5. A brief explanation of the differences between each version of the bill; and
6. A proposed amendment for the committee's consideration.

Your favorable consideration of this request will be appreciated.

Sincerely,

Sherry Hill, Special Assistant
Office of the Commissioner

cc: Honorable Lesil Mcguire
Alaska House of Representatives

Kevin Jardell, Legislative Director
Office of the Governor

Dr. Richard Mandsager Director
Division of Public Health

Stat News
-CSG
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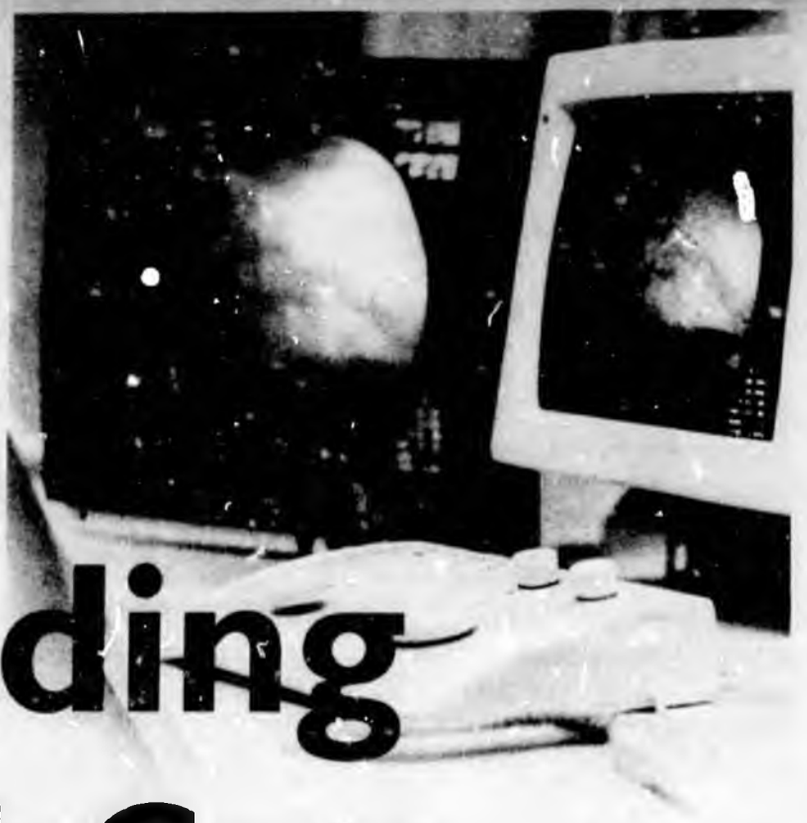

Upgrading Health Care

States promote health information technology

By Sarah Donta

Although the U.S. health care system is known worldwide for its high-tech advances, when it comes to adopting information technology, the health care sector lags behind many other industries. While other professions have eagerly embraced electronic tools, the doctor's office has become the last bastion of the handwritten record.

For years, health care experts have recognized that improving health information technology (HIT) has the potential to control or reduce health care costs and improve the quality of care. But actually implementing new technology faces major barriers.

Improving Communication

Health information technology can be defined simply as the use of technology to help health care providers communicate. This can include online educational resources for providers and consumers, electronic medical records, registries, diagnostic and monitoring tools, bar codes, electronic prescribing, and electronic processing of payments and claims. For state policymakers and others interested in the "big picture" of health care, implementing HIT is about the infrastructure and capability necessary for purchasers, providers, payers and researchers to share information securely at the touch of a button.

Health information technology has the potential to reduce medical errors, improve the quality of care, help doctors track important information about patients, and give consumers more information about their own providers, finances and overall health.

"IT is changing the way work gets done," said Dr. David Brailer, the first national coordinator for health information technology. "Decisions get made differently. Facts are recalled differently. Those are all positive things. It's much easier and less frustrating for a clinician to have tools that can do all that."

On April 27, 2004, President Bush issued an executive order calling for "widespread deployment of health information technology within 10 years to help realize substantial improvements

"It's not just about technology. It's about changing the culture, mindset and finances of health care."

—Dr. David Brailer, national coordinator for health information technology

in safety and efficiency." In May 2004, he appointed Brailer to implement the executive order.

Brailer helped establish the National Health Information Network (NHIN) to meet these goals and provide the infrastructure necessary to integrate health information technology nationwide. The network is a nationwide utility that allows for the secure and seamless exchange of health information. The NHIN, sometimes called the "Medical Internet," would allow doctors' offices, hospitals, clinics and laboratories to exchange information securely in real time. It would also connect clinicians to data about their patients at the point of care. Capital expenses would be paid by public and private investments, and private organizations would operate the network. Federal agencies would use it to collection and share data.

"Health care information exchange interoperability is not just about the technology. It's about the legal, financial, cultural, clinical, operational and organizational policy issues that come up whenever we allow on a widespread basis information to be shared among and across doctors, patients and other players," Brailer said.

In order to develop this network, the federal government has developed Regional Health Information Organizations (RHIOs) to oversee the exchange of health care information. RHIOs consist of stakeholder groups that make sure that the networks meet the needs of individual communities and comply with national goals and policies.

"Our goal, very simply, is to have every American covered by [an RHIO]. We want to see the basic RHIO infrastructure up and running within two years in the United States. And I think we're well on our way toward doing that," said Brailer. Since funding has been an issue, [redacted] Although Congress denied the department's request last year for an additional $50 million appropriation for 2005, Brailer said HHS expects more funding in 2006.

Health IT Barriers

Despite this plan and the numerous benefits incorporating health information technology could bring to the medical community, a survey by Medscape and the Commonwealth Fund showed that physicians have been slow to adopt HIT. The report, titled *Information Technologies: When Will They Make It into Physicians' Black Bags?*, found the following:

- Seventy-nine percent of physicians use electronic billing.
- Only 27 percent of physicians use electronic medical records or order tests, procedures or drugs electronically.
- Only 6 percent of physicians routinely use electronic clinical decision support systems.
- Only 3 percent of doctors communicate with patients by e-mail; 7 percent communicate with other doctors by e-mail.

Given that the U.S. health care system has a reputation as the most technologically advanced, practitioners' reluctance to adopt new information technology seems almost ironic. Although other industries have eagerly implemented many of these technologies or their counterparts, several factors have slowed their adoption in health care:

- *High implementation costs.* Implementation of HIT takes a significant amount of time and money—money that some cash-strapped doctors' offices simply do not have. Other health care entities may have more resources to implement the latest HIT. However, the decentralized nature of the U.S. health care system means that returns on investment for HIT may be hard to document. For instance, a clinic that uses an electronic reminder system for ensuring patients with expensive chronic illnesses receive the care they need is not paid any more than its competitors that don't do this. Providers that use HIT to improve care face a double whammy: Although they spend the time and money on new technologies, their income may decrease because their patients are healthier and need fewer doctor visits.
- *Effectiveness.* Another challenge for health care purchasers and providers is determining which technologies will yield the biggest bang for the buck. There is not much solid scientific evidence on which technologies are cost-effective or improve quality. The high price tag of implementing a new software program, for instance, along with the training needed for health care professionals and staff, is hard

to justify without strong evidence that the new technology will make the delivery of care more efficient, reduce errors or simplify health care for patients.

- *Privacy.* Patients, physicians and government officials all have concerns about sharing personal health care information. The Health Insurance Portability and Accountability Act of 1996 addressed this concern by requiring the U.S. Department of Health and Human Services to set standards for protecting confidentiality and security of health data. The department developed rules to ensure the security of electronic health information, including medical, administrative and financial records. These rules were published in the *Federal Register* on February 20, 2003, and are available at *www.hhs.gov/ocr/hipaa/*.

State Actions

Seeing the potential for health information technology to decrease costs and improve quality, some states have moved forward with efforts to promote HIT and electronic information networks in health care.

Delaware

The Delaware Health Information Network is a statewide health information and electronic data interchange program managed by the Delaware Health Care Commission. Created in 1997, this initiative was established to reduce costs, increase competition, and improve access to care by providing easy access to timely, reliable and relevant health care information.

"Our vision is that of a sort of hub, if you will, that connects and transmits information to clinicians with patient permission," explained Paula Roy, executive director of the commission. "We focus on how you move data across labs, hospitals and providers so that physicians can make better decisions."

The initiative provides resources and information for policy-makers, physicians, patients and researchers. Some features planned for the future include:

- medical record access for patients and health care professionals;
- links to proposed state and federal legislation;
- information on state health programs and outside insurance programs;
- a Digital Health Library; and
- links to health resources, such as Intellihealth, Kaiser Permanente and Hospital Finder.

Funding for the network comes from local foundations and a grant from the Agency for Healthcare Research and Quality. "Those amounts of money are allowing us to move forward, but they're only seed money," Roy said."The investment to build and operate these kinds of systems is significant. One of the things we are putting the finishing touches on is a revenue model and sustainability model."

Rhode Island

Through a partnership with SureScripts, the Rhode Island Quality Institute has founded an e-prescribing initiative to modernize the prescription process and improve prescribing accuracy for physicians, pharmacists and patients. Rhode Island is working as a test site for implementing a statewide electronic system among all retail pharmacies and all prescribers in the state.

The pilot program linked 39 physicians to 70 percent of Rhode Island's pharmacies. More than 10,000 prescriptions went through the system. To date, the results have been very positive. Streamlining the renewal process reduced the processing time by more than half. Calls to and from the physicians' offices have been reduced as well. At Anchor Medical, a 10-physician office, e-prescribing led to 50 fewer phone calls per day.

"We were finally able to produce for our clinical community a genuine, bona fide value-added program. Not just another unfunded mandate, but value added. That helped our adoption tremendously here," said Laura Adams, president and CEO of the Rhode Island Quality Institute.

Health information technology offers many potential benefits to the health care industry and to states. However, some key players are concerned about privacy issues, high start-up costs and unproven effectiveness of some technologies. Because of the health care system's incentive structure, many observers believe that government funding and leadership will be essential for widespread adoption of these new technologies.

The potential to improve quality, reduce medical errors, and ultimately reduce health care costs is the enticing vision that is stimulating innovation at the national and state levels.

—Sarah Donta is a health policy research associate at The Council of State Governments.

Internet Resources

In December 2004, The Council of State Governments hosted a teleconference titled "Upgrading Health Care: State Plans for Health Information Technology." To hear an audio recording of the conference or for more information about health information technology, please see *www.csg.org* (keyword: Health IT).

THE PUBLIC HEALTH IMPROVEMENT PROCESS IN ALASKA: TOWARD A MODEL PUBLIC HEALTH LAW

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The Article is also based in part on LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (forthcoming 2000); Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59 (1999).

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I. INTRODUCTION

The mission of public health [is] fulfilling society's interest in assuring conditions in which people can be healthy.[1]

Preserving the public health is among the most important goals of government, and law is essential in helping to achieve this goal. Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. Laws define the jurisdiction of public health officials and specify the manner in which they may exercise their authority. Laws can also establish norms for healthy behavior and create the social conditions in which people can be healthy. Legislatures, courts, and administrative agencies serve as conduits for social debates on important public health issues within the legal language of rights, duties, and justice. As one public health lawyer has aptly stated, "[t]he field of public health . . . could not long exist in the manner in which we know it today except for its sound legal basis."[2] In a forthcoming book, we define the field of public health law as both the study of the legal powers and state duties necessary to assure the conditions of public health, and limitations on state power to constrain individuals' rights in the interests of community health.[3]

In its foundational 1988 text, *The Future of Public Health*, the Institute of Medicine ("IOM") agreed that law was essential for furthering public health, but questioned the soundness of public health law in the United States.[4] The IOM concluded that the United States "has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray,"[5]

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1. INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 7 (1988).

2. FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL 4 (2d ed. 1990); *see also* Scott Burris, *Thoughts on the Law and the Public's Health*, 22 J.L. MED. & ETHICS 141 (1994); Lawrence O. Gostin, *The Future of Public Health Law*, 12 AM. J.L. & MED. 461, 464 (1986).

3. *See* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (forthcoming 2000).

4. INSTITUTE OF MEDICINE, *supra* note 1, at 146-150.

5. *Id.* at 19; *see also* LAURIE GARRETT, THE COMING PLAGUE: NEWLY EMERGING DISEASES IN A WORLD OUT OF BALANCE 512 (1994) (claiming that the U.S. public health system exhibits levels of chaos and inaccuracy comparable to those of third world countries); Lawrence O. Gostin, *Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America*, 39

due partly to obsolete and inadequate state laws and regulations. Though its bleak view is not universally accepted,[6] the IOM further recommended that

> states review their public health statutes and make revisions necessary to accomplish the following two objectives: [i] clearly delineate the basic authority and responsibility entrusted to public health agencies, boards, and officials at the state and local levels and the relationships between them; and [ii] support a set of modern disease control measures that address contemporary health problems . . . , and incorporate due process safeguards (notice, hearings, administrative review, right to counsel, standards of evidence).[7]

In response to this challenge, some states have updated and revised their public health laws since 1988. Most, however, have not. In many states, public health law remains ripe for reform. Pursuant to a comprehensive survey of communicable disease law in the fifty states, we suggest existing state statutes are ineffective in responding to contemporary health threats for many reasons.[8] These statutes often (1) pre-date modern scientific and constitutional developments; (2) fail to equip public health officials with a range of flexible powers needed to control infectious disease; (3) lack adequate standards of privacy, due process, and risk assessment; and (4) are based on arbitrary disease classification schemes that no longer relate to modern disease threats or epidemiologic methods of infection control.[9]

The need for public health law reform is well-stated by the IOM and others. Yet, confusion regarding the field of public health law has confounded meaningful proposals for reform attempted by public health officials, state legislators, and the general

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ST. LOUIS U. L.J. 7, 16-17 (1994) (claiming that an array of public health services, not simply personal medical services, reduces morbidity and premature mortality).

6. *See* Leonard Robins & Charles Backstrom, *The Role of State Health Departments in Formulating Policy: A Survey on the Case of AIDS*, 84 AM. J. PUB. HEALTH 905 (1994) (finding health agencies took leadership role in HIV policy).

7. INSTITUTE OF MEDICINE, *supra* note 1, at 10; *see, e.g.*, Centers for Disease Control & Prevention, *Public Health Core Functions--Alabama, Maryland, Mississippi, New Jersey, South Carolina, and Wisconsin 1993* 43 (Morbidity & Mortality Wkly. Rep. 13 1994) (concluding that existing public health law too often fails to support public health departments in carrying out their core functions). More broadly, the IOM criticized health departments' alleged failure to provide clear political leadership in the legislative responses to important issues, such as HIV. *See* INSTITUTE OF MEDICINE, *supra* note 1, at 4-5.

8. *See, e.g.*, Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59 (1999).

9. *See id.* at 101-18.

public in many states. To address this, we have conducted comprehensive public health law case studies in several states (e.g., New Hampshire, Virginia, and Oregon) in an attempt to facilitate the understanding of public health law, as well as to provide objective, scholarly recommendations for legal and institutional reform. These studies reveal vastly different legal structures for the public health systems within each of these jurisdictions. Our case study in Alaska revealed perhaps the most complex and interesting system of public health law, presenting creative opportunities for reform.

In this Article, we present the findings of our study on the improvement of public health law in Alaska. We examine and analyze the public health laws supporting the state's public health system. The fact that Alaska has attained statehood comparatively recently, and has a governing structure involving state, municipal, rural, and tribal entities presents unique opportunities for the State to improve its public health system and its supporting legal infrastructure.

Part II begins with a framework that examines public health as a distinct field of law and policy. It briefly reviews and defines public health law within the constitutional structure of the United States. The Constitution limits government power in two ways: (1) it divides federal power among three branches of government. and (2) it allocates power between the federal government and the states. The tripartite separation of powers protects individual liberties and the ideology of federalism protects state sovereignty. Although the Constitution does not obligate the federal or state government to act in the interests of public health, the federal government draws its expansive authority to act in the field of public health from specific, enumerated powers provided within the Constitution. These powers include the power to raise revenue for public health services and, through its Commerce power, to regulate, both directly and indirectly, private activities that endanger human health.

Principles of new federalism, however, challenge the extent to which federal powers may lawfully extend into areas of traditional state concern, such as public health. Pursuant to the Tenth Amendment, states retain their sovereign powers. State police powers - or the inherent authority of the state to protect, preserve, and promote the health, safety, morals, and general welfare of the public - represent the state's residual authority to act in the interests of the public health. Local governments, including counties or boroughs, municipalities, and special districts, share public health authority through specific delegations of state police power.

Part III examines the legal authority for public health in Alaska through a comprehensive description of the constitutional,

statutory, and administrative laws underlying public health practice in the state and among tribal jurisdications. Like the federal Constitution, the Alaska Constitution sets limits on the powers of the state while providing affirmative grants of governmental powers. The Alaska Constitution guarantees many individual rights which specifically authorize the state legislature to promote and protect the public health and public welfare.[10] Part III reviews an array of statutes enacted by the Alaska Legislature, charging various state and local governmental agencies and departments to regulate and implement traditional public health functions.

Most public health matters in Alaska are administered by one of two state agencies, the Department of Health and Social Services ("DHSS") and the Department of Environmental Conservation ("DEC"). DHSS is primarily responsible for the control of communicable diseases, the administration of public health care, and some public safety issues. The DEC is delegated the authority to regulate environmental threats to health, including public health nuisances.

Alaska's boroughs and cities are delegated various public health powers based on their particular statutory classification under state law. However, Alaska Native villages and tribal groups owe their legal existence, and many of their public health powers, to the federal government. Congress previously assumed direct responsibility for the provision of health care to tribal governments. More recently, Congress encouraged the direct involvement of tribal governments in planning and operating health programs. While the federal-tribal relationship is strong, the United States Supreme Court has confirmed that Alaska has primary jurisdiction over tribal lands.[11] Nevertheless, the extent of state influence over tribal governments is conditioned upon the recognition of a federal partnership with tribal governments. This dual recognition of tribal health authorities as federal partners and local governments raises questions concerning the responsibilities for the public health that these tribal governments share with state and other local governments.

Part IV discusses the benefits of a public health law improvement process and our proposals for reform. Despite political limitations of the legislative approach, legal reform may advance public health by (1) defining the purposes and objectives of public health; (2) authorizing and limiting public health actions within a permissi-

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10. *See* ALASKA CONST. art. VII, § 4.

11. *See* Alaska v. Native Village of Venetie Tribal Gov't, 522 U.S. 520, 533 (1998).

ble degree of local flexibility; (3) serving as a tool of prevention to create healthier conditions; and (4) facilitating the planning and coordination of governmental and non-governmental health activities. Many benefits could be achieved through a public health improvement process, including the following: updating antiquated laws; incorporating modern scientific understanding of diseases and unhealthy conditions; modernizing current standards; and, perhaps most importantly, clarifying the legal powers, duties, and relationships of various state, local, and tribal actors.

Law reform in Alaska should express a clear vision for public health, promoting the best theories and practices in public health. Public health regulations should be based on uniform provisions that apply equally to all health threats. This would eliminate the unnecessary fragmentation of laws according to the type of disease or condition to be regulated. Public health interventions should be based on the degree of risk, the cost and efficacy of the response, and the burden on human rights. Authorities should be empowered to make decisions based upon the best available scientific evidence concerning the nature and extent of risks to the public health and have a wide range of powers to accomplish their mission. Implementing a graded series of flexible alternatives allows for the protection of the public health without devaluing individual rights. To further privacy protections, public health authorities should adhere to fundamental information privacy practices, which have been incorporated into our Model State Public Health Privacy Act.[12] These practices include: (1) providing justification for data collection; (2) sharing information about aggregate data collection by public health departments and its purposes; (3) eliminating secret data systems; (4) allowing persons to access data about themselves; (5) ensuring the reliability and accuracy of data; (6) attaching legally binding assurances of privacy to all personally - identifiable information such as non-disclosure provisions; (7) establishing security protections for data; and (8) imposing penalties for unauthorized disclosures.

Finally, we recommend that the state's primary executive public health agencies, the DHSS and DEC, should formalize their channels of communication and coordination.

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12. *See* Lawrence O. Gostin & James G. Hodge, Jr., *Model State Public Health Privacy Project* (last modified Oct. 8, 1999) <http://www.critpath.org/msphpa/privacy.htm>.

II. A FRAMEWORK FOR PUBLIC HEALTH LAW

Conceptualizing public health law is not easy. Lawmakers, judges, health officials, scholars, and others have often viewed public health law as being at the intersection of other disciplines, including health law, health care law, law and medicine, forensic medicine, environmental law, and bioethics. This Article will treat public health law as a distinct discipline. As one public health law treatise surmised in 1926

> [public health law] should not be confused with medical jurisprudence, which is concerned only in legal aspects of the application of medical and surgical knowledge to individuals. . . . [P]ublic health is not a branch of medicine, but a science in itself, to which, however, preventive medicine is an important contributor. Public health law is that branch of jurisprudence which treats of the application of common and statutory law to the principles of hygiene and sanitary science.[13]

Thus, while public health law is conceptually linked to the fields of law and medicine, and health care law, it is itself a distinct discipline susceptible to theoretical and practical differentiation from other disciplines at the nexus of law and health.[14] In this section, we briefly define public health law within a constitutional framework and demonstrate the various governmental responsibilities and powers relating to public health consistent with our definition.

A. Defining Public Health Law

Historically, public health has been associated with the control of communicable diseases and the improvement of unsanitary or unsafe conditions in the community.[15] Public health is actually more encompassing. Modern definitions of public health vary widely, ranging from the World Health Organization's utopian conception of the ideal state of physical and mental health[16] to definitions that merely list common public health practices.[17] The IOM has proposed one of the most influential contemporary definitions of public health, which, though simply stated, is quite accu-

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13. JAMES A. TOBEY, PUBLIC HEALTH LAW: A MANUAL OF LAW FOR SANITARIANS 6-7 (1926).

14. *See* GOSTIN, *supra* note 3.

15. *See* TOBEY, *supra* note 13, at 3.

16. *See, e.g.*, LAWRENCE O. GOSTIN & ZITA LAZZARINI, HUMAN RIGHTS AND PUBLIC HEALTH IN THE AIDS PANDEMIC 27-30 (1997).

17. *See, e.g.*, CHARLES EDWARD ARMORY WINSLOW, THE EVOLUTION AND SIGNIFICANCE OF THE MODERN PUBLIC HEALTH CAMPAIGN (1923).

rate: "Public health is what we, as a society, do collectively to assure the conditions for people to be healthy."[18]

Building on this definition of public health, we define public health law as follows:

> the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., to identify, prevent, and ameliorate risks to health in the population), and the limitations on the power of the state to constrain the autonomy, privacy, liberty, or other legally protected interests of individuals for protection or promotion of community health.[19]

From this definition, five essential characteristics distinguish public health law from the fields of medicine and law: (1) *Government*: Public health activities are the primary responsibility of government, rather than the private sector; (2) *Populations*: Public health focuses on the health of populations, rather than the clinical improvement of individual patients; (3) *Relationships*: Public health contemplates the relationship between the state and the population (or between the state and individuals who place themselves or the community at risk), rather than the relationship between the physician and patient; (4) *Services*: Public health deals with the provision of public health services, rather than personal medical services; and (5) *Coercion*: Public health possesses the power to coerce the individual for the protection of the community and, thus, does not rely on a near universal ethic of voluntarism. Although these broad parameters help distinguish public health law from other fields, it is necessary to further examine the concept of public health law through our constitutional system of government.

B. Constitutional Authority for Public Health Powers

The United States Constitution is the starting point for any analysis concerning the distribution of governmental powers. The Constitution divides power among the three branches of government (separation of powers); limits government power (to protect individual liberties); and allocates power among the federal government and the states (federalism).[20] In the realm of public health, the Constitution acts as both a fountain and a levee. It originates the flow of power to preserve the public health and it curbs that power to protect individual freedoms.[21]

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18. INSTITUTE OF MEDICINE, *supra* note 1, at 19.

19. GOSTIN, *supra* note 3.

20. *See* ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 1-6 (1997).

21. *See* JUDITH AREEN ET AL., LAW, SCIENCE AND MEDICINE 520 (2d ed. 1996).

1. *Separation of Powers.* The Constitution separates the federal governmental powers into three branches: (1) the legislative branch is vested with the power to create laws; (2) the executive branch is vested with the power to enforce the laws; and (3) the judicial branch is vested with the power to interpret the laws. States have similar schemes of governance pursuant to their own constitutions. By separating the powers of government, the Constitution provides a system of checks and balances that is thought to reduce the possibility of government oppression.

The separation of powers doctrine is essential to the field of public health law, for each branch of government possesses a unique constitutional authority to create, enforce, or interpret health policy. The legislature creates health policy and allocates the necessary resources to effectuate it. Some contend, however, that legislatures are unable to balance and make complex public health decisions. Legislators may respond too quickly without sufficient fact-finding or consideration of all the implications, lack expertise in the health sciences, and be influenced by popular beliefs that may be inconsistent with public health objectives. Yet legislators remain politically accountable for their actions, which are balanced with competing claims.

The executive branch significantly impacts public health law through establishing health policy and regulations, in addition to enforcing existing public health laws. Executive agencies at the federal and state levels are legislatively charged not only with implementing legislation, but with establishing complex health regulations. Executive branch agencies are uniquely positioned to govern public health. They are created for the very purpose of advancing public health, can focus on public health problems for extended periods, and may possess significant expertise and resources to address these problems. Conversely, however, agency officials may focus too narrowly on single topics and may serve for long durations, inadvertently leading to stagnant policies and procedures, and complicity with the subjects of regulation.

Through legal interpretation, the judiciary exerts substantial control over public health policy by determining the boundaries of legislative and executive government power. Courts decide whether a public health statute is constitutional, whether agency action is authorized by legislation, whether agency officials have gathered sufficient evidence to support their actions, and whether government officials and private parties have acted negligently. The judicial branch has the independence and legal training to make thoughtful decisions about constitutional claims regarding such things as individual rights or federalism. Courts, however, may be less equipped to critically review the substance of health

policy choices. Judges are often considered politically unaccountable if not subjected to elections, may be bound by the facts of a particular case, may be influenced by untested expert opinions, and may focus too intently on individual rights at the expense of communal claims to public health protection.

2. *Limited Powers.* A second constitutional function is to limit government power to protect individual liberties. Government actions undertaken to promote the communal good often infringe upon individual freedoms. Public health regulation and individual rights may directly conflict. Resolving the tension between population-based regulations and individual rights requires compromise. Thus, while the Constitution grants extensive powers to governments, it also addresses this trade-off through the declaration of individual rights that the government cannot infringe without some level of justification. The Bill of Rights, together with other constitutional provisions,[22] creates a zone of individual liberty, autonomy, privacy, and economic freedom that exists beyond the reach of the government. Public health law struggles to determine the point at which government authority to promote the population's health must yield to individual rights claims.

This tension is demonstrated in the 1905 United States Supreme Court opinion *Jacobson v. Massachusetts*.[23] In *Jacobson*, the Supreme Court considered a constitutional challenge to a general vaccination requirement for smallpox.[24] Massachusetts enacted a law empowering municipal boards of health to require the vaccination of inhabitants if necessary for the public health or safety.[25] The Cambridge Board of Health, under authority of this statute, adopted the following regulation: "Whereas, smallpox has been prevalent . . . in the city of Cambridge and still continues to increase; and whereas, it is necessary for the speedy extermination of the disease . . . ; be it ordered, that all inhabitants of the city . . . be vaccinated."[26] Henning Jacobson refused the vaccination. After his conviction by the trial court, he was sentenced to pay a fine of

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22. *See, e.g.*, U.S. CONST. art. I, §§ 9, 10 (federal and state government may not criminally punish conduct that was lawful when committed); *id.* art. I, § 10 (no state shall impair the obligation of contracts); *id.* art. IV, § 2 ("Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States.").

23. 197 U.S. 11 (1905).

24. *Id.* at 12.

25. *Id.* at 12-13.

26. *Id.*

five dollars. The Massachusetts Supreme Judicial Court upheld the conviction, and the case was appealed to the United States Supreme Court.[27] Jacobson argued that "a compulsory vaccination law is unreasonable, arbitrary and oppressive, and, therefore, hostile to the inherent right of every freeman to care for his own body and health in such way as to him seems best."[28] He asserted that his constitutional liberty interests supported the natural rights to bodily integrity and decisional privacy.[29]

Rejecting Jacobson's appeal, the Supreme Court adopted a narrower view of individual liberty. The Court emphasized a more community-oriented philosophy in which citizens have duties to one another and to society as a whole. Justice Harlan, writing for the Court, stated:

> [T]he liberty secured by the Constitution of the United States . . . does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members.[30]

Under a social compact theory, "a community has the right to protect itself against an epidemic of disease which threatens the safety of its members."[31] Justice Harlan concluded this theory is consistent with a state's traditional police powers which authorize an array of governmental action in the interests of public health, among other priorities.[32]

The legacy of *Jacobson* is its defense of police power regulation in support of a strong social welfare philosophy. However, the Court also recognized the limits of a broad police power. Utilizing state police powers in support of vaccination requirements or other public health initiatives is constitutionally permissible only if they are exercised in conformity with the following principles:

(a) *public health necessity* – Justice Harlan, in *Jacobson*, insisted that police powers must be based on the "necessities of the case" and could not be exercised in "an arbitrary, unreasonable

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27. *See id.* at 14.

28. *Id.* at 26.

29. *See id.*

30. *Id.* at 26.

31. *Id.* at 27.

32. *Id.* Police powers refer to the broad power of a sovereign state to regulate matters affecting the health, safety, and general welfare of the public. *See, e.g.*, ERNST FREUND, THE POLICE POWER: PUBLIC POLICY AND CONSTITUTIONAL RIGHTS 3-4 (1904); James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J.L. & HEALTH 309, 318-20 (1998).

manner" or go "beyond what was reasonably required for the safety of the public;"[33]

(b) *reasonable means* – The *Jacobson* Court introduced a means/ends test that required a reasonable relationship between the public health intervention and the achievement of a legitimate public health objective.[34] Even though the objective of the legislature may be valid and beneficent, the methods adopted must have a "real or substantial relation" to protection of the public health, and cannot be "a plain, palpable invasion of rights;"[35]

(c) *proportionality* – Justice Harlan wrote in *Jacobson*, "that the police power of a State . . . may be exerted in such circumstances or by regulations so arbitrary and oppressive in particular cases as to justify the interference of the courts to prevent wrong . . . injustice, oppression or absurd consequence."[36] Thus, a public health regulation may be unconstitutional if the intervention is gratuitously onerous or unfair; and

(d) *harm avoidance* – While those who pose a risk to the community can be required to submit to compulsory measures, including vaccination for the common good, the measure itself should not pose a health risk to its subject. Requiring a person to be immunized despite knowing the vaccination would cause harm would be "cruel and inhuman in the last degree."[37] Jacobson failed to present medical evidence that he was not a "fit person" for smallpox vaccination.[38]

Thus, while *Jacobson* stands firmly for the proposition that police powers authorize states to compel vaccination for the public good, government power must be exercised reasonably to pass constitutional scrutiny.

3. *Federalism*. Federalism, as a principle of law and by governmental design,[39] attempts to distribute power appropriately

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33. *Jacobson*, 197 U.S. at 28.

34. *See id.* at 28-29; *see also* JAMES A. TOBEY, PUBLIC HEALTH LAW 90 (2d ed. 1939).

35. *Jacobson*, 197 U.S. at 31; *see also* Nebbia v. New York, 291 U.S. 502, 525 (1933) (holding that public welfare regulation must not be "unreasonable, arbitrary or capricious, and the means selected shall have a real and substantial relation to the object sought to be attained").

36. *Jacobson*, 197 U.S. at 38-39.

37. *See id.* at 39.

38. *Id.*

39. *See* Texas v. White, 74 U.S. 700, 725 (1868); *see also* WORKING GROUP ON FEDERALISM OF THE DOMESTIC POLICY COUNCIL, THE STATUS OF FEDERALISM IN AMERICA 5 (1986) ("[F]ederalism is a constitutionally based, structural theory of government designed to ensure political freedom. . .").

among federal and state levels of government.[40] Pursuant to the United States Constitution, the federal government has certain limited powers to enact laws in areas where it has specific jurisdiction. To preserve the powers of the federal government from intrusion by the states, the Supremacy Clause[41] provides that federal laws and regulations override conflicting state laws via the doctrine of preemption.[42] State law is preempted by federal constitutional or statutory law, either by express provision,[43] by a conflict between federal and state law,[44] or by implication where Congress so thoroughly occupies a legislative field "as to make reasonable the inference that Congress left no room for the states to supplement it."[45]

With the passage of the Tenth Amendment, states reserved their sovereign power over "all the objects which, in the ordinary course of affairs, concern the lives, liberties and properties of the people, and the internal order, improvement, and prosperity of the State."[46] These powers, collectively known as police powers, give states broad jurisdiction to regulate matters affecting the health, safety, and general welfare of the public.[47]

The distinction between federal and state powers is not always predictable in application.[48] Even though the distribution of powers among governments was originally meant to be relatively clear,[49] federal and state government powers interact on a regular

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40. *See, e.g.*, *The Court and Federalism*, WASH. POST, Jan. 14, 2000, at A26 ("The proper question [of federalism] is whether . . . policy issues [are being] addressed by the appropriate level of government, [not] which level is likely to deliver a particular favored outcome.").

41. *See* U.S. CONST. art. VI, cl. 2.

42. *See id.*

43. *See, e.g.*, Rice v. Santa Fe Elevator Corp., 331 U.S. 218 (1947).

44. *See, e.g.*, Maryland v. Louisiana, 451 U.S. 725 (1981); New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995).

45. Fidelity Fed. Savings & Loan Assn. v. De la Cuesta, 458 U.S. 141, 153 (1982) (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)); *see also* Jones v. Rath Packing Co., 430 U.S. 519, 525-26 (1977).

46. Gregory v. Ashcroft, 501 U.S. 452 (quoting THE FEDERALIST NO. 45, at 292-93 (James Madison) (Clinton Rossiter ed., 1961)).

47. *See supra* note 32 and accompanying text.

48. *See, e.g.*, New York v. United States, 505 U.S. 144, 155 (1992) (stating that "the task of ascertaining the constitutional line between federal and state power has given rise to many of the Court's most difficult and celebrated cases.").

49. *See, e.g.*, K.C. WHEARE, FEDERAL GOVERNMENT 2 (1947); *see also* Younger v. Harris, 401 U.S. 37, 44 (1971) (stating that federalism involves "a proper respect for state functions . . . [and] the belief that the National Govern-

basis. It is precisely at the point when these powers collide that federalism takes on many shades and gradations.[50]

Issues of federalism can be classified by two broad categories. The first category encompasses state intrusions into the federal sphere. These include instances where states seek to intrude on the constitutional authority of the federal government (e.g., enacting laws that interfere with congressional regulation of interstate commerce)[51] or fail to recognize federal supremacy or authority (e.g., attempting to impose taxes on federal goods).[52] Such examples of state intrusion into the federal sphere proliferated during the nation's early years as states tested the limits of their sovereign powers.

The second category includes federal intrusions into traditional state duties. Originally, federal legislation that involved areas traditionally left to the states was viewed as beyond Congress' jurisdiction and, therefore, did not trump state law.[53] However, the expansion of the federal government during the New Deal relaxed such traditional notions of federalism.[54] Arguments stemming from

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ment will fare best if the States and their institutions are left free to perform their separate functions in their separate ways").

50. *See, e.g.*, Alan R. Arkin, *Inconsistencies in Modern Federalism Jurisprudence*, 70 TUL. L. REV. 1569 (1996).

51. *See, e.g.*, South Carolina Highway Dep't v. Barnwell Bros., Inc., 303 U.S. 177 (1938) (upholding the constitutionality of a South Carolina law that prohibited trucks over 90 inches wide or weighing over 20,000 gross pounds on state highways despite infringement on interstate commerce).

52. *See* McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316 (1819) (invalidating Maryland's attempt to tax the issuance of bank notes by the newly created federal Bank of the United States).

53. States were considered essential to the functioning of government because they retained the majority of powers. *See* A REPORT OF THE WORKING GROUP ON FEDERALISM, *supra* note 35, at 10. So powerful were the states under the original balance of power among the national and state governments that Alexander Hamilton commented "there is greater probability of encroachments by the [states] upon the federal [government] than by the federal [government] upon the [states]." *Id.* at 9 (citing THE FEDERALIST No. 31, at 197 (Alexander Hamilton) (Clinton Rossiter ed., 1961)); *see also* New York v. United States, 505 U.S. 144, 157 (1992) (stating that "the Federal Government undertakes activities today that would have been unimaginable to the Framers in two senses; first, because the Framers would not have conceived that *any* government would conduct such activities; and second, because the Framers would not have believed that the *Federal* Government, rather than the States, would assume such responsibilities" (emphasis added)).

54. *See, e.g.*, Daniel S. Herzfeld, Note, *Accountability and the Nondelegation of Unfunded Mandates: A Public Choice Analysis of the Supreme Court's Tenth Amendment Federalism Jurisprudence*, GEO. MASON L. REV. 419 (1999).

federal intrusion over states typify, though not exclusively, modern debates in an era of *new federalism*.[55] Increasingly, federalism has been the focal point of political[56] and judicial issues. The United States Supreme Court has played a major role in setting a new frontier of federalism.[57] Beginning with the Court's 1976 decision in *National League of Cities v. Usery*,[58] new federalism cases have resulted in significant changes in the Court's jurisprudence. These changes include (1) adoption of a powerful rule against federal in-

55. The term "new federalism" may have first been used by Donald E. Wilkes, Jr., in his article, *The New Federalism in Criminal Procedure: State Court Evasion of the Burger Court*, 62 KY. L.J. 421 (1974). *See* Richard C. Reuben, *The New Federalism*, ABA J., Apr. 1995, at 76-77 (the resurgence of federalism is partially the result of increased political efforts of the states to move toward greater autonomy from the federal government and the effects of such efforts on the political processes on Capitol Hill); *see also* Juliet Eilperin, *House GOP's Impact: Transforming an Institution*, WASH. POST, Jan. 4, 2000, at A4 (chronicling the failures of former House of Representatives Speaker, Newt Gingrich, Eilperin comments that "while Gingrich had once hoped to lead the country from the speaker's chair, some of the changes he set in motion may well diminish the legislative branch's power in the years to come by transferring power to state and local governments").

56. Although several state governors failed in their 1994 effort to organize a "Conference of States" to draft federal constitutional amendments in support of greater state rights, *see* William Claiborne, *Supreme Court Rulings Fuel Fervor of Federalists*, WASH. POST, June 28, 1999, at A2. Several bills have been introduced that would require it to consider federalism issues prior to the passage of legislation. *See* Ron Eckstein, *Federalism Bills Unify Usual Foes*, LEGAL TIMES, Oct. 18, 1999, at 1. In August 1999, President Clinton signed the second draft of his executive order concerning federalism. This initial draft of the order was roundly rejected by state and local government associations for its failure to reflect appropriately new federalism principles. *See* David S. Broder, *Federalism's New Framework*, WASH. POST, Aug. 5, 1999, at A21. The revised order disfavors federal preemptive laws or policies, requires executive officials to defer to states whenever possible in setting national standards, and features an enforcement mechanism against implementation of federal executive policies that lack a federalism "impact statement." *See id.*

57. *See* David S. Broder, *Challenge for the States*, WASH. POST, Aug. 10, 1999, at A19; *see also* Claiborne, *supra* note 56.

58. 426 U.S. 833 (1976) (holding Congress lacked the jurisdictional power under the Commerce Clause to regulate the wages and hours of public employees engaged in integral operations in areas of traditional governmental functions through the Fair Labor Standards Act); *see also* Robert H. Freilich & David G. Richardson, *Returning to a General Theory of Federalism: Framing a New Tenth Amendment United States Supreme Court Case*, 26 URB. LAW. 215 (1994).

vasion of core state functions;[59] (2) presumption against application of federal statutes to state and local political processes;[60] (3) disdain for federal action that "commandeers" state governments into the service of federal regulatory purposes;[61] (4) rejection of federal claims brought by private parties against states[62] for overtime wages,[63] patent infringements,[64] engaging in false advertising,[65] and to resolve gambling disputes,[66] and (5) adoption of the "plain statement rule" that Congress must "express its intention to abrogate the Eleventh Amendment in unmistakable language in the statute itself,"[67] when its action may alter the balance of federalism.[68] Most recently, the Court opined that state employees cannot sue states for violations of the Federal Age Discrimination in Employment Act[69] because Congress exceeded its power under the Fourteenth Amendment to abrogate the state's immunity under

59. *See, e.g.*, City of Boerne v. Flores, 521 U.S. 507 (1997) (invalidating the Religious Freedom Restoration Act of 1993 as beyond congressional authority under the 14th Amendment pursuant to a challenge based on the decision of a local zoning authority to deny a church a building permit); *see also* United States v. Lopez, 514 U.S. 549 (1995) (holding Congress lacked the commerce power to enact the Gun-Free School Zones Act of 1990, making criminal the knowing possession of a gun by a student while at school).

60. *See* City of Columbia v. Omni Outdoor Adver., Inc., 499 U.S. 365 (1991).

61. *See* Printz v. United States, 521 U.S. 898 (1997) (declaring unconstitutional the federal requirement under the Brady Handgun Violence Prevention Act that state chief law enforcement officers temporarily conduct background checks on prospective handgun purchasers); New York v. United States, 505 U.S. 144 (1992). "Take title" incentive provisions of the federal Low-Level Radioactive Waste Policy Amendments Act of 1985 are constitutionally invalidated where they require states to (1) either regulate pursuant to Congress' directions or (2) take title to, and possession of, the radioactive waste generated in-state or become liable to waste generators for all damages from the state's failure to take the wastes. Both of these "options" are unconstitutional based on principles of federalism because Congress cannot require states to implement legislation according to federal directives nor "commandeer" states into the service of federal regulatory purposes. *See id.*

62. *See, e.g.*, Joan Biskupic, *Justices, 5-4, Strengthen State Rights*, WASH. POST, June 24, 1999, at A1.

63. *See* Alden v. Maine, 527 U.S. 706 (1999).

64. *See* Florida Prepaid Post-Secondary Educ. Expense Bd. v. College Sav. Bank, 527 U.S. 627 (1999).

65. *See* College Sav. Bank v. Florida Prepaid Post-secondary Educ. Expense Bd., 527 U.S. 666 (1999).

66. *See* Seminole Tribe of Florida v. Florida, 517 U.S. 44 (1996).

67. Atascadero State Hospital v. Scanlon, 473 U.S. 234, 243 (1985).

68. *See* Gregory v. Ashroft, 501 U.S. 452, 469 (1991).

69. *See* Kimel v. Florida Bd. of Regents, 120 S. Ct. 631 (2000).

the Eleventh Amendment[70] when it attempted to subject states to such suits.[71] The majority of these cases concern the second classification of federalism issues, when federal intrusion into predominantly state matters exceeds the limits of federal powers. However, new cases before the Court evince atypical federalism disputes where states and private parties have aggressively begun to challenge issues under the federal domain. For example, in its first term of the new century the Court will decide whether (1) states can impose environmental regulations on oil tankers that are stricter than federal law (which the Court recently concluded that states cannot);[72] (2) private parties can bring state personal injury claims against automobile manufacturers who failed to install airbags in the late 1980s despite preemptive federal legislation and regulations that allowed manufacturers to install either automatic seatbelts or airbags;[73] and (3) states can enforce state laws that prohibit state purchasing agreements with companies doing business in objectionable international locales (based on their authoritarian governments, human rights issues, or other criteria), in possible contravention of the federal constitutional power to regulate foreign affairs.[74]

By any account, new federalism has mobilized the Tenth Amendment as a vehicle for challenging federal statutes that compel state legislative or administrative action. As a result, some federal public health laws may be vulnerable to state challenges on Tenth Amendment grounds. For example, future challenges may include environmental regulations that direct states to adopt or enforce a federal regulatory scheme[75] or loosely preemptive federal

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70. "The Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against any one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State." U.S. CONST. amend. XI.

71. *See* Linda Greenhouse, *Age Bias Case in Supreme Court Opens a New Round of Federalism*, N.Y. TIMES, Oct. 14, 1999, at A25; *see also* Joan Biskupic, *Court Curbs Suits By State Workers; Continuing Pattern, 5-4 Ruling Bars Claims of Age Bias Under Federal Law*, WASH. POST, Jan. 12, 2000, at A11.

72. *See* International Ass'n of Indep. Tanker Owners v. Locke, 148 F.3d 1053 (9th Cir. 1998), *rev'd*, 120 S. Ct. 1135 (2000).

73. *See* Geier v. American Honda Motor Co., 166 F.3d 1236 (D.C. Ct. App. 1999), *cert. granted*, 120 S. Ct. 33 (1999).

74. *See* National Foreign Trade Council v. Natsios, 181 F.3d 38 (1st Cir. 1999), *cert. granted*, 120 S. Ct. 525 (1999); *see also* Joan Biskupic, *High Court to Review Mass. Law on Burma*, WASH. POST, Nov. 30, 1999, at A4; Linda Greenhouse, *Justices to Decide Foreign Policy Question in Massachusetts Boycott of Myanmar*, N.Y. TIMES, Nov. 30, 1999, at A20.

75. *See* New York v. United States, 505 U.S. 144 (1992).

laws[76] that invade core state concerns in public health. The following discussion explores the constitutional authority and exercise of public health powers of federal, state, and local governments.

a. *Federal Powers.* Before an Act of Congress is deemed constitutional, two questions must be asked: (1) does the Constitution affirmatively authorize Congress to act, and (2) does the exercise of that power improperly interfere with any constitutionally protected interest?[77]

In theory, the United States is a government of limited, defined powers. In reality, political and judicial expansion of federal powers through the doctrine of implied powers allows the federal government considerable authority to act in the interests of public health and safety. The federal government may employ all means reasonably appropriate to achieve the objectives of constitutionally enumerated national powers.[78] For public health purposes, the chief powers are the power to tax, spend, and regulate interstate commerce. These powers provide Congress with independent authority to raise revenue for public health services and to regulate, both directly and indirectly, private activities that endanger human health.

b. *State Police Powers.* Despite the broad federal presence in modern public health regulation, states have historically and contemporaneously had a predominant role in providing population-based health services. States still account for the majority of traditional spending for public health services, excluding personal medical services and the environment.[79] The Tenth Amendment of the federal Constitution reserves to the states all powers not otherwise given to the federal government nor prohibited to the states by the Constitution.[80]

The police power represents the state's authority to further a primary goal of all government: to promote the general welfare of society. Police powers can be generally defined as "[t]he inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve and

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76. *See* Gregory v. Ashcroft, 501 U.S. 452 (1991).

77. *See* James G. Hodge, Jr., *The Role of New Federalism & Public Health Law*, 12 J.L. & HEALTH 309, 311 (1998).

78. *See* McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316, 323-24 (1819).

79. *See* INSTITUTE OF MEDICINE, *supra* note 1, at 178-83.

80. U.S. CONST. amend. X.

promote the health, safety, morals, and general welfare of the people."[81]

To achieve these communal benefits, the state retains the power to restrict, within federal and state constitutional limits, private interests--personal interests in liberty, autonomy, privacy, and association, as well as economic interests in freedom to contract and uses of property.[82] Police powers in the context of public health include all laws and regulations directly or indirectly intended to improve morbidity and mortality in the population. Police powers enable state and local governments to promote and preserve the public health in areas ranging from injury and disease prevention,[83] to sanitation and water and air pollution.[84]

c. *Local Powers*. In addition to the significant roles federal and state governments have concerning public health law in the constitutional system, local governments also have important public health interests. Public health officials in local governments, including counties (or boroughs), municipalities, and special districts, are often on the front line of public health dilemmas. They may be directly responsible for assembling public health surveillance data, implementing federal and state programs, administering federal or state public health laws, operating public health clinics, and setting public health policies for their specific populations.

To the degree local governments set local public health priorities, they do so pursuant to specific delegations of state police powers. Local governments in the constitutional system are recognized as subsidiaries of their state sovereigns. As a result, any powers local governments have to enact public health law or policies must be delegated from the state. Such delegation of power, which may be narrow or broad, provide local governments with a limited realm of authority, or "home rule," over public health matters of local concern within their jurisdiction. This delegation of power may be protected against withdrawal or infringement by state constitutions or statutes. Absent constitutionally--protected delegation of power to local governments, however, states may modify, clarify, preempt, or remove "home rule" powers of local government at will.

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81. Lawrence O. Gostin & James G. Hodge, Jr., *Reforming Alaska Public Health Law, A Report for the Alaska Public Health Improvement Process* 3 (1991) (on file with authors).

82. *See* Hodge, *supra* note 77, at 318-30.

83. *See* TOM CHRISTOFFEL & STEPHEN P. TERET, PROTECTING THE PUBLIC: LEGAL ISSUES IN INJURY PREVENTION 25-28 (1993).

84. *See* 39 AM. JUR. 2D *Health* § 34 (1968).

Exercises of local authority in the interests of public health cannot extend beyond limited jurisdictional boundaries or conflict with or impair federal or state law. As a result, the role of local governments in public health law is largely limited by federal and state laws and regulations that local governments must adhere to in setting or implementing public health policies.

III. PUBLIC HEALTH LAW IN ALASKA

Having defined public health law and framed it within the context of the constitutional system of American government, we turn to an examination of public health law in Alaska.

Alaska's public health system is deeply complex, with intricate relationships among the federal government (including the Indian Health Service, Centers for Disease Control and Prevention, and the Environmental Protection Agency), state government (primarily the Alaska Department of Health and Social Services and Department of Environmental Conservation), local governments (including boroughs and municipalities), and tribal organizations. We cannot attempt to delineate all of the intricacies of these varied agencies and their roles in Alaska public health. Rather, we examine Alaska public health powers under the Alaska Constitution, state statutory law, municipal law, and tribal law, consistent with our definitional and conceptual approach.

A. The Alaska Constitution

Like the federal Constitution, the Alaska Constitution sets limits on the powers of the state while providing affirmative grants of governmental powers. The Alaska Constitution explicitly guarantees many of the same or similar guarantees of individual rights set forth in the federal Constitution. These rights include due process rights to life, liberty, and the pursuit of happiness;[85] equal protection;[86] freedom of religion[87] and speech;[88] and a prohibition against unreasonable searches and seizures.[89]

The Alaska Constitution also provides additional protections of individual rights through provisions not explicitly stated in the federal Constitution. Notable among these additional protections

85. *See* ALASKA CONST. art. I, §§ 1, 7.
86. *See* ALASKA CONST. art. I, § 3.
87. *See* ALASKA CONST. art. I, § 4.
88. *See* ALASKA CONST. art. I, § 5.
89. *See* ALASKA CONST. art. I, § 14.

in Alaska is an explicit constitutional right to privacy[90] pertaining to governmental intrusions. The scope of state privacy rights is largely undefined[91] and dependent on the circumstances.[92] Alaska courts have interpreted the state constitution to provide broader privacy protections than the federal constitution.[93] The right, however, is not absolute.[94] Provided government can show that an infringement of the right to privacy is justified by a legitimate and compelling governmental interest, government action is likely constitutional.[95]

Unlike the federal Constitution and most other state constitutions, the Alaska Constitution explicitly authorizes the state legislature to "provide for the promotion and protection of public health"[96] and "provide for public welfare."[97] While these provisions seemingly require the State legislature to act to protect public health and promote the public welfare, the degree and manner in which public health goals are accomplished are largely left to the discretion of the legislative body. As a result, Alaska public health law and regulations are defined by the State legislature.

Concerning the right to privacy, these provisions have been interpreted to establish a presumption of validity of traditional measures taken by government in the interests of public health.[98] Consequently, the constitutional right to privacy in Alaska does not undermine many legitimate public health activities, like disease surveillance, reporting of infectious diseases, the abatement and control of nuisances, and registration of persons who pose threats to the public health.[99] These privacy rights may, however, protect the privacy of individuals within their homes against unnecessary infringements by the State, even though such actions may arguably further public health objectives. In *Ravin v. State*, for example, the Alaska Supreme Court upheld the right of individuals to use marijuana in the privacy of their own homes without governmental interference in the form of criminal prosecutions.[100] The court sub-

90. *See* ALASKA CONST. art. I, § 22 ("The right of the people to privacy is recognized and shall not be infringed.").
91. *See* Ravin v. State, 537 P.2d 494, 498 (Alaska 1975).
92. *See* State v. Glass, 583 P.2d 872 (Alaska 1978).
93. *See* Messerli v. State, 626 P.2d 81, 83 (Alaska 1980).
94. *See* State v. Erickson, 574 P.2d 1, 22 (Alaska 1978).
95. *See Messerli*, 626 P.2d at 84.
96. ALASKA CONST. art. VII, § 4.
97. *Id.* § 5.
98. *See* Ravin v. State, 537 P.2d 494, 510 (Alaska 1975).
99. *See* Rowe v. Burton, 884 F. Supp. 1372 (D. Alaska 1994).
100. *See Ravin*, 537 P.2d at 510.

sequently rejected a similar claim concerning the personal use of cocaine within the home, finding a sufficiently close and substantial relationship between the criminalization of the more dangerous substance, cocaine, and the legitimate governmental purpose of preventing harm to individuals and the public health.[101]

Pursuant to the state constitutional right to privacy, the Alaska legislature has enacted laws to protect the confidentiality of personal medical and public health records.[102] Though the State has declared virtually all information held by state agencies and departments to be public records open to inspection, it specifically exempts from disclosure "medical and related public health records."[103] Health information privacy protections are often coupled with anti-discrimination protections that prohibit discrimination against individuals on account of their physical or mental disabilities.[104]

The Alaska Constitution also authorizes the legislature to organize the state into organized and unorganized boroughs[105] (similar to counties), and incorporated cities within these boroughs.[106] Boroughs and cities are delegated liberal "home rule" powers to exercise legislative powers not otherwise prohibited by or inconsistent with state law.[107] Statutory law enacted pursuant to this constitutional authorization further defines and classifies boroughs and cities,[108] and clarifies the extent of their home rule authority.[109]

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101. *See* State v. Erickson, 574 P.2d 1, 23 (Alaska 1978).

102. ALASKA STAT. § 9.25.120 (LEXIS 1997).

103. *Id.* § 9.25.120.

104. Although the federal Americans with Disabilities Act, 42 U.S.C. §§ 12101-12201 (1992), presents a solid foundation of anti-discrimination protection, Alaska has statutorily provided additional protections. The Alaska State Commission for Human Rights (within the Office of the Governor) is statutorily authorized to promulgate regulations consistent with the legislature's general prohibition of individual discrimination in employment, credit practices, places of public accommodation, or the sale, lease, or rental of real property against persons on the basis of race, religion, color, national origin, sex, age, physical or mental disability, marital status, pregnancy, or parenthood. ALASKA STAT. §18.80 (LEXIS 1997).

105. *See* ALASKA CONST. art. X, § 3.

106. *See id.* § 7.

107. *See id.* §§ 1, 10, 11.

108. ALASKA STAT. §§ 29.03 *et seq.* (LEXIS 1997).

109. *See infra* Part III.C.

B. Constitutional and Statutory Provisions of Public Health Law in Alaska

Pursuant to explicit constitutional authorization, the Alaska Legislature has enacted an array of statutes that generally authorize various state and local governmental agencies to regulate and carry-out traditional public health functions. Many of these statutes, and some significant state constitutional provisions, are summarized in the Table below.

TABLE OF ALASKA'S PUBLIC HEALTH LAWS[110]

Provision	Legal Citation	Brief Description of Citation
Right to Privacy	ALASKA CONST. art. I, § 22.	"The right of the people to privacy is recognized and shall not be infringed."
Promote Public Health	ALASKA CONST. art. VII, § 4.	"The legislature must provide for the promotion and protection of public health."
Public Welfare	ALASKA CONST. art. VII, § 5.	"The legislature shall provide for public welfare."
Public Health Records--exception to right of inspection	ALASKA STAT. § 9.25.120 (LEXIS 1999).	Every person has right to inspect public records in the state, unless prohibited by other provisions.
Education--Physical Exam and Immunization	§ 14.30.120 § 14.30.125	Physical exams shall be delivered to child's parent. School district shall require children attending school be immunized if ordered by the Commissioner of Health and Social Services.
Health and Personal Safety Education	§ 14.30.360	"Each state public school system shall be encouraged to initiate a program in health education for kindergarten through grade 12."

110. This Table presents an index of significant Alaska state public health laws in order of appearance among statutory titles in the State's official statutory reporter, ALASKA STATUTES (LEXIS 1999). It does not include references to federal laws, state administrative laws, tribal laws, local ordinances, or case law of public health significance in Alaska. For these reasons, this Table should not be viewed as a complete listing of Alaska public health laws, but rather as a guide to those Alaska constitutional and statutory laws which significantly relate to the regulation in the interests of public health.

Fish Health Inspections	§ 16.05.868	Fish health inspections shall be performed as necessary.
Department of Health and Social Services ("DHSS") Administration	§ 18.05.010	DHSS shall "administer the laws and regulations relating to the promotion and protection of the public health, control of communicable diseases," and maternal/fetal health.
DHSS--Reports	§ 18.05.020	DHSS shall prepare an annual report of activities.
Planned Parenthood	§ 18.05.035	DHSS shall distribute planned parenthood information.
Fetal Health Effects and Pregnancy	§ 18.05.037	DHSS shall make available information on fetal health effects during pregnancy for distribution to patients.
Public Health Regulations	§ 18.05.040(a)(1)	DHSS shall adopt regulations consistent with existing laws for diseases of public health significance.
Persons with Impairments	§ 18.05.044	DHSS shall maintain a registry of consenting persons with impairments.
Board of Health – Office of Planning and Research	§ 18.07.021	This office "shall administer the certificate of need program . . . and perform other functions."
Emergency Medical Services	§ 18.08.010	"The department is responsible for the development, implementation, and maintenance of a statewide comprehensive emergency medical services system . . . ."
Health Units and Districts (Districts, Local Health Board, Municipal Corporations, Native)	§§ 18.10.010 *et seq.*	Establishes health units in unincorporated areas and designates consolidation into health districts.
Tuberculosis	§ 18.15.120	"DHSS may establish a comprehensive program for the control of tuberculosis in the state. . . ."
Blood Tests and Prenatal Blood Test	§ 18.15.150	A blood sample shall be taken for testing at a pregnant woman's first professional visit or within ten days thereafter.

Phenylketonuria ("PKU")	§ 18.15.200	A physician or nurse attending a delivery shall test the child for phenylketonuria.
Hospital Regulation	§ 18.20.010	Designed to provide for the development, establishment and enforcement of standards for the care and treatment of individuals in hospitals and related health care centers.
Nursing Facilities	§ 18.20.300	"[T]o ensure that the quality of care in nursing facilities in this state is maintained at a high standard in accordance with applicable state and federal law and regulations . . . ."
Patient Access to Records	§ 18.23.005	"[A] patient is entitled to inspect and copy any records . . . pertaining to the health care rendered to the patient."
Electronic Medical Records	§ 18.23.100	Health care providers may maintain and preserve medical records in an electronic format.
Department of Health and Social Services	§ 18.26.020	Creates Alaska medical facility authority to promote health and general welfare by finding means of financing medical facilities.
Community Health Aid Program	§ 18.28.010(c)(1)	Grant may be used for training primary community health aids.
Asbestos	§ 18.31.010	Coordinates efforts of state departments and agencies to abate asbestos health hazards in schools.
Public Accommodations	§ 18.35.010	Authorizes DHSS to maintain health standards in places of public accommodation.
Regulation of Public Smoking	§ 18.35.305	Designates places where smoking is prohibited.
Radioactive Materials	§ 18.45.030(1)	DHSS shall study the public health hazards of radioactive materials in the state.
Vital Statistics	§§ 18.50.010 *et seq.*	DHSS shall accumulate vital statistics.

Accident and Health Hazards; Accident Prevention	§ 18.60.010(b)	Authorizes a program to reduce the incidence of work-related accidents and health hazards in the state.
Employee Safety Education Programs	§ 18.60.066	Requires employers to conduct a safety education program for employees who may be exposed to toxic or hazardous substance or physical agent.
Council on Domestic Violence and Sexual Assault	§ 18.66.010	Provides for planning and coordination of services to victims of domestic violence and sexual assault.
State Commission for Human Rights	§ 18.80.050	Commission shall adopt regulations relating to discrimination because of physical or mental disability.
Mammogram Coverage	§ 21.42.375	Health care insurers shall cover low-dose mammography screenings.
Cervical and Prostate Cancer Detection	§ 21.42.395	Health care insurers shall cover the costs of cervical and prostate cancer screenings.
Local Air Quality Control Program	§ 29.35.055	Municipalities may establish a local air quality control program by ordinance.
Local Alcohol Regulation	§ 29.35.080	Municipalities may regulate the sale and consumption of alcoholic beverages.
Local Reporting of Hazardous Wastes	§ 29.35.500	Municipalities may create a program for the reporting of hazardous chemicals, materials, and wastes.
Inventories of Hazardous Materials	§ 29.35.530	Requires municipalities to inventory hazardous substances.
Hazardous Waste Information	§ 29.35.540	Information about hazardous wastes shall be made readily available to the public for inspecting and copying.
DHSS Duties	§ 44.29.020	DHSS shall administer state programs of public health and social services.

Department of Environmental Conservation ("DEC") – Declaration of Policy	§ 46.03.010	"[C]onserve, improve, and protect [Alaska's] natural resources and environment and control water, land, and air pollution, in order to enhance health, safety and welfare of the people of the state."
Alaska Environmental Plan	§ 46.03.040	DEC shall formulate and annually review a statewide environmental plan.
Hazardous Waste Reduction Matching Grants	§ 46.03.317	Establishes hazardous waste reduction grants.
Regulation of Pesticides and Broadcast Chemicals	§ 46.03.320	DEC may regulate the transporting, testing, inspection, packaging, and labeling of pesticides and chemicals.
Operation of Sewer and Water Facilities	§ 46.03.720	A person may not construct and operate a sewer system or treatment works without approval.
Pesticides; Oil Pollution	§§ 46.03.730-740	A person may not spray DDT or other commercial pesticides, or discharge oil products.
Water Nuisances	§ 46.03.800	A person may not befoul, pollute, or impair the quality of water used for domestic purposes.
Air and Land Nuisances	§ 46.03.810	A person may not publicly deposit any matter that would be "obnoxious or cause the spread of disease or in any way endanger the health of the community."
Definitions of DEC Terms.	§ 46.03.900	Defines air, water, soil, and other environmental terms.
Solid and Hazardous Waste Management Practices	§ 46.06.021	DEC shall promote waste source reduction, recycling of waste, and waste treatment and disposal to minimize threats to human health and environment.
Village Safe Water Act	§ 46.07.010	Establishes a program "to provide safe water and hygienic sewage disposal facilities in villages in the state."

Hazardous Substance Release Control	§ 46.09.010	Persons handling hazardous wastes must report releases to DEC and other appropriate public safety agencies.
Hazardous Substance Spill Technology Review Council	§ 46.13.100	Council shall assist in identification of containment and cleanup products and procedures.
State Air Quality Plan	§ 46.14.030	DEC shall act for the state in any state air quality control plan developed.
Publication of Records and Confidentialty	§ 47.05.020	DHSS may adopt regulations concerning records and the disclosure of such information.
Misuse of Public Assistance Records	§ 47.05.030	A person may not "solicit, disclose, receive, make use of, or authorize . . . the use of, a list of or names of or information concerning, persons applying for or receiving the assistance."
Public Policy—Children	§ 47.05.060	To secure for each child the care and guidance that will serve the moral, emotional, mental and physical welfare of the child and community.
Medical Assistance--Purpose	§ 47.07.010	"[T]he needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing."
Catastrophic Illness Assistance	§ 47.08.010	DHSS may reimburse providers of medical care for unpaid costs due to treatment of catastrophic illness.
Child Abuse and Neglect	§ 47.17.010	Requires the reporting of child abuse cases.
Developmentally Delayed Children - Early Intervention and Family Support Services	§ 47.20.060	Provides funding to certain children who exhibit or are at risk for developmental delays or disabilities.
Community Mental Health Services	§ 47.30.056	Establishes the Alaska Mental Health Trust Authority to ensure a comprehensive mental health program.

Alcoholism and Drug Abuse Treatment Act	§ 47.37.020	Organizes and administers treatment services for persons with alcohol and drug problems.
Payment Costs of Prenatal Services	§ 47.40.100	Requires DHSS to pay the cost of prenatal services that are not available from an existing state or federal program for pregnant women with social or economic difficulties.

As in most states, there are multiple state agencies in Alaska which regulate in the interests of public health. These agencies include the Department of Labor (which is primarily responsible for occupational safety and health); the Department of Commerce and Economic Development (which provides for licensure of physicians and nurses); and the Department of Public Safety (which provides support for victims of domestic violence and sexual assault).

Most traditional public health functions in Alaska are performed directly by one of two state agencies, the Department of Health and Social Services ("DHSS")[111] and the Department of Environmental Conservation ("DEC").[112] As summarized below, the respective duties and functions of these state agencies are distinguished by the general legislative intent underlying the agency's establishment. DHSS is primarily responsible for regulating public health matters related to the control of communicable diseases, administration of public health care, and some issues of public safety.[113] The DEC protects the environment and the state's natural resources by establishing regulations and inspecting premises where polluting activity occurs.[114]

1. *Department of Health and Social Services.* DHSS and its many divisions, including the Division of Public Health, are headed by the Commissioner of Health and Social Services.[115] Most

111. *See* ALASKA STAT. § 44.29.010 *et seq.* (LEXIS 1999); *see also Alaska Health and Social Services Online* (visited Mar. 30, 2000) <http://www.hss.state.ak.us>.

112. *See* ALASKA STAT. § 44.46.010 *et seq.* (LEXIS 1999); *see also Alaska Department of Environmental Conservation* (visited Mar. 30, 2000) <http://www.state.ak.us/dec>.

113. *See* ALASKA STAT. § 46.03.020 (LEXIS 1999).

114. *See id.*

115. *See id.* § 44.29.010 (LEXIS 1997); *see also Alaska Health and Social Services Online- Division of Public Health* (visited Mar. 30, 2000) <http://www.hss.state.ak.us/dph_home.htm>.

traditional public health duties and functions are broadly delegated to DHSS through loosely defined authorizations by the State Legislature.[116] DHSS is authorized to (1) "administer the laws and regulations relating to the promotion and protection of the public health"; (2) control communicable diseases; (3) conduct programs for the improvement of maternal and child health; and (4) perform "other duties provided by law."[117]

Public health duties of DHSS revolve around the administration of state public health regulations, programs, and initiatives concerning maternal and child health and welfare services;[118] preventive medical services;[119] public health nursing;[120] nutrition services;[121] health education;[122] public health laboratories;[123] mental health services;[124] management of state institutions (other than corrections facilities) and medical facilities;[125] the registration of persons with impairments;[126] and "general relief."[127]

Additional clarification of the public health functions of DHSS is legislatively set forth in subsequent sections of the Alaska Revised Statutes, primarily Title 18, "Health, Safety, and Housing."[128] Pursuant to Title 18, DHSS is authorized to oversee the following: (1) coordination and creation of a statewide emergency medical services system;[129] (2) establishment of a comprehensive program for the control of tuberculosis[130] and other infectious diseases including HIV/AIDS;[131] (3) accumulation of vital statistics;[132] (4)

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116. *See* ALASKA STAT. § 44.29.010 (LEXIS 1999).

117. *Id.* § 18.05.010.

118. Including, for example, the provision of planned parenthood information, *see id.* § 18.05.035, licensing of child care facilities, *see id.* § 44.29.20(a)(14), registration of midwifery birth centers, *see id.* §18. 040(a)(10), and study of fetal alcohol effects. *See id.* § 18.05.037.

119. *See id.* § 44.29.20(a)(2).

120. *See id.* § 44.29.20(a)(3).

121. *See id.* § 44.29.20(a)(4).

122. *See id.* § 44.29.20(a)(6).

123. *See id.* § 18.05.040(8).

124. *See id.* § 44.29.20(a)(7).

125. *See id.* § 44.29.20(a)(9).

126. *See id.* § 18.05.044(a)-(c). The statute defines persons with impairments as those with a physical or mental condition that, if not otherwise corrected, materially limits individual activities or functioning.

127. *Id.* § 44.29.020(a)(13).

128. *See generally id.* § 18.

129. *See id.* § 18.08.

130. *See id.* §§ 18.15.120-149.

131. *See id.* § 18.15.310.

132. *See id.* § 18.50.

regulation of the quality of hospitals;[133] (5) monitoring of asbestos levels;[134] and the health effects of radioactive materials in the state;[135] and (6) coordination with the Alaska Department of Labor and other agencies for the prevention of occupational accidents and injuries and the promotion of housing safety.[136]

These and other public health duties of the Department are also accompanied by the legislative authorization to enact administrative regulations that more precisely define the scope and extent of these powers. These administrative regulations may have the binding force and effect of statutory law, but have less force than federal and state constitutional and statutory laws.

2. Department of Environmental Conservation. DEC is the state's primary environmental protection agency.[137] DEC has also been assigned responsibility for abating public health nuisances that are primarily environmental in nature.[138] Specific duties of DEC include the following: (1) coordinating and developing statewide environmental policies; (2) establishing standards regarding air, water, surface, and subcutaneous pollution;[139] (3) preventing public health nuisances;[140] (4) maintaining health standards in places of public accommodation (including the prohibition of smoking in certain public places);[141] and (5) regulating sanitary practices in the interest of public health, including setting sanitation standards for a variety of commercial businesses (*e.g.*, food handling and manufacturing establishments, industrial plants, barbers and hairdressers, restaurants, and bars) and noncommercial establishments (*e.g.*, schools and any "other similar establishments in which lack of sanitation may create a condition that causes disease").[142]

Various divisions within DEC are responsible for implementing programs consistent with these broad legislative criteria. The Division of Air and Water Quality monitors air and water pollu-

133. *See id.* § 18.20.
134. *See id.* § 18.31.
135. *See id.* § 18.45.030(1).
136. *See id.* § 18.60.
137. *See id.* § 46.03.020
138. *See* FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL 16-17 (1990).
139. *See* ALASKA STAT. § 46.03.020(10) (LEXIS 1998).
140. *See id.*
141. *See id.* §§ 18.35.010 -365 (LEXIS 1998).
142. *Id.* § 44.46.020(5)(c).

tion.[143] The Division of Environmental Health is charged with administering laws and regulations concerning, among other things, solid waste management, safe drinking water, environmental sanitation, food safety and pesticide controls.[144] Through its Environmental Sanitation and Food Safety Program, this Division inspects more than 6,000 public facilities across the state to monitor food and public safety and may assist in epidemiological investigations of food- and water-borne contaminants.[145] The Division of Spill Prevention and Response regulates in areas of environmental contamination, including underground storage tanks.[146] Like DHSS, DEC has the authority to establish and enforce administrative regulations.[147]

C. Municipal/Local Adoption of Public Health Powers

Alaska's Constitution entrusts the legislature to enact laws governing the establishment and powers of the state's boroughs and cities. The state's seventeen incorporated boroughs are classified as either first, second, or third class.[148] Cities in the state may be designated as first or second class.[149] Boroughs or cities may be further classified. "Home rule municipalities" are local governments that have adopted a home rule charter.[150] These local governments have legislative powers not otherwise prohibited by state law or charter.[151] In addition, boroughs may be classified as "general law municipalities," which include unchartered boroughs or cities whose legislative powers must be specifically conferred by state law.[152]

While Alaska statutory law does not specifically define the relationship between the state and local governments concerning

143. *See Alaska Department of Environmental Conservation – Division of Air and Water Quality* (visited Apr. 14, 2000) <http://www.state.ak.us/local/akpages/ENV.CONSERV/dawq/dec_dawq.htm>.

144. *See Alaska Department of Environmental Conservation – Division of Environmental Health* (visited Apr. 14, 2000) <http://www.state.ak.us/dec/deh> (total public facilities mentioned under "Performance Measures").

145. *See id.*

146. *See Alaska Department of Environmental Conservation – Division of Spill Prevention and Response* (visited Apr. 14, 2000) <http://www.state.ak.us/dec/dspar/dec_dspr.htm>.

147. *See* ALASKA STAT. § 46.03.020(6)-(10).

148. *See id.* § 29.04.030.

149. *See id.*

150. *Id.* § 29.04.010.

151. *See id.*

152. *Id.* § 29.04.020.

public health responsibilities, the classification of these subsidiary governmental units is important when examining the degree of public health powers delegated to the local government. For example, first-class boroughs may proclaim area-wide regulations concerning water pollution, air pollution, animal control, and the licensing of day-care facilities, as well as any non-area-wide regulations not otherwise prohibited by state law.[153] Second-class boroughs may regulate in similar fashion on an area-wide basis, but are limited to defined subjects of regulation on a non-area-wide basis.[154] First- or second-class boroughs may acquire additional powers by holding an area-wide election.[155] In 1998, for example, residents of Kenai Peninsula Borough voted (albeit unsuccessfully) against allowing the local government to extend animal control policies to areas outside of the borough's cities.[156]

Third-class boroughs, which are the functional equivalent of special service districts in many states, lack any public health regulatory powers absent the power shared by first- and second-class boroughs to prevent the release of oil or other hazardous substances in the environment.[157] Only one third-class borough exists in the state.[158] No additional third-class boroughs may be created.[159] Similar delegations of home-rule powers apply to cities depending on whether they exist within or outside a borough.[160] Cities may also transfer their powers to the boroughs in which they exist.[161]

Alaska delegates certain public health functions to all municipalities, whether home rule or general law, borough or city. For example, any municipality may establish a local air quality control program;[162] regulate the sale and consumption of alcoholic beverages;[163] create a program for reporting hazardous chemicals, materials, or wastes;[164] take advantage of incentives in the form of state

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153. *See id.* § 29.35.200.

154. *See id.* § 29.35.210.

155. *See id.* § 29.35.300.

156. *See* Heather A. Resz, *Animal Issues Goes to Voters*, PENINSULA CLARION, July 16, 1998, at A1 (on file with authors).

157. *See* ALASKA STAT. § 29.35.220 (LEXIS 1998).

158. *See* LOCAL BOUNDARY COMMISSION, LOCAL GOVERNMENT IN ALASKA 5 (1998) (last modified October 1998) <http://www.dced.state.ak.us/mra/Local_Gov_AK.pdf>).

159. *See* ALASKA STAT. §§ 29.05.031(b), 29.06.090(a) (LEXIS 1998).

160. *See id.* §§ 29.35.250, 260.

161. *See id.* § 29.35.310.

162. *See id.* § 29.35.055.

163. *See id.* § 29.35.080.

164. *See id.* § 29.35.500.

funds to establish health facilities and hospitals;[165] and receive grants of state funds to clean-up or prevent oil and hazardous substance spills.[166] Delegations do not include, however, traditional public health functions such as communicable disease control.

Antiquated state law also authorizes the creation of health units (defined as a community or settlement outside an incorporated city) and health districts (comprised of two or more contiguous health units).[167] These health units or districts are not assigned specific duties, other than to report to the Commissioner of Health and Social Services.[168] Despite their authorization under state law, DHSS reports that there are no functional health units or districts, as defined by law, in Alaska.[169]

D. Tribal Public Health Powers

Alaska Native villages predate statehood.[170] Their current legal existence and many of their public health powers derive from the federal government.[171] Congress has recognized the unique status of Alaska's Native and Indian tribal governments in the constitutional system of government in ways similar to its recognition of American Indian tribal governments outside Alaska.[172]

The federal government's relationship with the American Indians is the product of compromise. In the mid 1800's, American Indians executed treaties with the United States that turned over vast quantities of Indian land to federal control.[173] In return, American Indians were granted limited set-asides of land (reservations), were allowed to form sovereign tribal governments, and were to receive direct federal assistance.[174] When Russia sold the territory of Alaska to the United States in 1867, the treaty executing the exchange secured similar terms for Alaska Natives.[175] In

165. *See id.* § 29.60.120.

166. *See id.* § 29.60.500.

167. *See id.* §§ 18.10.010-050.

168. *See id.* § 18.10.050.

169. *See* Lawrence O. Gostin & James G. Hodge, Jr., *Reforming Alaska Public Health Law, A Report for the Alaska Public Health Improvement Process*, 23 (1999) (on file with authors).

170. *See A Brief History of Alaska Statehood (1867-1959)* (visited Apr. 12, 2000) <http://xroads.virginia.edu/~CAP/BARTLETT/49state.html>.

171. *See* DAVID S. CASE, ALASKA NATIVES AND AMERICAN LAWS 5 (1984).

172. *See id.*

173. *See* FELIX S. COHEN, HANDBOOK OF FEDERAL INDIAN LAW 63-66 (1988).

174. *See* AMERICAN INDIAN LAW DESKBOOK 15-16 (Conference of Western Attorneys General ed., 2d ed. 1988).

175. *See* CASE, *supra* note 171, at 67.

1971, the Alaska Native Claims Settlement Act ("ANCSA")[176] settled all land claims by Alaska Natives and transferred land to state-chartered Native corporations.[177]

Pursuant to the Snyder Act of 1921,[178] Congress directly assumed responsibility for the provision of health care to tribal governments.[179] Such federal assistance continues today through long-term commitments for comprehensive health services administered by the Indian Health Service ("IHS") of the federal DHHS, and to a lesser extent, the Bureau of Indian Affairs ("BIA").[180] Congress has legislatively strengthened its commitment to provide health care benefits to Alaska Natives through the Indian Self-Determination and Education Assistance Act of 1975[181] and the Indian Health Care Improvement Act of 1976.[182] Together these Acts clarified federal objectives for the provision of health-related services and encouraged the direct involvement of tribal governments in planning and operating health programs.[183]

In 1991, Congress began the IHS Tribal Self-Governance Demonstration Project.[184] This Project, which is scheduled to continue until 2006, specifically authorizes IHS and BIA to execute agreements (or compacts) with Alaska Natives and American Indians for the purpose of providing federal funds for health programs and facilities without significant federal oversight.[185] Under this law, general management and supervision of such programs and facilities is left to the tribal governments. In Alaska, many of these tribal groups collaborated to form the Alaska Tribal Health Compact ("ATHC"), which successfully negotiated a health services agreement with IHS.[186] As a result, the setting of public health goals and objectives has become a primary responsibility of local

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176. *See* 43 U.S.C. §§ 1601-29 (1994).

177. *See* Alaska v. Native Village of Venetie Tribal Gov't, 522 U.S. 520, 524 (1998).

178. *See* 25 U.S.C. § 13 (1994).

179. *See* CASE, *supra* note 174, at 246-47.

180. *See* Donald Craig Mitchell, *Alaska v. Native Village of Venetie: Statutory Construction or Judicial Usurpation? Why History Counts*, 14 ALASKA L. REV 353, 401 (1997).

181. *See* Pub. L. 93-368, 88 Stat. 2206 (1975).

182. *See* Pub. L. 94-437, 90 Stat. 1400 (1976).

183. *See* Betty Pfefferbaum et al., *Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care*, 20 AM. INDIAN L. REV. 365, 383-89 (1996).

184. *See* 25 U.S.C. § 450f (1994).

185. *See* Pfefferbaum et al., *supra* note 183, at 387.

186. *See* Nancy Pounds, *Native group ready to take over hospital management in January*, 23 ALASKA J. COM. 1 (1999).

tribal governments. This movement toward self-governance was further solidified with the congressional enactment of the Tribal Self-Governance Act of 1994.[187]

Village and group members of the ATHC receive their funds directly from IHS.[188] They can use the funds for specific health programs within their discretion, provided the spending is consistent with the general conditions for federal funding.[189] This flexibility allows local tribal governments to target and respond to differing health needs across their populations of which they are aware. Organizations like the Alaska Native Health Board[190] assist with community-wide planning of health services and needs.[191]

Despite their distinct existence and relationship with the federal government, Alaska Natives are also citizens of the state. In *Alaska v. Native Village of Venetie Tribal Government*,[192] the United States Supreme Court held that non-reservation tribal land allotted to Alaskan Natives through the Alaska Native Claims Settlement Act of 1971 was not "Indian country," and thus was not subject to direct federal jurisdiction and did not form a territorial basis for certain types of tribal jurisdiction related to the exercise of general governmental powers.[193] The state has civil and criminal jurisdiction over the villages and tribal lands of Alaska Natives.[194] Consequently, state law generally applies to these residents.

Although the Court's decision in *Venetie* confirmed that Alaska had primary jurisdiction over tribal lands, the extent of state powers remains conditioned on the recognition of the federal partnership with tribal governments.[195] Tribal health organizations are registered as state-chartered nonprofit institutions. However, to the extent that they originated as federally-sponsored entities, they have been treated by state authorities as federal facilities for certain purposes.[196] For example, in certain circumstances, health

187. *See* 25 U.S.C. § 450 (1994).

188. *See* Cook Inlet Treaty Tribes v. Shalala, 166 F.3d 986, 988 (9th Cir. 1999).

189. *See id.*

190. *See Alaska Native Health Board* (visited Mar. 30, 2000) <http://www.anhb.org>.

191. *See Alaska Native Health Board – All About ANHB* (visited Apr. 10, 2000) <http://www.anhb.org/sub/about.html>.

192. 522 U.S. 520 (1998).

193. *See id.* at 532.

194. *See* 18 U.S.C. §§ 1162, 1360 (1994).

195. *See generally Venetie*, 522 U.S. 520.

196. *See* Gostin & Hodge, *supra* note 169, at 25-26.

care employees of tribal affiliated health facilities have not been required to be licensed under state law.[197]

Less certain are the responsibilities these tribal governments share with state and local governments for the public health. Tribal governments undertake public health initiatives with their federal funds. Federal monies helped establish the Alaska Native Epidemiology Center, which surveys rates of disease and other health conditions among Alaska Natives.[198] Tribal governments are also entitled to apply for state public health grants. Tribal health facilities may treat residents other than Alaska Natives.[199] Disputes have arisen as to when and whether tribal governments must adhere to state public health initiatives and requirements. Though overall responsibility for public health should likely reside with the state, theoretical and practical issues complicate the achievement of purely state public health objectives where tribal organizations dispute state jurisdictional authority or where conflicts arise between local and tribal governments serving the same community.

IV. THE PUBLIC HEALTH LAW IMPROVEMENT PROCESS

Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. As such, public health law serves as a foundation and a framework for public health activity. It should assure that public health agencies are fully capable of responding to current and potential public health threats. Unfortunately, existing public health laws too often fail to support health departments in carrying out their essential services and accomplishing their goals. Reform of the law can promote more effective decision-making and protect individual rights.

Before explaining why public health law improvement can yield many benefits, it is important to be candid about the limitations of reform. Public health problems may not be remedied primarily through law reform, but rather through better leadership and training, improved infrastructure for surveillance and epidemiological investigations, comprehensive counseling and health education, and innovative prevention strategies. In making policy, public health authorities must consider prevailing social values and

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197. *See id.*

198. *See EpiCenter Home Page* (visited Apr. 12, 2000) <http://www.anhb.org/Web%20Site/Epidemiology/index.htm>.

199. *See* Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 222 (1997).

respect multiple constituencies, including scientists, politicians, and community leaders. Despite these limitations, there are at least four possible roles for the law in advancing public health.

(1) *Law can define the objectives of public health and influence its policy agenda.* Public health statutes should establish the purposes, goals, and core functions of public health, the personnel and infrastructure realistically needed to perform these functions, and budgeting mechanisms to provide reliable levels of support. By doing so, the law can inform and influence the activities of government and the expectations of society about the scope and fundamental importance of public health. Courts give deference to statements of legislative intent and may permit a broad range of activities that are consistent with legislative objectives. No government program can be assured full funding during budgetary crises. However, structuring public health law to embrace defined functions, minimum infrastructure and personnel needs, and funding mechanisms can provide a yardstick for health departments and policy makers in the future.

(2) *Law can authorize and limit public health actions.* Public health law must provide broad authority for the exercise of public health powers and coextensively limit that authority where necessary for the protection of individual rights. In considering law reform, it is important to distinguish between duties and powers in public health. The legislature should impose duties on health departments[200] to initiate a broad range of activities relating, for example, to surveillance, communicable disease control, environmental protection, sanitation, and injury prevention. It is important that health officials retain *flexibility* in the powers used to achieve public health purposes. While providing for a flexible range of public health powers, the law must also place appropriate limits on those powers to protect human rights. This is best accomplished by adhering to certain strategies including the following: establishing clear criteria for the exercise of compulsory powers by requiring health authorities to use scientific evidence to demonstrate a significant risk to the public health; providing procedural due process for all individuals who face serious constraints on their liberty; and safeguarding the privacy of individuals and preventing or punishing invidious discrimination.

(3) *Law can serve as a tool of prevention.* Public health law is, and should remain, a tool of prevention. Public health law should

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200. The term "health department" is used in the generic sense to include all public health functions carried out by the State, including those in the Department of Health and Social Services and those in the Department of Environmental Conservation.

use a wide variety of legal means to prevent injury and disease, as well as enhance health-promoting conditions for the people.

(4) *Law can facilitate planning and coordination of governmental and non-governmental health activities.* The private sector (*e.g.*, managed care and other health insurers, individual health care providers, and researchers) have an important role to play in assuring healthy conditions. The law can foster and encourage this role for the benefit of public health.

A. Benefits of a Public Health Law Improvement Process

Having observed the role of law in protecting and preserving the public health, we turn to our analysis of the potential benefits of legal reform of Alaska public health law. In Part B, we present our specific guidelines for legal reform. First, however, we summarize below some of the fundamental and structural dilemmas of Alaska public health law, as well as the benefits that can be achieved through a public health improvement process.[201]

1. *Updating Antiquated Laws.* Many of Alaska's public health enabling laws were enacted nearly fifty years ago before formal statehood. As such, they are old and antiquated. Like most public health laws in the United States, Alaska's statutes and regulations have been passed piecemeal in response to specific disease threats such as tuberculosis, sexually transmitted diseases, and HIV/AIDS. Thus, the law has developed, layer-upon-layer, from one time period to another. Discussions with public health authorities in Alaska pursuant to our case study revealed, at times, confusion about who has what public health powers and when to exercise those powers. Given the multiplicity and layering of laws and regulations concerning Alaska public health law, even the most expert lawyers have difficulty providing clear answers to public health officials about their authority to act. One major benefit of public health law reform would be to provide greater clarity about legal powers and duties.

Certainly, older laws are not necessarily bad laws. A well-written statute may remain efficacious for many decades. However, older laws are often outmoded in ways that directly reduce their efficacy and conformity to modern legal standards. Older laws may not reflect contemporary scientific understanding of disease, current medical treatments, or constitutional limits on the States' authority to restrict individual liberties.

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201. *See, e.g.*, Gostin et al., *supra* note 8.

When the Alaska public health enabling laws were enacted, the scientific understanding of diseases was very different than it is today. Not surprisingly, public health laws from that era reflect a more limited understanding of disease and may lack a public health justification based on contemporary scientific knowledge. These laws also predate contemporary developments in constitutional law, disability discrimination law, health information privacy, and other modern legal requirements. At the constitutional level, the United States Supreme Court now has more exacting standards for equal protection of the laws, substantive due process, and procedural due process. Public health powers that affect liberty (*e.g.*, quarantine and directly observed therapy), privacy (*e.g.*, reporting and partner notification), and autonomy (*e.g.*, compulsory testing, immunization, or treatment) may undergo more careful scrutiny under the federal Constitution. At the same time, the federal Constitution may require more rigorous procedural safeguards before one may exercise compulsory powers.

Federal disability law may be construed to prohibit discrimination against persons because of a health deficiency, such as an infectious disease.[202] This may require health officials to adopt a standard of "significant risk" before resorting to compulsion. A significant risk may be defined as a direct threat "to the health or safety of others that cannot be eliminated by modification of policies, practices, or procedures."[203] Thus, under this standard, adverse treatment, such as a decision to use compulsory powers, would be permitted only if the person posed a significant risk to the health or safety of others. A significant risk regarding communicable diseases, for instance, would be determined through "an individualized assessment of the mode of transmission, probability of transmission, severity of the harm, and the duration of infectiousness."[204]

2. *Improving Dialogue.* Alaskans have engaged in passionate, systematic, and highly constructive conversations about the public health system. These conversations have occurred among various levels of government, public health officials, community representatives, and other interested individuals. Even though true legal reform is not accomplished, the dialogue process emanating from the state's public health improvement process is valuable in many ways. Careful thought has been put into the legal

202. *See* Lawrence O. Gostin et al., *Disability Discrimination in America*, 281 JAMA 745 (1999).

203. *Id.* at 246.

204. *Id.*

powers and duties of health officials. Concerns of the Alaskan people have been expressed and considered by senior health officials. Tensions concerning intergovernmental and tribal relationships have been aired. The willingness of multiple parties to reflect on public health improvement in Alaska has educated health authorities and communities about public health practice throughout the state.

Perhaps more importantly, the dialogue process has been an important first step in improving working relationships in public health throughout the state. As we examined during our case study, Alaska is unique in America for the depth and complexity of its governmental and non-governmental relationships between federal, state, tribal, and local officials.

Historically, the federal government has been intricately involved in public health in Alaska. Federal investment was intended to develop the infrastructure of a relatively new state and, particularly, to fulfill the federal trust commitments made to Native Alaskans. As the Indian Health Service completes the transfer of health care responsibility to tribal authorities, federal involvement is decreasing, although there remains a need for strong relationships among federal, state, and tribal authorities.

State legislators and public health officials sometimes had markedly different understandings of the role of government within public health. Public health authorities frequently sought greater freedom to exercise their discretion in matters concerning the health of the community. They sometimes perceived legal requirements and the political process as impediments to a well-functioning health department and expressed concern and distrust over how legislators would approach public health law reform. Public health authorities also were concerned about funding and development of an adequate public health infrastructure. At the same time, legislators saw a need for clear criteria and procedures under which public health officials could operate. One prominent legislator in another state objected to "the notion that public health officials (despite being political appointees) make decisions that are scientific and good, and legislators make decisions that are political and bad."[205] The tone of conversations and the relative infrequency of prior high-level discussions suggest the need for more regular communications between public health authorities and legislators which are not merely in response to the latest political issue.

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205. LAWRENCE O. GOSTIN ET AL., MILBANK MEMORIAL FUND, IMPROVING STATE LAW TO PREVENT AND TREAT INFECTIOUS DISEASE 6 (1998).

Given the size and diversity of the state, local dialogue on public health is critical in Alaska. Health officials at the state and local level have cordial and warm relationships and discuss public health issues regularly. A lack of regular communication between these authorities could carry serious implications for the public health. If, for example, the State had to discontinue a public health service because of budgetary constraints or otherwise, local governments should be made aware of the decision in order to prepare for their potential responsibility to provide these services. Otherwise temporary, serious gaps in public health services may occur.

Finally, the relationship between the state (and its subsidiary local governments) and tribal authorities is critically important to public health in Alaska. Since the tribes are responsible for many public health services, there exists a sort of concurrent authority (state and tribal) to protect the health of Natives. This requires careful and deliberate coordination. Without systematic coordination and ongoing discussion, occasional mistrust between the two entities arises. As a result, some efforts have been made to improve dialogue between state and tribal authorities. The Rural and Alaska Native Community and Public Health Advisory Group, for example, meets regularly to provide a forum for ongoing and deliberative discussions among state and tribal representatives. Yet there remain theoretical differences concerning the roles of the state and tribal authorities in public health.

From the perspective of some state officials, there is sometimes a need to intervene in Native communities to avert a public health threat. However, tribal communities view themselves as governments with jurisdiction over the land and its peoples. From their perspective, the State often fails to provide Natives with sufficient services such as clean water, sewage, and proper sanitation. These different theoretical visions of state and tribal authority can lead to mistrust and misunderstanding. For example, when a highly knowledgeable, senior-level individual representing Native Alaskans was asked during our case study if negotiations with the State would be useful, this person expressed the fear that negotiations with the State inevitably meant concession.

The rich diversity in Alaska is a unique strength. It is evident that all groups want the same thing – a vibrant public health program. While the ideals and work ethic of federal, state, tribes, municipal public health authorities, policymakers, and others are admirable, maintaining the lines of active communication is critical. Communication and coordination should be routine and ongoing, and not simply in response to public health crises.

B. Guidelines for Reforming Public Health Law in Alaska

As indicated earlier,[206] whether Alaska should reform its public health law remains open. Although the potential exists, law reform is not the inevitable result of the public health law improvement process. While there are many benefits of law reform, there are also risks. Once a bill is introduced in the legislature, it can become politicized. Enacted laws can tie the hands of public health officials. For this reason, many public health professionals emphasize the need for flexibility. Finally, once the relationships among various groups are delineated in legislation, great distrust could result. Despite these evident risks, we propose the following statutory guidelines for public health law reform, some of which directly relate to the benefits of a public health law improvement process in Alaska.

1. *Mission Statement: Essential Public Health Services.* Most state laws do not give clear authority for all of the essential public health services recommended by the Institute of Medicine and the federal Department of Health and Human Services ("DHSS").[207] Alaska's public health law, like other states, does not articulate a clear mission for public health, nor does Alaska law spell out core or essential public health services necessary for serving the state. Consequently, Alaska law reform should express a clear vision for public health. This vision should articulate the best theory and practice in public health and make a symbolic statement about assuring the conditions necessary for the health of the people. This does not just include personal medical services, but a rich array of services for disease and injury prevention, and health promotion.

2. *Avoid Separate Disease Classifications and Disease-Specific Laws.* The primary epidemiologic rationale for classifying diseases and treating them differently is to distinguish between modes of disease transmission. However, the origins of this differential treatment may be better explained by historical and political influences than by reasoned distinctions or thoughtful strategies. The result often creates different legal standards and procedures for different diseases depending on how they are classified. Public health law should be based on uniform provisions that apply equally to all health threats. Public health interventions should be based on the degree of risk, the cost and efficacy of the response,

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206. *See supra* Part IV.A.

207. Kristine M. Gebbie & Inseon Huang, *Identification of Health Paradigm in Use in State Public Health Agencies*, Columbia Univ. School of Nursing, Center for Health Policy and Health Services Research (Oct. 28, 1997) (on file with authors).

and the burdens on human rights that cut across disease classifications.

Alaska public health law is a complicated amalgam, difficult for the public to comprehend and challenging for health officials to implement. A single set of standards and procedures would add needed clarity and coherence to legal regulation and might diminish politically motivated disputes about existing and newly emergent diseases.

3. *Base Public Health Decisions on the Best Scientific Evidence of Significant Risk.* In combatting public health threats, health officials need clear authority and flexibility to exercise powers, as well as sufficient guidance. Consequently, an effective and constitutionally sound Alaska law requires a rational and reliable way to assess risk and establish fair procedures. Alaska public health law should give public health authorities the power to make decisions based upon the best available scientific evidence. Public health officials should examine scientific evidence in the following areas: (a) what is the nature of the risk (*e.g.*, the mode of transmission)? (b) what is the probability that the risk will result in harm? (c) what potential severity of harm does the risk present? and (d) what is the duration of the health risk? Provided health officials act with a good foundation in science, they should be supported by public health law.

4. *Provide a Flexible Range of Powers for Public Health Authorities.* Good public health law should give health officials a wide and flexible range of powers to accomplish their mission. This would range from coercive measures such as isolation, licensure, removal, and nuisance abatement, to directly observed therapy, cease and desist orders, and requirements to attend courses for counseling, education, and treatment. It would also include a full range of powers for health promotion and education. By giving health officials a flexible and graded series of alternatives, public health can be protected and individual rights promoted.

Public health law must set forth and ensure fair procedures. The nature and extent of the process required depends upon several factors including: (a) the nature of the interests affected; (b) the risk of an erroneous decision; (c) the value of additional safeguards; and (d) the administrative burdens of additional procedures. Except in an emergency when rapid response is critical, public health law should assure a fair and open process for resolving disputes about the exercise of powers and authority.

5. Data Protection: Public Health Data Needs and Privacy Considerations. The collection, storage, maintenance, and use of vast amounts of information about the health of populations are among the core functions of public health. Surveillance is one of the most important duties of public health, permitting early identification of health threats, targeted delivery of prevention services, and links to treatment and other services.[208] Public health law must enable, encourage, and fund a strong public health information infrastructure.

The collection of large quantities of personally identifiable data, however, creates privacy concerns. Increasingly, health information is being stored in electronic form. Users can access this data more easily than ever before. A resulting tension between public health information and privacy is evident in emerging technologies often referred to as "telemedicine." Due to the size of Alaska and its remote rural populations, Alaska is at the forefront of telemedicine. This will require the State to meet challenges relating not only to privacy, but to issues of quality control, licensure, and liability.

Statutory provisions governing data collection and privacy must seek to satisfy two goals that at times conflict: ensuring up-to-date information for public health purposes and protecting that information from inappropriate disclosure. Balancing these competing goals can be accomplished only through the implementation of policies and practices consistent with set, statutory guidelines. These guidelines have been drafted within the context of our "Model State Public Health Privacy Project,"[209] sponsored by the Centers for Disease Control and Prevention and the Council of State and Territorial Epidemiologists. With the assistance of a multi-disciplinary panel of public health, privacy, and governmental experts, we have produced a model state public health privacy law, which, if passed, will codify privacy and security principles concerning the use and disclosure of public health information. The model act only concerns personally-identifiable data (because non-identifiable data pose no or minimal individual privacy concerns) and is based on the following broad principles:

(a) *Justification for Data Collection.* Public health authorities must justify their need for identifiable data, although they should

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208. *See, e.g.*, Lawrence O. Gostin & James G. Hodge, Jr., *The "Names Debate": The Case for National HIV Reporting in the United States*, 61 ALB. L. REV. 679, 689-724 (1998).

209. Lawrence O. Gostin & James G. Hodge, Jr., *Model State Public Health Privacy Project* (last modified Oct. 8, 1999) <http://www.critpath.org/msphpa/privacy.htm>.

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

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have great flexibility in making this showing. Valid justifications would include: surveillance, disease monitoring, epidemiological (and related) research, preventing a public health risk, and providing services for the community, including interventions in avoiding and ameliorating public health threats.

(b) *Community Access to Information.* A community should be generally informed about aggregate data collection by public health departments and its purposes. Even where information is non-identifiable, people should generally be aware of the type of data collection undertaken by public health departments. Aggregate public health data should be made accessible by community members for virtually any purpose.

(c) *Fair Information Practices.* Fair information practices demand that no secret data systems exist, that persons have access to data about themselves, and that public health officials should ensure the reliability and accuracy of the data.

(d) *Privacy Assurances.* Legally binding assurances of privacy should attach to all personally-identifiable information. Public health officials should maintain confidentiality and ensure a secure data system. Unwarranted disclosures should be prohibited. This does not mean that public health officials should be restricted in essential health uses of data. Rather, they should have wide flexibility in using data for all important public health purposes. Thus, public health officials could share information across professional job descriptions and programs provided the information is necessary to achieve a valid public health purpose.

Penalties should exist for unauthorized disclosure for non-public health purposes. Legal protections should prevent unauthorized disclosure to commercial marketers, employers, insurers, law enforcement, and others who might use the information for inconsistent, unwarranted, discriminatory, or commercial purposes.

The model act permits all legitimate public health uses of data for the common good, but prohibits potentially discriminatory use of personal data. This gives public health authorities discretion to protect human health, and it gives communities a sense of fairness and privacy protection. The solution is not perfect. Conflicts will continue to arise. Yet the model act recognizes both public health and privacy interests, and seeks fair resolution in law.

6. *Improving Coordination Between the Department of Health and Social Services and the Department of Environmental Conservation.* DHSS and DEC share responsibility in Alaska for ensuring the public health. As a result of this dual system of public health responsibility, it is important that these agencies coordinate their efforts. Each requires the expertise and power held by the

other to fully accomplish the public health mission. Some public health functions undertaken by these agencies overlap to some degree. For example, the broad authority of DHSS to control public health diseases intersects with DEC's responsibility for monitoring and preventing food- and water-borne contaminants in the interests of public health. Some infectious diseases, such as hepatitis A and crypto sporidium, may be spread through contamination of food or water supplies, thus requiring potential action from both agencies to monitor and prevent their spread.

For the most part, this dual system of public health regulation works well. Each department performs its functions and draws from the considerable expertise within the department. Where one department has particular resources, it is usually willing to lend its expertise to the other. While dual responsibility will in some cases work to better the public health, conflicts of agency authority and action may arise should these agencies fail to communicate and coordinate their efforts toward accomplishing public health goals.

Surprisingly, Alaska public health law does not include formal procedures for the ongoing dialogue and sharing of information between these agencies. The State should improve coordination of public health services by establishing formal structures to promote communication and coordination between DHSS and DEC. This could include regular meeting times for high-level discussions, systematic coordination of complimentary functions, and planning for population-based public health services in the state. Stronger relationships, coordination, and dialogue between these two governmental entities, as well as others within the public health system in Alaska, would likely improve the public health.

V. CONCLUSION

Alaska is unique in many ways. It is a relatively new state, it has a distinct and highly innovative sense of community health, and many public and private groups in the state are intensely interested in public health. This provides an important opportunity to improve the public health system, including the public health law infrastructure. We have attempted in this Article to examine Alaskan public health law systematically and provide meaningful guidelines for legal reform. As recommended, some of these reforms may require statutory alteration, while others may emanate from the resolution of judicial cases or through administrative regulations. However, a major benefit of the public health law improvement process in Alaska may not be the guidelines themselves, but the process by which they are produced. Alaska public health officials have dedicated themselves to an intense process of educa-

tion and inquiry. Alaska is tentatively developing Phase III of its public health law improvement process, which will include education, continued dialogue, dissemination, due deliberation, and possible implementation of public health reforms. The public health benefits to date have already been well worth their efforts. We recommend Phase III to ensure the continued progress of the Alaskan public health improvement process.

PUBLIC HEALTH

PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

HB 95: An Act Relating to Public Health

Presentation to the House Rules Committee

March 31, 2005

Richard Mandsager, M.D., Director
Alaska Department of Health & Social Services
Division of Public Health

"Public Health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

Institute of Medicine

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

PUBLIC HEALTH IS NOT HEALTH CARE

- Focus on **Populations**, not individuals
- Focus on **Prevention**, not treatment
- **Government** plays a unique role – legal obligations to prevent disease, disability, injury, and illness among populations

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

Division of Public Health

Core Services

- Infectious Disease Control
- Chronic Disease Control
- Injury Prevention
- Respond to Disasters
- Assure Access to Quality Care
- Protect Against Environmental Health Hazards

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

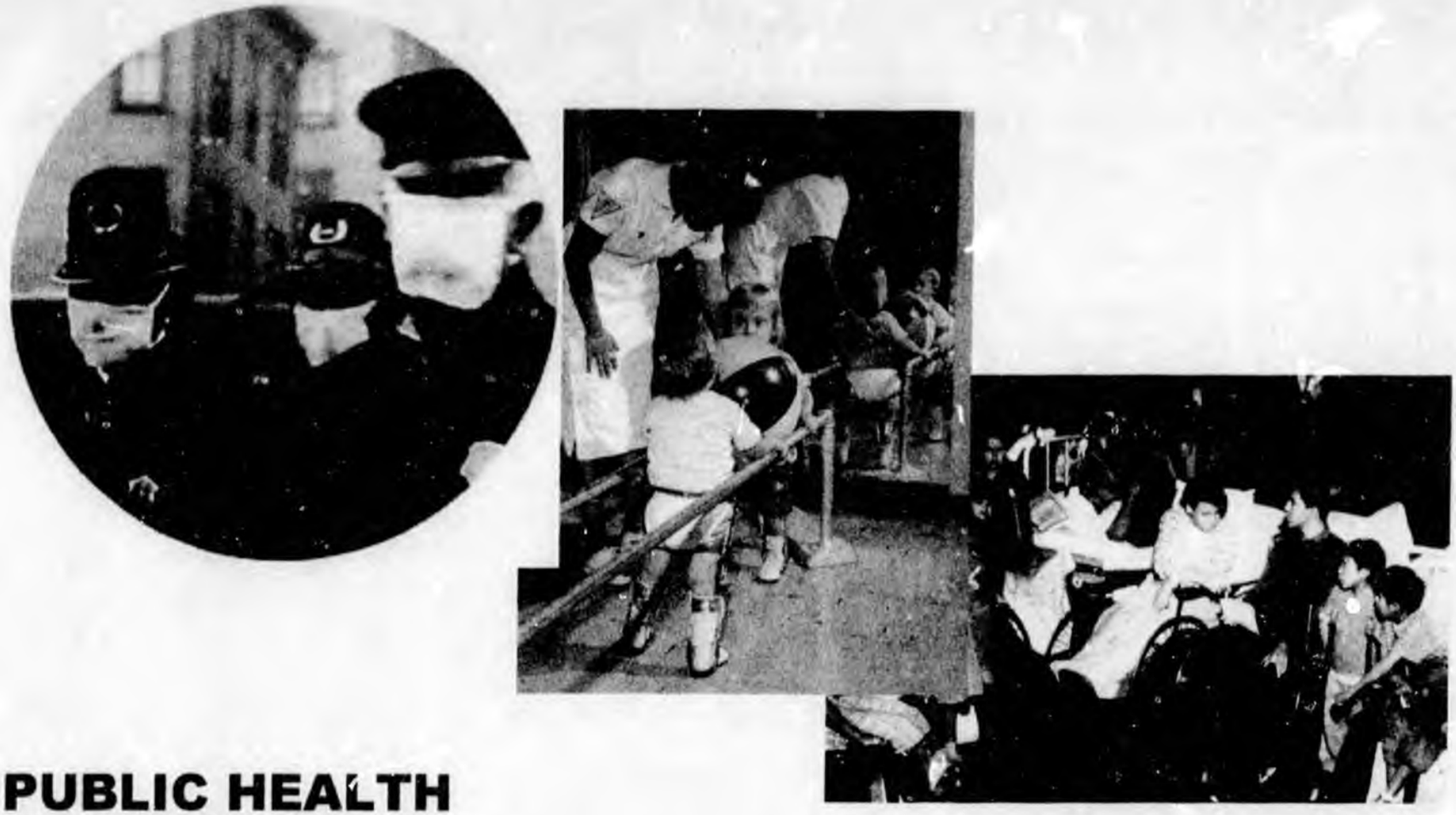
How Prepared are we for a Public Health Emergency?

- Strong disease surveillance systems
- Specialized emergency operations plans
- Enhanced communication protocols and systems
- New or enhanced laboratory testing capabilities
- Consultative expertise re: human health effects and remediation of chemical and radiological exposures
- Specialized training for public health and health care providers
- Planning and coordination with others (hospitals, emergency management, law enforcement and FBI, 1st Responders)

Preparedness Weaknesses

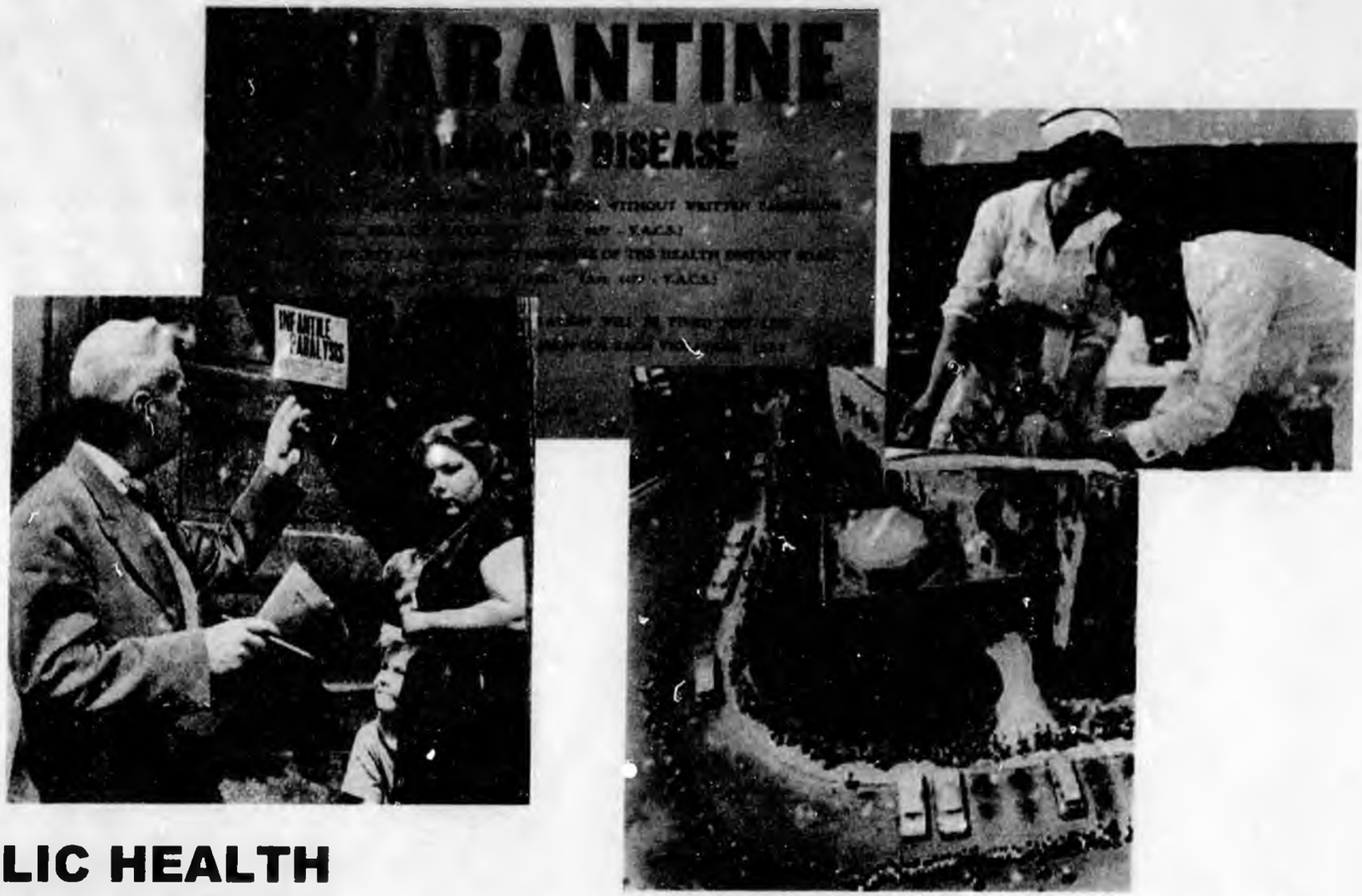
- Inadequate legal authorities (HB 95)
- Inadequate laboratory facility for virology (HB 100)
- Dependence on federal funds
- Insufficient staff capacity to allow time for both 1) response to existing priorities, and 2) training and exercises for disasters

Old Public Health Enemies



PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

Traditional Disease Control



PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

The Next SARS?

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

Alaska Public Health Law Reform Proposal

The Problem – *Our laws don't protect us anymore*

- Alaska's public health laws are antiquated and layered – Alaska Law Review, 2000
- Alaska is the only state in the nation that does not have adequate statutory authority to quarantine – Trust for America's Health, 2004

1949: AS 18.05.010	Administration of Laws by the Department
1995: AS 18.15.120	Tuberculosis Control
2003: AS 18.15.350	SARS Control

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

Alaska Public Health Law Reform Proposal

The Proposed Solution - Updated Laws that Provide:

- A statutory framework that supports the public health mission, services and role
- Clear authority for control of conditions of public health importance; and,
- Modern due process provisions for the protection of individual rights

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

HB 95: An Act Relating to Public Health

- Defines "Essential Public Health Services"
- Describes State's role in health protection and promotion
- Provides clear authority for disease control through:
  - Surveillance
  - Epidemiologic Investigation
  - Medical Treatment, Quarantine & Isolation
- Requires protection of individual rights - due process
- Strengthens requirements for confidentiality and data security

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

CSHB 95 (JUD): An Act Relating to Public Health

I. Purpose/Intent (Sec. 1)

II. Administration of Public Health Laws by the Department (Sec. 4, 5, 7)

III. Public Health Authority and Powers (Sec. 8)

IV. Legal Representation and Court Powers
- a) Right of indigent person to counsel (Sec. 9)
- b) Judicial powers augmented (Sec. 10)
- c) Guardian ad litem responsibilities (Sec. 11)
- d) Indirect court rule amendments (Sec. 12,13)

V. General Provisions
- a) State Immunity (Sec. 2)
- b) Repeal and changes to citations of statutes (Sec. 3, 6, 14)
- c) Effective Date (Sec. 15)

PUBLIC HEALTH
PROTECTING AND PROMOTING THE HEALTH OF ALL ALASKANS

CSHB 95(JUD): An Act Relating to Public Health

I. Purpose/Intent (Sec. 1)

- To protect and promote the health of the citizens of this state to the greatest extent possible through the public health system
- Not intended to mandate provision of certain services or implementation of unfunded programs

II. Administration of Public Health Law by DHSS (Sec. 4, 5, and 7)

- Modernize and clarify department's public health powers
- Clarifies nature of mandated regulations for public health reporting and adds regulatory mandate for data security and confidentiality
- Adds definition of "conditions of public health importance"

III. Public Health Powers and Authority (Sec. 8)

- Prevention and control of conditions of public health importance
- Surveillance through data collection and public health reporting
- Epidemiological investigations
- Medical treatment
- Quarantine and isolation
- Public health disasters

HB 95: An Act Relating to Public Health

Balancing Individual Rights vs. Common Good

- Constitutional Constraints on Governmental Public Health Powers
- Constitutional Protections of Individual Rights
- Limitations Imposed by Provisions in Bill
- Due Process Provisions in Bill

HB 95: An Act Relating to Public Health

Balancing Individual Rights vs. Common Good

- Constitutional Constraints on Public Health Powers (Case Law):
  - Public health powers are constitutionally permissible only if they are exercised in conformity with four standards:
    - **Public Health Necessity** – government may act only in response to a demonstrable threat to the community; and
    - **Reasonable Means** – there must be a reasonable relationship between the public health intervention and the achievement of a legitimate public health objective; and
    - **Proportionality** – there must be a reasonable balance between the public good to be achieved and the degree of personal invasion; and,
    - **Harm Avoidance** – the control measure should not pose a health risk to its subject.

- Constitutional Protections of Individual Rights (Bill of Rights):
  - **1st Amendment:** Freedom of religion, speech, press, assembly, petition
  - **4th Amendment:** Freedom from unreasonable search and seizure
  - **5th Amendment:** Due process clause
  - **14th Amendment:** Bill of Rights applicable to states

Gostin, Lawrence O., *Public Health Law: Power, Duty, Restraint*, University of California Press, 2000, (pgs. 61 – 83)

CSHB 95 (JUD): An Act Relating to Public Health

Balancing Individual Rights vs. Common Good

- Limitations placed on governmental public health powers in this bill:
  - The department must establish confidentiality and security standards in regulation for information and records received under this statute (AS 18.05.040 (a))
  - The department may not acquire identifiable health information without complying with provisions and regulations adopted under this statute (AS 18.15.360 (d))
  - The department must adhere to statutory conditions for acquisition and use of identifiable health information (AS 18.15.362)
  - Information confidentiality and security safeguards required (AS 18.15.365)
  - "Conditions of public health importance" limited to those that "can reasonably be expected to lead to adverse health effects in the community" (AS 18.05.070 (4); AS 18.15.390)
  - The department may require testing
    - only upon an order of a state medical officer, and only upon a finding that the individual has or may have been exposed to a contagious disease that poses a significant risk to the public health (AS 18.15.375(c)(2))
    - for the sole purpose of identifying a condition that 1) poses a threat to the public health, and 2) may be avoided, cured, alleviated, or made less contagious through public health intervention (AS 18.15.375 (c)(5))
  - A judicial officer may issue an order for testing of an individual against their will
    - Upon a showing of probable cause, supported by oath or affirmation, that the individual has or may have been exposed to a contagious disease that poses a significant risk to the public health (AS 18.15.375 (d)) [due process provisions: AS 18.15.375 (e)]
  - An individual has the right to refuse treatment and may not be required to submit to involuntary treatment (AS 18.15.380)

Continued on next slide

CSHB 95(JUD): An Act Relating to Public Health

Balancing Individual Rights vs. Common Good

- Limitations placed on governmental public health powers in this bill (Continued from Previous Slide):
  - The department must establish regulations regarding isolation and quarantine, and may only use this method of disease control if it is the least restrictive alternative (AS 18.15.385(a))
  - The department shall isolate or quarantine by the least restrictive means necessary to prevent the spread of disease, including allowing individuals to choose to remain in their own home if to do so would not jeopardize the public's health (AS 18.15. 385(b)(1))
  - The department shall regularly monitor health status of quarantined/isolated individuals, and shall immediately terminate an isolation and quarantine order when the subject poses no substantial risk of transmitting the disease to others (AS 18.15.385(b)(5))
  - The department shall obtain a court order for isolation/quarantine if the individual refuses, and must provide an affidavit signed by a state medical officer that the individual poses a substantial risk to public health (AS 18.15.385(d))
  - The department may issue an emergency administrative order for isolation/quarantine only from a state medical officer and only when there is probable cause to believe that delay in imposing isolation/quarantine would pose a clear and immediate threat to public health (AS 18.15.385(e))
  - The court may commit individual to isolation/quarantine only through finding by clear and convincing evidence that it is necessary to prevent or limit transmission to others of disease that poses a substantial risk to the public health (AS 18.15.385(h) & (i))
  - The department shall adopt regulations to protect the privacy rights of individuals subject to isolation/quarantine (AS 18.15.385(l))

CSHB 95(JUD): An Act Relating to Public Health

Balancing Individual Rights vs. Common Good

- Due process provisions in this bill
  - The department shall obtain an ex parte judicial order for testing an individual who objects to a testing order from the state medical officer (AS 18.15.375(c)(3))
  - An individual subject to an ex parte judicial order for testing may request a hearing to vacate the order (AS 18.15.375(e))
  - The department shall obtain a court order before quarantine/isolation of an individual who objects to quarantine/isolation (AS 18.15.385(d))
  - An individual served with an emergency administrative order of temporary quarantine/isolation has the right to a court hearing (AS 18.15.385(f))
  - An isolated/quarantined individual may apply to the court for termination of isolation/quarantine (AS 18.15.385(j))
  - An individual who is a respondent in proceedings under these statutory provisions has the right to be represented by counsel (AS 18.15.392)