Alaska:
A Case Study in Public Health Law Reform & the Turning Point Model Public Health Act

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The Turning Point Model State Public Health Act (Turning Point Act), published in September 2003, provides a comprehensive template for states interested in public health law reform and modernization. This case study is the first in a series examining the political and policy efforts undertaken by states following the development of the Turning Point Act. Through this eighteen-month project, we will compare four to five states that have acted (or failed to act) to reform their public health laws pursuant to the Turning Point Act. Through this comparative case study and ongoing legislative tracking in all fifty states, we can investigate how the Turning Point Act is codified into state law and how these modernized state laws can influence or change public health practice, leading to improved health outcomes. The series of case studies is intended to provide the public health practice community with information that can facilitate successful modernization of public health statutes across the country and inform scholarship on the role of law and policy in building enhanced public health infrastructure.

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For years, many public and private sector policymakers, scholars, and public health officials have argued that state-based public health laws are ripe for reform.[1] From 2000 to 2003, the Turning Point Public Health Statute Modernization Collaborative (Turning Point Collaborative) brought together representatives from five core states (Alaska, Colorado, Nebraska, Oregon, and Wisconsin) and multiple other state and local public health partners to study and assess state public health law.[2] From its inception, the Turning Point Collaborative set the aggressive goal of developing of a model act for state public health law. Alaska was selected as the lead state for this effort, with one of its representatives serving as the Chair of the project. Following three years of public meetings, drafting, input, and discussions, the Turning Point Collaborative released the final version of the Turning Point Model State Public Health Act (Turning Point Act).[3] As a model set of laws for state public health law modernization, the Turning Point Act serves as a tool or template for states, tribal governments, and local municipalities considering core public health legal reforms.

Alaska was identified as the first case study in this series for several reasons, including: (1) public health officials from Alaska were leaders in the Turning Point Collaborative that produced the Turning Point Act and (2) these same leaders had consistently intended to use the Turning Point Act to reform Alaska state public health law. This case study describes and assesses the ways in which the Turning Point Act was used in Alaska to modernize state public health laws. Attempts to reform Alaskan public health law pursuant to the Turning Point Act were made in two consecutive sessions of the Alaska legislature, with only the latter leading to statutory reform. Considering the divergent underlying conditions that caused these different policymaking results, this

research analyzes the major independent variables to which informants attribute the failure or success of each respective modernization effort. In so doing, we seek to elucidate approaches more likely to support passage of public health law modernization efforts, providing information to policy-makers and public health officials on how to frame future public health law reforms.

I. Background

Congress granted statehood to Alaska in 1958, making it the forty-ninth state. For this reason, the legal structure of Alaskan public health is considerably newer than that of older states. However, many of Alaska's regulations predated statehood, adopted by the Territorial Legislature in 1949 in response to public health concerns far removed from the current public health issues facing Alaska. Recognizing this, Alaskan officials have long understood the need to modernize their laws in accordance with contemporary understandings of disease prevention and health promotion. However, they lacked the legislative capacity to draft public health reform legislation.

Alaska poses many unique obstacles to public health law modernization. Alaska has the largest land mass of any American state (its geography comprises nearly 20% of the entire United States) but one of the smallest populations (just under 500,000). Although over half of Alaska's population resides in the city of Anchorage, the remaining population resides in a plethora of small, isolated communities, some only accessible by air or water. Compounding issues of weather and geographic isolation, the Alaska public health system is challenged by three overlapping health infrastructures, the state, local governments and infrastructure serving Alaska Natives. Although the Alaskan Division of Public Health took the lead in the legislative efforts described herein, it has only

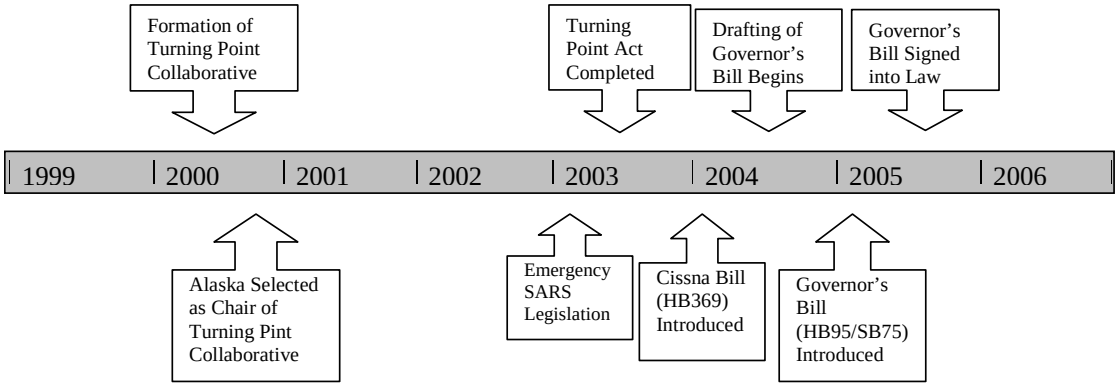
limited responsibility for many public health conditions throughout the state. Like many other states, public health powers in Alaska are split between the Division of Public Health within the Department of Health and Social Services and the Division of Environmental Health within the Department of Environmental Conservation. (The Model Act is largely silent on the issues of environmental health, partly because of this common separation, and partly because of the specialized and complex nature of much environmental health law.[4]) In addition, a relatively large population of Alaska Natives resides in rural areas, with various functions of public health and health delivery under the jurisdiction of the federal Indian Health Service and the independent Alaska Native Regional Health Corporation. Further apportioning public health powers, Anchorage has constitutionally-vested "home rule" of its public health efforts through the Anchorage Division of Health and Human Services, giving the city public health office sole purview over more than half of Alaska's population and the authority to deal with the largely urban public health problems of Anchorage.[5]

Prior to the legislative activity that is the focus of this case study, the state of Alaska's public health laws had been analyzed and discussed in a number of meetings and corresponding articles in the public health and legal literature.[6] Many of these discussions sprung from the Institute of Medicine's 1988 report, *The Future of Public Health*, which was critical of states for failures to modernize their public health laws.[7] The Alaska Department of Health and Social Services first identified Alaska's failure to update its public health laws as a major obstacle to improvements in public health in 1993, advocating public health law reform in its *Health Alaska 2000* plan.

At the forefront of states' efforts to modernize their public health laws, Alaska received funding from the Robert Wood Johnson Foundation and the Kellogg Foundation as part of their joint "Turning Point Initiative" to consider, among other things, the public health law modernization process. To this end, Alaska hired Lawrence Gostin, a professor at Georgetown Law School and Johns Hopkins's Bloomberg School of Public Health, to serve as a consultant. Professor Gostin, working with Professor James G. Hodge, Jr., traveled to Alaska several times to discuss these issues. Together, they produced the report, *Reforming Alaska Public Health Law*, in June 1999. Through this report and subsequent articles in the Alaska Law Review and other publications, they argued that "[l]aw reform in Alaska should express a clear vision for public health, promoting the best theories and practices in public health."[8] Although the Alaska public health community embraced many of the specific recommendations from these studies, few immediate attempts were made to modernize public health law. When the Robert Wood Johnson Foundation created the second phase in its public health modernization efforts under the Turning Point Project, Alaska took advantage of this new forum for public health law discussions by joining the Turning Point Public Health Statute Modernization Collaborative (Turning Point Collaborative).[9]

II. Transforming The Turning Point Act into Alaska Public Health Law Reforms

As noted in the prior section, attempts to reform Alaskan public health law were made in two consecutive sessions of the Alaska legislature, with only the latter leading to statutory reform. Following the course of events in the timeline below, this part chronicles the events and actions that defined the public health law modernization process in Alaska.



A. HB369/SB304 – An Act Related to Public Health

Public health advocates in Alaska had long argued for the need of modernizing Alaska's public health laws. With many Alaska public health laws predating statehood,[10] it was felt that "the general evolution of public health . . . was not reflected in state law." Throughout the 1980s and 1990s, the Alaska Public Health Association (ALPHA) led several failed efforts for public health law reform, attempting to clarify the state's public health authority and expand both the mission and infrastructure of public health authorities.[11] Given the complexity of the Alaskan public health system and a lack of coalition-building with legislators and other organizations, ALPHA's calls for public

health law reform repeatedly fell "dead on arrival," with even the Division of Public Health preferring to rely on informal understandings of its authority rather than risk opening up its governing statutes to legislative amendment. To spur legislative changes and further the work of the previous aforementioned Alaskan public health law studies, ALPHA encouraged Alaskan health officials to take part in the Turning Point Collaborative.

Following the conclusion of the Turning Point Collaborative process in September, 2003, public health advocates returned to Alaska with what they felt to be the legislative momentum to press for sweeping reform of Alaska's public health laws. ALPHA thereafter passed several resolutions pushing for public health law reform pursuant to the Turning Point Act. Believing that legislative reform would take several years, ALPHA's President took the Turning Point Act to Representative Peggy Cissna, a friend and sympathetic minority legislator, who sent the Turning Point Act to the legislative affairs staff for statutory drafting in anticipation of filing.

The Spring of 2003 (prior to the completion of the Turning Point Act) highlighted the immediacy of the need for public health legislative reform. As the legislature returned to Juneau for the second and final year of the 2002-2004 session,[12] the state Division of Public Health was compelled to act locally in preparing a response to the burgeoning global threat of Severe Acute Respiratory Syndrome (SARS). At that time, Alaska's only formal legislation addressing quarantine related specifically to a 1995 law on tuberculosis control, leaving a legislative vacuum with regard to other infectious diseases.[13] While state public health officials felt that this quarantine authority was sufficiently broad as to cover all infectious diseases even in the absence of a specific

mandate, a stance based largely on informal understandings with the Attorney General's Office, a new Attorney General overruled the Division of Public Health's interpretation. When it became clear to Alaskan public health authorities that they lacked the formal legal authority to quarantine for SARS under then-current state law, the legislature was urged to act quickly, enacting a one-paragraph piece of "special legislation" providing for specific authority with relation to SARS.[14] Although the power granted by this legislation ultimately was not needed during the SARS epidemic, the need for an emergency stop-gap measure in public health law substantiated the need for comprehensive public health law reform. With public health law in Alaska then covering only tuberculosis and SARS, public health sources within the Administration informed majority and minority legislators to expect a bill in the near future that would address broader public health issues.

Minority legislators, at the urging of public health advocates, felt that the time was ripe for introduction of comprehensive legislation modeled on the Turning Point Act. On January 12, 2004, Representative Cissna introduced in the House of Representatives HB369, *An Act Related to Public Health.* At ALPHA's request, a companion bill of the same name, SB304, would be introduced in the Senate by Senator Hollis French (referred to collectively hereinafter as the "Cissna and Hollis bills"). The Cissna and Hollis bills largely reproduced the entire Turning Point Act, making modifications for application in Alaska but comprehensively addressing the various subjects of the Turning Point Act.

Ultimately, neither bill received a committee hearing, and both bills expired without any action at the end of the legislative session. The informants expressed a variety of reasons why the Cissna and Hollis bills never advanced beyond introduction.

With the Governor's office and the majority of both houses of the legislature controlled by the Republican Party, Democratic legislators are wont to introduce bills that have little chance of passage merely to raise and draw attention to those issues. Because public health advocates pushed for the Cissna and Hollis bills simply to send the message that public health statutory reform was necessary, these organizations—not well-acquainted in the processes of lobbying for legislation and under the belief that introduction alone would be sufficient to highlight the issue and advance their legislative cause—did little to lobby for these bills after their introduction. Most importantly, the Administration acted affirmatively to assure that no hearing was held on the bills. Acting through its Commissioner of Health and Social Services and Division of Public Health, the Administration informed majority legislators that these bills were to be scuttled. While these Administration actors were generally supportive of the bill's substance, they felt that debate on an "unpassable" Democratic bill would stymie support for future public health modernization efforts. Given that the Division of Public Health was contemporaneously working "behind closed doors" to draft its own bill (discussed in greater detail below), it was felt that any effort to address the issue prematurely would rob future legislation of its momentum.

B. HB95/SB75 – An Act Relating to the Duties of the DHSS

At the time of the introduction of the Cissna and Hollis bills, the Department of Health and Social Services already was working feverishly to prepare its own bill based on the Turning Point Act. Alaska's public health representatives on the Turning Point Collaborative felt, like their public health advocacy counterparts, that the completion of the Turning Point Act provided the momentum on which Alaska could launch public

health statutory modernization. They sought to capitalize on the SARS epidemic and response by presenting the legislature with a bill for public health law modernization on an expedited timeframe. To this end, the Division of Public Health met with and turned over documents to the Alaska Attorney General's Office for a legal review of Alaskan law public health law in comparison to the provisions of the Turning Point Act.

Members of the Division of Public Health had presented their ideas to the Commissioner of Health and Social Services, who, holding advanced degrees in law and public health, had encouraged them to move forward in developing legislation for public health law reform.[15]

The Division of Public Health had wanted to submit its bill for consideration in the 2004 legislative session, taking momentum from the SARS legislative experience after the Administration had promised legislators that broader legislation would soon be forthcoming. However, the Commissioner insisted that passage of the bill would best be served by waiting to introduce the bill until the start of the subsequent two-year legislative term (beginning in January 2005), giving the legislature a full eighteen months to consider and pass the bill.[16] Because of the Commissioner's detailed understanding of the legislative process and a widespread belief that public health modernization would be controversial enough to require two full legislative sessions to move through the relevant legislative committees, the Division of Public Health agreed with his assessment. Further, given the Commissioner's close relationship with the Governor, public health actors understood that by deferring to the Commissioner on the timing of the bill, the eventual bill would be introduced as a Governor's Bill and thereby go to the legislature with the full support and backing of the Administration.[17]

In June 2004, the Governor appointed a new Executive Director for the Division of Public Health. Although the incoming Executive Director was unfamiliar with Alaska's prior experience in drafting the Turning Point Act, he entered his office as a strong supporter of the prospect of public health law modernization. As a physician and long-serving public health practitioner with the Alaska Native community, the Executive Director was aware of the intricacies of Alaska's public health system and actively sought ways to support the public health infrastructure through his new state office.

During the summer of 2004, the Executive Director, his Deputy Director (who had served on the Turning Point Collaborative), and an Assistant Attorney General worked to incorporate parts of the Turning Point Act into a bill commensurate to the public health needs of Alaska, with the Division Executive Director and the Deputy Director of Public Health offering public health experience and the Assistant Attorney General drafting the legislative text and serving as a legal advisor.[18] Consistent with Alaska statute and a tradition that Governor's bills are confidential until introduced, these three individuals worked with minimal input from others and no public announcement of their actions.[19] Although the drafters kept the Commissioner of Health and Social Services apprised of their efforts, no one from the Governor's Office commented on the legislative language or drafting process, deferring to the drafters alone to find the statutory language necessary for the state's expanded public health authority.

The drafters decided, and Administration officials agreed, that the state's limited public health authority necessitated a broader, comprehensive update such as that of the Turning Point Act. In doing so, this small group employed the Turning Point Act as the basis for their legislative drafting, using the language of the Act to enumerate the ten

essential public health services, codifying—for the first time in Alaska—the regulatory purview of public health as extending far beyond infectious disease control.

The drafters had completed their work on the bill by the end of November 2004, with the Commissioner of Health and Social Services announcing the effort to the larger public health community on November 29, 2004 at the beginning of the annual "Alaska Health Summit." Despite announcing that the Governor would introduce new legislation on the state's public health authority in the coming January,[20] the Commissioner revealed few of the details of the draft bill to the general public or public health advocates.

On January 21, 2005, the Governor introduced HB95 in the House and SB75 in the Senate, both bills initially entitled:

> *An Act relating to public health and public health emergencies and disasters; relating to duties of the public defender and office of public advocacy regarding public health matters; relating to certain claims for public health matters; making conforming amendments; and providing for an effective date*

(referred to collectively hereinafter as "the Governor's Bill").[21]

1. Legislative Drafting: Transforming the Turning Point Act into State Legislation

The Governor's Bill incorporated (or created functionally equivalent provisions of) many of the major facets of the Turning Point Act. To clarify and expand the public health authority of the state beyond tuberculosis and SARS, Alaska incorporated much of Section 1 (definitions) and 2 (scope of authority) of the Turning Point Act, enumerating the roles and responsibilities of the state for its public health function. Drawing heavily

on the cost-neutral provisions of Section 5 (surveillance), the Governor's Bill sought to identify specifically those powers that fell under the state's public health authority, including surveillance, reporting, epidemiologic investigation, isolation and quarantine. To constrain the power of the state under Section 5, the Governor's Bill codifies information security provisions from Section 7 and procedural due process provisions from Section 8. As highlighted in the table below, language derived from or related to 3 of the 6 substantive articles of the Turning Point Act were included in the draft:

SUBJECT:	HB 95 ("GOVERNOR'S BILL")	TURNING POINT ACT
Surveillance	Section 18.15.360 "Data Collection" The department may "collect, analyze and maintain databases of information related to (1) risk factors for specific conditions of public health importance, (2) morbidity and mortality rates for conditions of public health importance, (3) community indicators relevant to conditions of public health importance"	Section 5-102 "Surveillance Activities – Sources of Information" The state or local agency may "collect, analyze, and maintain databases of identifiable or non-identifiable information related to "(1) risk factors for specific conditions of public health importance, (2) morbidity and mortality rates for conditions of public health importance, (3) community indicators relevant to conditions of public health importance"
Reporting	Section 18.15.370 "Reportable Disease List" The department "shall maintain a list of reportable diseases or other conditions of public health importance that must be reported to the department."	Section 5-103 "Reporting" "The state public health agency shall establish a list of reportable diseases or other conditions of public health importance."
Mandatory Testing or Examination	Section 18.15.375 "Epidemiological Investigation" (c)(2) Pursuant to an epidemiological investigation, the department may "require testing, examination, or screening of a nonconsenting individual …only upon a finding that the individual has or may have been exposed to a contagious disease that poses a significant risk to the public health…."	Section 5-106 [c] "Mandatory Testing and Examination" [c] "The state or local public health agency may require testing or medical examination of any individual who has or may have been exposed to a contagious disease that poses a significant risk of danger to others or the public's health."
Medical Treatment	Section 18.15.380 "Medical Treatment" "A health care practitioner or public health agent who examines or treats an individual who has or may have been exposed to a contagious disease shall instruct the individual about the measures for preventing transmission of the disease and the need for treatment."	Section 5-107 "Compulsory Medical Treatment" "Any health care provider or public health agent who examines or treats an individual who has a contagious disease shall instruct the individual about (1) measures for preventing reinfection and spread of the disease; and (2) the need for treatment until the individual is no longer infected."
Quarantine and Isolation	Section 18.15.385 "Isolation and Quarantine" "The department may isolate or quarantine an individual or group of individuals if isolation or quarantine is the least restrictive alternative necessary to prevent the spread of a contagious or possibly contagious disease to others…."	Section 5-108 "Quarantine and Isolation" [b](1) "Isolation and quarantine must be by the least restrictive means necessary to prevent the spread of a contagious or possibly contagious disease to others and may include…confinement to private homes or other public premises."
Information Security	Section 18.15.365 "Confidential Security Safeguards" The department "shall acquire, use, disclose, and store identifiable health information in a confidential manner that safeguards the security of the information and maintain the information in a physically and technologically secure environment."	Section 7-104 "Security Safeguards" "State and local public health agencies have a duty to acquire, use, disclose, and store identifiable health information in a confidential manner that safeguards the security of the information."

The drafters deviated from the Turning Point Act where it was felt to be either (a) inapplicable to the public health needs of Alaska or (b) unpassable given the legislatures resistance to government programs.[22] Given the comparatively heightened privacy protections in the Alaska Constitution, several monitoring and surveillance sections of the Turning Point Act were either amended or eliminated entirely in drafting HB95. Specifically, it was felt that Section 7 of the Turning Point Act, "Public Health Information Privacy," was too specific, containing too many detailed provisions, to withstand legislative scrutiny. To stymie opposition to this and other problematic articles in the Turning Point Act, the drafters opted for short, general, ambiguous language.

2. Legislative Hearings: Key Testimony in Support and Opposition

The Governor's Bill was introduced just over a week into the 2005 legislative session. Because these separate bills were introduced concurrently in both the House of Representatives and Senate, the hearings process proceeded simultaneously at first, shortening the time for debate and blunting an extended buildup of resistance to the bill. In this context, the bill progressed through the Health, Education, & Social Services (HESS), Judiciary, and Rules Committees[23] in the House, and, in addition to these three committees, in the State Affairs Committee in the Senate.[24] Although the Senate ultimately deferred to the House before scheduling its second committee hearings, the Senate quickly moved the Governor's Bill through the committee process once the House had finished its debates and passed the bill. Because the preponderance of disagreement took place in the House, the sections that follow relate mainly to those House debates.

a. Supportive Testimony

The Executive Director of the Division of Public Health served as the Administration spokesperson in committee hearings. The other two drafters of the legislative language—the Deputy Director of Public Health and Assistant Attorney General—attended each hearing and served behind-the-scenes to prepare the Executive Director for his testimony. No other public health experts were provided by the administration for testimony. The Executive Director drew on Alaska's legislative experience with SARS to make the case for comprehensive public health law modernization.[25] He provided the first testimony sought in each committee, beginning with a presentation highlighting the need for public health statutory reform and detailing the major tenets of the Governor's Bill. Despite the interest in a new statute associated with infectious disease control, the Executive Director repeated time and again that the Governor's Bill should not be referred to as simply the "quarantine and isolation bill," but rather as a bill that modernized and enumerated all public health authority and responsibility.

In making the case for the Governor's Bill, the Executive Director saw it as his role in hearings to "bridge differences," between both legislators and advocacy groups. While providing public health and medical expertise on issues relating to the Governor's Bill, he largely deferred to legislators in drafting the legislative language, attempting to serve as a "negotiator" between the Administration and legislators. In this role, he attempted to strike a balance to assuage the concerns of all sides, most prominently in drafting statutory language balancing individual liberties and collective public health goals.

With the Executive Director having spoken with many advocacy groups prior to and following the release of the Governor's Bill, several groups had mobilized their membership to support the bill, both in testimony and direct lobbying of individual legislators. Through this process, the Bill received the support of the Alaska Hospital Association, the Alaska Nurses Association, the Alaska Medical Association, and the Department of Health and Human Services of the City of Anchorage, many of which had representatives testify in support of the Governor's Bill. In turn, this advocate group support led to a series of articles in the Anchorage Daily News, Alaska's largest newspapers, and a spate of local television reports.[26]

Testifying before the relevant committees, representatives from these advocacy groups argued that public health modernization was necessary and that the Governor's Bill adequately addressed the needs of public health practitioners. In particular, the Alaska Public Health Association (ALPHA), learning from the lessons of the Cissna and French bills, created a lobbying campaign to push for the passage of the Governor's Bill. Meeting often with the Executive Director and Deputy Director of the Division of Public Health, ALPHA saw its role as providing legislators with an understanding of public health principles and why those principles should take precedence over the individual liberties concerns expressed by opponents to the Governor's Bill.[27] In this capacity, ALPHA held working sessions on the bill with its membership, testified at every opportunity, and placed constituent calls to legislators' offices. While ALPHA could not afford to hire a registered lobbyist to work specifically on the Governor's Bill, ALPHA leaders spoke with lobbyists for other health-related organizations, who kept them apprised of the pace of legislation and concerns of individual legislators.

Representatives from the Anchorage Department of Health and Human Services spoke in committee hearings to issues of urban health.[28] With the Anchorage city officials having long argued for public health law modernization and having stayed abreast of Alaska's involvement in the Turning Point Collaborative, these local officials were pleased to work with their state counterparts in advancing the Governor's Bill. After consulting with their counterparts at the state level, these local public health representatives testified in every committee hearing in the House and Senate, attempting to educate legislators on the advantages of the Governor's Bill in overcoming obstacles to urban infectious disease control. In addition, because approximately half the legislative bodies represent Anchorage constituencies, the Anchorage Department of Health and Human Services could highlight the public health concerns of interest to a majority of the legislative delegation and provide strong local advocacy for this change at the state level.

b. Opposition Testimony

Only two major groups—Christian Scientists and the Alaska Civil Liberties Union—testified in opposition to HB95. This opposition was far less than anticipated by Administration officials and public health actors,[29] leading the Governor's Bill to passage far sooner than was originally envisioned.

The Christian Scientist lobby objected in letter and testimony that the initial draft of the Governor's Bill enabled the state under its police powers to mandate treatment for disease, contradicting a central tenet of the Christian Scientist faith. While few agreed with the religious principle, several legislators were inclined to support the policy position given their belief that the Governor's Bill had given the government more police powers than were necessary. To accommodate this opposition and gain credibility

through its willingness to compromise, the Administration stripped the bill of its mandatory treatment provisions, finding that the same policy result of protecting the public's health could be reached by quarantine or isolation of anyone who would decline the indicated treatment.

As soon as the Governor introduced HB95 the Executive Director of the Division of Public Health, foreseeing a legitimate avenue of opposition, brought the Bill to the attention of the Alaska Civil Liberties Union and went to Anchorage to meet personally with its new Executive Director. This was the only specific effort made to alleviate anticipated opposition prior to debate on the Governor's Bill. Despite their conflicting opinions on several issues, this outreach effort led to "good will" between the Alaska Civil Liberties Union and the Division of Public Health, with the Executive Director of the Alaska Civil Liberties Union beginning each of his many testimonies on this bill by thanking the Division of Public Health for allowing his input to be heard in the process.[30] As a result of his established relationship in the public health law modernization process and continuing conversations with the Executive Director of the Division of Public Health, the Executive Director of the Alaska Civil Liberties Union felt that many of his concerns were addressed, even if not often accommodated, in the debate of the Governor's Bill. For example, despite efforts to accommodate organizational objections in many parts of the Bill, the Division of Public Health steadfastly refused to accommodate opposing viewpoints on the issue of access to medical records. Although the Alaska Nurses association joined the Alaska Civil Liberties Union in objecting to this, no change was made to this section of the Governor's Bill.

However, given the Alaska Civil Liberties Union's lack of resources, its small staff (3 attorneys), and the level of legislative support, the Executive Director became aware early in the process that his testimony would not change the civil liberties implications in the Governor's Bill. Members and staff of the Alaska Civil Liberties Union did not attempt to derail the legislation, seek out media attention on the issue, or lobby individual legislators, seeking only to have input in the legislative debate and influence some of the bill's provisions that impacted civil liberties.

In many ways, the objections of the Alaska Civil Liberties Union mirrored those of other state branches of the American Civil Liberties Union (ACLU). While the Alaska Civil Liberties Union acted without formal ACLU assistance or collaboration, state directors are able to access the legislative testimony of other state directors through an ACLU internal website and discussions on an internal listserv. In the context of the Governor's Bill, the Alaska Civil Liberties Union sought the opportunity to present at several of the committee hearings and presented the committees with their line-by-line comments on the Bill. Even though the Republican legislature rarely finds common ground with the Alaska Civil Liberties Union, it was felt—despite negative legislative preconceptions of the organization in the legislature—that they would have greater leverage on issues of quarantine, prevention of government abuse, and medical privacy. The Alaska Civil Liberties Union's objections focused on the quarantine provisions of the Governor's Bill, specifically objecting to the standards for quarantine and isolation and the due process protections that would accompany those public health actions. As explained by the Executive Director of the Alaska Civil Liberties Union, "[w]e understood sort of the countervailing public health reasons for needing to act quickly, but

we thought we could accommodate those and still have a more comprehensive set of due process protections available to the individuals that were going to be subject to those orders." Although the Executive Director does not believe that many significant changes were made as a result of his input and testimony—a result he expected given Alaska's constitutional obligation for public health and the overwhelming support for public health reform—he was nevertheless satisfied that his input was respectfully received and considered in the debate.

3. Legislative Opposition: Libertarian Values Meet Exigencies of Public Health

The drafters of the Governor's Bill also expected far more legislative opposition than materialized. It was expected that the majority Republican legislature would object stringently to any expansion of the state's police power.[31] While there was legislative opposition—in particular on issues of quarantine, isolation, and surveillance—meetings with legislators early and often helped to stem the voracity of this opposition. In particular, through meetings with the chairs of the Health, Education, & Social Services committees, the Executive Director of the Division of Public Health and Governor's liaison to the legislature on health issues were able to assuage concerns through ongoing dialogue.

To alleviate opposition on the basis of expanding public health services, the Administrative prepared a fiscal note to certify that the public health modernization effort would add no cost in the state budget. The Executive Director of the Division of Public Health used this fiscal note as justification for arguing that the Governor's Bill would add no additional work that public health authorities had not already been doing. While

politically advantageous in lessening opposition, this "zero fiscal note" compelled the drafters of the Governor's Bill to strip any Turning Point components that would bear any cost (e.g., counseling for substance abuse) or with expand current programmatic activities.

In order to focus legislative attention on the dangers of Alaska's antiquated public health authority, public health administrators and activists drew upon legislator's "fears" of infectious disease outbreaks.[32] With the Division of Public Health having recently prepared for a SARS outbreak and the legislature having rushed to prepare statutory authority for that response, legislators were concerned that they had not adequately prepared for public health threats to the state.

While political opposition from the minority party was minimized through individual consultation and explanation,[33] it was not eliminated entirely. In the context of the House Judiciary Committee, a body known for exacting scrutiny of legislation, minority Democrats questioned the Executive Director for over five hours during the course of several days. On the House floor, two minority legislators contested the legislation for a lack of stringency in protecting civil liberties,[34] faulting the Governor's Bill on three grounds. First, these legislators sought to increase the penalties levied against government officials who are convinced of intentionally misusing their authority for surveillance, quarantine, or isolation. Second, it was argued that if the government inappropriately put someone into quarantine or isolation, that person should be able to seek a remedy against the government for misusing its authority. Lastly, there was challenge, albeit less stringent that the former two, over the state's emergency authority to hold someone for a certain number of hours without a court hearing.[35] While many in

the majority and Division of Public Health considered this to be merely the political theater of minority legislators (particularly in light of the subsequent unanimous passage of the Governor's Bill), this did not lessen the degree to which these minority legislators voiced mistrust of the majority party for trampling the minority in "steamrolling" the Governor's Bill through the legislature. To accommodate these objections, the Governor's Bill was amended to include remuneration for intentional or grossly negligent quarantine or isolation and also criminal penalties for those who intentionally disclose identifiable health information.[36]

4. Legislative Passage and Regulatory Implementation

After lengthy delays in scheduling a Senate vote on the Governor's Bill in the final months of the legislative session, the bill ultimately passed unanimously in both houses on May 8, 2005 and was signed into law on June 23, 2005. Despite changes to the provisions regarding (1) definitions of public health, (2) an individual's right to redress, and (3) penalties for unlawful quarantine, *An Act Relating to the Duties of the DHSS* was enacted largely as the Governor's Bill was first introduced. No actor in the process has expressed—either publicly or in the interviews—a need to amend any part of it. Only one Republican legislator has introduced a bill in the House of Representatives in the current legislative session related to the issue of medical records.[37]

The Division of Public Health has just completed the public comment period for its implementing regulations on the quarantine and isolation sections of the Governor's Bill. Few of the key actors who lobbied for or against the Governor's Bill took part in this implementation stage of the policymaking process, finding the implementing regulations to reflect the intent of the Governor's Bill and trusting the Division of Public

Health as the steward of this new public health authority. With this new authority, the Division of Public Health has found the Governor's Bill to "change the whole tenor of the conversation with communities," employing enacted portions of the legislation to work with local activists and public health officials in preparing a state-wide response to a possible avian influenza pandemic.

Because of the short time since passage, few implementing changes have yet taken place. As of April 2006, the only changes made are revisions of forms necessary to request judicial consent of a quarantine or isolation. In response to the public comments, the implementing regulations are slated to be redrafted and approved by the summer of 2006. Given these proposed changes to public health regulations, representatives of the Division of Public Health have already noted that they possess "more confidence as we deal with potential pandemics." From outside the Division, there is a widespread perception that the Governor's Bill has provided the foundation necessary for public health preparedness.

IV. Analysis: Lessons Learned

This Governor's Bill has been a story of success in transforming the Turning Point Act into state legislation. The actors universally commented on the unexpected ease and speed of this public health modernization effort. As one senior state public health official noted, this was "the civic story you would like to have your kids believe in ninth grade civics, the way government really does work." This part explores the reasons underlying this ease of legislative change, exploring lessons that can be employed by other states seeking public health law modernization. While no specific causal lynchpin can be identified based upon this single case, it is clear from the themes of informant

interviews that the variables outlined in the chart below[38] and sections that follow predisposed the Alaskan effort to success.

A Process Model for State Public Health Law Reform

Stage I: The Emergence and Utilization of the Turning Point Act
- *Dominant Actors*
  - Turning Point Collaboration
  - Division of Public Health
- *Key Forces*
  - Agenda Setting
- *Result*
  - Model Developed for Discussion of Issue

Stage II: The Development of Draft Law
- *Dominant Actors*
  - Division of Public Health
  - Office of the Attorney General
- *Key Forces*
  - Necessities of Public Health
  - Political Considerations
- *Result*
  - Law Developed to Pursuant to Turning Point Act but Specific to State Needs and Political Circumstances

Stage III: Legislative Action
- *Dominant Actors*
  - Legislators
  - Division of Public Health
  - Executive Branch
  - Advocacy Groups
- *Key Forces*
  - The Turning Point Experience
  - Politicization of Public Health
  - Executive Prerogative
- *Result*
  - Reformed State Public Health Law

A. The Turning Point Experience

Alaska's statutory reform process was greatly buttressed by Alaskan officials' longstanding commitment to public health law modernization and participation in the

Turning Point Collaborative. Given the burgeoning need to update public health laws in the face of infectious disease threats and changes to public health practices, many actors noted that the Turning Point Act was "a good place to start" in reforming state public health laws.

Public health advocates in Alaska had long supported public health law modernization efforts and had strongly encouraged state officials to take part in the Turning Point Collaborative. Through the Turning Point Collaborative, Alaska public health officials familiarized themselves over several years with the need for and process of public health law modernization. As part of the Turning Point process, this framework for statutory protection of public health was reinforced through Alaska's contribution to and rapid implementation of elements of the Model State Emergency Health Powers Act (MSEHPA), drafted by the *Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities* for the Centers for Disease Control and Prevention and others in the weeks immediately after the events of September 11, 2001 and ensuing anthrax exposures that Fall.[39]

Working with the consultants of the Turning Point Collaborative—many of them the same consultants who had worked on early Alaska public health law modernization efforts—these public health officials became acquainted with the statutory language and the means to effect change through law. Further, having participated in the Turning Point Collaborative and worked closely with its legal consultants prior to the collaborative, Alaskan public health officials were able to draw upon subsequent advice from both Professors Gostin and Hodge in drafting the Governor's Bill.[40] This reliance on outside experts had pronounced importance in Alaska, which possesses neither a medical school

nor a law school, leaving state legislators without a local scholarly foundation necessary to support comprehensive public health law reform. Almost as important as interactions with Professors Gostin and Hodge were, drafters of the Governor's Bill were also able to draw on the vast publicly-accessible public health law literature by these and other scholars, providing drafters with a comprehensive overview of the Turning Point Collaborative and analyses of ways in which the Turning Point Act could inform state law.

In developing interest in public health law modernization, the Turning Point Collaborative experience helped to forge Alaskan leadership for change. As Chair of the Turning Point Collaborative, the Deputy Director of the Division of Public Health brought her in-depth knowledge of the Turning Point Act to covert its provisions into Alaska state law. Throughout this multi-state collaborative process, the Deputy Director remained focused on "questions about how we would use it [the Turning Point Act] and what we needed and what seemed appropriate for Alaska." Given Alaska's extended participation and review of the Turning Point Act, she had long considered the applicability of the Turning Point Act to the specific public health needs of Alaska and the resistance that would likely arise from certain provisions of the Turning Point Act, in particular quarantine and isolation procedures. This gave her parochial credibility and respect from Alaskan actors wary of "East Coast academics." Based upon the Deputy Director's longstanding service within the Division of Public Health, she was well-known and trusted within public health communities and her opinions on the Turning Point Act carried great weight with opinion leaders.[41] In preliminary discussions within the Administration, her experience with the Turning Point Collaborative gave her the

credibility necessary to advance ideas that had previously lacked support beyond the few members of the Division of Public Health. Although she was not the public spokesperson for the Governor's Bill by virtue of her subsidiary position in the Administration, her personal connections and expertise derived from the Turning Point Act made her an indispensable actor for statutory change. Based upon this understanding of and enthusiasm for it, the Turning Point Act served as a useful model for statutory development.

The Turning Point Act is invaluable to small states lacking the government capacity to draft and carefully consider detailed legislation. With legislative resources comparatively smaller than many other states, Alaska's Department of Health and Human Services lacked the bureaucratic personnel necessary to draft a comprehensive bill on public health. In the Governor's Office, the legislative liaison for issues dealing with the Department of Health and Social Services also had responsibility over legislation dealing with the Department of Administration, the Department of Education, the Regulatory Commission, an the Housing Finance Authority. Alaska simply lacked the governmental resources to craft comprehensive public health reform. Rather than adapting a bill from another state to meet Alaska's needs, the Turning Point Act provided the carefully considered and tested language acceptable to public health officials from many states.

Once the Governor had introduced HB95, the Turning Point Act served to provide legitimacy to the government's efforts to reform public health law. Rather than appearing to originate from a small group of public health bureaucrats, the Turning Point experience allowed the Governor's Bill to appear to represent the nation's "best practices"[42] for public health, as carefully considered and derived by experts and

policymakers throughout the country. This allowed legislators to have "faith in the origin" of the Governor's Bill, deferring to much of the statutory language simply because it was based on the national model. Where amendments were suggested to the language of the Governor's Bill, public health actors found that the Turning Point Act and experiences from the Turning Point Collaborative were "invaluable in being able to respond really quickly, sometimes literally overnight." In aspects where the Governor's Bill did not initially adopt the language of the Turning Point Act, objections to Alaska's statutory language at times led drafters to amend the Governor's Bill in greater accordance with the Turning Point Act.[43]

However, many compromises were necessary to create viable Alaska legislation from the Turning Point Act. The Governor's Bill does not follow comprehensively from the Turning Point Act—particularly as compared with the Cissna and Hollis bills—eliminating various sections of the Turning Point Act that, as discussed above, either posed political or budgetary hurdles. In what was described as a "stripped down" version of the Turning Point Act, it was felt that a less expansive bill could "fly in low and fast" through the legislative hearings and better guarantee passage. Further, even among those sections employed, the Alaskan drafters of the Governor's Bill often pared down the language of the Turning Point Act, finding that the length of the Act's language would pose political problems in gaining legislative consensus. The drafters believed that a summary of these articles would lead to fewer questions and concerns from legislators, particularly in Articles VI (Public Health Emergencies) and VII (Public Health Information Privacy). While a lack of specificity remains a concern for state public health officials (because it may limit the state's public health authority, as learned during

the SARS epidemic regarding quarantine authority), legislators have taken comfort in the broad legislative mandate for public health, believing that state public health officers will have more flexibility through general regulatory language.

B. Politicization of Public Health

Many political actors found public health reform to be less contentious than other medico-legal issues. Although there were disagreements as to the approach the specific legislation should take, everyone agreed that the *status quo* was not commensurate with modern public health threats, necessitating some type of public health law reform. As one senior administration official stated, "public health is not that much of a political issue," deferring to the Division of Public Health to decide the statutory authority necessary to carry out its own mission. Other actors referred to the Governor's Bill as largely "public health housekeeping" as a way of routinizing the process and minimizing any contentiousness surrounding the issues. Because public health law modernization was not felt to pose any political risks for the Administration, the Governor's Office made no attempt to dictate the scope or content of the Governor's Bill. With many considering the majority of the Governor's Bill to be "too boring" for comment, there was little media attention on the Governor's Bill[44] and few took notice of it outside of those concerned with its quarantine and isolation provisions. In fact, several key informants were surprised by the lack of involvement of even public health faculty and students, given their prior advocacy on public health legislation. Aside from the opposition testimony of the Alaska Civil Liberties Union and Christian Scientists, no registered lobbyists worked against the Governor's Bill.[45]

Despite this perception of a nonpoliticized public health authority, this case study has found instances of political disagreement in the scope of the state's public health authority, albeit far less than was envisioned by its drafters. As mentioned previously, the Alaskan legislature—cutting across both party and demographic (urban vs. rural) lines—has cultivated an aversion to both costly governmental programs and invasive governmental regulations.[46] To the degree that there had been detailed public health regulation in Alaska, it had come in punctuated, fleeting moments in time in order to meet specific public health threats, among them tuberculosis and SARS. What informants referred to as the "frontier mentality"[47] led individual legislators to remain deeply skeptical of the possibility for abuse by the state, particularly on issues of quarantine and isolation. It is for this reason, among others, that the Cissna and Hollis bills met stiff resistance from majority lawmakers. Only through the dedicated and personable efforts of the Administration's public health spokespersons, acting to bring legislative perceptions of an abusive public health authority in line with the reality of the legislative mandate, was the Governor's Bill able to overcome and reflexive mistrust of public health authority and gain universal support for an initially unpopular initiative.

In overcoming political resistance, supporters of public health modernization mobilized a "politics of fear," employing the specific threat of SARS to generate widespread support for comprehensive public health law reform. The informants found the legislators to respond favorably to security threats emanating from outside the state or country. The influenza pandemic of 1918 still resonates in Alaska public health politics. In this context, SARS provided an ideal tool for stoking fears of an unknown, foreign threat to Alaska's survival.[48] The Administration focused on the fear of a SARS-like

public health emergency in announcing the need for comprehensive revision of public health law and the introduction of the Governor's Bill, with the Governor arguing that "[w]e need to prepare now so we are able to act quickly to protect the public from unnecessary death and disability in the event of a public health emergency."[49] With the SARS fear felt to be behind them, the Executive Director was able to stoke fears of new Alaska epidemics, with many legislators' questions turning unexpectedly to the perceived risk of a monkeypox or "flesh eating bacteria" outbreak. Working with his counterpart at the local level, the Anchorage public health representatives testified to the danger of Anchorage's "global position," being only "one plane ride away from any . . . unknown infectious disease." Heightening fears of infectious disease was the perceived threat that terrorists would employ infectious disease as a bioterror weapon, adding a national security imperative to modernizing the state's public health authority.

C. Bottom-Up vs. Top-Down Approaches to Public Health Law Reform

In many respects, the unsuccessful and successful efforts to reform public health law in Alaska are distinguished on the basis of the sponsors of the respective bills. The Cissna and Hollis bills failed because they were unsupported legislative proposals by minority legislators. Based on the work of ALPHA and the Turning Point experience, the bills had the support of many public health advocates; however, they lacked the support of those with the political capital necessary to advance these ideas into law.[50] Much of this stems from a lack of communication between the relevant actors. Although the efforts were advanced by minority legislators largely to start a public dialogue on public health statutory modernization, they were done without knowledge that the

Administration was concurrently crafting its own bill. Despite good relations with the Division of Public Health, Democratic legislative aides felt constrained in approaching members of the Administration in planning or advancing their public health modernization bills, denying the Cissna and Hollis bills the expertise and support necessary to provide testimony for a legislative hearing. Compounding this confusion, the Administration had no advance knowledge that these bills would be introduced, catching the Administration by surprise and forcing public health actors to oppose a bill on procedural grounds that they agreed with in substance. Public health actors within the Administration recognized that the Cissna and Hollis "could have killed our efforts . . . because it could have brought up a bunch of red flags around the issues that we wouldn't have been able to overcome with a better bill but also that it might have been perceived as a Democrat issue." Once it became clear to the Administration that the Cissna and Hollis Bills would serve to open a public dialogue, the Administration was put in the position of blocking the minority bills from receiving any legislative hearings, blunting this otherwise valuable effort because it would serve to steal momentum from what would become the Governor's Bill.

Having a bill introduced by the Governor changed the legislative calculus in supporting public health modernization. Ironically, although the majority party would unanimously support the Governor's Bill, no Republican legislator had previously expressed any interest in public health reform.[51] The debate in this case was driven by the political power of the governor, with a prominent Administration source noting bluntly that success was predetermined largely "because it was a Governor's Bill and the Governor was a Republican and the Republicans were in power in the House and the

Senate." Because many actors felt that this was a "democratic bill" introduced by a Republican Governor,[52] and given that the Governor's Bill had no budgetary implications, there was little reason or opportunity for either Democratic or Republican legislators to oppose the bill.

As a proposed Governor's Bill, the drafters were able to conference outside of the political process without disclosing their plans to any outside actors or seeking any public comment. Because the Governor's Bill affected one department within the administration almost exclusively, there was no need for the Department of Health and Social Services to collaborate with other agencies before presenting its draft legislation to the Governor's staff. With an ally in the Commissioner of Health and Social Services, public health law modernization had a forceful advocate in enlisting the Governor's support. Through this process, the drafters found the freedom necessary to move quickly in drafting a final bill for introduction, knowing that the Governor's support would obviate the need to enlist legislative support through collaboration prior to introduction. Although some local public health actors and advocates resented their exclusion from the drafting process, they respected the state public health department's need for secrecy and supported the Bill without any public reservations.

Having a bill for public health law modernization introduced by the Governor gave it instantaneous credibility and momentum. With the Governor's Republican Party in the majority in both legislative houses, a Governor's Bill would command committee hearings and get preferential treatment through those hearings, stymieing any individual legislator's attempt to blunt legislative action through committee wrangling.[53] Although it remained the "Governor's Bill," the Division of Public Health could work independent

of the Governor's Office in moving the Bill forward, allowing the Governor, as in this case, to sponsor a successful bill without ever having to become personally involved in legislative wrangling.

Because the Bill was introduced and supported by the Governor, the resources of executive agency employees can be brought to bear on bill passage. Although internal administrative sources had considered having the bill introduced by a persuasive public health advocate in the legislature, it was felt that the Administration's expertise could best be applied and controlled through a governor's bill. To move the Bill through the House and Senate, the Governor's legislative liaison for health issues met with legislators to schedule committee hearings and votes. Acting behind-the scenes, the Commissioner of Health and Social Services, closely aligned with the Governor himself,[54] assured reluctant legislators that public health reform was necessary and not adverse to their interests. With degrees in both public health and law, experience working in the U.S. Senate, and two full years as Commissioner, he became a vital actor in the Governor's efforts, possessing the credibility, expertise, and political capital necessary to sway legislators to this effort and leaving public health law modernization as his legacy to the Department of Health and Social Services.

In addition, the leadership and expertise of the Executive Director of the Division of Public Health proved invaluable in shepherding the Governor's Bill through legislative committees. As noted above, the Executive Director was the lone representative of the Administration in committee hearings, sharing his expertise as a physician and public health practitioner with legislators as they revised the Governor's Bill. In this capacity, legislators found him to be "extremely knowledgeable" but not "threatening or

arrogant,"[55] giving him the rapport necessary to generate confidence in the bill that he and his staff had crafted.

Nevertheless, there were some disadvantages to having the Governor's Bill sponsored by the Administration. With the Administration sponsoring multiple bills in the legislative session, public health reform became one of the bargaining chips used by senators to force Administration action on other issues. To the degree that the Administration was able to push this bill through the legislature—getting it passed in the session's final days—is a testament to the commitment that the Administration had for public health law modernization and the lengths to which it would go to assure its passage. While this analysis does not mean to suggest that Administration support is a necessary prerequisite for public health law modernization,[56] it is clear that executive branch support fundamentally alters the nature and terms of the debate on such statutory reform efforts.

V. Conclusion

The Governor's Bill was the culmination of over a decade's efforts by Alaskan public health actors, who—working with academics, the Robert Wood Johnson Foundation, other states, legislators, and the executive branch—changed opinions on the need to modernize Alaska's public health statutes in codifying the Turning Point Act into state law. The public health modernization efforts in Alaska educated legislators in the importance of public health and the statutory basis for the state's public health powers. It is unclear whether this newfound appreciation and prioritization of public health will have beneficial effects for other public health commitments in the years to come. Because these reforms are still in their infancy, additional research will be necessary to

assess the long-term effect of public health law modernization on bureaucratic structures for public health and, more importantly, public health indicators.

It is clear that the Turning Point Act had a dramatic and crucial impact on efforts to modernize Alaskan public health law. Nevertheless, it is also clear that many state actors were previously unaware of its existence and applicability. In moving forward, it is important that other state public health actors become aware of the Turning Point Act and develop the connections necessary to inform legislators of its application to state law.

When translating the Turning Point Act from universally-applicable model wording to state-specific legislation, it is advantageous for these efforts to gain support from the executive branch. The executive branch is often the only organ of government with both the expertise and insularity necessary to draft comprehensive reform of public health laws. With control over departments of health, state public health officials, and (given party constraints) legislative priorities, the Administration can be an instrumental ally in highlighting the need for public health modernization, drafting legislation, and moving this legislation through the legislature.

Despite the lessons drawn from the success of the Governor's Bill, there are reasons to take pause before drawing analogies to other states. As noted in the introduction, there are many facets of Alaskan public health practice and legislation that may be unique to Alaska. In the practice of legislative reform, Alaska's small size gives what was described as a "personal approach" to legislation, with key actors often advancing legislation simply by virtue of knowing other key actors and rarely putting agreements into writing. Because of these informal lines of communication, there was no

need for a concerted mobilization effort, which may prove necessary in larger states with more disparate actors.

Time will be the ultimate arbiter of the success of this effort, with this legislation too recent to have any significant impact on public health indicators. Like much of public health planning, many health contingencies were put into law with little way of predicting how these public health powers will be employed when an unforeseen health event strikes. While hoping for the best, Alaska has taken specific steps to prepare its public health system to respond to the worst.

Appendix: Research Methods

The purpose of this case study was not purely descriptive. This Alaska case study is but the first of a series of comparative case studies of states that have proposed bills to amend their state public health laws subsequent to the Turning Point Act. Given the preexisting theory that the Turning Point Act is a catalyst for state public health law reform, this first case study will serve both to confirm that theory and to generate specific hypotheses to be tested in future case studies.

The case study method is a method of discovering empirical relationships among variables. As compared with experimental or statistical methods, the case study is a type of observational test that allows the researcher to uncover general empirical relationships among variables but without explicit measurement of those variables. Process tracing, the research technique employed in this study, examines the chain of events and decision-making processes by which case outcomes (the success or failure of a proposed bill in becoming law) are dictated by yet-unknown independent variables. By examining evidence at each step, the researcher can present a plausible causal chain of actions which led to the enactment of state public health law.

The present case study used intrusive qualitative methods, drawing primarily from interviews with key informants and other forms of ethnographic observation. This study is based on eleven semi-structured qualitative interviews with Alaskan actors from the public health bureaucracies at the state and local level, public health advocacy groups, the Alaska legislature and Governor's office. The table below identifies the number of interviewees by category. Of these eleven informants, eight were selected in advance in

consultation with a senior member of the Alaska Division of Public Health, and three were added based upon recommendations by the original interviewees.

Informant Role	**No. of Informants**
Administration Officials	2
Legislators/Legislative Staff	2
State & Local Public Health Officials	4
Nongovernmental Advocates	3

With the exception of two telephonic interviews, these interviews all took place in Alaska, either in Juneau or Anchorage, with follow-up communication by electronic mail. Interviewees were also invited to provide the study team with any documentation available, such as copies of legislative testimony, newsletters of advocacy groups, correspondence about the legislative process, and the like. Interviews were tape recorded for subsequent transcription and analysis. Although interviewees were given the option of interviewer note-taking rather than tape recording, no interviewee requested this option.

Through semi-structured interviews, the researcher asked these individual informants about 1. the role of the informant in the legal/regulatory changes; 2. the public health problems addressed by the changes; 3. obstacles to changes in state law and the strategies used to overcome these obstacles; 4. subsequent changes in public health regulation, organization or programs based on legal reforms; and 5. the expected changes in public health outcomes. Based upon notes and transcripts of these interviews, and

careful reading of the documents, a narrative description of the legislative process was drafted (Part III of this report) and themes were identified for analysis (Part IV).

Any case study of this type is burdened by the potential for bias. The researchers attempted to minimize these biases to the largest degree possible. The interviewer for the present case study had no role in the drafting of the Turning Point Act and constructed the interview guide without the influence of those who had previously received funding to construct the Turning Point Act. Although a key informant in the Alaska Division of Public Health was consulted to identify the sample of informants, the researcher also spoke with several informants outside of this network, finding corresponding narratives among those inside and outside the network.

While complete anonymity in reporting data would have been ideal in avoiding design effects, the results based on the interviews have validity only by virtue of the status of the actors informing the interviewer. Because Alaska has such a small population, it became clear through various interviews that the informants all knew about the work of other informants, if not knowing them personally, both before and after the legislative efforts discussed herein. Given that informants were often aware of other the identities of other informants in this study, efforts were made to shield informants from the statements made previously to the interviewer by other informants. Informants are identified where necessary by the individual's job title or a generic description of his or her activities. Individuals are identified by name when associated with an act of public record such as sponsorship of bills or authorship of public documents.

References

[1] *E.g.*, Nat'l Ass'n Attys. Gen., *Resolution Urging States to Review Their Public Health Laws*, Dec. 2-6, 2003; LAWRENCE O. GOSTIN & JAMES G. HODGE, JR., STATE PUBLIC HEALTH LAW - ASSESSMENT REPORT (2002), *available at* http://www.publichealthlaw.net/Resources/ResourcesPDFs/PHL_Assess_Rep.pdf; James G. Hodge, Jr. et al., *Transforming Public Health Law: The Turning Point Model State Public Health Act*, 34 J. L., MED. & ETHICS 77 (2006).

[2] This State Public Health Law Assessment Report, drafted by Professors Lawrence Gostin and James Hodge and released in April 2002, can be accessed at http://www.publichealthlaw.net/Resources/ResourcesPDFs/PHL_Assess_Rep.pdf.

[3] Turning Point Model Public Health Act (Turning Point Pub. Health Statute Modernization Nat'l Collaborative 2003), *available at* http://www.hss.state.ak.us/dph/improving/turningpoint/MSPHA.htm.

[4] The Division of Environmental Health is currently working with the legislature to draft an animal quarantine and isolation counterpart to the legislation discussed herein.

[5] Alaska Constitution, Title 29. Whereas many states address public health issues through state government, several states, including New York, Oregon, and California, employ home rule to allow major urban centers to develop parallel public health hierarchies at the local level. Outside of Anchorage, the North Slope Borough has also elected to have home rule over public health; however, because of its small size, it did not have a role in the debates discussed herein.

[6] *E.g.*, Lawrence O. Gostin & James G. Hodge, Jr., *The Public Health Improvement Process in Alaska: Toward a Model Public Health Law*, 17 ALASKA L. REV. 77 (2000); LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000); Lawrence O. Gostin et al., *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59 (1999).

[7] COMM. FOR THE STUDY OF THE FUTURE OF PUBLIC HEALTH, INSTITUTE OF MED., THE FUTURE OF PUBLIC HEALTH (1988).

[8] Gostin & Hodge, *supra* note 6, at 83.

[9] This Turning Point Public Health Statute Modernization Collaborative was one of five "national excellence" collaboratives created under the second phase of the Turning Point Initiative, with states choosing to take part in only one of these five collaboratives.

[10] A.S. § 18.05.010 (1949) (enabling the state's authority for public health).

[11] As an example, ALPHA advocated in the early 1990s for the Alaska legislature to adopt many aspects from Michigan's public health law, given Michigan's state and regional public health governance structures.

[12] The Alaska legislature meets in two-year sessions, with the legislative houses meeting in Juneau from January through June.

[13] *See* A.S. § 18.15.120 (1995).

[14] SARS Control Program Authorization, ALASKA STAT. § 18.15.350 (2003) (noting, with few exceptions, that "the SARS control program shall be administered in the same manner and has the same powers, authority, obligations, and limited immunities as does the program for the control of tuberculosis").

[15] As a lawyer and public health specialist, the Commissioner had particular interest in public health law reform. Although he did not involve himself in the drafting of the bill, he remained involved in the strategy of enacting the relevant legislation.

[16] As noted *supra* note 12, the legislature of the state of Alaska operates in two-year legislative cycles. Although bills can carry over from year to year within the legislative cycle, any bill that remains unpassed at the conclusion of the legislative session must be reintroduced and submitted again to the committee process when a new legislature is convened. [Cite.] Relevant in this context, it should be noted that elections are held for all forty representatives and half of the twenty senators at the conclusion of each legislative cycle.

[17] For a discussion of the comparative advantages of a bill introduced by a governor as compared to a legislator, see *infra* Part IV.C.

[18] An Assistant Attorney General was necessary because the Department of Health and Social Services, like all executive agencies in Alaska and many executive agencies across the country, does not have any staff attorneys, and relies on the Attorney General's Office for all legal counsel.

[19] While the Executive Director had spoken with several groups during this time, he spoke only generally in informing supportive groups to prepare themselves for an Administrative initiative to advance public health.

[20] This announcement was also made in Administration Press Releases and articles in state newspapers. *See, e.g.*, Joel Gilbertson & Richard Mandsager, *Commentary: Alaska Ready to Fight Bioterrorism*, ANCHORAGE DAILY NEWS, Dec. 28, 2004, at B4 ("Recognizing the need for clarification in our public health statutes, including addition of modern due-process protections of individual rights should these measures ever become necessary, Gov. Murkowski is proposing new legislation to update our public health laws.").

[21] H.R. 95, 24th Leg., 1st Sess. (Alaska 2005); S. 75, 24th Leg., 1st Sess. (Alaska 2005);

[22] Legislative opposition to public health programs is detailed *infra* Part III.B.3.

[23] Although the Governor's Bill passed through the Rules Committee, this committee exists largely for calendaring and agenda control, scheduling debates but not largely holding hearings or taking testimony.

[24] H.R. 24-12, 1st Sess., at 125-26 (Alaska Jan. 21, 2005); S. 24-12, 1st Sess., at 115-17 (Alaska Jan. 21, 2005), *reprinted at* http://www.legis.state.ak.us/BASIS/.

[25] As an example of this, the Executive Director kept behind him during committee hearings the Trust for America's Health Map, which singled out Alaska as the only state with a public health service that lacked comprehensive quarantine authority.

[26] For reasons discussed in further detail in the analysis section, advocacy groups did not attempt to garner media attention for the Governor's Bill, hoping to avoid "creating drama." *See infra* note 44 and accompanying text.

[27] The individual liberties concerns of the opposition, as manifested most vociferously by the Alaska Civil Liberties Union and Christian Scientists, are discussed *infra* Part III.B.2.b.

[28] In addition, these local actors spoke to issues of home rule that were largely excluded from the Governor's Bill. For example, despite the existence of "home rule" for the Alaska Department of Health and Human Services, the local actors lack the explicit authority to quarantine in the absence of direction from the state.

[29] Supporters of the bill attribute this lack of opposition either to the mainstream qualities of the bill or, in the alternative, to a lack of public attention to public health law issues.

[30] This good will did not go unnoticed, with several legislators commenting on the record that they were pleased that there was advanced discussion to resolve differences between the Division of Public Health and Alaska Civil Liberties Union.

[31] The informants spoke often of unique cultural aspects of Republican political philosophy in Alaska, notably a widespread belief that Republicans in Alaska traditionally oppose any government intrusion through regulation.

[32] This incitement of fear is analyzed in greater detail in the context of politicization of public health. *See infra* Part IV.B.

[33] In minimizing opposition specific to minority legislators, the Executive Director, working with the Governor's liaison on health matters, met directly with many of the minority leaders to discuss the implications of the Governor's Bill.

[34] One democratic house member objected to the Governor's Bill on civil liberties concerns, bluntly questioning "how can we even talk about doing this [quarantine] in a state that prides itself on individual liberty?"

[35] House Journal 0869-0870 (Apr. 5, 2005).

[36] *Id*.

[37] "An Act relating to disclosure of confidential or privileged information." Alaska H.B. 327, introduced Jan. 9, 2006.

[38] This chart has been adapted from Kristine M. Gebbie, *Washington State Reorganization: More of the Story*, 18 J. PUB. HEALTH POL. 188, 213 (1997).

[39] Model State Emergency Health Powers Act (2001), *available at* http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf. For additional information on the Model State Emergency Health Powers Act, see Lawrence O. Gostin, et al. The Model State Emergency Health *Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622 (2002).

[40] However, despite conversations with the drafters and legal advisors for the Turning Point Act, no formal consultative arrangements were made in drafting the Alaskan bill and no detailed outside assistance was provided.

[41] The enormous respect that informants had in the Deputy Director cannot be overstated, with many Alaskan actors stating that the Deputy Director's opinions carried great weight because, *inter alia*, she was "never dishonest," of "high integrity," and "one of us."

[42] Many public health officials and advocates noted the public health principle of developing and applying "best practices" model, which, in this case, was felt to derive from the national collaborative effort to create the Turning Point Act.

[43] An example of this is seen in the ACLU's objection to the state's expansive quarantine and isolation authority, whereupon the state reintroduced the Turning Point Act's language requiring a "significant" threat to public health and a "substantial" risk of transmission, alleviating the ACLU's fundamental objection on this point.

[44] The only mainstream media coverage of the Governor's Bill came after much of the legislative debate had concluded. *See* Maria Rendon, *Quarantine Quandary: Experts Try to Balance Privacy and Safety*, ANCHORAGE DAILY NEWS, Mar. 15, 2005, at B1 ("The public health bill is

moving forward as Senate Bill 75 and House Bill 95, but the House bill is moving more quickly through committees."); Timothy Inklebarger, *Governor Wants to Legislate Quarantine Power*, ANCHORAGE DAILY NEWS, Apr. 5, 2005, at B1 ("The state could quarantine people who become infected with diseases under a proposal given preliminary approval Monday by the state House of Representatives.").

[45] Further, given the Alaska Civil Liberties Union's inclusion in the modernization process, many public health administration informants felt that the Alaska Civil Liberties Union, but for its "reasonableness," could have, for example, "played on the fears of the legislators to get [its] way."

[46] Speaking specifically to the issue of quarantine regulation, a senior administration official noted that legislators "tend to trust government less" and are "more suspicious of it [public health authority]."

[47] As an example of a lack of state intrusion into privacy matters, many informants referred to Alaska's concealed weapons law, which permits concealed weapons without licensure or permit. Alaska Statute § 11.61.220 (2003) (allowing anyone 21 or older, other than convicted felons, who may legally carry a firearm to also carry it concealed without having to obtain a special permit).

[48] A public health actor involved in testifying on behalf of the Governor's Bill argued that the ad hoc legislative response to SARS represented "the poster child for going to the legislature with the public health law [Governor's Bill] and say . . . 'you're going to have a lot more of that if we don't pass a more comprehensive public health law that addresses these things.'"

[49] New Public Health Legislation, Press Release, Governor Frank Murkowski, Nov. 29, 2004, *at* http://www.gov.state.ak.us/news.php?id=1396; Governor Introduces New Public Health Bill, Press Release, Governor Frank H. Murkowski, Jan. 21, 2005 (on file with lead author).

[50] Administration representatives noted that the Cissna and Hollis bills had bearing on neither the substance of the Governor's Bill nor process of its legislative passage.

[51] Although ALPHA initially attempted to get a Republican sponsor for 2004 legislation (the bill that would eventually be introduced by Representative Cissna and Senator Hollis), ALPHA leaders found that no Republican legislator was "poised and ready to do this."

[52] As a senior public health official described the conflicting party dynamic described above, "regulation, governmental role, governmental authority. All this stuff that you think Democrats would want to back. It played out exactly opposite."

[53] As a counterfactual to this experience, many informants noted that governor's bills did not proceed as smoothly through the Republican legislature when the Governor had been a Democrat.

[54] The Commissioner of Health and Human Services had long worked for the Governor, having previously worked as a legislative aid to the Governor when the Governor was the Alaskan representative to the U.S. Senate.

[55] This assessment of the Executive Director was shared by many legislators and public health officials, with a prominent public health official noting him to be "very unassuming, very articulate and sort of non-thretening."

[56] By way of pondering a counterfactual situation in which an individual legislator, not the Administration, had introduced a successful bill, a public health actor within the Administration noted that:

If the political dynamic had been set up differently in the state, what we would have done is gone through probably a multi-year process of really working with all of our partners in the public health system, the public health association, and hospital and medical associations and other groups who we work with on a routine basis on lots of different things to get their attention to the issue and to work on a political strategy and political advocacy program for coming up with some very collaborative way to develop a bill that everybody could be brought in on and to.