REFORMING ALASKA PUBLIC HEALTH LAW

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Preface and Acknowledgments - Lawrence O. Gostin

The public health law improvement process is the product of many talented and dedicated Alaskans. I had the privilege of listening to and learning from a wide variety of people in law, public health, medicine, nursing, environmental health, epidemiology, and many other disciplines. I was educated by legislators, public health officials, tribal representatives, municipal officials, public health professionals, and volunteers.

I was able to make site visits to the Epidemiology Center Advisory Committee; Alaska Native Health Board; the Division of Public Health Management Team; officials and community members in Kenai and Soldotna; the Anchorage Department of Health and Human Services; the Rural and Alaska Native Community and Public Health Advisory Group; the Rural Governance and Empowerment Commission; the Alaska Municipal League; the Maniilaq Association Staff in Kotzebue; and tribal leaders in the village of Selawik.

I am deeply grateful to the following individuals and others who generously devoted their time to educate me about Alaskan public health: Representative Con Bunde, Myra Munson, Mary Anaruk, Anne Lanier, Jim Cheek, Mike Bradley, Dan Adams, Margaret Wilson, Anne Marie Holen, Karen Perdue, Kristen Bomengen, Karen Pearson, John Middaugh, Pam Muth, Mike Propst, Greg Hayes, Nancy Davis, Al Zangri, Mark Johnson, Brad Whistler, Mike Navarre, Kathy Scott, Jeanne Berger, Rulon Barlow, Bonnie Nichols, Kathy Corrigan, Representative Gary Davis, Representative Mark Hodgins, Mary Jackson, Amy Ragula, John Williams, Susan Fine, Mary Jane Hanley, Carol Histand, Patricia Morrison, Delisa Culpepper, Jan Wills, Mike Huelsman, Lura Morgan, Miles Fujimoto, Bruce Chandler, Jewel Jones, Paul Sherry, Cynthia Navarrette, Tracy Speier, Ruth Bullock, Wendy Craytor, Margaret Wright, Dan Adams, Jim

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I am particularly grateful to several individuals for their deep commitment to this process. The Commissioner of Health and Social Services, Karen Purdue, took a personal interest in this project and met me to discuss its importance and scope. John Middaugh, the State Epidemiologist has long advocated a critical inquiry into public health law in the State. Alaskans owe Dr. Middaugh a debt of gratitude for his years of dedication to public health in the State. Deb Erickson, head of the Alaska Public Health Improvement Process superbly organized this project during every phase. Her professionalism and insights have been indispensable to the process.

Finally, and most importantly, I want to acknowledge Peter Nakamura, Director, Division of Public Health. It is not often that the head of public health in a state takes a full week out of his schedule to listen to community perspectives on public health. Dr. Nakamura educated me a great deal during our week of travel together. His exceptional commitment to public health in Alaska reflects well upon the State.

This report, in many senses, does not contain original ideas. My job was to listen and to reflect on the advice and counsel I received from all of these experienced and dedicated professionals and volunteers.

It will be evident that for at least part of the report the purpose was to broadly educate readers about the field of public health law. Public health leaders, workers, and volunteers in Alaska were uniformly intrigued with public health law, and demonstrated enthusiasm for the subject. For those readers seeking more information on public health law, I am working on a book

on this subject, and some of the information in this report is derived from my work on the book.

See LAWRENCE GOSTIN, AMERICAN PUBLIC HEALTH LAW (University of California Press, Forthcoming 1999).

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REFORMING ALASKA PUBLIC HEALTH LAW

Executive Summary

This project report, produced as part of the Alaska's Public Health Improvement Process (APHIP), assesses and reviews the laws supporting the public health system in the State of Alaska for the purpose of making recommendations on reforming state public health law and improving relationships among public health actors at the federal, state, local, and tribal levels of government.

"Public health" has been defined as "what we, as a society, do collectively to assure the conditions for people to be healthy." Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. It is the study of the legal powers and duties of the state to assure the conditions for people to be healthy and the limitations on the power of the state to constrain legally-protected interests of individuals to promote community health.

While the United States Constitution does not obligate governments to act in the interests of public health, it does allocate power among the federal government and the states [federalism], divide power among the three branches of government [separation of powers], and limit government power [to protect individual liberties]. The federal government draws its expansive authority to act in the field of public health from specific, enumerated powers. The federal government has the power to raise revenue for public health services and to regulate, both directly and indirectly, private activities that endanger human health. Principles of new federalism question the extent to which federal powers may lawfully extend into areas of traditional state concern (such as public health).

States are the primary repository of public health powers. State police powers, or the inherent authority of the state to protect, preserve, and promote the health, safety, morals, and general

welfare, represent the residual authority to act for the public health. Local governments, including counties [or boroughs], municipalities, and special districts, share public health authority through delegations of state police power, or "home rule."

Like the federal Constitution, the Alaska Constitution sets limits on the powers of the state while providing affirmative grants of governmental powers. The State of Alaska constitution guarantees many individual rights (including a right to privacy) and authorizes the State legislature to promote and protect public health and public welfare and organize the state into boroughs, cities, and other municipal governments. The Alaska legislature has enacted an array of statutes which generally authorize various state and local governmental agencies and departments to regulate and carry out traditional public health functions.

While several state agencies regulate in the interests of public health, most public health functions are centrally administered, if not performed directly, 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 regulating public health matters related to the control of communicable diseases, administration of public health care, and some issues of public safety. DEC is delegated the authority to regulate environmental threats to health, including public health nuisances.

Alaska's boroughs and cities are classified by statutory law and delegated varied public health powers based on their particular classification. The Alaska legislature has also statutorily provided health information privacy and anti-discrimination protections.

Alaska Native villages and tribal groups owe their legal existence and many of their public health powers to the federal government. Congress has previously assumed direct responsibility for

the provision of health care to tribal governments. More recently, Congress has 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. Nevertheless, the extent of state influence over tribal governments is conditioned on the recognition of the federal partnership with tribal governments. This dual recognition of tribal health authorities as federal partners and local governments raises questions concerning the responsibilities these tribal governments share with state and other local governments for the public health.

Within this legal structure of public health law in Alaska, reform is recommended to promote more effective decision-making and protect individual rights. Despite 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 permissible degree of local flexibility; (3) serving as a tool of prevention to create the conditions for people to be healthy; and (4) facilitating planning and coordination of governmental and non-governmental health activities. Many benefits could be achieved through a public health improvement process including updating antiquated laws; reflecting modern scientific understanding of diseases and unhealthy conditions; modernizing current standards in individual protections, disability discrimination, and health information privacy; and, perhaps most importantly, clarifying the legal powers, duties, and relationships of various state, local, and tribal actors.

Improving the relationships among public health authorities as part of an ongoing dialogue has been an important first step in improving working relationships in public health throughout Alaska. Continued efforts must be made to open discussion and improve the working relationships

between federal and state authorities, state and local governments, and state and tribal actors. DHSS and DEC should continue to work together to promote inter-agency coordination.

While acknowledging the risks and problems associated with public health law reform, we propose several guidelines for public health law improvement. First, Alaskan law reform should express a clear vision for public health which articulates the best theory and practice in public health and make an asparational statement about assuring the conditions necessary for the health of the people. Second, public health regulations should be based on uniform provisions that apply equally to all health threats to eliminate unnecessary fragmentation of laws according to the type of disease or condition to be regulated. Third, public health interventions should be based on the degree of risk, the cost and efficacy of the response, and the burdens on human rights.

Fourth, public health 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. Fifth, public health officials should have a wide range of powers to accomplish their mission. By legislatively implementing a series of flexible and graded series of alternatives, public health can be protected and individual rights respected. Sixth, public health law should ensure fair procedures depending 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.

Finally, public health law must develop a strong public health information infrastructure which accommodates issues of health information privacy while ensuring up-to-date information for public health purposes. To further privacy protections, public health authorities should adhere to fundamental information privacy practices, including: (a) providing justification for data collection;

(b) providing the community information about aggregate data collection by public health departments and its purposes; (c) eliminating secret data systems; (d) allowing persons to access data about themselves; (e) ensuring the reliability and accuracy of data; (f) attaching legally binding assurances of privacy to all personally-identifiable information such as non-disclosure provisions; (g) establishing security protections for data; and (h) imposing penalties for unauthorized disclosures and security for non-public health purposes.

Legal reform may not dramatically improve the complex inter-relationships among Alaskan public health authorities. Several options for improving relationships, particularly those among state/tribal and state municipalities, include raising and resolving disputes on a case-by-case basis or through planned discussions or formal conflict resolution procedures. A final option is to formalize and clarify the structure of these relationships before conflicts arise.

Through these recommendations, Alaska may capitalize on its distinct and highly innovative sense of community health and intense interest and commitment in public health by rebuilding its public health law infrastructure and improving core public health relationships.

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

Introduction

The preservation of the public health is among the most important goals of government. In its 1988 report, THE FUTURE OF PUBLIC HEALTH, the Institute of Medicine strongly recommended that the United States reform its public health infrastructure, training capacity, and body of enabling laws and regulations. More recently, the United States Department of Health and Human Services recommended public health law reform as part of its "Healthy People 2010" initiative. In response, some states have updated and revised their public health laws. Most states, however, have not. The law in many states remains ripe for reform. Because law enables government to exercise public health powers, outdated laws may thwart public health goals.

This report reviews the laws supporting the public health system in the State of Alaska. Alaska's public health laws pre-date statehood. The State public health system is deeply complex, with intricate relationships among the federal government (including the Indian Health Service, Centers for Disease Control and Prevention, Environmental Protection Agency, and Department of Defense), 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. The fact that Alaska has comparatively recently attained statehood and has a governing structure involving state, municipal, rural, and tribal entities, presents a unique opportunity for the State to improve its public health system and its supporting legal

infrastructure. Through proper reform, Alaska can become a model for public health and public health law in America.

The Alaska Public Health Improvement Process

This project on public health law is part of Alaska's Public Health Improvement Process (APHIP) (*www.hss.state.ak.us/dph/aphip/home.htm*), supported by a grant from the Robert Wood Johnson Foundation. In addition, local public health partnerships in the communities of Sitka, Fairbanks, and Central Kenai Peninsula have each been awarded grants from the W.K. Kellogg Foundation to strengthen the public health system. The Robert Wood Johnson and W.K. Kellogg Foundation's joint initiative, *Turning Point: Collaborating for a New Century in Public Health*, also provides technical support for state and community public health partnerships. The Alaska Division of Public Health was awarded a *Turning Point* grant for conducting a statewide, collaborative effort to study the current public health system, recommending changes to strengthen the system, and developing strategies for implementation. The State asked the Georgetown/Johns Hopkins Program on Law and Public Health to assist the Alaska Division of Public Health with an assessment of the public health system. Particularly, the Division seeks greater understanding of the current constitutional and legal structure of public health powers in Alaska, with a view toward improving the legal infrastructure.

The project has been conducted in two phases. **Phase I** involved consultations, fact finding, and planning to ascertain the needs of the State, tribes, and local communities. This phase involved a fact finding mission to Alaska with site visits and intensive interviews with state and local legislators and their aides, state and local health and environmental officials, tribal authorities and Native health workers, legal experts, and many dedicated professionals and volunteers working for the health of Alaskan communities. The names of many of these dedicated individuals are provided in the Preface

and Acknowledgments in this report. **Phase II** focused on the preparation of this report which examines the major constitutional and legal aspects of public health law.

This report provides guidelines for law reform which could evolve into a new set of public health laws for Alaska that would be a model for other states. On the other hand, Alaska may choose not to reform its law. The decision to statutorily implement these guidelines requires complex political, legal, and public health decision-making processes that are for the State of Alaska alone to consider.

This report provides both a general and sometimes specific review and analysis of public health law. First, the report reviews public health law, particularly issues of federalism in public health. Second, the report examines the current status of Alaska law. Third, the report explains the importance of the public health law improvement process. Finally, the report provides guidelines for reforming Alaskan public health law.

Having met with individuals across the State who work and volunteer in many different capacities, I [LOG] have been impressed by the knowledge of public health and community needs. More importantly, I have been inspired by the deep commitment to healthy communities shown by all those who are involved in the public health improvement process — the State, Native Alaskan and Indian tribal governments, and local governments.

Public Health Law: A Review

A Definition of Public Health Law

At the crux of the field of public health law is the definition of public health. Public health has historically been associated with the control of communicable diseases and the improvement of unsanitary or unsafe conditions in the community. Public health is actually more encompassing. Modern definitions of public health vary widely, ranging from the utopian conception of the World Health Organization of an ideal state of physical and mental health[2] to definitions which merely list common public health practices.[3] The Institute of Medicine has proposed one of the most influential contemporary definitions of public health which, though simply stated, is quite accurate:[4] "Public health is what we, as a society, do collectively to assure the conditions for people to be healthy."

Building on this definition of public health, we define ***public health law*** in the following way:

> *public health law is 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.*

From this definition five essential characteristics distinguish public health law from the fields of medicine and the 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.

(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.

Having distinguished public health law from other fields through the setting forth of broad parameters, it is necessary to further examine the concept of public health law in our constitutional system of government.

Constitutional Authority for Public Health Powers

The United States Constitution is the starting point for any analysis concerning the distribution of governmental powers. Though the Constitution is said to impose no affirmative obligation on governments to act, to provide services, or to protect individuals and populations, it does serve three primary functions: it (1) allocates power among the federal government and the states (federalism), (2) divides power among the three branches of government (separation of powers), and (3) limits government power (to protect individual liberties).[5] In the realm of public health, then, 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.[6]

If the Constitution is a fountain from which governmental powers flow, federalism represents a partition in the fountain which separates federal and state powers.[7] By separating the pool of legislative authority between two tiers of government, federalism preserves the balance of power

among national and state authorities. Theoretically, the division of governmental powers is distinct and clear. The federal government is a government of limited power whose acts must be authorized in the Constitution. The states, by contrast, retain the powers they possess as sovereign governments.[8] These powers include the power to protect the health, safety, morals, and general welfare of the population (police powers) and to protect the interests of minors, incompetent persons, and other specific individuals (*parens patriae* powers). In practice, however, the powers of the federal and state governments intersect in innumerable areas of traditional state concern, like public health.

Federalism functions as a sorting device for determining which government, federal or state, may legitimately respond to a public health threat. Often, inter-level governments may exercise public health powers concurrently. Where conflicts among national and state or tribal governments arise, however, federal laws and regulations likely preempt state or tribal actions pursuant to the federal constitutional Supremacy Clause (the "Constitution, and the Laws of the United States . . . and all Treaties made . . . shall be the supreme law of the Land.").[9]

In addition to establishing a federalist system, the Constitution separates governmental powers into three branches: (1) the legislative branch (which has the power to create laws); (2) the executive branch (which has the power to enforce the laws); and (3) the judicial branch (which has 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 which is thought to reduce the possibility of government oppression.

A third constitutional function is to limit government power to protect individual liberties. Government actions to promote the communal good often infringe on individual freedoms. Public

health regulation and individual rights may directly conflict. Resolving the tension between population-based regulations and individual rights requires a trade-off. Thus while the Constitution grants extensive powers to governments, it also addresses this trade-off through the declaration of individual rights which government cannot infringe without some level of justification. The Bill of Rights (the first ten amendments to the Constitution), together with other constitutional provisions,[10] 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.

Understanding and defining the limits of public health powers by the federal, state, and tribal governments is thus dependent on our constitutional system of government. In the following sections, the constitutional authority and exercise of public health powers by each of these governments is explored.

Federal Powers

The federal government must draw its authority to act from specific, enumerated 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?

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.[11] For public health purposes, the chief powers are the power to tax, to

spend, and to 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.

State Powers: Police Powers

Despite the broad federal presence in modern public health regulation, states have historically and contemporaneously had a predominate role in providing population-based health services. States still account for the majority of traditional spending for public health services (not including personal medical services or the environment).[12] The Tenth Amendment of the federal Constitution reserves to the states all those powers not otherwise given to the federal government nor prohibited to the states by the Constitution.

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:

> *The inherent authority of the state (and, through delegation, local government) to enact laws and promulgate regulations to protect, preserve and promote the health, safety, morals, and general welfare of the people.*

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. 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. The police powers enable state and local governments to promote and preserve the public health in areas ranging from injury and disease prevention[13] to sanitation and water and air pollution.[14] Police powers exercised by the states include laws authorizing vaccination,[15] isolation and quarantine,[16] inspection of commercial and residential

premises,[17] abatement of unsanitary conditions or other health nuisances,[18] regulation of air and surface water contaminants as well as restriction on the public's access to polluted areas,[19] standards for pure food and drinking water,[20] extermination of vermin,[21] fluoridization of municipal water supplies,[22] and licensure of physicians and other health care professionals.[23]

Local Powers

In addition to the significant roles which federal, state, and tribal 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 which local governments have to enact public health law or policies must be delegated from the state. Such delegations 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. These delegations of power may be protected against withdrawal or infringement by state constitutions or statutes. Absent constitutionally-protected delegations of power to local governments, however, states may modify, clarify, preempt, or remove "home rule" powers of local government at will.

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 to which local governments must adhere in setting or implementing public health policies.

New Federalism

Since the inception of the American constitutional history, the judiciary has seen the division of federal and state governmental powers as integral in our federalist system of government. Courts have balanced conflicting state and federal claims of authority to regulate the public health, at least in part, by whether the subject of regulation fits neatly within traditional understandings of the police power.

Despite the accepted ability of the federal government to enter the field of public health, American politics and jurisprudence has entered an era where the political process has emphasized and the Supreme Court has placed enforceable limits on Congress' powers. What has been coined *new federalism*[24] is a principle of political change spurred by mini-revolutions among the states and judicial activism that is enveloped in the idea that the existing powers of the federal government should be limited and returned to the states.[25] The modern question of new federalism is at what point does federal intrusion into predominantly state matters exceed the limits of federal powers.

The Supreme Court's decision in *United States v. Lopez,*[26] along with several non-commerce clause cases, is reflective of the judicial trend.[27] In *Lopez,* the Court held that Congress exceeded its Commerce powers by making gun possession within a school zone a federal criminal offense.[28] Concluding that possessing a gun within a school zone did not "substantially affect" interstate commerce, the Court declared the statute unconstitutional.

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, environmental regulations that direct states to adopt or enforce a federal regulatory scheme[29] or loosely preemptive federal laws[30] which invade core state concerns in public health.

The Current Status of Alaska Public Health Law

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 State of 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,[31] equal protection,[32] freedom of religion[33] and speech,[34] and a prohibition against unreasonable searches and seizures.[35]

The Alaska constitution also provides additional protections of individual rights through provisions not explicitly stated in the federal Constitution. Notable among these additional protections in Alaska is an explicit constitutional right to privacy[36] pertaining to governmental intrusions. The scope of state privacy rights is largely undefined[37] and dependent on the circumstances.[38] Alaska courts have interpreted the state constitution to provide broader privacy protections than the federal Constitution.[39] The right, however, is not absolute.[40] Provided government can show that an abridgment of the right to privacy is justified by a legitimate and compelling governmental interest, governmental action is likely constitutional.[41]

Unlike the federal Constitution and most other state constitutions as well, the Alaska Constitution explicitly authorizes the State legislature to "provide for the promotion and protection of public health,"[42] and "provide for public welfare."[43] These provisions seemingly require the state legislature to act to protect public health and promote the public welfare. However, 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.[44] 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.[45] 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*,[46] 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. The same court subsequently rejected a similar claim concerning the personal use of cocaine within one's 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.[47]

The Alaska Constitution also authorizes the state legislative body to organize the state into incorporated[48] and unincorporated [49]boroughs [which are similar to counties in other states] and incorporated cities within these boroughs.[50] Boroughs and cities are delegated liberal "home rule" powers to exercise legislative powers not otherwise prohibited by or inconsistent with state law.[51] Statutory law enacted pursuant to this constitutional authorization further defines and classifies boroughs and cities,[52] and clarifies the extent of their home rule authority.

Alaska Public Health Law

Pursuant to explicit constitutional authorization, the Alaska state legislature has enacted an array of statutes which generally authorize various state and local governmental agencies and departments to regulate and carry out traditional public health functions. As in most states, there are multiple state agencies in Alaska which regulate in the interests of public health. These 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 centrally administered, if not performed directly, by one of two state agencies, the Department of Health and Social Services (DHSS)[53] (www.hss.state.ak.us) and the Department of Environmental Conservation (DEC)[54] (www.state.ak.us/dec). 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. DEC is delegated the authority to regulate environmental threats to health, including the control of public health nuisances through licensing and monitoring of relevant commercial and noncommercial establishments.

Department of Health and Social Services (DHSS)

DHSS and its many divisions, including the Division of Public Health (www.hss.state.ak.us/dph), are headed by the Commissioner of Health and Social Services.[55]

Most traditional public health duties and functions are broadly delegated to DHSS through loosely-defined authorizations by the state legislature. DHSS is statutorily authorized in general to (1) "administer laws and regulations relating to the promotion and protection of the public health;" (2) control communicable diseases[56] including tuberculosis and other "diseases of public health significance;"[57] (3) conduct programs concerning maternal and child health; and (4) perform "other duties provided by law."[58]

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 (including, for example, the provision of planned parenthood information,[59] licensing of child care facilities,[60] registration of midwifery birth centers,[61] and study of fetal alcohol effects[62]); preventive medical services; public health nursing; nutrition services; health education; public health laboratories;[63] mental health services; management of state institutions (other than corrections facilities) and medical facilities; the registration of persons with impairments,[64] and "general relief."[65]

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. Pursuant to Title 18, DHSS is authorized, among other things, to coordinate the creation of a statewide emergency medical services system,[66] establish a comprehensive program for the control of tuberculosis[67] and other infectious diseases including HIV/AIDS, accumulate vital statistics,[68] regulate levels of quality and other factors concerning hospitals,[69] monitor asbestos levels,[70] monitor the presence of radioactive materials in the state,[71] and coordinate, with

the Alaska Department of Labor and other agencies, to prevent occupational accidents and injuries and promote housing safety.[72]

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

Department of Environmental Conservation (DEC)

The Department of Environmental Conservation (DEC) has primary authority for additional, significant public health efforts.[73] DEC is the state's primary environmental protection agency. DEC has also been assigned responsibility for abating public health nuisances[74] that are primarily environmental in nature. Specific duties of DEC include the coordination and development of state-wide environmental policies and the setting of standards governing air, water, surface, and subcutaneous pollution;[75] the prevention of public health nuisances;[76] maintaining health standards in places of public accommodation (including the prohibition of smoking in certain public places);[77] and the regulation of 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 non-commercial establishments (e.g. schools and any "other similar establishments in which lack of sanitation may create a condition that causes disease").[78]

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 pollution. 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. Through its Environmental Sanitation and Food Safety Program, this Division inspects over 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. The Division of Spill Prevention and Response regulates in areas of environmental contamination, including underground storage tanks. Like DHSS, DEC has the delegated authority to establish and enforce administrative regulations.

As mentioned above, some public health functions undertaken by government agencies in Alaska 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. While dual responsibility will in many 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.

Public Health Information Privacy

Consistent with the state constitutional right to privacy, the Alaska legislature has enacted laws to protect the confidentiality of personal medical and public health records.[79] 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."[80] Health information privacy protections are often coupled with anti-

discrimination protections that prohibit discrimination against individuals on account of their physical or mental disabilities. Although the federal Americans with Disabilities Act[81] 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.[82]

Municipal/Local Adoption of Public Health Powers

As mentioned above, Alaska has constitutionally provided for the establishment of boroughs and cities and delegated home rule authority to these subsidiary governments in the discretion of the state legislature. Alaska statutory law classifies boroughs and cities, and subsequently clarifies their home rule powers. The state's seventeen incorporated boroughs are classified as either first, second, or third class. Cities in the state may be designated as first or second class.[83] Boroughs or cities are further classified as either "home rule municipalities," which are local governments that have adopted a home rule charter. These local governments have legislative powers not otherwise prohibited by state law or charter.[84] "General law municipalities" are unchartered boroughs or cities. Their legislative powers must be specifically conferred by state law.[85]

While Alaska statutory law does not specifically define the relationship between the state and local governments concerning public health responsibilities, the classification of these

subsidiary governmental units is important toward examining the degree of public health powers delegated to the local government. For example, first-class boroughs may ordain 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.[86] 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.[87] First- or second-class boroughs may acquire additional powers by holding an area wide election on the issue.[88] In 1998, for example, residents of Kenai Peninsula Borough voted (albeit unsuccessfully) as to whether to allow the local government to extend animal control policies to areas outside cities in the borough.[89]

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.[90] Similar delegations of home rule powers apply to cities depending on whether they exist within or outside a borough.[91] Cities may also transfer their powers to the boroughs in which they exist.[92] Only one third-class borough exists in the State. No additional boroughs of the third class may be created.

Alaska delegates some 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,[93] regulate the sale and consumption of alcoholic beverages,[94] create a program for the reporting of hazardous chemicals, materials, or wastes,[95] take advantage of incentives in the form of state funds to establish health facilities and hospitals,[96] and receive grants of state

funds to clean up or prevent oil and hazardous substance spills.[97] 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).[98] These health units or districts are not assigned specific duties, other than to report to the Commissioner of Health and Social Services.[99] Despite their authorization under state law, DHSS reports that there are no functional health units or districts, as defined by law, in Alaska.

Tribal Public Health Powers[100]

Unlike the state executive agencies and local governments which have been established and vested with public health powers via the state constitution and statutory laws, Alaska's many tribal governments predate statehood. These rich and diverse Alaska Native villages and groups are not "established" pursuant to state law. Rather, their legal existence and many of their public health powers derive from the federal government. The federal 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.

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. 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. When Russia sold the territory of

Alaska to the United States in 1867, the treaty executing the exchange secured similar terms for Alaska Natives. In 1971, the Alaska Native Claims Settlement Act[101] (ANCSA) settled all land claims by Alaska Natives and transferred land to state-chartered Native corporations.

Pursuant to the Snyder Act of 1921,[102] Congress directly assumed responsibility for the provision of health care to tribal governments. Such federal assistance continues today through long-term commitments for comprehensive health services administered by the Indian Health Service (IHS) of the federal Department of Health and Human Services (DHHS), and to a lesser extent, the Bureau of Indian Affairs (BIA). 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[103] and the Indian Health Care Improvement Act of 1976.[104] 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.

In 1991, Congress began the IHS Tribal Self-Governance Demonstration Project.[105] 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. 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. As a result, the setting of public health goals and objectives has become a primary responsibility of

local tribal governments. This movement toward self-governance was further solidified with the Congressional enactment of the Tribal Self-Governance Act of 1994.[106]

Village and group members of the AHTC receive their funds directly from IHS. They can use the funds for specific heath programs within their discretion, provided the spending is consistent with the general conditions for federal funding. 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 (*www.anhb.org*) assist with community-wide planning of health services and needs.

Despite their distinct existence and relationship with the federal government, Alaska Natives [other than those living within the Indian reservation of Metlakatla] are also citizens of the state. In *Alaska v. Native Village of Venetie Tribal Government*,[107] 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. The State has civil and criminal jurisdiction over the villages and tribal lands of Alaska Natives. 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. Tribal health organizations are registered as state-chartered nonprofit institutions. To the extent, however, that they originated as federally-sponsored entities, they have been treated by state authorities as federal facilities for certain purposes. For

example, in certain circumstances, health care employees of tribal affiliated health facilities have not been required to be licensed under state law.

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 to establish the Alaska Native Epidemiology Center which surveys rates of disease and other health conditions among Alaska Natives. Tribal governments are also entitled to apply for state public health grants. For example, the St. George Traditional Council has received state funds to support its Community Health Aide Training and Supervision program. Tribal health facilities may treat residents other than Alaska Natives. 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.

The Benefits of a Public Health Law Improvement Process

> *The field of public health is firmly grounded in law and could not exist in the manner in which we know it today except for its sound legal basis.*[108]

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. Public health law should assure that public health agencies are fully capable of responding to current and coming 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 the legislative approach. Many of the problems observable in public health are remedied not primarily though 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 will have to consider prevailing social values and respect multiple constituencies, including scientists, politicians, and community leaders.

The Role of Public Health Law

There are at least four possible roles for the law in advancing public health. Law can define the objectives of public health and influence its policy agenda, authorize and limit public health actions, serve as a tool of prevention, and facilitate planning and coordination of governmental and non-governmental health activities.

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 that will 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.

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[109] 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:

- Establishing clear criteria for the exercise of compulsory powers by requiring health authorities to use scientific evidence of 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;

Public health law is, and should remain, a tool of prevention. Public health law should use a wide variety of legal means to prevent injury and disease by creating the conditions for people to be healthy.

The following benefits could be achieved through a public health improvement process.[110]

Update Antiquated Laws

Alaska public health enabling laws, as explained earlier, pre-date statehood. 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. Certainly, older laws are not necessarily bad laws. A well-written statute may remain useful, efficacious, and constitutional 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 of choice, or constitutional limits on the States' authority to restrict individual liberties.

Keep Pace with Scientific Developments

When the Alaska public health enabling laws were enacted nearly fifty years ago, 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 that is based on contemporary scientific knowledge.

Comply with Modern Constitutional and Other Legal Requirements

The Alaska public health laws predate contemporary developments in constitutional law, disability discrimination law, health information privacy, and other modern legal requirements. As a result, state law may not meet evolving standards enunciated by state and federal courts and legislatures.

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 Constitution may require more rigorous procedural safeguards before exercising compulsory powers.

Federal disability law prohibits discrimination against persons based on their health status, such as an infectious disease. 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. Thus, under this standard, adverse treatment, such as a decision to use compulsory powers, would only be permitted if the person posed a significant risk to the health or safety of others. A significant risk regarding communicable diseases would be determined through an

individualized assessment of the mode of transmission, probability of transmission, severity of harm, and the duration of infectiousness.[111]

Clarify the Law

Discussions with public health authorities in Alaska revealed, at times, confusion about who has what public health powers and when to exercise those powers. This confusion is typical. Given the multiplicity and layer-upon-layer 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.

The Dialogue Process

The public health law improvement process in the State of Alaska has involved passionate, systematic, and highly constructive conversations about the public health system among all different levels of government and community. Discussions ranged from the commissioner level at DHSS and the director level at DHSS and DEC to public health nurses and volunteers; from senior state legislators and their aides to borough and city mayors; and from tribal leaders to Natives concerned about community health.

Even if the Alaska public health improvement process does not stimulate true legal reform, it will have been of considerable value. The dialogue process has contributed to community involvement in many ways. Careful thought has been put into the legal 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. At the beginning of each meeting, for example, the Director of the Public Health, Dr. Peter

Nakamura, would emphasize that he had come to listen and learn about public health in Alaska. This willingness to reflect on public health improvement in Alaska sends a meaningful message to the community. And health authorities learned a great deal from these discussions about public health practice throughout the State.

Improving Relationships

The dialogue process was an important first step in improving working relationships in public health throughout the State. Alaska is almost unique in America for the depth and complexity of its governmental and non-governmental relationships. During the dialogue phase at least six kinds of relationships were discussed.

(i) Legislative and Public Health Authorities

Legislators and public health officials sometimes had markedly different understandings about public health and the role of government. 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. They 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."[112] Legislators and public health authorities need to listen to

one another through discussions which are motivated on the sole issue of improving Alaska's public health system.

The tone of conversations and the relative infrequency of high level discussions in the past suggest the need for more regular communications between public health authorities and legislators. Such communications should not occur mainly in response to the latest political issue. One benefit of public health law reform would be the coming together of public health authorities and legislators for the common good of the people of the State of Alaska.

(ii) Federal and State

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

(iii) State and Local

Most states delegate certain public health functions to their subsidiary local governments. Alaska has not specifically defined local public health powers in state statutes. Rather, several local jurisdictions have "adopted public health powers." What "adoption" of public health powers means is unclear. Different jurisdictions have adopted these powers to a greater or lesser extent.

State and local dialogue on public health is critical in Alaska given the size and diversity of the State. Health officials at the state and local level have cordial and warm relationships and discuss public health issues regularly. Maintaining channels of communication between state and

local public health authorities is important. A lack of regular communication between these authorities could carry serious implications for the public health. If the State, for example, 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 there may be temporary, serious gaps in public health services. For example, DEC decided to discontinue some of its animal and rabies control services (which is an important public health issue in Alaska). DEC had justifiable reasons for discontinuing services (i.e., concerns about worker safety), but localities were not always prepared to replace the services which the State abandoned. Clearly local governments may not be able to assume public health functions previously provided by the State, but early communication may facilitate local resource allocation and perhaps avoid public health repercussions from sudden discontinuances of programs.

(iv) State and Tribal Governments

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, it is possible to think of a concurrent authority (state and tribal) to protect the health of Natives. This requires careful and deliberate coordination. Systematic coordination and ongoing discussion is not always achieved. As a result, there is occasional mistrust between the two entities.

From the perspective of some state officials, there is sometimes a need to intervene in Native communities to avert a public health threat. For example, if the State suspects child abuse, it may seek to investigate or remove the child from an unsafe environment. Tribal authorities

usually cooperate in such cases, but occasionally there exists a difference of opinion about who has jurisdiction. The State of Alaska appears not to recognize tribal authorities as lawful governments.

As discussed above, the United States Supreme Court's decision in *Venetie* appears to settle the question of tribal jurisdiction over land.[113] Tribal communities, however, view themselves as governments with jurisdiction over the land and its peoples. From their perspective (whether actual or misguided), the State often fails to provide Natives with sufficient services such as clean water, sewage, and proper sanitation.

The different theoretical vision of state and tribal authority sometimes leads to mistrust. Public health and tribal authorities have warm personal relationships, but there remains a residual level of misunderstanding. For example, when a highly knowledgeable, senior-level individual representing Native Alaskans was asked if negotiations with the State would be useful, the person expressed the fear that negotiations with the State inevitably meant concession.

There exist pockets of excellence in State/tribal relationships. The Rural and Alaska Native Community and Public Health Advisory Group meets regularly under the co-chairmanship of Dr. Nakamura and Paul Sherry, Executive Director of the Alaska Native Tribal Health Consortium. This group provides a forum for ongoing and deliberative discussions among State and tribal representatives. While the forum is of immense value in improving relationships, members of the group acknowledged the underlying tensions among State and tribal people.

(v) City and Rural

Closely related to State and tribal relationships are the different perspectives of city and rural dwellers. State legislators from urban areas have distinctly different visions of public health

and financial responsibilities than persons from rural communities. It was evident that each constituency lacked some trust in the other. It was equally evident that a constructive and systematic dialogue process would improve relationships.

(vi) The Department of Health and Social Services and the Department of Environmental Conservation

In Alaska, DHSS and DEC share responsibility for ensuring the public health. As a result of this dual system of public health responsibility, it is important for these two agencies to coordinate their efforts. Each requires the expertise and power held by the other to fully accomplish the public health mission. DHSS and DEC certainly work together and desire to strengthen their ties. Yet, dialogue at the senior level and below needs to improve. Stronger relationships, coordination, and dialogue between these two governmental entities would likely improve the public health.

The rich diversity in Alaska is a unique strength. It is evident that all groups want the same thing --- a vibrant public health program. It is impossible not to be deeply impressed with the ideals and work ethic of the State (DHSS and DEC), municipalities, tribes, and others. Yet, it is important to keep the communication process active and vibrant. Communication and coordination should be routine and ongoing, and not simply in response to public health crisis.

Guidelines for Reforming Alaskan Public Health Law

As indicated earlier, the question about whether Alaska should reform its public health law remains open. Law reform is not the inevitable result of the public health law improvement process (although it could be). While this report has discussed many of the benefits of law reform, there are also risks. First, once a bill is introduced in the legislature, it can become politicized. Public health officials, for example, are concerned about a recent experience where the legislature made knowing HIV transmission a criminal offense against the advice of state public health officials. The Governor vetoed the bill, but this example illustrates the politicization of public health law. Second, 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, it could result in great distrust. Despite these evident risks, it is important to see the benefits of public health law improvement. With this in mind, we propose the following guidelines for public health law improvement in Alaska.

Mission Statement: Essential Public Health Services

A recent report by the Columbia University School of Nursing found that most public health laws contain inadequate mission statements: 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.[114]

Alaska's public health law, like other states, does not articulate a clear mission for public health. Nor does Alaskan law spell out core or essential public health services necessary for serving the State. Consequently, Alaskan 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.

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 standards and procedures for different diseases. Thus, the legal environment for controlling health risks depends on how the disease is classified.

A strong argument exists that 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, and the burdens on human rights. These considerations cut across disease classifications.

The Alaskan 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.

Base Public Health Decisions on the Best Scientific Evidence of Significant Risk

In combating public health threats, health officials need both clear authority and flexibility to exercise powers and sufficient guidance. Consequently, an effective and constitutionally-sound Alaskan law requires a rational and reliable way to assess risk and establish fair procedures.

The Alaskan 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: (1) what is the nature of the risk (e.g., the mode of transmission)? (2) what is the probability that the risk will result in harm? (3) what is the severity of harm should the risk ensue? and (4) 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.

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 respected.

Provide Fair Procedures

Public health officials need ample and flexible powers to protect the common welfare. Coextensively, the community needs to have confidence in the fairness of public health practice. Consequently, public health law should ensure fair procedures. The nature and extent of the process required depends upon several factors including: (1) the nature of the interests affected; (2) the risk of an erroneous decision; (3) the value of additional safeguards; and (4) 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.

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 is one of the core functions of public health. Surveillance is among the most important functions of public health, permitting early identification of health threats, targeted delivery of prevention services, and links to treatment and other services. Public health law must enable, encourage, and fund a strong public health information infrastructure, which is the life-blood of public health.

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 these 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." Because of the size of the state 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 will, at times, conflict: ensuring up-to-date information for public health purposes and protecting that information from inappropriate disclosure. Balancing these competing goals can only be accomplished through the implementation of policies and practices consistent with set guidelines. These guidelines are being considered within the context of a "Model Public Health

Privacy" project (*www.critpath.org/msphpa/privacy.htm*) chaired and directed by the authors of this report and sponsored by the Centers for Disease Control and Prevention and the Council of State and Territorial Epidemiologists. The project is designed to produce a model state public health law which, if passed, will codify privacy and security principles concerning the use and disclosure of public health information. The guidelines below concern only personally identifiable data because they pose minimal privacy concerns.

(i) Justification for Data Collection

Public health authorities should justify the need for data collection. Public health authorities should be given flexibility in making these justifications. Thus, valid justifications would include surveillance, disease monitoring, and epidemiological (and related) research; preventing a public health risk; and providing services for the community, including interventions in avoiding and ameliorating public health threats.

(ii) 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 sorts of data collection undertaken by public health departments. Aggregate public health data should be made accessible by community members for virtually any purpose.

(iii) 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.

(iv) 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. Thus, 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.

This model 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 recognizes both public health and privacy interests, and seeks fair resolution in law.

Improving Relationships and Resolving Disputes

Legal reform is unlikely to dramatically improve the complex inter-relationships that have developed in Alaskan public health over decades. During the fact-finding phase, various forms of dispute resolution were thoroughly discussed. Several options for improving relationships, particularly state/tribal and state/municipal relationships, follow. These options are not meant to

be mutually exclusive. It is possible that each could be considered at different times and circumstances.

Option 1: Case-by-Case Resolution

At present, the State and tribes have different theoretical visions of who has governing authority, particularly relating to the exercise of police powers. One option is to resolve disputes on a case-by-case/issue-by-issue basis. For the most part, this is how dispute resolution works in Alaska. In some ways, it works very well. Disputes are rare and in most cases they are peaceably resolved. But, there does exist a residual level of distrust. Some Alaskans want to maintain the *status quo*, and would not wish to formalize or regularize the process.

Option 2: Planned Discussions

This option relies on case-by-case resolution, but adds a planned forum for discussion. Rather than simply reacting in a crisis, this option would engage major public health officials in meaningful and ongoing discussion with community leaders. This could have several beneficial effects. First, it helps to plan in advance to avoid conflicts. Second, it provides a mechanism for responding to crises when they arrive. Third, and most important, it enhances familiarity and trust among different groups.

The Rural and Alaska Native Community and Public Health Advisory Group provides an excellent model for Option 2. This group has not managed to ease all tensions or to resolve all disputes. But, the advisory group has instilled confidence. Some mechanism for regular, routine, and systematic dialogue among groups is essential in Alaska.

Option 3: Formal Conflict Resolution

A third option is to pre-establish a means for resolving differences of opinion. Alternative dispute resolution is popular in progressive legal circles. Some method of mediating disputes might provide a sense of fairness and confidence among different groups.

Option 4: Formalize Relationships

A final option is to formalize relationships. Rather than leaving the structure of relationships unspoken, this method would try to clarify them. This could be accomplished, for example, in memoranda of understanding or even in law or regulation.

Here is a model of how relationships among the state and municipalities could be formalized in law. Public health law would specify what states must do for public health. States must engage in essential public health services to protect the health of the community. Local governments, in turn, could perform services (but not exercise police powers), provided those services were not inconsistent or incompatible with state programs. There is no reason why the state and localities could not offer concurrent and complementary services. There must, however, be coordination to assure that no significant gaps in service occur. Finally, localities could adopt police powers (e.g., personal control measures, inspections, licensure, and nuisance abatement) only with the agreement of the State. Since the State exercises police powers, any exercise by local authorities of these powers should constitutionally be in the form of a delegated power. Again, there should be no reason why the State should not delegate certain police powers to cities. For example, the Municipality of Anchorage undertakes food inspections, and the State is happy to have the city perform this important function.

Improving Coordination Between the Department of Health and Social Services and the Department of Environmental Conservation in Alaska

In Alaska, two agencies (DHSS and DEC) perform essential public health functions. For the most part, this dual system of public health regulation works well. Each department performs its functions and can draw from the considerable expertise within the department. Where one department has particular resources, it is usually willing to lend its expertise to the other department. For example, if DEC requires expertise relating to new epidemiology, it can turn to the Division of Public Health within DHSS for assistance.

The State may exercise two primary options to improve coordination of public health services. It can maintain the status quo whereby assistance is asked for, and granted, on a case-by-case basis. Alternatively, DEC and DHSS can establish formal structures to promote communication and coordination. 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.

Conclusion

Alaska is unique in many ways. It is a new state; it has a distinct and highly innovative sense of community health; and it has many public and private groups intensely interested in public health. This provides an important opportunity to improve the public health system, including the public health law infrastructure. The commitment to public health improvement among all groups in the State is admirable.

The major benefit of the public health law improvement process is not the guidelines themselves, but the process of education and inquiry. Alaska tentatively plans a Phase III of this project which will include education, continued dialogue, dissemination, due deliberation, and possible implementation. Phase III is highly recommended to ensure that the Alaskan public health improvement process comes to fruition.

ENDNOTES

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

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

3. *See, e.g.*, C. E. A. Winslow, book title and page.

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

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

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

7. James G. Hodge, Jr., *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH LAW & POLICY 93, 97 (1997).

8. Gibbons v. Ogden, 22 U.S. 1, 87 (1824) ("The constitution gives nothing to the States or the people. Their rights existed before it was formed; and are derived from the nature of sovereignty and the principles of freedom.").

9. U.S. CONST. Art. VI, cl. 2.

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

11. McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316 (1819).

12. INSTITUTE OF MEDICINE, THE FUTURE OF PUBLIC HEALTH 178-183 (1988).

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

14. 39 AM. JUR.2d Health §§ 22, *et seq.* (1968) (state citations omitted).

15. Zucht v. King, 260 U.S. 174 (1922).

16. Leisy v. Hardin, 135 U.S. 100 (1890).

17. Givner v. State, 124 A.2d 764, 774 (Ct. App. Md. 1956); See v. Seattle, 387 U.S. 541, 550-52 (listing historical examples of state inspection) (Clark, J., dissenting) (1967).

18. Jones v. Ind. Livestock Sanitary Bd., 163 N.E.2d 605, 606 (Ind. 1960); Francis v. La. St. Livestock Sanitary Bd., 184 So.2d 247, 253 (La. 1st Cir. 1966).

19. Oklahoma ex rel. Corp Comm'n v. Texas County Irrigation & Water Res. Ass'n, Inc., 818 P.2d 441 (Okla. 1991).

20. Strandwitz v. Board of Dietetics, 614 N.E.2d 817, 824 (Ct. App. Oh. 1992).

21. Kaul v. Chehalis, 277 P.2d 352, 354 (Wash. 1955) (en banc).

22. Safe Water Ass'n, Inc. v. Fond Du Lac, 516 N.W.2d 13, 15 (Ct. App. Wis. 1994); Douglas A. Balog, *Note, Fluoridation of Public Water Systems: Valid Exercise of State Police Power or Constitutional Violation?*, 14 PACE ENVTL. L. REV. 645 (1997).

23. State v. Otterholt, 15 N.W.2d 529, 531 (Iowa 1944); Adams v. Dept. of Health & Human Resources, 458 So.2d 1295,1298-99 (La. 1985).

24. 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).

25. Richard C. Reuben, *The New Federalism*, ABA J., Apr. 1995, at 76-77.

26. United States v. Lopez, 115 S.Ct. 1624 (1995).

27. *See, .e.g.*, Printz v. United States, 117 S.Ct. 2365 (1997); Seminole Tribe v. Florida, 517 U.S. 44 (1996); New York v. United States, 505 U.S. 144 (1992).

28. United States v. Lopez, 115 S. Ct. 1624 (1995).

29. New York v. United States, 505 U.S. 144 (1992).

30. Gregory v. Ashcroft, 501 U.S. 452 (1991).

31. ALASKA CONST. Art. I, §§ 1, 7.

32. ALASKA CONST. Art. I, § 3.

33. ALASKA CONST. Art. I, § 4.

34. ALASKA CONST. Art. I, § 5.

35. ALASKA CONST. Art. I, § 14.

36. ALASKA CONST. Art. I, § 22. "The right of the people to privacy is recognized and shall not be infringed."

37. Ravin v. State, 537 P.2d 494 (Alaska 1975).

38. State v. Glass, 583 P.2d 872 (Alaska 1978).

39. Messerli v. State, 626 P.2d 81 (Alaska 1980).

40. State v. Erickson, 574 P.2d 1 (Alaska 1978).

41. Messerli v. State, 626 P.2d 81 (Alaska 1980).

42. ALASKA CONST. Art. VII, § 4.

43. ALASKA CONST. Art. VII, § 5.

44. Ravin v. State, 537 P.2d 494 (Alaska 1975).

45. Rowe v. Burton, 884 F. Supp. 1372 (D. Alaska 1994).

46. 537 P.2d 494 (Alaska 1975).

47. State v. Erickson, 574 P.2d 1 (Alaska 1978).

48. ALASKA CONST. Art. X, § 3.

49. ALASKA CONST. Art. X, § 6.

50. ALASKA CONST. Art. X, § 7.

51.ALASKA CONST. Art. X, §§ 1, 10, 11.

52. ALASKA STAT. §§ 29.03 *et seq.* (Michie 1997).

53. ALASKA STAT. §§ 44.29.010 *et seq.* (Michie 1997).

54. ALASKA STAT. § 44.46.010 (Michie 1997).

55. ALASKA STAT. § 44.29.010 (Michie 1997).

56. ALASKA STAT. § 18.05.040(1) (Michie 1997).

57. ALASKA STAT. § 18.05.040(1) (Michie 1997).

58. ALASKA STAT. § 18.05.010 (Michie 1997).

59. ALASKA STAT. § 18.05.035 (Michie 1997).

60. ALASKA STAT. § 44.29.020 (Michie 1997).

61. ALASKA STAT. § 18.05.040(10) (Michie 1997).

62. ALASKA STAT. § 18.05.037 (Michie 1997).

63. ALASKA STAT. § 18.05.040(8) (Michie 1997).

64. ALASKA STAT. § 18.05.044(a-c) (Michie 1997). Persons with impairments are statutorily defined as those with a physical or mental condition that, if not otherwise corrected, materially limits individual activities or functioning.

65. ALASKA STAT. § 44.29.020 (Michie 1997).

66. ALASKA STAT. §§ 18.08.010 - 18.08.090 (Michie 1997).

67. ALASKA STAT. §§ 18.15.120 - 18.15.149 (Michie 1997).

68. ALASKA STAT. §§ 18.50.010 - 18.50.990 (Michie 1997).

69. ALASKA STAT. §§ 18.20.010 - 18.20.390 (Michie 1997).

70. ALASKA STAT. §§ 18.31.010 - 18.31.500 (Michie 1997).

71. ALASKA STAT. §§ 18.45.030(1) (Michie 1997).

72. ALASKA STAT. §§ 18.60.010 - 18.60.850 (Michie 1997).

73. ALASKA STAT. § 46.46.020 (Michie 1997).

74. FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL 16-17 (1990).

75. ALASKA STAT. § 46.46.020(1-3) (Michie 1997).

76. ALASKA STAT. § 46.46.020(5)(A) (Michie 1997).

77. ALASKA STAT. §§ 18.35.010 - 18.35.365 (Michie 1997).

78. ALASKA STAT. § 46.46.020(5)(B, C) (Michie 1997).

79. ALASKA STAT. § 09.25.120 (Michie 1997).

80. ALASKA STAT. § 09.25.120 (Michie 1997).

81. 42 U.S.C. §§ 12101-201 (1992).

82. ALASKA STAT. §§ 18.80.010 - 18.80.300 (Michie 1997).

83. ALASKA STAT. § 29.04.030 (Michie 1997).

84. ALASKA STAT. § 29.04.010 (Michie 1997).

85. ALASKA STAT. § 29.04.020 (Michie 1997).

86. ALASKA STAT. § 29.35.200 (Michie 1997).

87. ALASKA STAT. § 29.35.210 (Michie 1997).

88. ALASKA STAT. § 29.35.300 (Michie 1997).

89. Heather A. Resz, *Animal Issues Goes to Voters*, PENINSULA CLARION, July 16, 1998, at A1.

90. ALASKA STAT. § 29.35.220 (Michie 1997).

91. ALASKA STAT. §§ 29.35.250, 260 (Michie 1997).

92. ALASKA STAT. § 29.35.310 (Michie 1997).

93. ALASKA STAT. § 29.35.055 (Michie 1997).

94. ALASKA STAT. § 29.35.080 (Michie 1997).

95. ALASKA STAT. § 29.35.500 (Michie 1997).

96. ALASKA STAT. § 29.60.120 (Michie 1997).

97. ALASKA STAT. § 29.60.500 (Michie 1997).

98. ALASKA STAT. §§ 18.10.010 *et seq.* (Michie 1997).

99. ALASKA STAT. § 18.10.050 (Michie 1997).

100. *See, e.g.*, Maniilaq Association, *Self-Determination for Health Care Delivery* (1998).

101. 43 U.S.C. § 1601 *et seq.* (1996).

102. 25 U.S.C. § 13 (1997).

103. P.L. 93-638.

104. 25 U.S.C. §§ 1601-1683 (Supp. 1998).

105. 25 U.S.C. § 450f (Supp. 1998).

106. 25 U.S.C. § 450 (Supp. 1988).

107. ___ U.S. ___, 118 S. Ct. 948 (1998).

108. FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL (2d ed. 1990).

109. 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.

110. *See, e.g.*, Lawrence O. Gostin, Scott Burris, and Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUMBIA L. REV. 59 (1999).

111. *See* Lawrence O. Gostin, Chai Feldblum, & David W. Webber, *Disability Discrimination in America*, 281 JAMA 745, 746 (1999).

112. LAWRENCE O. GOSTIN, SCOTT BURRIS, ZITA LAZZARINI & KATHLEEN MAGUIRE, IMPROVING STATE LAW TO PREVENT AND TREAT INFECTIOUS DISEASE (Milbank Memorial Fund) (1998).

113. ___ U.S. ___, 118 S. Ct. 948 (1998).

114. 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).