NEW HAMPSHIRE PUBLIC HEALTH LAW

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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 Because law enables government to exercise public health powers, outdated laws may thwart public health goals.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 state constitutional and statutory laws supporting the public health system in the State of New Hampshire and identifies potential areas for statutory reform. New Hampshire's public health system is deeply complex, with intricate relationships among the federal government (including the Centers for Disease Control and Prevention, Environmental Protection Agency, and Department of Defense), state government (primarily the New Hampshire Department of Health and Human Services (DHHS) and Department of Environmental Services (DES)), and local governments (including counties, towns, cities, and other municipalities).

The report is part of New Hampshire's Turning Point Initiative, *Collaborating For A New Century in Public Health*, a project of the New Hampshire Public Health Association supported by a grant from the Robert Wood Johnson Foundations. This initiative provides technical support

for state and community public health partnerships. New Hampshire is one of fourteen original states to receive a Turning Point grant. Through its Steering Committee and the Community Health Institute, a nonprofit entity based in Concord, New Hampshire that provides administrative and technical support for the project, the Project asked the Georgetown/Johns Hopkins Program on Law and Public Health to assist with an assessment of the State's public health laws. Particularly, the Committee seeks greater understanding of the current constitutional and legal structure of public health powers in New Hampshire, with a view toward improving the legal infrastructure at the State and local levels of government.

The project is conducted in two stages. **Stage I** involves a summary analysis of state constitutional and statutory public health laws toward the preparation of this report which examines public health law in New Hampshire. This report provides both a general and sometimes specific review and analysis of constitutional and statutory public health law. The substance of the report is not intended to be exhaustive, but rather demonstrative of various facts of New Hampshire public health law. While additional legal considerations may arise from relevant administrative regulations and case law [federal or state case decisions], these sources of law have not been systematically studied nor incorporated into the report.

The report first reviews the concept and definition of public health law, including issues of federalism, to provide some context for a discussion of state public health law. Second, the report examines the current status of New Hampshire law, addressing in some detail three principal issues: (1) public health authority and functions at the state and local levels, (2) the legal

relationship between state and local public health entities, and (3) the status of laws concerning health information privacy and confidentiality.

Stage II involves expert consultation between members of the Steering Committee and one of the report's authors [James Hodge]. Mr. Hodge will present the findings of the report and discuss how the current status of public health law in New Hampshire relates to the implementation of three specific Turning Point recommendations:

1. The development of a state level Public Health Council which includes public and private representatives at the state and local levels;
2. The development of guidelines to facilitate local level public health efforts; and
3. The collection, analysis, and dissemination of public health information at the smallest geographic level [e.g. county, city, towns] to support local level planning and implementation.

An additional consultation will focus on proposed changes concerning New Hampshire public health law which may be needed to facilitate Turning Point recommendations.

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.[2] Public health is actually more encompassing. Modern definitions of public health vary widely, ranging from the holistic conception of the World Health Organization of an ideal state of physical and mental health[3] to definitions which merely list common public health practices. 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*** as:

> *. . . 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. While personal medical services, like physical examinations, vaccinations, and treatment for communicable diseases, constitute a part of public health services, public health focuses more so on community-wide assistance programs. Thus, fundamental public health services include epidemiological investigations, surveillance activities such as reporting and partner notification services, and health inspections of food servers, medical providers, and others. These and other services are geared toward communal goods in relation to public health, not necessarily improvements in individual health.

(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. Encouraging individuals to engage in health behaviors through educational campaigns or other voluntary measures is an important part of public health practice. However, state and local public health officials may also utilize coercive measures pursuant to their delegated police or parens patriae powers [discussed below] to require individuals to act in accordance with certain health standards. Thus, for example, where an individual with HIV who is counseled as to the harms to others of engaging in unsafe sexual or needle-sharing practices wilfully exposes unknowing persons to HIV transmission, public health officials may seek to prohibit the individual from engaging in such behaviors through involuntary confinement or other measures.

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 governments arise, however, federal laws and regulations likely preempt state 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 and state 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 briefly 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 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.[12] States still account for the majority of traditional spending for public health services (not including personal medical services or the environment).[13] 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's health in areas ranging from injury and disease prevention[14] to sanitation and water and air pollution.[15] Police powers exercised by the states include laws authorizing vaccination,[16] isolation and quarantine,[17] inspection of commercial and residential premises,[18] abatement of unsanitary conditions or other health nuisances,[19] regulation of air and surface water contaminants as well as restriction on the

public's access to polluted areas,[20] standards for pure food and drinking water,[21] extermination of vermin,[22] fluoridization of municipal water supplies,[23] and licensure of physicians and other health care professionals.[24]

Local Powers

In addition to the significant roles which federal and state governments have concerning public health law in the constitutional system, local governments also have important public health interests. Public health officials in local governments, including counties, towns, cities, 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.

Although local governments are often viewed as a third major level of government in the United States, their relationship to state government differs extensively from the federal/state relationship discussed above. The mutually-restraining relationship inherent in principles of federalism which federal and state governments adhere does not relate to state and local governments. Local governments in the constitutional system are generally 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. Thus, to the degree local governments set local public health priorities, they do so pursuant to specific delegations of state police powers.

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*[25] 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.[26] The modern question of new

federalism is at what point does federal intrusion into predominantly state matters exceed the limits of federal powers.

The United State Supreme Court's decision in *United States v. Lopez,*[27] along with several non-commerce clause cases, is reflective of the judicial trend.[28] In *Lopez*, the Court held that Congress exceeded its Commerce powers by making gun possession within a school zone a federal criminal offense.[29] Concluding that possessing a gun within a school zone did not "substantially affect" interstate commerce, the Court declared the statute unconstitutional. Several additional decisions, including three recent Opinions of the Supreme Court,[30] continue the new federalism trend.

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[31] or loosely preemptive federal laws[32] which invade core state concerns in public health.

New Hampshire Public Health Law

The New Hampshire Constitution

Like the federal Constitution, the New Hampshire State constitution provides affirmative grants of power while simultaneously limiting the powers of the state to preserve individual freedoms. The New Hampshire constitution explicitly provides 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,[33] equal protection,[34] freedom of religion[35] and speech,[36] and a prohibition against unreasonable searches and seizures.[37]

Unlike the federal Constitution (and most other state constitutions), the New Hampshire constitution expressly affirms one of the fundamental premises of police power regulation -- that individual rights must give way to collective goods in an organized society:

> When men enter into a state of society, they surrender up some of their natural rights to that society, in order to ensure the protection of others; and, without such an equivalent, the surrender is void.[38]

In return for this surrender of individual rights, the constitution further affirms that:

> Every member of the community has a right to be protected by it, in the enjoyment of his life, liberty, and property; he is therefore bound to contribute his share in the expense of such protection, and to yield his personal service when necessary.[39]

While these provisions suggestively require the State to act to promote the public welfare, including the public health, the degree and manner in which public health goals are accomplished are largely left to the discretion of the State legislative body (i.e. the General Court) which is invested with the supreme power to make law[40] consistent with federal and state constitutions.[41]

New Hampshire executive authority is uniquely split between an elected Governor and a popularly-elected, five-member Executive Council. In reality, the Council wields the bulk of executive power in the State, as it is effectively charged with overseeing the administration of executive authority. The Governor and state departments must seek the Council's approval for major executive decisions including receipt and distributions of state funds and the appointment of executive officials.

The State legislature has virtual plenary power to create and govern political subdivisions, subject to few limits. One such constitutional limitation on the legislative ability of the General Court is the 1984 prohibition against imposing unfunded mandates upon local governments.[42] "The state shall not mandate or assign any new, expanded or modified programs or responsibilities to any [local government] in such a way as to necessitate additional local expenditures. . . " unless the state fully provides funding or the local government's legislative body votes in approval.[43] In other words, the state cannot constitutionally require local governments to pay for state-based programs conceived after 1984. State mandates in existence prior to 1984 [like local welfare requirements - discussed in sections below] may continue without violating the state constitution. However, where the state attempts to impose funding mandates on local governments, New Hampshire courts have clarified that local governments may simply ignore the legislation or executive action.[44]

Pursuant to this concentration of lawmaking power, the State legislature has organized the state into counties, towns (known also as parishes), cities, village districts, and unincorporated areas. Unlike some states, the New Hampshire constitution currently does not expressly empower

local governments with "home rule" powers.[45] A proposed amendment[46] to the state constitution (accompanied by a statutory enactment[47] to clarify the amendment's broad language) would expressly delegate some home rule authority to local governments. The amendment's passage via election in 1999 is uncertain, however, especially where several prior attempts to amend the state constitution to empower local governments with home rule have failed.

While the State legislature occasionally allows local governments greater flexibility in administering the law, this should not be confused with a grant of home rule jurisdiction. Local governments in New Hampshire owe their existence and delegated powers to the State legislature. As a result, New Hampshire public health law and regulations are largely defined by the State legislature, executed and refined by state agencies, and subsequently followed and administered at the local level of government. Sometimes, as discussed below, the State legislature specifically assigns local governments the power to create ordinances or other laws in the interest of public health. Occasionally the delegations of public health powers to state and local governments overlap. When this occurs, the authority of the state to act prevails.

New Hampshire Public Health Statutes

Pursuant to explicit constitutional authorization, the New Hampshire 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 New Hampshire which regulate in the interests of public health. These include the ***Department of Labor*** (which regulates to improve workplace safety by limiting occupational hazards and injuries); the ***Highway Safety Agency*** (which is responsible for

developing and implementing programs to reduce traffic crashes and resulting deaths and injuries); the ***Commission for Human Rights*** (which has jurisdiction over multiple types of discrimination, including discrimination based on mental or physical disability); the ***State Liquor Commission*** (which regulates the sale and distribution of alcohol); the ***Department of Education*** (which administers public health educational efforts in schools, such as HIV/AIDS education[48]); the ***Department of Agriculture*** (which regulates in the interests of rabies and communicable disease control among animal populations and pesticide contamination) and the ***Joint Board of Licensure and Certification*** (whose purpose is to safeguard the public health, safety, and welfare by regulating the practices of professional engineering, architecture, land surveying, forestry, and natural science).

The ***Department of Safety*** is a multifarious state agency which promotes the effectiveness of public safety programs, including the enforcement and promotion of motor vehicle and highway safety laws; various criminal laws; and fire, building, equipment, and boating safety. Its Governor-appointed commissioner serves on state boards that regulate the transportation of hazardous materials, low level radioactive waste, wetlands preservation, water supply, and other matters.

The Governor's ***Office of State Planning*** works to develop and manage New Hampshire's resources and otherwise assists in the planning and growth activities of state agencies and local governments. Many of its responsibilities center on coordinating state and local services in areas such as environmental control and grant administration. The Office has previously collaborated with local government officials in the drafting of model ordinances for

local passage, including a sketch Model Health Ordinance to Regulate Public Health Issues and Establish Local Enforcement Procedures in April, 1999.

Most traditional public health functions in New Hampshire, however, are centrally administered, if not performed directly, by one of two state agencies, the ***Department of Health and Human Services*** (DHHS)[49] (http://www.dhhs.state.nh.us/) and, to a lesser extent, the ***Department of Environmental Services*** (DES)[50] (http://www.des.state.nh.us/descover.htm). As summarized below, the respective duties and functions of these state agencies are distinguished by the general legislative intent underlying their establishment. DHHS is primarily responsible for regulating public health matters related to the control of communicable diseases, administration of public health care, and issues of public safety, including some environmental concerns. DES is delegated the primary authority to regulate environmental threats to health. Its specific duties include regulating water quality and resources, air pollutants, and municipal and industrial waste.

Department of Health and Human Services (DHHS)

DHHS and its many newly-organized Offices and divisions are headed by the Commissioner of Health and Human Services.[51] Many of its health-related responsibilities are focused around the provision or management of health care services to individuals. DHHS is active in organizing and managing hospitals, physicians, and other health care providers in the State. It seeks to improve access to care, contain health care costs, and ensure quality care through improved purchasing, planning, and organization of health care systems.

While its 1998 report, *The New Hampshire Health Care System – Guidelines for Change*, focuses predominantly on this role of the department concerning the provision of individual health

care, public health goals of disease and injury reduction and state-wide health improvement also pervade the report. These recommendations lend support to the continuing work of the state's Turning Point Initiative to further clarify and advance public health recommendations.

DHHS recognizes that regulations concerning individual health care are synergistic with public health. The Department counts among its major responsibilities the public health need to prevent disease and protect the health of New Hampshire citizens. Its relatively-new **Office of Community and Public Health** collaborates many traditional state public health services [which were formerly administered principally by the distinct Division of Public Health Services]. The Office's eight major subdivisions carry out a variety of core public health tasks. The **Family and Community Health Division**, for example, administers women's and children's health programs, including the federally-sponsored Women, Infants, and Children Nutrition Services (WIC).

Other divisions, including **Community Support**, **Disease Prevention and Health Promotion**, and **Epidemiology and Vital Statistics**, oversee or directly provide many public health services, including laboratory services; disease surveillance (i.e. reporting and partner notification) for sexually-transmitted diseases and HIV/AIDS; risk reduction projects (such as diabetes and tobacco prevention); immunization programs; vital records and statistics; and a variety of primary care programs. The Office also serves as a direct liaison between DHHS and local health officers, providing advice and training to the health officers concerning local public health issues.

These and other traditional public health duties and functions are broadly delegated to DHHS through loosely-defined authorizations by the state legislature. DHHS is statutorily

authorized in general ". . . to provide a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety, and well-being of the citizens of New Hampshire."[52] Many of DHHS' specific public health functions are legislatively set forth in subsequent sections of the New Hampshire Revised Statutes Annotated, primarily Title 10 (Public Health), Title 11 (Hospitals and Sanitaria), and Title 12 (Public Safety and Welfare).

DHHS is statutorily authorized, among other things, to: (1) collect vital statistics and health records;[53] (2) identify, investigate, and test for communicable diseases, including HIV/AIDS;[54] (3) provide educational services and coordinate medical, municipal, and other services to control communicable diseases;[55] (4) license[56] and inspect food establishments for public health threats[57] (5) issue regulations concerning public health nuisances generally;[58] (6) establish, equip, and operate public health laboratories;[59] (7) promote maternal and child health;[60] (8) establish, maintain, and coordinate a comprehensive system of mental health services;[61] (9) administer public health programs, including a state-wide reporting system concerning "critical health problems," (defined as lead poisoning, Reye's syndrome, and any other public health disease, condition, or procedure as determined by DHHS);[62] (10) prevent lead paint poisoning;[63] (11) license and regulate hospitals, residential care facilities, nursing homes, emergency care technicians, and ambulatory care clinics;[64] (12) regulate and enforce the State's Indoor Smoking Act;[65] and (13) investigate the sanitary conditions of school facilities.[66]

DHHS is also statutorily charged with some duties that, in many states, may be assigned to state environmental departments. Some of these duties are remnants from the agency's past

when it was responsible for virtually all the duties now relegated to DES (see below). Thus, for example, DHHS is responsible for (1) regulating sources of radiation to protect occupational and public health and safety;[67] (2) assisting other state agencies in assessing whether the state can safely store high-level radioactive wastes;[68] (3) monitoring and assessing environmental hazards (defined as any biological, chemical, or physical agent present in the environment which has the potential of causing disease or adverse health outcome);[69] (4) conducting comprehensive policies and programs for evaluation of hazards associated with the use of chemical or physical agents;[70] and (5) coordinating asbestos health protections with DES.[71]

Although the statutes authorizing these and other public health duties of DHHS are often very general, even simplistic, DHHS is usually authorized to enact administrative regulations which allows the agency to precisely define the scope and extent of its powers. Such administrative regulations have the binding force and effect of statutory law, but are subservient to federal and state constitutional and statutory laws. To the extent that administrative regulations exceed DHHS' statutory authorization or are inconsistent with constitutional or New Hampshire statutory law, they are without effect.

Department of Environmental Services (DES)

The Department of Environmental Services (DES) has primary authority for significant public health efforts of an environmental nature.[72] DES is the state's primary environmental protection agency. Its responsibilities generally include ensuring the quality of water supplies,

regulating air pollutants,[73] and managing municipal and industrial waste.[74] DES coordinates and develops state-wide environmental policies and sets standards governing air, water, surface, and subcutaneous pollution.[75] The Department was legislatively created in 1987 through the consolidation and reorganization of four existing state agencies: the Air Resources Agency, the Office of Waste Management, the Water Supply and Pollution Control Commission, and the Water Resources Board. These prior entities and their respective functions have been organized into DES' three existing Divisions: **Air Resources**, **Waste Management**, and **Water**, which are assisted by statutorily-created Councils. Each Council (1) consults with and advises the corresponding Division Director regarding the Divisions' policy, programs, goals, and operations, with an emphasis on long-range planning and education of the public; (2) reviews rules proposed by DES that relate to the corresponding Division's programs; and (3) hears administrative appeals from final DES' decisions in the corresponding Division's programs.

The **Air Resources Division**, guided by the New Hampshire Air Resources Council,[76] attempts to abate air pollution through industrial permitting, setting and enforcement of regulatory standards, monitoring of air quality, and control of ozone, acid precipitation, asbestos (which it shares responsibility for with DHHS), and other air emissions. With assistance from the New Hampshire Water Council[77] and the Wetlands Council,[78] DES' **Water Division** regulates water quality among hundreds of public water supply systems in the state. It also oversees wastewater control activities and surface water contaminants due to leaky or improperly functioning sewage or septic systems. The Division monitors water quality levels in lakes, rivers, and streams, inspects public beaches and swimming pools, and checks levels of acid rain. The **Waste**

Management Division is primarily responsible for regulating generators of municipal and industrial waste, including hazardous waste. With federal Superfund assistance and guidance stemming from the Waste Management Council,[79] the Division helps locate and clean up hazardous waste sites. It also conducts a comprehensive underground storage tank control program, an emergency response program to address petroleum spills, and oversees the disposal of solid wastes in landfills.

Like DHHS, DES often has the delegated authority to establish and enforce administrative regulations which allows the agency some flexibility to determine the scope and extent of its regulatory authority concerning environmental matters.

Municipal/Local Public Health

As mentioned above, New Hampshire has constitutionally assigned the State legislature the authority to establish, or charter, local governments and endow them with powers. Among the general powers of towns (and other local governments via statutory reference[80]) is the power to make bylaws for a variety of purposes, including the "[m]aking and ordering [of] their prudential affairs."[81] While this statutory provision could arguably be interpreted to grant local governments home rule, this is not the State's opinion. As New Hampshire's Attorney General has previously concluded, the State authorization for the enactment of bylaws concerning a town's prudential affairs is not an independent grant of significant legislative authority. Rather, it is merely a grant of power to towns to do what is necessary and proper in carrying out State-imposed statutory duties.[82]

Perhaps the closest example of home rule concerning issues of public health in New Hampshire is seen in the State legislature's delegation to town or city councils the power to enact ordinances ". . . which may be for the well-being of the city."[83] Subsequent to this grant of power, however, is the qualification that such ordinances may not be ". . . repugnant to the constitution or laws of this state."[84]As judicial courts have clarified, the power of local governmental councils to enact broad ordinances under this statute is expressly limited to ordinances which are consistent with state law.[85] Where the State legislature has enacted a comprehensive regulatory scheme, city councils cannot pass ordinances which contravene it.[86] Thus, a town or city cannot use this general grant of power to zone out a hazardous waste plant because the location of such facilities is completely regulated by state law.[87]

Although local governments in New Hampshire are not vested with broad home rule powers to enact local laws without state interference, they have a vital role in New Hampshire government. Many of the State's 235 chartered municipal corporations existed before the State joined the newly-formed nation,[88] and all have the choice of the type of governing bodies.[89] As one municipal law expert in New Hampshire has stated:

> These municipal corporations affect almost every aspect of community life. They regulate the way in which land is used, homes are constructed, protection is provided, children are educated and taxes are raised and paid.[90]

These local governments also are important in the delivery and execution of public health services and responsibilities in New Hampshire.

Local Government in New Hampshire

New Hampshire statutory law establishes and classifies the State into counties, cities, towns, village districts, and unincorporated places.[91] The State is divided into ten counties,[92] each of which are governed principally by an elected board of county commissioners which is overseen and supplemented by the elected state representatives from the county (known as the county convention).[93] While county governments carry out some important governmental functions, including providing local correctional facilities, nursing home regulation, registries for deeds and probate matters, and maintenance of county courthouses, the bulk of local government power is concentrated among the State's thirteen (13) cities and 221 towns.

Although cities and towns in New Hampshire are legislatively viewed differently, the primary difference between them is unrelated to size or population, but rather their form of government. Consistent with the State's rich pre-colonial history, most **towns** are governed by the traditional town meeting. These town's legislative body is comprised of the town's residents which assemble and vote on the major actions which the town undertakes. In this example of a pure democracy, a town's authority to act, consistent with State constitutional and statutory law, is determined by a majority vote of citizens attending regular town meetings under procedures set by State law.

Cities, however, are governed by bodies of elected representatives of which there are two types: (1) the council-city manager plan, and (2) the mayor-alderman plan. These classifications, which are similar to many other states' forms of local government, concentrate the local legislative powers in elected representatives or appointed officials, instead of the body politic. Thus, the

city's legislative authority in a mayor-alderman form of government is concentrated in a board of elected alderman with executive authority largely residing with the city's elected mayor.

This clear demarcation between towns and cities is confused by the existence of **towns with "home rule" charters**, or official recognition of limited local authority by the State. Like cities, these towns are governed by bodies (i.e. town councils) of elected officials (i.e. selectman). There are three alternate forms of government among these "chartered" towns, including (1) board of selectmen-town meeting,[94] (2) town council-town manager *and* mayor (with or without a budgetary town meeting),[95] or (3) town council-town manager *or* mayor (with or without a budgetary town meeting).[96]

Within towns or cities, **village districts** may be formed upon petition of as few as ten legal voters who live within the proposed district.[97] These districts, often known as "special districts" in other states, may be established to provide firefighting services, street lighting, tree planting, water supplies, sidewalks, sewers and treatment facilities, parks, electrical utilities, pest control, limited police and ambulance services, roadway maintenance, and flood control.[98] These districts, which should not be confused with "district departments of health" (discussed below), are funded through distinct taxes levied on property located within the specific district.

Finally, New Hampshire officially recognizes twenty-four **unincorporated places** with specifically-defined geographical boundaries. Though these units are not towns or cities, their governments may be similar in form and duties. The counties in which these areas are located owe similar responsibilities to unincorporated areas as are owed to towns or cities.[99] State law related to the governance of towns applies to unincorporated places.[100]

The Relationship Between State and Local Public Health Entities

New Hampshire statutory law does not always clearly define the relationship between the state and local governments concerning public health responsibilities. The State legislature commonly assigns a state agency, such as the Department of Health and Human Services, with responsibility for a public health matter. DHHS may subsequently utilize and oversee local government health officials, discussed below, to help accomplish public health objectives. For example, the State legislature broadly assigns DHHS the power to regulate to control communicable diseases.[101] Local health officials are statutorily assigned a subservient role, as if they are mere agents of DHHS. They "[a]ssist the commissioner [of DHHS], *when requested to do so*, in the establishment and maintenance of quarantine and isolation. . . " and [a]ttend meetings with the commissioner, *when requested*, for consultation on matters relating to public health" (emphasis added).[102]

Health Officers

Each traditional, non-chartered town is statutorily required to recommend a health officer which DHHS' commissioner subsequently appoints.[103] The commissioner may appoint a health officer of his or her choosing for unincorporated areas[104] or if the local government fails to select a candidate.[105] The only statutory qualification for appointed health officers is that they be state residents.[106] They hold office for three years (or until a successor is appointed), unless removed for cause.[107] Together with the local legislative body, the health officer constitutes the local health board.[108] In cities and towns operating under a representative council form of government, the powers vested in local boards of health exist in the local legislative body which may appoint its

own health officers.[109] The New Hampshire Health Officers Association helps to coordinate the relationship between local health officers, DHHS, and other state agencies.

District Departments of Health

Alternatively, local governments can unite to form district departments of health,[110] although none have to date. Each participating city or town helps to fund the district department[111] and is entitled to appoint a number of officials to its governing board. The number of persons representing each local government varies depending on the size of the local government, but in no event is less than two representatives.[112] The representative board of the district department subsequently appoints a health officer via election within sixty days of the formation of the district (otherwise the commissioner of DHHS will appoint a health officer).[113] The health officer must be professionally-educated, experienced in public health, and meet other qualifications set by DHHS. The individual, who may only be removed by the district board for cause, shares similar duties as those required of town health officers via state law, in addition to any duties specifically assigned by DHHS.[114] The district health official replaces prior existing town health officials and appoints and oversees the department and its staff.

Local Government Public Health Duties

Town health officers (and district health officials via statute[115]) are statutorily required to enforce State public health laws and regulations.[116] They may conduct investigations as required by local boards of health or DHHS.[117] This includes the power to enter private property, other than private living quarters, to investigate and take appropriate action to safeguard the public health or prevent water pollution.[118] While most of the public health duties of local health officers

are statutorily prescribed, the State legislature has given health officers some discretion to regulate locally in the interests of public health. Representative town or city councils have the general power to enact ordinances and bylaws concerning, among other things, "disorderly houses" and gaming establishments,[119] use of public ways,[120] nuisances and the "collection, removal, and destruction of garbage or other waste material,"[121] warnings and citations for health and safety code violations,[122] and "drug-free zones."[123]

Pursuant to New Hampshire Revised Statutes, Title 10, Chapter 147 (Nuisances), town health officers (in conjunction with the town's legislative body) may make regulations ". . . for the prevention and removal of nuisances, and such other regulations relating to the public health as in their judgment the health and safety of the people require."[124] They may also issue regulations, subject to DHHS' approval, concerning the sanitary and health conditions for issuing licenses to food serving establishments.[125]

Consistent with the dominance of state authority in public health, however, local regulations extending from these types of statutory delegations of power may be supplemented and supplanted by DHHS.[126] Similar statutory arrangements exist between the Department of Environmental Services and local governments concerning solid waste disposal,[127] sewage disposal systems and public sewers,[128] and water supplies.[129]

Cities and towns, however, have legislatively been granted greater authority to regulate in some areas of public health concern, including the setting of housing standards;[130] enforcement of rules related to hazardous and dilapidated buildings;[131] and building, plumbing, and electrical codes.[132]

Finally, one of the more remarkable statutory duties of towns and cities in New Hampshire is its obligation to care for the downtrodden. New Hampshire's local welfare laws[133] require local governments to provide some level of care to individuals, whether local residents or not, who are poor and unable to support themselves. While the extent of care depends on individual communities and federal and state welfare and health laws, the local obligation to provide for its less fortunate citizens has potentially significant public health repercussions. Does this statutory duty, for example, mandate local governments to provide health care to an individual with a non-contagious, life-threatening disease where the illness greatly contributes to his poverty status?

New Hampshire Public Health Privacy Laws

The New Hampshire legislature has enacted numerous laws to protect the confidentiality of personal medical and public health records. Though the state has declared information held by state agencies to be public records open to inspection pursuant to its Right-to-Know-Law, it specifically exempts from disclosure "[r]records pertaining to . . . medical. . . and other files whose disclosure would constitute an invasion of privacy."[134] This exception, however, does not prohibit a state agency from releasing confidential health or safety information to persons whose health or safety is affected.[135]

Like most states, New Hampshire has not implemented broad public health information privacy protections through the passage of a single statute. Rather, the State legislature has enacted a series of privacy provisions relating to specific public health information, including vital records and health statistics, HIV/AIDS data, communicable disease information, data held in the

State's cancer registry, hospital discharge data, medical research data held by DHHS, and mental health records.

Concerning vital records and statistics, the commissioner of DHHS is authorized to appoint a registrar to collect personally-identifiable health records of numerous types. DHHS is further required to enact administrative regulations[136] (a review of which has not been undertaken for the purposes of this report) to insure that (1) the minimal amount of data is collected to accomplish a specific purpose; (2) no information is made available to unauthorized personnel; (3) only the minimal amount of information is made available to authorized personnel; and (4) no information that could possibly adversely affect identified individuals be made public.[137]

Statutory law furthers prohibits the registrar from permitting inspection of or disclosing vital health records unless the applicant has a "direct and tangible interest" in the record.[138] Persons having such direct and tangible interests include (1) the person who is the subject of the record; (2) the person's parents, guardians, or legal representatives;[139] (3) others with a demonstrable need for the information "for determination or protection of a personal or property right,"[140] (query as to what this means?); (4) members of the press when the information requested is "of a public nature;"[141] (5) federal, state, and local governments; (6) genealogical researchers;[142] and (7) health researchers.[143] They do not include commercial entities seeking lists of names and addresses,[144] but by statutory definition would include a commercial entity seeking a single name and address, or personally-identifiable information other than names or addresses.

Pursuant to state law, hospital discharge data are explicitly public data, provided that individual patients or practitioners are not directly or indirectly identifiable.[145] Health researchers,

however, can access identifiable data related to hospital discharge records provided such is consistent with DHHS' regulations.[146] Similar provisions apply to data held in state cancer registries.[147] HIV test results submitted for laboratory analysis may not be disclosed to anyone, except: (1) the physician ordering the text;[148] (2) the person who is the subject of the test;[149] (3) DHHS' commissioner pursuant to reporting requirements;[150] (4) parents or legal guardians of minors;[151] (5) medical directors of institutions where HIV-positive individuals may be confined;[152] (6) via subpoena or legal discovery;[153] (7) pursuant to written informed consent of the person tested;[154] (8) to other health care workers to protect the person's health;[155] (9) to agencies which receive blood donations;[156] and (10) to victims of sexual assaults involving the person.[157]

Personal medical or other scientific data held by DHHS for research purposes is statutorily declared "confidential" and cannot be disclosed by DHHS, its employees, or others unless such is related to the furthering of the research study.[158] DHHS' communicable disease reports which are personally-identifiable can only be disclosed to persons ". . . demonstrating a need which is essential to the health-related research or to protecting the health of the public."[159]

Recommendations for Public Health Law Reform

Our analysis of New Hampshire's statutory public health laws has so far attempted to objectively describe the status of the law without suggesting where the law may need reform. Although there are many instances where statutory legal reform may be advisable, whether New Hampshire should reform its public health law remains open. Law reform is not the inevitable result of a public health law improvement process (although it could be). And while many benefits may flow from law reform, there are also risks. Public health bills are difficult to draft, involve sensitive public issues, and can become politicized. Enacted laws can tie the hands of public health officials for better or worse. Once relationships among various groups or agencies are delineated in legislation, it could result in great distrust. Despite these evident risks, legal reform may serve a valuable end toward improving public health in New Hampshire. These and other benefits underlying a public health improvement process are discussed below, consistent with three stated objectives arising from the Turning Point Initiative: (1) developing a statewide Public Health Council [including discussion of some of our specific recommendations for legal reform]; (2) coordinating local health departments and officers; and (3) improving public health information privacy protections.

The Benefits of a Public Health Law Improvement Process

Public health law contemplates the responsibilities of individuals and the duties of government to act for the health of society. As such, public health law serves as a foundation and a framework for public health activity. 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 have to consider prevailing social values and respect multiple constituencies, including scientists, politicians, and community leaders.

The Role of Public Health Law

There are several 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.

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[160] 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 that uses a variety of legal means to create the conditions for people to be healthy.

The following benefits could be achieved through a public health law improvement process.[161]

Update Antiquated Laws

Like most public health laws in the United States, New Hampshire's statutes and regulations have been passed piecemeal in response to specific disease threats such as tuberculosis and HIV/AIDS. The law has thus developed, layer-upon-layer, from one time period to another. Many old laws remain a part of New Hampshire's public health law. 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 and public health standards. Older laws may not reflect contemporary scientific understanding of disease, current medical treatments of choice, or constitutional limits on the state's authority to restrict individual liberties.

Keep Pace with Scientific Developments

When many of New Hampshire's public health laws were enacted decades ago, the scientific understanding of diseases was very different than it is today. Not surprisingly, public health laws from prior times reflect a limited understanding of disease and may lack a public health justification based on contemporary scientific knowledge.

Comply with Modern Constitutional and Other Legal Requirements

Many of New Hampshire's 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 (i.e. the Americans With Disabilities Act) 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.[162]

Clarify the Law

General provisions concerning public health duties and responsibilities sometime result in confusion about who has what public health powers and when to exercise those powers. This

confusion is understandable. Given the multiplicity and layer-upon-layer of laws and regulations concerning New Hampshire 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.

Improving Relationships

Improving the working relationships in public health throughout the State is an important goal. New Hampshire public health practice involves complex relationships between governmental and non-governmental entities and actors. These relationships are of several kinds.

(i) Legislative and Public Health Authorities

Legislators and public health officials may have markedly different understandings about public health and the role of government. Public health authorities frequently seek greater freedom to exercise their discretion in matters concerning the health of the community. This appears to be the impetus underlying New Hampshire's increasing political push for local home rule. Legal requirements and the political process can be viewed as impediments to a well-functioning health department. Concerns exist over how legislators approach issues of public health law, funding, and development of an adequate public health infrastructure.

Legislators and public health authorities must listen to one another through discussions which are motivated on the sole issue of improving New Hampshire's public health system. Such communications should not occur mainly in response to the latest public health issue. Rather, a primary benefit of public health law reform would be the coming together of public health

authorities and legislators for the common good. Through the Turning Point Initiative, many of these discussions have taken place, although additional work remains.

(ii) Federal and State

As with every state, the federal government is intricately involved in public health in New Hampshire, and thus, there remains a need for strong relationships among federal and state public health officials.

(iii) State Public Health Agencies

Regular communication and effective working relationships between state level agencies like DHHS and DES are important, especially where some public health functions undertaken by these and other agencies overlap to some degree. For example, the broad authority of DHHS to control communicable diseases and monitor food contaminants may intersect DES' responsibility for monitoring and preventing water-borne contaminants. 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 often works 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.

(iv) State and Local

State and local dialogue on public health is critical in New Hampshire given the legal structure and cultural diversity of the State and its urban, suburban, and rural populations. Channels of communication between hundreds of State and local public health authorities must be maintained. A lack of regular communication and planning between these authorities carries 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. 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.

Public Health Council

One of the principal recommendations of the Steering Committee for New Hampshire's Turning Point Initiative is to establish a state-wide Public Health Council. While the details concerning the membership, scope of authority, and duration of this body continue to be debated, the Council may work to improve communications among various federal, state, and local government public health officials, as well as private sector actors. This alone would be an important contribution to improving public health in the State.

The creation of a Public Health Council that serves purely in an advisory capacity is relatively easy. For example, public health authorities in New Hampshire could simply agree to convene open meetings of the Council, with attendance open to all interested parties, that

discusses needed public health improvements. Such dialogue would be valuable. However, as members of the Steering Committee have suggested, a more purposeful Council would have the aura of governmental status and authority, be limited in size to select representatives of certain governmental and private sector bodies or organizations, be substantially funded to study specific legislative or executive requests, and perhaps even be given some control over executive public health budgets or the power to create administrative regulations [through the State's standard administrative procedures act].

The vision of a New Hampshire Public Health Council having any or all of these attributes is progressive and exciting, but legally and politically challenging. Whether created as a legislative committee, a special commission under the Governor's Office, or a subdivision under DHHS, among other options, its establishment will likely require legislative action in the form of an authorizing bill and require funding approval through the same approval procedures required for other state expenditures. Political debates concerning the membership, tenure, funding, and authority of the Council may threaten the creative vision underlying its purpose. Such legal and political impediments do not, of course, prohibit its creation: they only complicate it.

One of the more valuable contributions which the Council could make is the development of specific recommendations for legal reform based on informed consideration and understanding of New Hampshire's current political structure and public health needs. These substantive and structural reforms may flow from the following broad recommendations.

Mission Statement: Essential Public Health Services

A recent report 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.[163]

New Hampshire's public health law, like other states, does not articulate a clear mission for public health. Nor does New Hampshire law spell out core or essential public health services necessary for serving the State. Consequently, legal reform should begin with an expression of a clear mission for public health. This mission statement 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.

New Hampshire 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 Principles of Significant Risk

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

New Hampshire 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

While public health officials need ample and flexible powers to protect the common welfare, the community needs to have confidence in the fairness of public health practice. As a result, 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.

Local Coordination of Public Health

One of the principal structural impediments to effective public health practice in New Hampshire is the current statutory system which involves the designation of a local health officer in each of the hundreds of cities and towns in the State. Without discounting the potential value which arises from each community having a local health authority, this statutory requirement has actually led to a fragmented, uncoordinated, and, at times, unsophisticated practice of public health in the State for several reasons: (1) local health officials may lack any public health experience or training since there are virtually no statutory requirements for persons assuming these positions; (2) these officials may be politically-influenced within their own communities to avoid implementing certain needed public health measures; (3) in some communities, these

officials also serve other roles, such as plumbing inspectors, which compromise their ability to attend to many other public health issues; (4) in other communities with very small populations, public health issues may not require local health enforcement; (5) although statutory law in New Hampshire allows local governments to fund local public health officials through ad valorem taxes, local health departments regularly compete with other local funding priorities and are often chronically under-funded; and (6) without home rule, local health officials may lack authority to address some local public health issues. This, alone, is not a problem where state public health officials may be relied upon in the absence of local authority. However, state support for public health initiatives, such as environmental threats, varies extensively and may fail to assist local health authorities with problems their local governments cannot possibly remedy due to legal, financial, or other constraints.

Turning Point officials in New Hampshire suggest that at least part of what is needed to remedy these and other local public health issues is the consolidation of local health departments to create economies of scale, facilitate state and local relationships, and improve the level of sophistication and response to local public health dilemmas. Through the creation of district departments of health,[164] New Hampshire statutory law provides a ready mechanism through which such consolidation may occur. District departments of health involve the collaboration of towns or cities to combine their respective jurisdictions for the purposes of creating and funding a single health territory. This health district is overseen by a governing board made up of representatives from each local government. The district's representative board elects a health officer, (otherwise DHHS' commissioner will appoint a health officer), who is professionally-

educated and experienced in public health. The district health officer replaces prior existing town health officials and appoints and oversees the department and its staff.

Under the guidance of its board and health officer, the district department of health has the same authority to carry out public health duties as any town or city, but this authority extends across a broader jurisdiction, without the same degree of political influence, and potentially with greater funding and sophistication. If implemented state-wide, these departments may effectively align the State's local public health practice into several contiguous districts with influential working relationships with state and federal authorities. Such alignment may bring New Hampshire closer to a goal, shared by other states,[165] of providing meaningful and consistent public health services to its entire population (regardless of race, income-level, or other factors) on a regional basis.

Without the need to pursue additional legislative authorization for the consolidation of public health services, the creation of district departments of health is an important component of public health reform in the State. We recognize, however, that since 1949 (the year in which the law allowing for the creation of district health departments was passed), local governments have not shown interest in creating such departments. This lack of interests is due primarily to issues of local politics and control. Overcoming political opposition to their creation is problematic, but may be facilitated through increased education about the potential fiscal and public health benefits which may stem from their establishment.

Public Health Information Privacy

That legal reform may contribute immensely to the improvement of public health is perhaps best demonstrated through practical reforms in New Hampshire concerning public health information privacy. As discussed above (see *New Hampshire Public Health Privacy Laws*), New Hampshire's legislative provisions generally support the privacy and confidentiality of personally-identifiable, government-held health information. However, these statutes singularly and collectively raise privacy concerns. The laws often fail to provide meaningful privacy protections, tend to imprecisely define privacy protections which are provided (although DHHS' administrative regulations may remedy some of this imprecision), exceptionalize some data to the exclusion of other, equally-sensitive health information, and generally represent overly-centralized, antiquated responses to individual privacy needs in an increasingly electronic public health information infrastructure. In the absence of a structured statutory approach to protecting public health information privacy, certain privacy infringements and breaches may occur (or may have already) which could have deleterious effects on public health in New Hampshire.

New Hampshire and other states are in the process of reforming their public health privacy statutes consistent with recommendations arising from the Model State Public Health Privacy Project (www.critpath.org/msphpa/privacy.htm). With the assistance and guidance of an expert panel of privacy and public health experts and sponsorship by the Centers for Disease Control and Prevention (CDC), the Council of State and Territorial Epidemiologists (CSTE), the Association of State and Territorial Health Officers (ASTHO), and the National Conference of State Legislatures (NCSL), the Georgetown/Johns Hopkins Program on Law and Public Health has developed a Model State Public Health Privacy Act (MSPHPA).

The MSPHPA addresses privacy and security issues arising from the collection, maintenance, use, disclosure, and storage of identifiable health information by public health agencies at the state and local levels. The underlying objective of the law is to clearly identify the ways in which governmental public health departments can acquire, use, store, and disclose identifiable, health-related information. Non-identifiable health-related information is not subject to the Act's provisions because it does not seriously implicate individual privacy concerns.

The Act attempts to balance individual privacy and security interests versus the need of public health departments for health information by focusing its protections on the information itself. The Act empowers individuals (to a degree) to control their information held by public health departments. It affirmatively allows people to access, inspect, and amend their health information; learn the ways in which it is used and disclosed; request a record of disclosures; and seek criminal or civil sanctions for actions inconsistent with the Act.

Coextensively, the Act limits (to a degree) the ability of public health departments to acquire, collect, and use identifiable health information. Public health departments may acquire, collect, and use individually-identifiable health information only so long as such information is needed to accomplish legitimate public health purposes. A legitimate public health purpose, as defined by the Act, means a population-based activity or individual effort primarily aimed at the prevention of injury, disease, or premature mortality, or the promotion of health in the community, including [a] assessing the health needs and status of the community through public health surveillance and epidemiological research, [b] developing public health policy, and [c] responding to public health needs and emergencies.

Public health departments must de-identify the information whenever possible, expunge unnecessary information confidentially, and maintain the accuracy of public health information.

The MSPHPA strictly regulates disclosures of identifiable health information to persons or entities outside state and local public health departments. While the uses of public health information historically present little opportunity for abuse or discrimination under existing legal frameworks that project government-held information, disclosures of information to persons outside public health departments may result in employer and insurer discrimination and public humiliation. The Act allows disclosures of health information to be made for any purpose with the advance informed consent of the person to whom the information relates. Absent consent, the Act generally prohibits disclosures subject to only a few, narrow exceptions, including disclosures (1) to individuals to whom the information relates; (2) to appropriate federal agencies pursuant to federal or state law; or (3) to medical personnel in the event of an emergency to protect the health or life of the individual to whom the information relates. Any disclosures of information must be as least intrusive as possible to personal privacy and include common-sense language that describes basic privacy protections to which the subsequent holder must adhere under the Act. Persons receiving the information are legislatively bound to adhere to the same disclosure provisions.

Finally, public health agencies and all subsequent holders, users, or storers of identifiable public health information are obligated to hold and use information securely. Various physical and technological security safeguards must be implemented. Failures to adhere to the provisions of the Act may subject public health departments and their officials to criminal or civil liability.

Conclusion

The preceding Recommendations, supported by our study of public health statutes in New Hampshire, present guidelines for legal reform. Specific statutory language needed to accomplish these reforms and rebuild New Hampshire's public health system remains to be drafted, reviewed, critiqued, and ultimately submitted to the legislature. The decision whether to undertake legal reform must be carefully weighed by key public health actors in the State. This decision should be ultimately motivated not by political interests nor potential complications, but rather by a desire to improve public health practice. Ultimately, this is the overriding and commendable goal of the Turning Point Initiative in New Hampshire.

ENDNOTES

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

2. James G. Hodge, Jr., *The Role of New Federalism and Public Health Law,* 12 J. L. & HEALTH 309, 317 (1998).

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

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

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

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

15. 39 AM. JUR.2d Health §§ 22, *et seq.* (1968).

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

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

18. 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).

19. 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).

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

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

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

23. 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).

24. 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).

25. 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).

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

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

28. *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).

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

30. For a historical and contemporary discussion of the public health roles of the federal, state, and local governments under principles of federalism, see James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J. L. & HEALTH 309 (1998), and the companion article, *Implementing Modern Public Health Goals: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMPORARY HEALTH L. & POLICY 93 (1998). See also Susan Wall, *Transformations in Public Health Systems*, 17 HEALTH AFFAIRS 21 (1998).

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

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

33. N.H. CONST. part I, art. 2.

34. N.H. CONST. part I, arts. 1, 2.

35. N.H. CONST. part I, art. 5.

36. N.H. CONST. part I, arts. 22, 30.

37. N.H. CONST. part I, art. 19.

38. N.H. CONST. part I, art. 3.

39. N.H. CONST. part I, art. 12.

40. N.H. CONST. part I, art. 31; part II, art. 2.

41. N.H. CONST. part II, art. 5.

42. N.H. CONST. part I, art. 28-a.

43. N.H. CONST. part I, art. 28-a.

44. N.H. Workers' Comp. Fund v. Flynn, 133 N.H. 17 (1990); see also New Hampshire Municipal Association, *Knowing the Territory: A Survey of Municipal Law for N.H. Local Officials* 5-6 (1999).

45. New Hampshire Municipal Association, *Knowing the Territory: A Survey of Municipal Law for N.H. Local Officials* (1999).

46. This amendment is referred to as CACR 6 (1999) by the New Hampshire Municipal Association.

47. NEW HAMPSHIRE HOUSE BILL 468 (1999).

48. N.H. REV. STAT. ANN. 141-F:3[I].

49. N.H. REV. STAT. ANN. 126-A:1 *et seq.*

50. N.H. REV. STAT. ANN. 21-0:1 *et seq.*

51. N.H. REV. STAT. ANN. 126-A:1 *et seq.*

52. N.H. REV. STAT. ANN. 126-A:4[I].

53. N.H. REV. STAT. ANN. 126:1 *et seq.*

54. N.H. REV. STAT. ANN. 141-F:1 *et seq.*

55. N.H. REV. STAT. ANN. 141-C:1 *et seq.*

56. N.H. REV. STAT. ANN. 143-A:1 *et seq.*

57. N.H. REV. STAT. ANN. 143:1 *et seq.*

58. N.H. REV. STAT. ANN. 147:2.

59. N.H. REV. STAT. ANN. 131:1 *et seq.*

60. N.H. REV. STAT. ANN. 132:1 *et seq.*

61. N.H. REV. STAT. ANN. 135-C:1 *et seq.*

62. N.H. REV. STAT. ANN. 141-A:1 *et seq.*, 142:1 *et seq.*

63. N.H. REV. STAT. ANN. 130-A:1 *se seq.*

64. N.H. REV. STAT. ANN. 151:1 *et seq.*, 151-D:1 *et seq.*

65. N.H. REV. STAT. ANN. 155:64 *et seq.*

66. N.H. REV. STAT. ANN. 200:1 *et seq.*

67. N.H. REV. STAT. ANN. 125F:1 *et seq.*

68. N.H. REV. STAT. ANN. 125G:1 *et seq.*

69. N.H. REV. STAT. ANN. 125H:1 *et seq.*

70. N.H. REV. STAT. ANN. 140:1 *et seq.*

71. N.H. REV. STAT. ANN. 141-E:1 *et seq.*

72. N.H. REV. STAT. ANN. 21-0:1 *et seq.*

73. N.H. REV. STAT. ANN. 125-C:1 *et seq.*, 125-I:1 *et seq.*

74. N.H. REV. STAT. ANN. 149-M:1 *et seq.*

75. N.H. REV. STAT. ANN. 146-C:1 *et seq.*

76. N.H. REV. STAT. ANN. 21-O:11.

77. N.H. REV. STAT. ANN. 21-O:7.

78. N.H. REV. STAT. ANN. 21-O:5-a.

79. N.H. REV. STAT. ANN. 21-O:9.

80. N.H. REV. STAT. ANN. 47:12.

81. N.H. REV. STAT. ANN. 31:39[I](l).

82. N.H. OP. ATTY. GEN. #0-93-6.

83. N.H. REV. STAT. ANN. 47:17[XV].

84. N.H. REV. STAT. ANN. 47:17[XV].

85. State v. Driscoll, 385 A.2d 218 (NH 1978); State v. Paille, 9 A.2d 6663 (NH 1939).

86. Wasserman v. City of Lebanon, 474 A.2d 994 (NH 1984).

87. *See* New Hampshire Municipal Association, *Knowing the Territory: A Survey of Municipal Law for N.H. Local Officials* (1999 ed.), *citing* Stablex v. Town of Hooksett, 122 N.H. 1091 (NH 1982).

88. Peter J. Loughlin, *Local Government Law*, in NEW HAMPSHIRE PRACTICE, Vol. 13, at 4 (1990).

89. New Hampshire Municipal Association, *Knowing the Territory: A Survey of Municipal Law for N.H. Local Officials* 7 (1999 ed.).

90. Peter J. Loughlin, *Local Government Law*, in NEW HAMPSHIRE PRACTICE, Vol. 13, at 1 (1990).

91. *See, e.g.*, LEONARD S. MORRISON, THE GOVERNMENT OF NEW HAMPSHIRE (1943).

92. N.H. REV. STAT. ANN. 22:1 *et seq.*

93. N.H. REV. STAT. ANN. 24:1, 24:13.

94. N.H. REV. STAT. ANN. 49-B:2[II](a).

95. N.H. REV. STAT. ANN. 49-B:2[II](b).

96. N.H. REV. STAT. ANN. 49-B:2[II](c).

97. N.H. REV. STAT. ANN. 52:1 *et seq.*

98. Peter J. Loughlin, *Local Government Law*, in NEW HAMPSHIRE PRACTICE, Vol. 13, at 10 (1990).

99. N.H. REV. STAT. ANN. 28:7-a.

100. N.H. REV. STAT. ANN. 53:1 *et seq.*

101. N.H. REV. STAT. ANN. 141-C:1 *et seq.*

102. N.H. REV. STAT. ANN. 141-C:5.

103. N.H. REV. STAT. ANN. 128:1.

104. N.H. REV. STAT. ANN. 128:2.

105. N.H. REV. STAT. ANN. 128:1.

106. N.H. REV. STAT. ANN. 128:2.

107. N.H. REV. STAT. ANN. 128:4.

108. N.H. REV. STAT. ANN. 128:3.

109. N.H. REV. STAT. ANN. 47:12.

110. N.H. REV. STAT. ANN. 127:1 *et seq.*

111. N.H. REV. STAT. ANN. 127:4.

112. N.H. REV. STAT. ANN. 127:2.

113. N.H. REV. STAT. ANN. 127:5.

114. N.H. REV. STAT. ANN. 127:6.

115. N.H. REV. STAT. ANN. 127:6.

116. N.H. REV. STAT. ANN. 128:5[I].

117. N.H. REV. STAT. ANN. 128:5[II].

118. N.H. REV. STAT. ANN. 128:5[III].

119. N.H. REV. STAT. ANN. 47:17[III].

120. N.H. REV. STAT. ANN. 47:17[VII].

121. N.H. REV. STAT. ANN. 47:17[XIV].

122. N.H. REV. STAT. ANN. 47:17[XVI].

123. N.H. REV. STAT. ANN. 47:17[XVII].

124. N.H. REV. STAT. ANN. 147:1[I].

125. N.H. REV. STAT. ANN. 147:1[II].

126. N.H. REV. STAT. ANN. 147:2.

127. *See* Peter S. Loughlin, *Public Health, Safety, and Highways*, in NEW HAMPSHIRE MUNICIPAL PRACTICE SERIES, § 1:16 *et seq.*

128. *See* Peter S. Loughlin, *Public Health, Safety, and Highways*, in NEW HAMPSHIRE MUNICIPAL PRACTICE SERIES, § 2:01 *et seq.*

129. *See* Peter S. Loughlin, *Public Health, Safety, and Highways*, in NEW HAMPSHIRE MUNICIPAL PRACTICE SERIES, § 3:26.

130. N.H. REV. STAT. ANN. 48-A:1 *et seq.*; *See* Peter S. Loughlin, *Public Health, Safety, and Highways*, in NEW HAMPSHIRE MUNICIPAL PRACTICE SERIES, § 5:01 *et seq.*

131. N.H. REV. STAT. ANN. 155-B:1 *et seq.*; *See* Peter S. Loughlin, *Public Health, Safety, and Highways*, in NEW HAMPSHIRE MUNICIPAL PRACTICE SERIES, § 7:01 *et seq.*

132. *See* Peter S. Loughlin, *Public Health, Safety, and Highways*, in NEW HAMPSHIRE MUNICIPAL PRACTICE SERIES, § 6:01 *et seq.*

133. N.H. REV. STAT. ANN. 165:1 *et seq.*

134. N.H. REV. STAT. ANN. 91-A:5[IV].

135. N.H. REV. STAT. ANN. 91-A:5[IV].

136. N.H. REV. STAT. ANN. 126:3-a[I], [IX].

137. N.H. REV. STAT. ANN. 126:1[II].

138. N.H. REV. STAT. ANN. 126:14.

139. N.H. REV. STAT. ANN. 126:14[I].

140. N.H. REV. STAT. ANN. 126:14[I].

141. N.H. REV. STAT. ANN. 126:14[IV].

142. N.H. REV. STAT. ANN. 126:14[V].

143. N.H. REV. STAT. ANN. 126:14[VI].

144. N.H. REV. STAT. ANN. 126:14[III].

145. N.H. REV. STAT. ANN. 126:28[I].

146. N.H. REV. STAT. ANN. 126:28[II].

147. N.H. REV. STAT. ANN. 141-B:9.

148. N.H. REV. STAT. ANN. 141-F:7[I](a).

149. N.H. REV. STAT. ANN. 141-F:7[II].

150. N.H. REV. STAT. ANN. 141-F:7[I](b).

151. N.H. REV. STAT. ANN. 141-F:7[III].

152. N.H. REV. STAT. ANN. 141-F:7[IV].

153. N.H. REV. STAT. ANN. 141-F:8[II].

154. N.H. REV. STAT. ANN. 141-F:8[III].

155. N.H. REV. STAT. ANN. 141-F:8[IV].

156. N.H. REV. STAT. ANN. 141-F:8[V].

157. N.H. REV. STAT. ANN. 632-A:10-b[I-a].

158. N.H. REV. STAT. ANN. 126-A:11.

159. N.H. REV. STAT. ANN. 141-C:10.

160. The term "health" department is used in the generic sense to include all public health functions carried out by the state.

161. *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).

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

163. 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).

164. N.H. REV. STAT. ANN. 127:1 *et seq.*

165. *See, e.g.*, COMMUNITY HEALTH CARE ACT, NEB. REV. STAT. §§ 71-7514, 7516. The Act, though inoperable due to a lack of funding, conceived of the establishment of several regions across Nebraska to blanket the state through systematic, organized, and coordinated efforts under the direction of the state department of health and human services.