values because they operated within the political system. Participants cited needle exchange programs for intravenous drug users as an example of a simple program that public health professionals know would reduce the rate of disease transmission, but which they could not undertake for political reasons. They were concerned that either they individually or their departments might suffer if they presented data and supported some types of public health programs.

Other ethical dilemmas for health officials involve their relationships with the legislative and regulatory arms of government. Participant questions included: How much should they advocate "on principle" for a certain piece of legislation or for a certain vulnerable population or take a public position to correct misinformation circulated by a politician? Also, once a piece of legislation is written, what is their duty when writing the regulations to honor the intent of the statute? Or alternately, if the law is bad, is it ethical to write the regulations to better address public health needs? Legal issues also presented ethical challenges for public health officials, since many of the community members most in need were "on the other side" of the law. How can they as government representatives work with populations engaged in illegal behavior (prostitutes, drug addicts)?

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Principles or Values that Animate Public Health

Although many practitioners in governmental public health organizations have backgrounds in medicine and nursing, their knowledge about treating individual patients in an ethically appropriate manner may not easily transfer to public health settings. The primary value public health officials identified was population benefit or utility, although there was some discussion about whether a utilitarian perspective was just the default position in the absence of other clearly stated values.[9] Participants also identified the following public health values or principles in the focus group discussions, both when asked directly and when discussing particular topics: social justice, "do no harm" and prevent harm, truth-telling, and respect for individuals.[10] In addition, building and maintaining trust with the communities they served, which included promise-keeping, was a high priority and, indeed, was a thread throughout the discussions.

While public health professionals at the state level seemed to focus more on utility as a principle, local health department officials suggested social justice was a primary value. A number of participants were concerned that public health officials were not voicing this value strongly enough because it was politically dangerous to do so. Regarding the value, "do no harm" or prevent harm, some public health professionals stated that one could never act in public health without the risk, if not reality, of resulting harm. The example of exposing people to pesticides to prevent West Nile Virus infection raised the following questions: Was there a difference between the harm caused by omission (not acting) or commission (intervention)? Between harm to identifiable people in the short term or unidentifiable people in the future? Some discussed the notion that even collecting data on a condition to declare it a public health issue may result in harm, and pondered whether that activity had ethical dimensions that needed to be considered.

Need for Ethics Training and Support

While many of the participants in the focus groups had taken a course or two in ethics during their education, almost all felt that they would benefit from additional training and support in ethics. A number of participants cautioned that, to be useful, ethics education must be based on actual cases and involve professionals in actual practice. They suggested that good training in ethics would include internships and opportunities to shadow professionals, particularly when the professionals were interacting with community, political and legislative groups. In addition, some participants expressed an interest in establishing and consulting with standing ethics boards or committees.[11]

Concluding Comments

At least two types of ethical issues emerged from focus group discussions. The first involved the kinds of assessments and trade-offs of public benefits, harms, and risks that are similar to other public policy decisions, for example, when making allocation decisions in environmental policy or transportation. A question for both the fields of public health ethics and law to address is whether the health of the population is different from other public goods, and if so, how this distinctiveness might lead to different ethical and legal analyses? The second type of ethical issue described in the focus groups is related to the professional practice of public health. The profession is clearly evolving, as the field of public health itself expands. With public health now emphasizing community empowerment and greater community participation, partnerships with the private sector, and a population approach that addresses multiple determinants of health, the roles of public health officials become increasingly complex.[8,12,13] In addition to their responsibility to monitor and ensure that public health interventions are based on data and solid evidence, public health officials are now expected to fill many roles, including regulators, authorities in emergencies, managers, advocates, educators, mediators, and negotiators, to name just a few.

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Difficult ethical conflicts seem to arise from multiple obligations and identities. As one focus group participant asked, "So, what captures more of a sense of our primary purpose, being a partner with the community, a public servant, or an employee of the government?" Others replied, "You're in the middle, you're a bridge, you're a forced ambassador, trying to make peace."

The focus group discussions suggest that public health professionals today are often operating in new territory, with new partners, new obligations, and new ethical concerns. And the trend is likely to continue. The recent Institute of Medicine report, *The Future of the Public's Health in the 21st Century*, calls for building yet a "new generation of intersectoral partnerships."[8] The focus group discussions suggest that public health officials are still struggling over the legal and ethical parameters of current partnership opportunities. The fields of public health law and public health ethics have important and complementary roles to play in helping public health officials define these new partnerships and other new relationships. If public health officials can clarify the boundaries between what they legally can do and what they ethically choose to do — they will take an important defining step, along with the articulation of a Code of Ethics, in the profession's evolution.

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Appendix A

Conference Planning Committee

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The Centers for Disease Control and Prevention
Public Health Law Team

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Appendix B

Collaborating Conference Organizations and Centers for Disease Control and Prevention Programs

Alfred P. Sloan Foundation

American Bar Association Standing Committee on Law and National Security

American Public Health Association

Association of State and Territorial Health Officials

Center for Law and the Public's Health, Johns Hopkins University and Georgetown University

Department of Health Policy, School of Public Health and Health Services, George Washington University

Emory University Rollins School of Public Health

Greenwall Foundation

Healthcare Georgia Foundation

Institute for Bioethics, Health Policy and Law, University of Louisville

Institute for Practical Ethics, University of Virginia

Milbank Memorial Fund

National Association of Attorneys General

National Association of County and City Health Officials

National Association of Local Boards of Health

National Conference of State Legislatures

National Strategy Forum

Northeastern University School of Law and Tufts University School of Medicine JD/MPH Dual Degree Program

Public Health Law Association

The Robert Wood Johnson Foundation

Trust for America's Health

Turning Point Public Health Statute Modernization National Collaborative

The following Centers, Institutes, and Offices at the Centers for Disease Control and Prevention:

CDC Office of the Director

Office of Terrorism Preparedness and Response

Office of Minority Health

Office of General Counsel

National Center for Infectious Disease

Epidemiology Program Office

Public Health Practice Program Office

National Center for Chronic Disease Prevention and Health Promotion

National Center for Injury Prevention and Control

National Center for Environmental Health

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Calendar of Professional Education Events

- 28th Annual Health Law Teachers Conference

  Date: June 4 – 5, 2004
  Location: Seton Hall University School of Law, Newark, New Jersey

  Seton Hall University School of Law will co-sponsor this two day conference intended for professionals who teach law or bioethics in schools of law, medicine, public health, health care administration, pharmacy, nursing, and dentistry. The program is designed to provide participants with updates on issues at the forefront of law and medicine and to provide them with the opportunity to share strategies, ideas, and materials.

- The Public's Health and the Law in the 21st Century

  Third Annual Partnership Conference on Public Health Law
  Date: 14 – 16, 2004
  Location: CDC, Atlanta, Georgia

  The Centers for Disease Control and Prevention (CDC) will co-sponsor this three day conference to explore the vital role the law plays in protecting the public's health now and in the future. The theme for this year's conference is the application of law for improved health at the community level. Among the topics featured will be land use laws to support "smart growth/healthy growth" policies, legal lessons learned from the SARS and monkeypox outbreaks, legal tools for obesity prevention and control, promising new approaches to tobacco control, coordination between public health and law enforcement professionals, ethics in community public health practice, and the scientific basis for public health law.

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