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Chapter 2

THE STRUCTURE OF LAW IN PUBLIC HEALTH SYSTEMS AND PRACTICE

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Public health practice in the United States is carried out by an estimated workforce of 448,000 persons who serve in government agencies at federal, state, and local levels.¹ At the federal level, examples of agencies with primary public health missions or some public health-related roles are the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the Environmental Protection Agency (EPA). Federal agencies have explicit, statutorily created regulatory powers passed by Congress; implemented by the Executive Branch; and interpreted by the federal judiciary to ensure compliance with the U.S. Constitution. Some of these agencies function as regulatory bodies; others do not. At the state and local levels, legislative bodies—including state legislatures—act under state constitutions to pass statutes creating state and local public health agencies and boards of health, articulating powers to ensure the public's health, and delegating public health-related powers to government subdivisions and an estimated 2912 local public health agencies.²

This chapter examines the structure of law underlying U.S. public health practice by focusing on the statutory basis of the federal and state/local infrastructure of the U.S. public health system, including creation of federal agencies having public health or related responsibilities and powers under the U.S. Constitution and, similarly, state and local agencies with public health roles, responsibilities, and powers. The chap-

*The findings and conclusions in this chapter are those of the author(s) and do not necessarily represent the views of the U.S. Department of Health and Human Services or the Centers for Disease Control and Prevention.

ter describes the structure of law and statutory basis of public health systems and practice in two main sections. The first section examines the statutory basis of public health practice at the federal level, and the second section explores this for state-level public health systems and practice. These sections also implicate certain key foundational legal concepts, including federalism and preemption, that are highly relevant to understanding the interplay between legislative enactments and public health practice at all levels.

Statutory Basis of Federal Public Health Practice

The federal government's statutorily created roles in public health practice date at least to 1796 when, on May 27 of that year, Congress passed the first National Quarantine Act, which addressed federal quarantine activities in relation to the states' enforcement of their own quarantine laws.³ In the more than two centuries since then, Congress has acted under a core set of Constitutional provisions to pass numerous statutes providing for a broad spectrum of federal roles in U.S. public health practice. These statutes have provided for public health systems and the federal government's involvement in public health practice in at least three ways: (1) creation of a federal infrastructure in public health through, for example, the strategic and administrative framework of the U.S. Public Health Service (PHS), and the explication of authorities and powers for carrying out key public health functions (e.g., quarantine) under certain circumstances; (2) establishment of federal public health agencies with explicit regulatory authorities and functions (e.g., FDA and the Occupational Safety and Health Administration), public health nonregulatory agencies (e.g., CDC), and several other federal agencies that have major public health-related powers and duties (e.g., EPA and the National Highway Traffic Safety Administration); and (3) appropriation of funds to directly support federal agencies' work in public health or for federal agencies to disburse to the states for public health activities.

This section begins by providing a historical context for understanding the statutory basis for public health systems and practice at the level of the federal government. This historical context reviews selected milestones in Congressional legislation relating to public health. Following the historical context, the section briefly reviews the concepts of federalism and preemption, both of which are major determinants framing and modulating the relation between federal and state laws involving public health. The section then examines organizational schemes for, and provides examples of, more contemporary, federally enacted public health and related programs, mandates, powers, and practice activities.

Historic Milestones in Federal Public Health Legislation

In 1939, after Congress' creation of the Federal Security Agency and the transfer of PHS from its longstanding home in the Treasury Department to that new agency, then-Surgeon General Thomas Parran observed: "The past 141 years have witnessed the evolution of the Service from a small organization, devoted solely to the medical care of American merchant seamen, to a national health agency, broad in scope and

manifold in its functions which affect directly or indirectly the health of the people."⁴ Surgeon General Parran's perspective emphasized the historic scope and scale of federally legislated changes affecting public health in the United States dating from PHS's origins in 1798 and, as noted above, even earlier to at least 1796, when Congress passed the first national act on quarantine.

Milestone federal legislation involving public health included creation of federal public health infrastructure, establishment of federal public health agencies, appropriation of funds supporting federal and state public health activities, and explication of public health legal authorities and powers. From the nation's origins until nearly the middle of the 20th century, when the Public Health Service Act of 1944 (PHSA) was passed, these federal statutes constituted a broad range of public health interests. These interests included the federal government's uses of quarantine authorities, a federal role in a system of prepaid medical care for merchant seamen that ultimately evolved into part of PHS, promotion of smallpox vaccination, creation of a National Board of Health, health inspection of immigrants, regulation of biologics, fostering of cooperation with state and local public health agencies, response to the influenza pandemic of 1918–1919, creation of the National Institutes of Health (NIH), and addressing the nursing shortage during World War II (Table 2-1). One of these milestones, the early and subsequent enactment of federal quarantine authorities, illustrates clearly the formative and enduring influence of federal law on U.S. public health practice.

The first National Quarantine Act, an early piece of federal legislation involving public health, also implicated states' rights concerns.³ This Act, passed by Congress on May 27, 1796, limited federal quarantine activities to any cooperation first requested by the states in enforcing their own quarantine laws. Enactment of this law followed debate within Congress focusing on states' rights and the issue of whether quarantine should be a function of the federal government or of the states. The first act was superseded by a second quarantine act in 1799 with language that strengthened the requirement for federal personnel to assist in enforcing state and local health laws.

On April 29, 1878, Congress passed a new National Quarantine Act, which created a "disease-intelligence system" managed at the federal level. The Act authorized the Supervising Surgeon General of the Marine Hospital Service to make rules and regulations for detaining ships either having cases of contagious diseases onboard or coming from foreign ports in which contagious diseases were present.³ Consular officers in foreign ports were to report to the Surgeon General the existence of contagious diseases in those ports and the departure of ships from those ports bound for the United States. They also were to make weekly reports about sanitary conditions in those ports. The Surgeon General, in turn, was required to notify U.S. ports of entry about ships inbound from such originating ports. In addition, the Surgeon General was to make reports on a weekly basis to medical officers of the Marine Hospital Service and to state and local public health authorities regarding information received from the consular officers. The first report, issued July 13, 1878, was entitled "Bulletin of the Public Health" and has been cited as the forerunner to today's public health bulletin, the *Morbidity and Mortality Weekly Report*, published by CDC.⁸ Even though this 1878 legislation resulted in federal-level public health authority,

TABLE 2-1 Selected Milestones in the Early Evolution of Federally Legislated Policy Relating to Public Health, 1796-1944

Date	Law and Significance
1796	<i>National Quarantine Act</i> : Passed by Congress on May 27, this Act limited federal quarantine activities to any cooperation first requested by the states in enforcing their own quarantine laws. ⁴ The enactment followed Congressional debate about states' rights and whether quarantine should be a federal or state function. (This Act was superseded in 1799 by a second quarantine Act with language that strengthened the requirement for federal personnel to assist in enforcing state and local health laws. ⁴)
1798	<i>Act for the Relief of Sick and Disabled Seamen</i> : Effective on July 16 and signed into law by President John Adams, this Act compelled prepayment of medical care for merchant seaman and helped lay groundwork for the eventual U.S. Public Health Service. ⁵
1813	<i>Act to Encourage Vaccination</i> : Signed by President James Madison on February 27, this Act authorized the President to appoint an agent to promote smallpox vaccination and also provided for letters and packages containing vaccine matter to be sent through U.S. mail free of postage. ⁶ It was repealed effective May 4, 1822, at the recommendation of a Congressional committee investigating a cluster of deaths in persons who inadvertently had been vaccinated with real smallpox scabs
1878	<i>National Quarantine Act</i> : Passed by Congress on April 29, this Act created a "disease-intelligence system" managed at the federal level, providing authority for the Supervising Surgeon General of the Marine Hospital Service (MHS) to make rules and regulations for the detention of ships either having cases of contagious diseases on board or coming from foreign ports in which contagious diseases were present. ⁷ The Surgeon General was to report weekly to MHS medical officers and to state and local public health authorities regarding information received from the consular officers. The first report, issued July 13, 1878, was entitled "Bulletin of the Public Health" and has been cited as the forerunner to the <i>Morbidity and Mortality Weekly Report</i> . ⁸
1879	<i>National Board of Health</i> : On March 3, Congress enacted legislation creating a National Board of Health and a supporting appropriation of \$50,000. ⁹ The Board's roles were to include framing rules and regulations for preventing the introduction of contagious diseases into the United States; making special investigations any place in the United States or at foreign ports; obtaining information about matters affecting public health and responding to relevant questions from government departments and the states; and reporting to the next session of Congress on a plan for a national public health organization, "special attention being given to the subject of quarantine, both maritime and inland, especially as to regulations which should be established between State or local systems of quarantine and a national quarantine system."
1891	<i>Immigration law and health inspections</i> : An immigration act passed on March 13 contributed to the expansion of federal quarantine stations during the early 1890s and required the health inspection of immigrants by physicians of the MHS. ¹⁰ The law mandated the exclusion of "all idiots, insane persons, paupers or persons likely to become public charges, persons suffering from a loathsome or dangerous contagious disease" and criminals.
1893	<i>New national quarantine act</i> : During the international cholera epidemic, President Benjamin Harrison signed a new national quarantine act into law that had been enacted on February 15 with provisions including the requirement that ships departing foreign ports for the United States must have a bill of health signed by a

TABLE 2-1 (continued)

Date	Law and Significance
	U.S. consul; authorization for the President to detail MHS physicians to foreign ports to serve in consuls' offices and inspect vessels; the requirement that ships arriving in the United States must obtain a certificate of rules compliance from the federal quarantine officer before passengers were discharged; expansion of the number of federal quarantine stations; and provisions mandating the Surgeon General to examine all state and municipal quarantine regulations. ¹¹ In the case of any regulations deemed inadequate, the Secretary of the Treasury was empowered to make additional rules.
1902	<i>An Act to increase the efficiency and change the name of the United States Marine Hospital Service</i> : On July 1, the term "public health" was formally institutionalized within the federal government when President Theodore Roosevelt signed this act into law, changing the Hospital Service's name to "Public Health and Marine Hospital Service of the United States." ¹² This act also legalized the federal government's role in public health by establishing key administrative divisions (e.g., domestic quarantine, foreign and insular quarantine, sanitary reports and statistics, and scientific research); providing for an annual meeting of state and territorial health authorities with the Surgeon General; and empowering the Surgeon General to prepare and distribute to state and territorial health authorities forms for the compilation and collection of statistics on morbidity, mortality, and other vital statistics data.
1902	<i>An act regulating biologics</i> : On July 1, the President also signed "An Act to regulate the sale of viruses, serums, toxins and analogous products in the District of Columbia, to regulate interstate traffic in such articles, and for other purposes." ¹³ This act—which was attributed to concern some physicians had about the adulteration of smallpox vaccine and diphtheria antitoxin—established a national system of biologics standards.
1912	<i>Act changing name of the Service</i> : On August 14, the President signed into law yet another new name, the Public Health Service. ¹⁴ The act mandating this name change covered other provisions, including authorizations for additional federal powers and functions in public health, such as authority for the Public Health Service "to study and investigate the diseases of man and propagation and spread thereof, including sanitation and sewage and the pollution either directly or indirectly of the navigable streams and lakes of the United States."
1913	<i>Sundry Civil Appropriations Act</i> : This act, signed by the President on June 23, provided funds to support the new Public Health Service law of 1912. ¹⁵ These funds included \$200,000 for field investigations; \$47,000 and \$25,000 earmarked for addressing pellagra and trachoma, respectively; and \$20,000 more allocated to the Hygienic Laboratory.
1918	<i>Act appropriating monies for cooperation with state agencies</i> : On July 1, Congress appropriated \$1,000,000 "[f]or cooperation with state and municipal health authorities in the prevention of the spread of contagious and infectious diseases in interstate traffic, including the sanitation of areas adjoining military and naval reservations and Government industrial plants, in order to properly to safeguard the health of the military forces and Government employees." ¹⁶
1918	<i>Authorizations for combating venereal diseases</i> : On July 9, Congress passed legislation authorizing the establishment of a Division of Venereal Disease in the Public Health Service and broadening the scope of control activities to a joint effort by state health departments and the Public Health Service. ¹⁷

(continued)

TABLE 2-1 (continued)

Date	Law and Significance
1918	<i>Appropriations to counter the Spanish influenza pandemic:</i> On October 1, Congress appropriated \$1,000,000 for response efforts to the "Spanish influenza" pandemic. ¹⁸ The Public Health Service's Director of Interstate Quarantine was made responsible for managing these funds.
1921	<i>Sheppard-Towner Act providing for grants-in-aid to states:</i> On November 19, President Harding signed this act which expired on June 30, 1929. ¹⁹ On the basis of a grants-in-aid model used to promote road building, this act provided federal grants to establish state centers for teaching mothers about prenatal and infant care and created a Federal Board of Maternity and Infant Hygiene with authority to approve states' plans for use of the funds.
1929	<i>Act establishing the Narcotics Division:</i> On January 19, President Coolidge signed into law an act establishing the Narcotics Division of the Public Health Service which specified the creation of two hospitals for confining and treating federal prisoners addicted to certain drugs and addicts who voluntarily presented for treatment. ²⁰ The unit's name eventually was changed to the Division of Mental Hygiene.
1930	<i>Ransdell Act creating the National Institutes of Health:</i> On May 26, President Hoover signed into law the Ransdell Act passed in order "To establish and operate a National Institute of Health, to create a system of fellowships in said institute, and to authorize the Government to accept donations for use in ascertaining the cause, prevention, and cure of disease. . . ." ²¹
1935	<i>Title VI of the Social Security Law:</i> The Public Health Title (Title VI) of the Social Security Law of 1935 authorized annual expenditures of up to \$2,000,000 for "the investigation of disease and the problems of sanitation." ²² In October 1936, Surgeon General Parran reported that "[u]nder the provisions of the Social Security Act, a national health program has been made possible for the first time in the history of the Public Health Service" and that this program, implemented with the advice and assistance of the state health officers, included grants-in-aid to the states which especially addressed venereal disease control.
1939	<i>Impact of the Reorganization Act:</i> As a result of the Reorganization Act—which combined federal health, education, and welfare agencies—at the close of the fiscal year on June 30, 1939, the Public Health Service was transferred from the Treasury Department to the Federal Security Agency. ²³ Other organizations included in the Federal Security Agency were the Children's Bureau, with programs in maternal and child health services, and the Food and Drug Administration, formerly of the Department of Agriculture.
1943	<i>Law creating Nurse Corps:</i> The United States Nurse Corps bill, aimed at solving the nursing shortage of WWII by providing financial support for nurse education, was signed into law by President Roosevelt in June 1943. ²⁴ This legislation was to be administered by the Public Health Service.
1944	<i>Public Health Service Act:</i> Enacted on July 1, The Public Health Service Act of 1944 (Public Health Law 410) recodified Public Health Service laws, consolidating and revising existing legislation. ²⁵ One provision empowered the Surgeon General to "make grants in aid to universities, hospitals, laboratories, and other public or private institutions and individuals," providing a legislative basis for grant support for expanding research beyond cancer. This law also created a new Division of Tuberculosis Control.

Source: Unless otherwise indicated, adapted from Furman.³

language inserted within the Act reflected ongoing debate about state and local roles in public health, including a stipulation that such rules and regulations must not "conflict with or impair any sanitary or quarantine laws or regulations of any State or municipal authorities."¹³

Contemporary federal quarantine authority resides in Section 361 of the PHSA.³⁶ Under circumstances described in this statute, the U.S. government has the authority to make and enforce regulations necessary to prevent introduction, transmission, and spread of communicable diseases from foreign countries into the United States and from one state or possession to another.³⁷ Such regulations are found at 42 C.F.R., Parts 70 and 71, and address both interstate and foreign quarantine. By Executive Order, the communicable diseases are specified for which individuals are subject to apprehension, detention, and conditional release (see Executive Order 13295 of April 4, 2003, as amended by Executive Order 13375 of April 1, 2005). The following communicable diseases are listed in the executive order: cholera; diphtheria; infectious tuberculosis; plague; smallpox; yellow fever; viral hemorrhagic fevers (Lassa, Marburg, Congo-Crimean, South American, and others not yet isolated or named); severe acute respiratory syndrome; and influenza caused by novel or reemerged influenza viruses causing, or having the potential to cause, a pandemic.

Federalism and Preemption

The concepts of both federalism and preemption are important determinants affecting the interplay between federal and state laws involving public health. These concepts, defined more fully elsewhere in this book (see Chapter 3), are briefly reviewed here because of their critical relevance to understanding the operation of legislatively enacted laws in relation to public health practice at the federal, state, and local levels.

As is the case for many services provided and some areas regulated by government, public health practice in the United States is carried out within a dual government and legal system of federalism. Federalism is the relationship and distribution of power between the individual states and the national government.³⁸ In this system, and under the U.S. Constitution, each of the 50 states possesses substantial independent legal authority but also is subject to the federal government's legal authorities, which overlap those of the states.³⁹ The federal government, under the U.S. Constitution, is a government of limited powers, possessing authority only when expressly or impliedly grounded in the U.S. Constitution. All other powers are reserved to the states or to the people.⁴⁰ The 18 express powers begin with the essential General Welfare Clause, include the Commerce Clause, and conclude with the Necessary and Proper authority to enact all laws appropriate to its powers.⁴¹ Public health in the U.S. system of federalism comprises laws, agencies, authorities, and exercise of powers at local, state, and federal levels of government.

Preemption refers to the power of the federal government to prevent or preclude state efforts to regulate a particular area or, similarly, for state government to prevent local efforts to regulate. More specifically, under the Supremacy Clause of Article VI of the Constitution, when direct conflict exists between a federal statute (that has independent constitutional grounding) and state statute, then the state law must

yield to the federal law (i.e., the federal law preempts the state law), and the state statute cannot be enforced to the extent of the conflict. The Supreme Court recently underscored this when it stated, "The Supremacy Clause unambiguously provides that if there is a conflict between federal and state law, federal law shall prevail."³²

Some intricacies of the preemption principle are illustrated in the potential operation of federal and state quarantine authorities. Although preemption may be found without express statutory language indicating that it applies, in the quarantine statute, it specifically states that neither Section 361 nor regulations promulgated under its authority shall supersede any provision in state law, unless it conflicts with the exercise of federal authority (see 42 U.S.C. §264[e], added in 2002 by Public Law 107-188). A state's exercise of its quarantine authority, even if the Department of Health and Human Services (DHHS) believed this authority to be wrongly asserted, probably would not conflict with an exercise of federal authority. Thus, although regulations implementing the quarantine statute provide for the assertion of federal authority when it is determined that "inadequate local control" exists, this is not likely to authorize federal preemption of state authority when it believes a state has wrongly imposed quarantine.

In addition to the preemption principle applying in the situation of a federal-state conflict, preemption may be found under other conditions, including when Congress acts to cover or "occupy the field" (e.g., in the field of nuclear regulation), when uniform national standards are needed, and when interests of the federal government are at stake. Similarly, a state legislature may "preempt" the exercise of local power by a subdivision or inferior government unit by adopting legislation that covers an area of concern also covered by a local ordinance. Therefore, even though a municipality may have the power to adopt a regulatory ordinance or to impose a tax, state legislation may preempt the municipal power or the local ordinance may be held to conflict with the state statute. For example, in relation to efforts to establish tobacco smoke-free indoor environments, preemptive state legislation in some states may prohibit communities from enacting laws that are more stringent than state law. As of December 31, 2004, a total of 19 states had at least one type of preemptive provision for smoke-free indoor air legislation.³³

Federally Legislated Public Health: Mandates, Powers, and Programs

The basis for Congress to enact legislation involving the federal government in public health derives from grants of power enumerated by the Constitution. These powers reside especially within Article I, Section 8, and include the Commerce Clause—which permits Congress to address health through regulation of interstate and foreign commerce—and the Tax and Spend Clause, which enables Congressional legislation to cover health through revenue generation and spending in support of the general welfare and public good, tax burdens that deter health-risk behaviors, and tax relief that creates incentives for health-enhancing activities (see also Chapter 1).^{34,35} Constitutional delegations of authority also could allow Congress to enact statutes related to the public's health by way of plenary authority over immigration

matters, and regulation of the mails through empowerment to establish post offices.³⁴ Another Article I provision implicated in Congress' ability to enact laws directly and indirectly affecting public health is the Necessary and Proper Clause (Article I, §8, Cl. 18), which permits Congress to legislate on a spectrum of matters not specifically touched on in the Constitution.

The remainder of this section is divided into three subsections outlining three broad categories of federal statutes involving public health. These categories include statutes that (1) create federal public health infrastructure; (2) establish federal public health agencies, programs, and services; and (3) appropriate funds supporting federal and state public health activities.

Statutes Creating Federal Public Health Infrastructure

Federal statutes creating federal public health infrastructure include laws that establish personnel frameworks, such as PHS itself, and laws explicating authorities and powers, such as federal quarantine authority. The category of statutorily created infrastructure also includes laws that, while not creating agencies, might otherwise affect both regulatory and nonregulatory agencies. Examples of this category are laws governing the management and safekeeping of or access to information maintained by public health agencies, such as the federal Freedom of Information Act, the Health Insurance Portability and Accountability Act, and the federal Privacy Act (see also Chapter 10), as well as laws such as the federal Administrative Procedure Act, the Federal Advisory Committee Act, and the Paperwork Reduction Act, which establish operating principles and rules for certain activities carried out by federal agencies.

Legislation authorizing federal public health powers is found in the PHSA, which was first passed by Congress in 1944 and codified to Title 42 of the United States Code. At the outset, those authorities set forth the organizational structure for federal agencies authorized to carry out public health functions for the Executive Branch; gave broad authorities for carrying out certain public health functions; and established relationships with other entities (e.g., foreign, state, and local governments; institutions of higher education; and other private nonprofit institutions, for-profit organizations, and individuals concerned with public health). PHS was established in what now is DHHS, and its power was delineated in numerous sections of the PHSA.

The Secretary of Health and Human Services carries out the power of PHS under Section 301 to "conduct in the Service, and encourage, cooperate with, and render assistance to other appropriate public authorities, scientific institutions, and scientists in the conduct of, and promote the coordination of, research, investigations, experiments, demonstrations, and studies relating to the causes, diagnosis, treatment, control, and prevention of physical and mental diseases and impairments of man. . . ."³⁶ This section provides these sweeping powers in the context of a spectrum of activities, including making grants to universities, hospitals, laboratories, and other public or private institutions, and to individuals; allowing the sharing of PHS facilities with appropriate public authorities, health officials, and scientists engaged in special study; providing for treatment of persons at PHS institutions, hospitals,

and stations as part of a study; making available technical advice and assistance on relevant statistical methods, as well as the practical application of public health research; and supplying to individuals and entities, for research purposes, substances and living organisms.

The passage of other provisions within the PHS Act is responsible for the strong and enduring relations between federal and state public health authorities. For example, Section 311, entitled Federal-State Cooperation, authorizes four important powers. First, this section explicitly addresses the imposition of quarantine and response by public health authorities at both the federal and state levels. Specifically, it allows the Secretary to accept from state and local authorities "any assistance in the enforcement of quarantine regulations made pursuant to this Act." The Secretary is required to assist state and local authorities in enforcing "their quarantine and other health regulations" and is expected to help those authorities in preventing and suppressing communicable disease and in other public health matters, and to advise on matters relating to the preservation and improvement of public health in those jurisdictions. A second power given to the Secretary is to encourage cooperative activities between the states in planning for their current and future public health needs and establishing and maintaining adequate public health services and other public health activities. For example, CDC developed a "best practices" guide for states, based on the demographics and unique needs of each state, that can be used to custom design and implement tobacco-control programs that effectively prevent and reduce tobacco use. Elements of such a program could include initiatives aimed at cessation and counter-marketing, and enforcement of ordinances and laws prohibiting smoking in public places or sales of tobacco products to minors. Surveillance and evaluation also are key contributors to implementing a successful tobacco-control program. The "best practices" guide is particularly useful because it includes estimated costs for these programs.

A third power described in Section 311 authorizes the Secretary of Health and Human Services to "deploy" personnel, equipment, medical supplies, and "other resources of the Service and other agencies under the jurisdiction of the Secretary" to control epidemics of any disease or condition and to respond to other health emergencies or problems. To cooperatively plan for emergencies and other public health problems, this provision also allows for the Secretary to enter into agreements between PHS and public and private community health programs and agencies. Finally, under the federal-state cooperation authorities, the Secretary is granted broad authority to temporarily lend aid and assistance to state and local authorities who request it in responding to health emergencies: the Secretary may seek reimbursement of such aid if it is determined to be reasonable.

Statutes Establishing Federal Public Health Agencies, Programs, and Services

Through statutory enactments, Congress has created federal agencies that have a broad spectrum of responsibilities for programs, services, and other activities affecting the public's health. These agencies may be fundamentally regulatory or nonregulatory. Examples of fundamentally regulatory agencies are FDA and the Occupational Safety and Health Administration, both of which possess congressionally delegated powers for policy development, rulemaking, and adjudication (see also Chapters 15 and 22).

An example of a fundamentally nonregulatory agency is CDC, which (with several exceptions) has not been given rulemaking or other such congressionally delegated powers. In addition to their rulemaking powers and roles, regulatory agencies may be responsible for enforcing certain statutes. For example, EPA enforces provisions of the Clean Air Act and the Federal Insecticide, Fungicide, and Rodenticide Act, as well as numerous other environmental statutes (see also Chapter 20).

Although the broad authorities of sections 301 and 311 of the PHS Act might appear to sufficiently enable PHS to address public health matters on the federal level, the PHS Act and other statutes in fact provide PHS with many additional statutory authorities that are disease-, condition-, or population-specific. These authorities cover a wide range of public health matters and enable a variety of public health responses. Such authorities include programs and funding to address mental health and substance-abuse disorders conducted by the Substance Abuse and Mental Health Services Administration, whose grants to states, territories, federally recognized tribes or tribal organizations, and private nonprofit community-based organizations, among others, provide for comprehensive substance-abuse and mental health clinical treatment and recovery support. An important responsibility of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention is its compliance oversight of the Synar Amendment, a law found at 42 U.S.C. 300x-26, requiring that, as a condition of receiving federal funding, states have laws prohibiting the sale and distribution of tobacco products to any person younger than age 18 years (see also Chapter 18). Additionally, the Health Resources and Services Administration (HRSA), another PHS agency, provides for a wide range of health-care services, including programs for delivery of HIV/AIDS services, primary health care, maternal and child health, health professions, health-care systems, and rural health policy. Through such funding mechanisms as grants, contracts, and loans, HRSA carries out its mission to lead and direct programs and activities that will improve the health services for all people of the United States.

In addition to authorizing public health services and activities, federal statutes create the organizational infrastructure to conduct those activities. For example, the numerous institutes of NIH are authorized explicitly in the PHS Act. By comparison, HRSA and CDC were not created by statute, although (as noted above) they have specific authorities throughout the PHS Act. HRSA, as it is known and organized today, formally was established through a reorganization published in the *Federal Register* in September 1982 (47 FR 38409). With Congressional approval, CDC was established in 1946 as the Communicable Disease Center (formerly the Malaria Control in War-time Areas).³⁷ Whether by administrative action or statutory design, agencies of PHS are legally authorized to carry out a remarkable number of programs and activities that are funded in the billions of dollars.

Statutes Appropriating Funds Supporting Public Health Activities

Although Section 311 does not provide for awards of grants to states and their political subdivisions, the Secretary of Health and Human Services is authorized to make grants to such entities in numerous other sections of the PHS Act, including the aforementioned Section 301. Provisions throughout the PHS Act generally provide for

a ceiling of financial support for states; Congressional appropriations committees determine whether such authorized appropriations will be funded and at what levels.

The appropriations law that Congress passes every fiscal year for the operation and activities of DHHS serves more than the legal authority for funding the department; it also provides substantive law. For example, it authorizes the receipt of user fees into the CDC account when the agency is legally authorized to charge user fees, such as for preparation of biologic products for use in the laboratories of private entities. CDC may not, however, use funds available for injury prevention and control to advocate or promote gun control.

Just as the federal government uses the authorities in the PHS and DHHS appropriations to build and maintain critical relationships with state and local public health authorities, Section 307 of the PHS (42 U.S.C. 2421) allows collaboration and consultation by DHHS with other countries in endeavors in biomedical research, health-care technology, and health services research and statistical activities. While permitting a variety of collaborative activities and authorizing the expenditure of federal funds and use of resources from foreign countries, this section requires a showing that the activity undertaken, or funding spent, was to advance or improve the health status of the American people.

Statutory authorities also have provided for establishment of private nonprofit foundations to support the work—both financially and through the provision of voluntary services—to two PHS agencies, CDC and NIH. In this and other ways, CDC and NIH can accept gifts that support the agencies' respective missions. In recent years, the foundations have raised several million dollars and helped facilitate opportunities for scientists and other health experts to support the work of CDC and NIH, including at their facilities, often in areas that otherwise would not be funded through Congressional appropriations. Additionally, the foundations have worked to promote development of public-private partnerships that serve the agencies' public health and biomedical research missions.^{38,39}

State and Local Public Health Systems and Practice

The Nature of State Law

At the level of state and local governments, both law and legal authority differ markedly from national-level law and authority. The fact that state law differs from federal law is only the beginning of the complexity in this area, for no two states have identical constitutions, and within each state exist a wide range of public health law and authority among the variety of local governments.⁴⁰ Public health law at the level of state and local governments is grounded in their unique legal status in our constitutional system.

In contrast to the federal government structure, the nature of fundamental legal authority of state governments is that plenary authority exists in the state as expressed through the state legislature. The state legislature has all authority except and unless limited by the state constitution. State constitutions generally exist as limits on the inherent power of the state, not as grants of authority to the state government. Both

state and local governments are constrained by the federal Constitution—although the U.S. Supreme Court has resurrected in the last decade conceptions of states' rights as against the federal government in ways not seen since immediately before the Civil War.^{41–44} With this different paradigm for the allocation of power and authority at the state level, state constitutions still retain many provisions that parallel the federal Constitution, such as fundamental rights (due process and equal protection) and liberties (free speech and religion).

State constitutions tend to be relatively silent on the topic of public health. Possible explanations for this include the relatively recent history of diversification of program roles and responsibilities that state and local government agencies have for public health, the plenary legislative authority of state governments, and the fact that when many states' constitutions were written, public health services were assumed to be within the power of the government. Regardless of the reasons, few express references to public health exist in state constitutions today. New York and Washington are two of the few exceptions, and even these tend to confirm the inherent authority—but not the obligation—of the state to legislate in the field of public health.^{45,46} The Kansas constitution is one of the few that impose an affirmative obligation on the state to meet public health needs, and this is in the context of "institutions for the benefit of mentally or physically incapacitated or handicapped persons."⁴⁷

No two states possess identical legal frameworks for public health. This heterogeneity of law and public health is compounded by the complex allocation of authority between state governments and the multitude of local governments that exist in each state (counties, cities, townships, villages). As a threshold proposition, local governments in the United States have no special standing or rights under the federal Constitution.⁴⁸ The rights, powers and authority of local governments are either delegated by the state legislature or derived directly as a grant of authority from the state constitution. The extent of local government authority and autonomy to legislate and to regulate is loosely referred to as local government "home rule."

Many states, particularly those in the Midwest, follow a doctrine known as "Dillon's Rule."⁴⁹ Developed largely in the 19th century, this doctrine provides that local governments have only such authority and power as is expressly granted to them by the legislature. In the face of legislative silence on an issue—such as local regulation of handguns or of smoking in public facilities—or ambiguity in the interpretation of a statute, Dillon's Rule is commonly invoked to deny the legal authority of a local government to act.

The strongest form of local government home rule powers is found in states where the state constitution explicitly grants legal authority to local governments. This "constitutional home rule" typically provides that counties or municipalities (or both) may exercise certain powers on behalf of the inhabitants and property within their jurisdictional boundaries. When the constitutional provision directly authorizes a local government to exercise "police powers" or to act in pursuit of "the general welfare," the local government will have broad authority to act in the field of public health unless and until the state legislature limits such authority. An example of a strong constitutional home rule provision for public health is the grant in the Illinois constitution of "the power to regulate for the protection of the public health."⁵⁰ Georgia's constitution has a parallel provision authorizing counties and municipalities to pro-

vide "public health facilities and services, including hospitals, ambulances and emergency rescue services, and animal control."⁵¹ However, even when a constitutional provision addresses public health powers of local governments, such authority is likely to be subject to being overridden by a "general law" in which the state legislature specifically addresses the subject matter.⁵²

When a state constitution does not address home rule powers of local governments, the most common approach is for the state to enact general legislation that summarizes, or lists, the powers of local governments. Known collectively as "legislative home rule," such statutes are the primary source of powers of the local governments. As with constitutional provisions, if a state's general statute on municipalities, counties, or other local governments contains a broad grant of or provision for "general welfare" or "police power," then such a provision will provide sufficient authority for at least the basic range of public health regulation and licensing. Some states have yet another variation on this allocation of power: state grant to a specific city of a "charter." These charter cities most commonly have a much broader and stronger range of home rule powers.⁵³

When a local government has apparent authority to act in the field of public health, it will in most instances still be subject to the possibility of state legislative action that limits, restricts, or contradicts local action. This "preemption" of local actions by state law directly parallels federal preemption of state law as noted above (also see Chapter 3). As creatures of the state that depend primarily on delegated authority, local governments may find that state law preempts ordinances addressing public health issues. Such preemption can occur even when the state chooses not to regulate the subject matter but simply to deny authority to local governments to regulate in that field.³³

Sources and Definitions of Public Health Authority

The sources of public health law at the level of state and local governments are as broad as the range of topics that fall within the meaning of public health. One commentator has suggested four basic categories of public health exist in the context of law and policy: health promotion and disease prevention; assessment, data collection, and data analysis; medical services; and leadership and policy development.⁵² Given this broad range of activities that may exist at the state and local levels, one is not likely to find a single statute, a single ordinance, or even a single administrative agency that encompasses the entire scope of law and public health. For example, in a given state, the operation of mental health facilities may rest in an express constitutional provision, while at the same time no express constitutional or statutory authority may exist for compulsory vaccinations—leaving such authority to be grounded in the state's "inherent" police power.

State and Local Public Health Systems

Under the constitutional doctrine of reserved powers, the 50 states retain enormous authority to protect the public's health. The states shoulder their broad public health responsibilities through work carried out by both state and local health agencies. Tra-

ditionally, state health departments exercise "border-to-border" regulatory authority, whereas local health agencies act within a smaller region, such as a county or city.

Although state and local health agencies are the backbone of the nation's public health system, even at the state level, public health responsibilities extend well beyond the "health department." Many other public-sector, as well as private-sector, organizations also play key roles in public health. For example, school boards help enforce mandatory vaccination requirements; sanitation and water supply authorities manage waste and protect drinking supplies; and local hospitals and private health insurers may support local clinics and related outreach programs. In recent years, state labor departments have supported workplace smoking restrictions in an effort to protect employees from health hazards associated with exposure to environmental tobacco smoke.

The relationship between state and local health agencies can be structured in different ways. As discussed previously, certain municipalities and counties may have "home rule" authority that grants the local jurisdiction preeminent responsibility for establishing and enforcing health standards. New York City and Baltimore operate in this manner. Not all localities, however, are afforded this type of independent authority. Many local health agencies exercise powers delegated to them by the state health department. In addition, a state legislature may pass a statute imposing direct responsibilities on the local department. Regardless of the source of local health powers, state law will generally vest responsibility for exercising these responsibilities in a policy-setting body such as a city council, board of county commissioners, or board of health. The local health officer typically functions as an agency's chief executive officer and supervises the staff, who implement the programs on a daily basis.

On a broader level, states often consolidate core public health functions into some form of "state health department." No single model best describes the "typical" state department. In recent decades, however, as health expenditures have absorbed larger portions of states' budgets, a trend has existed toward the creation of omnibus agencies responsible for an array of health-care delivery and financing functions. These organizations may combine traditional public health activities with environmental programs or with other human service agencies. These organizational arrangements are not necessarily static and evolve over time as a function of new initiatives and funding mandates.

This movement toward consolidation of health functions into a single cabinet-level agency is illustrated by the statutes creating the Maryland Department of Health and Mental Hygiene (DHMH) and its related county health departments.⁴ This comprehensive health agency was not created from whole cloth. Instead, DHMH, like other comparable agencies, evolved as community health priorities changed and scientific capabilities evolved. For example, Maryland's first psychiatric hospital was chartered by the legislature in the mid-18th century. The state's current mental health code, which DHMH administers, descended directly from this initial statutory act. A similar evolutionary process began in 1933 when Maryland's Commissioner of Health invited the Rockefeller Commission to study the state's antiquated "bedding and hygiene" laws. The resulting recommendations formed the basis for Maryland's modern public health code. The Maryland DHMH was formed in 1969 to administer these provisions.⁵³

In its modern form, DHMH is directed by statute to "adopt general policy for, and adopt standards to promote and guide the development of, the physical and mental hy-

gic services of the [state] and its subdivisions."⁵⁴ Maryland's Secretary of Health and Mental Hygiene acts as the agency's chief executive officer and is "responsible for the health interests of the people of [Maryland] and shall supervise generally the administration of the health laws of this State and its subdivisions."⁵⁵ As a part of this mandate, the agency exercises each of the traditional public health functions. In particular, DHMH plays a leading role in statewide disease prevention efforts (see Health-General Title 18), health statistics recordkeeping (see Health-General Title 4), provision of medical services (see Health-General Titles 7, 8, and 10), and overall policy development (see Health-General Title 19 and §2-105(c)) (requiring, respectively, development of both a "State health plan" and a more specific "State health improvement plan").

Also, like other omnibus agencies, the scope of DHMH's statutory responsibilities has changed over time. For example, environmental and juvenile service programs have been reorganized into their own cabinet-level departments, and in recent decades, health-care financing responsibilities have grown substantially. DHMH administers the Medicaid Program (see Health-General Article Title 15) and funds an elaborate system of care for persons with mental and developmental disabilities (see Health-General Article Titles 7 and 10). Moreover, the agency licenses all health-care professionals, sets hospital payment rates, and controls health-care facility expansion through a certificate-of-need program.

Regardless of the organizational design of the state agency, several key powers and responsibilities are essential to the operation of a public health system. First, some entity typically is given overall responsibility for protecting the health of all residents of a particular jurisdiction. As already noted, in Maryland, the Secretary of Health and Mental Hygiene is "responsible for the health interests of the State" and is given explicit authority to "carry out and enforce the provisions of [the health] article . . ." (see Health-General Article §2-104(m)). In the absence of more specific language, this plenary grant of authority is the basis for many public health measures. Second, the agency often is afforded "rulemaking" power, which permits executive branch officials to propose regulations needed to implement public health programs. In Maryland, the Secretary "may adopt rules and regulations to carry out the provisions of law that are within the jurisdiction of the Secretary" (see Health-General Article §2-104(b)). Finally, the public health agency must have implicit or explicit authority to conduct the business of health care. In particular, agencies need the legal authority to receive funds, collect fees, make grants, issue contracts, and enter into cooperative arrangements with public and private entities (see Health-General Article Titles 2, 11, 15, 16, and 18).

In addition to these generic responsibilities, state health codes authorize state and local officials to engage in a range of more specific public health functions. Some of these responsibilities and functions predate the formation of the nation. Many other measures intended to enhance health status have grown incrementally over the last two centuries. Part of this growth may be attributable to the inclusion of constitutional protections in otherwise traditional public health-related statutes. One modern version of illustrative public health functions is found in the Turning Point Model Public Health Act (Table 2-2).⁵⁶ In comparison, the state law often will be more detailed than its Model Act counterpart. Today, state licensing statutes—regardless of whether they regulate restaurants, doctors, or hospitals—are unlikely to be adopted without some

enunciation of legislative intent. State officials and legislators involved in framing new public health measures typically join with interest groups to define the scope of the legislative grant of authority and to specify the parameters of the new regulatory program.

In Maryland, although the state health code addresses each of the public health functions shown in Table 2-2, implementation of these programs is not solely the responsibility of a state health department. To the contrary, citizens expect their local officials to respond to needs and complaints related to public health. For example, they may contact the local clinic to obtain vaccination schedules, the sanitation department to report rodent infestations, and the county health department to complain about possible foodborne diseases or outbreaks. Knowing this, state legislators can choose to delegate primary oversight of these functions to a local board of health. In Maryland, each county has a local board—comprising the county commissioners or members of the county council—which appoints the local health officer with the approval of the state's Secretary of Health (see Health-General Article §3-202). In conjunction with the county health officer, the board of health implements state and local health laws. Except for areas where a county exercises independent home rule authority, Maryland's Secretary of Health and Mental Hygiene and the local health officer work together to implement the state's public health programs.

TABLE 2-2 Core Public Health Functions and Comparison of Selected Provisions from the Model Public Health Act and Maryland's Health-General (HG) Statutes

Core Public Health Function	Model Act Provision*	Maryland Statutory Provision
Disease surveillance activities	Agency may collect information needed to "further the mission or goals of public health" (§5-102)	Agency may investigate and obtain reports about contagious and infectious diseases (HG §18-102)
Disease control activities	Agency may use powers to "prevent [and] control" public health threats (§5-101)	Local health officer shall "act immediately" to halt the spread of infectious or contagious disease (HG §18-208)
Authority to abate nuisances	Agency may order owner to "avoid, correct, or remove" nuisance (§5-111)	County board of health may "adopt and enforce" rules on "any nuisance or cause of disease" (HG §3-202)
Authority to adopt licensing standards	Agency shall license business or activity "that may be detrimental to" public health—includes food service, health-care facilities and practitioners (§5-110)	Over 500 pages of statutes governing facility and practitioner licensing requirements (Health Occupations and Health-General Articles)

* Adapted from the Turning Point Collaborative Model Act (www.turningpointprogram.org).⁵³

Most regulatory bodies, including state and local health departments, can choose to enforce their public health objectives by either (1) adjudicating individual cases or (2) adopting broader rules or regulations that will govern resolution of the problem for all affected members of the public. The calculus for choosing the appropriate enforcement mechanism can be complex. However, once an enforcement action is under way or a regulatory standard is challenged in litigation, a degree of judicial deference often is afforded the agency's expert policy judgments. The state's Administrative Procedure Act may establish deferential standards for judicial review of an agency's scientific or regulatory decisions.⁶

To achieve a particular public health objective, mere statutory authority of a health department to take certain actions may not alone be sufficient. Rather, the regulatory body should be able to persuasively convey to citizens why certain actions are in their self-interest. When these persuasive measures fail to achieve the needed outcome, the state or local health department then may use defined legal strategies and mechanisms to achieve these ends (Table 2-3 and Table 2-4).

A limited number of legal mechanisms (e.g., regulations and injunctions) allow state and local agencies to implement public health policies. Depending on the circumstances, some mechanisms more effectively protect the public health than others. Regulations are broad-based but difficult to adopt and expensive to enforce. Injunctive actions seeking abatement of a specific nuisance can be crafted to quickly address particular conditions or threats. However, injunctions have limited utility where the threat is posed by numerous individuals, each of whom has "a different story to tell." The following example illustrates how, when confronted with an emerging threat, public health authorities might consider the relative merits of several legal interventions (Box 2-1). This process of considering interventions raises two fundamental questions. First, does the state or local official have the legal authority to respond to the problem? Second, given the interplay of federal, state, and local laws, what is the most effective means of responding to the threat? This complex interaction between powers and practical constraints, and between mandated standards and voluntary compliance, can make the practice of public health law as much an art as a science.

Summary

In this chapter, we aimed to examine the structure of law under the U.S. Constitution, which frames and specifies public health practice. In particular, we focused on the statutory basis of the federal and state public health systems. The basis for Congress to enact legislation involving the federal government in public health derives from grants of power enumerated by the Constitution, including the general welfare clause, the Commerce Clause, the Tax and Spend Clause, and the Necessary and Proper Clause. The federal government's statutorily created roles in public health practice date to the late 18th century. Since then, Congress has assigned the federal government a spectrum of roles in public health practice by passing laws that create federal public health infrastructure; establish federal pub-

TABLE 2-3 Selected Legal Strategies and Mechanisms for Implementing Public Health Objectives and Related Limitations

Legal Strategies for Achieving Public Health Objectives	Limitations on the Use of This Legal Strategy
State legislature enacts public health statute	Adoption of legislation may require several months or years. Legislative amendments may modify meaning and scope of original legislative proposal. Difficult to revise statute in subsequent years. Subject to constitutional limitations such as federal preemption doctrine and due process requirements. Public health agency must have general authority to adopt regulations.
Public health agency proposes and adopts regulations	Public health regulation must be no broader than and consistent with the agency's existing statutory authority. Regulation subject to legislative override through passage of subsequent legislation. Public health agency must have statutory or regulatory enforcement authority.
Public health agency initiates enforcement action in court or through administrative proceeding	Strict rules apply to judicial proceedings while more flexible rules may govern administrative cases. Resolution of particular enforcement action governs only the rights of the parties to the proceeding. Restricts applicability of specific statute to specific set of facts.
Declaratory judgment action	Is not "self-executing" and may require agency to initiate subsequent enforcement action. Give agency limited capacity to specify goals and "deliverables."
Public health agency grants and contracts	Permit funding of only selected vendors or grantees. More useful as "carrot" to encourage desired behavior; less useful as "stick" to prohibit adverse behavior. Vehicle for providing only advisory health information and recommendations for protective measures. If voluntary compliance not forthcoming, then formal enforcement action required.
Public health agency issues informal directive	

lic health agencies, programs, and services; and appropriate funds supporting federal and state public health activities.

Under the constitutional doctrine of reserved powers, the 50 states retain enormous authority to protect the public's health. At the state and local levels, state legislatures and other legislative bodies act under state constitutions to pass statutes creating state and local public health agencies and boards of health, articulating powers to assure the public's health, and delegating public health-related powers to government subdivisions. In contrast to the federal government structure, the nature of fundamental

TABLE 2-4 Illustrative Public Health Objectives and Applications of Legal Interventions

Public Health Objective	Statute	Regulation	Enforcement Action	Grant or Contract
Reducing West Nile virus threats through community-wide abatement of standing water pools.	Applies broadly to entire community. Slow legislative process.	Requires statutory authority. Flexible standards allow varied enforcement approaches. Same as above.	Case specific. Demonstrates seriousness of agency intent.	Allows agency to select vendors with needed abatement expertise. Expenses may be charged to violators. Payment of living expenses to patient may encourage voluntary compliance.
Patient with antibiotic-resistant TB receives needed inpatient treatment.	Provides needed basis for coercive treatment. Specifies due process protections.	Same as above.	Same as above.	
Restaurant adopts new food-handling protocols reducing threat of bacterial contamination.	Applies broadly to entire regulated community. Legislative exceptions may limit breadth of enforcement.	Same as above.	Same as above.	Grants may cover implementation expenses. Speeds compliance.

BOX 2-1. Case Study: *Pfiesteria* in Tidal Rivers

Background/Problem

Beginning in 1997, watermen on Maryland's Eastern Shore began reporting mysterious fish-kill outbreaks on several tidal rivers. Thousands of menhaden and other fish species would suddenly exhibit lesions and abnormal patterns of movement just before dying. Also, a local internist was quoted in the paper stating that he had treated several watermen and recreational fishermen for rashes, lethargia, and unexplained loss of memory.

State and local health department officials began assembling case studies. Patients consented to release of their medical records to a group of medical-school professors and other experts who confirmed the clinical findings. At the same time, state environmental scientists examined the relation between certain types of algae blooms, the menhaden lesions, and environmental exposures to local fishermen, and preliminarily concluded this problem may have been associated with exposures to blooms of the marine microorganism *pfiesteria piscicida*.

On the basis of these clinical findings, state and local health officials issued a series of public health declarations restricting recreational and commercial activities on certain rivers. The Secretary of Health issued an "open letter" to consumers explaining the research findings. Within the next several years, groundbreaking legislation aimed at regulating agricultural use of fertilizers and requiring waste-management plans passed the Maryland General Assembly.

Comment

State health departments may exercise a broad array of powers to protect the public health. As the *Pfisteria* example illustrates, however, regulatory and "coercive" powers are not necessarily the most effective tool available to public health officials. The ability to focus specialized clinical resources on a particular health threat through cooperative agreements and funding arrangements with professional societies and academic institutions can be of enormous use in persuading members of the public to take certain actions. Once empirical support for a public health intervention is established, public health officials are better able to motivate voluntary compliance by members of the public. Boating and fishing on the Pocomoke River ceased during *Pfisteria* blooms not because a regulation was adopted. Instead, voluntary compliance occurred largely because credible scientific evidence indicated that fisherman could suffer serious health consequences. Toronto health officials reported much the same behavior during the SARS outbreak. With relatively few exceptions, when court orders were required, citizens voluntarily complied with quarantine directives issued by city health workers.

legal authority of state governments is that plenary authority exists in the state as expressed through the state legislature—the state legislature has all authority except and unless limited by the state constitution. Partly because state constitutions tend to be relatively silent on the topic of public health and because no two states have identical constitutions, no two states possess identical legal frameworks for public health. This heterogeneity of law and public health is compounded by the complex allocation of authority between state governments and the multitude of local governments within each state.

The states shoulder their broad public health responsibilities through work carried out by both state and local health agencies. States often consolidate core public health functions into some form of “state health department.” No single model best describes the “typical” state department. In recent decades, a trend has existed toward creation of omnibus agencies responsible for an array of health-care delivery and financing functions. These organizations may combine traditional public health activities with environmental programs or with other human service agencies. Regardless of the state agency’s organizational design, several key powers and responsibilities are essential to the operation of the public health system, including overall responsibility for protecting the health of all residents of a particular jurisdiction; “rulemaking” power that permits executive branch officials to propose regulations needed to implement public health programs; and implicit or explicit authority to conduct the business of health care (e.g., legal authority to receive funds, collect fees, make grants, issue contracts, and enter into cooperative arrangements with public and private entities). In addition to these generic responsibilities, state health codes authorize state and local officials to engage in a range of more specific public health activities.

We gratefully acknowledge the assistance provided by Michael Smith and by Karen McKie, J.D., in research related to the development of this chapter, and the suggestions provided by David E. Benor, J.D.

Notes

a. For example, see *South Dakota v. Dole*, 483 U.S. 203 (1987) (holding for constitutionality of making receipt of funds for federal highways contingent on a state’s increasing its drinking age).

b. Georgia Constitution, Article IX, §2, ¶ 1 (“for which no provision has been made by general law”); New Mexico Constitution, Article X, §6 (municipality may “exercise all legislative powers and perform all functions not expressly denied by general law”).

c. The City of Baltimore has express home rule authority in the Maryland constitution to borrow funds for emergencies for “preserving the health” of the City (Maryland Constitution, Article XI, §7).

d. Examples of the statutory basis of state public health practice included in this section especially are drawn from Maryland because of the expertise of one of the authors (DO).

e. See *Spencer v. Maryland State Board of Pharmacy*, 380 Md. 515, 846 A.2d 341 (2004). See also State Government Article §10-213(i) (under Maryland’s APA, “[t]he agency . . .

may use its expertise, technical competence, and specialized knowledge in the evaluation of evidence”).

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Chapter 3

REGULATING PUBLIC HEALTH: PRINCIPLES AND APPLICATION OF ADMINISTRATIVE LAW

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Public health practice frequently involves regulatory endeavors shaped by and grounded in administrative law. The core functions of public health practice are authorized, developed, and implemented through the administrative law’s regulatory processes. Most public health actions, whether developing sanitation codes, responding to a disease outbreak, or enforcing environmental regulations, are subject to administrative law requirements. In this sense, public health practice can be viewed as a branch of administrative law. Proper use of the administrative process is therefore an essential aspect of successful public health practice and management.

In this chapter, we examine the key aspects and requirements of public health regulation. We will focus on how state and local public health practitioners can translate legal authority into effective public health practice and management. Our goals are twofold: first, to set forth the mechanics of the administrative process; and second, to provide a practical context for using the administrative process to the practitioner’s advantage. Understanding and effectively using the administrative process will both facilitate public health practice and invite public support for public health policies.

Background

Administrative law is simply the body of law created by regulatory agencies through rules, regulations, orders, and procedures designed to further legislatively enacted policy goals.¹ All regulatory agencies, including public health departments, are