

South Carolina Public Health Law Reform Pursuant to the Turning Point Model Public Health Act: Considerations for Transforming National Collaboration into State Legislation

Benjamin Mason Meier,* Kristine M. Gebbie[†] & James G. Hodge, Jr.[‡]

I. Background.....	4
II. South Carolina Considers the Turning Point Act.....	9
III. Analysis.....	12
A. Lack of an External Galvanizing Force	13
1. <i>Preference for Vague Statutory Authority for Public Health</i>	14
2. <i>Lack of Commitment from State Legal Staff</i>	15
B. Bureaucratic Expansiveness and the Risk of Backsliding	18
Conclusion	23
Appendix: Research Methods.....	25

* Project Manager, Comprehensive Assessment of Changes in State Public Health Laws, Center for Health Policy, Columbia University.

[†] Director, Center for Health Policy, Columbia University.

[‡] Executive Director, Center for Law and the Public’s Health, Johns Hopkins Bloomberg School of Public Health.

This study has been funded through the generous support of the Robert Wood Johnson Foundation as part of its continuing funding of the Turning Point Project.

Many public and private sector policymakers, scholars, and public health officials agree that state public health laws throughout the country are ripe for reform.¹ Beginning in 2000, the Turning Point Public Health Statute Modernization Collaborative (Turning Point Collaborative) brought together representatives from five core states (Alaska, Colorado, Nebraska, Oregon, and Wisconsin) and multiple other state and local public health partners to study and assess state public health law.² Following three years of public meetings, drafting, input, and discussions, the Turning Point Collaborative released the final version of the Turning Point Model State Public Health Act (Turning Point Act),³ a comprehensive template for states interested in public health law reform and modernization. This research examines the political and policy efforts undertaken by actors in South Carolina to translate the Turning Point Act into state legislation.

This case study is the second in a series of comparative case studies of states that have considered amendments to their state public health laws subsequent to the development of the Turning Point Act. The investigators have hypothesized that the Turning Point Act is a catalyst for state public health law reform, but that consideration of reform leads to very different responses depending on the underlying circumstances of the state. Building on the preliminary confirmation of that theory in the first case study,

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

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

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

Alaska: A Case Study in Public Health Law Reform & the Turning Point Model Public Health Act,⁴ the researchers set out to examine South Carolina, a state in which the Turning Point Act was considered but ultimately rejected as a means of reforming state public health law. Through this comparative case study and ongoing legislative tracking in all fifty states, the present case study, as part a series of similar and ongoing case studies, will provide the public health practice community with information that can facilitate successful modernization of public health statutes across the country and inform scholarship on the role of law and policy in building enhanced public health infrastructure.

Investigating the South Carolina experience, the research team met personally with eight individuals who considered, alone and in concert with others, the application of the Turning Point Act to South Carolina state law. These individuals represented a range of public health practitioners and advocates in South Carolina, including government public health officials, academics, and advocates in and around the Columbia area. What comes from their recollections is a thorough elaboration of the reasons underlying the decision of South Carolinian actors not to pursue state legislation based on the Turning Point Act. Drawing upon their experiences, the authors analyze the historical, institutional, and personal factors that influenced the decisions of South Carolina actors, seeking generalizable conclusions that can be applied to other states considering public health law reform.

⁴ BENJAMIN MASON MEIER ET AL., *ALASKA: A CASE STUDY IN PUBLIC HEALTH LAW REFORM & THE TURNING POINT MODEL PUBLIC HEALTH ACT*, available at http://www.nursing.hs.columbia.edu/research/ResCenters/chphsr/law_pubHealth.html.

I. Background

The state of South Carolina has one of the longest continuous public health infrastructures in the nation, arising out of the creation of the nation's first provincial health officer in 1712 and continuing through the creation of the Charleston Board of Health in 1712 and continuing through the creation of the Charleston Board of Health in 1808 and state Board of Health in 1878.⁵ Leadership of the public health system is currently the responsibility of the Department of Health and Environmental Control (DHEC), housed in Columbia. DHEC, led by a Commission, holds expansive authority over both public health and environmental programs, with an annual budget of over \$400 million. In exercising its authority, DHEC, like many Southeastern health departments, employs a significant majority of its resources in providing health services directly to indigent citizens. Rather than organizing through separate city and county local health departments, South Carolina's health system is centralized and vertically integrated, with DHEC having sole authority for public health throughout the state and with regional offices all directly controlled by the DHEC Commissioner,⁶ leading to uniform public health responses by DHEC's 4,500 employees across the state. The DHEC Commissioner and all deputy commissioners (including the Deputy Commissioner of Health Services)⁷ are selected by a seven-member panel, the Board of Health, its members appointed by the Governor with the advice and consent of the state senate. Outside of naming the Board of Health, the Governor has far less control over the

⁵ JOHN H. ELLIS, *YELLOW FEVER AND PUBLIC HEALTH IN THE NEW SOUTH* (1992).

⁶ DHEC's statewide authority over public health precluded discussion of many aspects of the Turning Point Act dealing with the organization of state health departments and the interactions between state and local health departments and simplified the state's consideration of the Turning Point Act without the consideration of the needs of local public health actors.

⁷ Within DHEC, the Commissioner has a Chief of Staff and four deputy commissioners, one for each Department of (1) Ocean & Coastal Resource Management, (2) Environmental Quality Control, (3) Health Service, and (4) Health Regulation.

public health function than many other state chief executives, a remnant of Reconstruction that places far greater emphasis on the legislature in introducing and passing legislation.

Much of the current thinking on South Carolina's public health authority is framed by the state's response in the early-1980s at the start of the HIV/AIDS epidemic.⁸ When the state was faced by this then-unknown threat, the two legislative houses convened a Special Legislative Task Force, wherein select legislators heard extensive expert testimony before working with DHEC to develop legislation for "presentation" to the full legislative bodies. Working with this Special Legislative Task Force and building on earlier responses to tuberculosis, DHEC actors negotiated with policymakers to create confidential testing for HIV (rather than DHEC's proposal for anonymous testing) and create criminal sanctions to quarantine involuntarily those who knowingly and intentionally infect others (rather than specific legislative proposals for harsher and more discriminatory public health practices).⁹ DHEC actors were comfortable with this approach, feeling that novel public health legislation, if left to the entire legislative body, would be reactionary and ill-defined in responding to the problem. As noted by a former legislative advisor and current public health scholar, this process proved "successful in having a group that looked at all the issues thoughtfully, made recommendations, and the

⁸ Dave Murday, *Health Policy in the Palmetto State: Muddling Through*, in SOUTH CAROLINA GOVERNMENT: AN INTRODUCTION (Charlie B. Tyer ed. 2002).

⁹ S.C. CODE ANN. § 44-29-90 (1988) ("To the extent resources are available to the Department of Health and Environmental Control for this purpose, when a person is identified as being infected with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immunodeficiency Syndrome (AIDS), his known sexual contacts or intravenous drug use contacts, or both, must be notified but the identity of the person infected must not be revealed. Efforts to notify these contacts may be limited to the extent of information provided by the person infected with HIV."). As an example of a harsher practice, one informant described a legislative proposal that would have required DHEC to impose HIV tests on all restaurant workers out of a legislator's fear that "there would be an AIDS terrorist who would cut his finger and spill blood...on the rare steaks."

bill was pretty much adopted without a whole lot of discussion or debate.” However, at the end of this period of legislative activity, South Carolina was left with different, “patchwork” legal frameworks for tuberculosis, various specified sexually transmitted diseases, and HIV/AIDS, as is typical of many states’ late 20th century state public health laws. No comprehensive legal framework existed for the state’s public health authority.

Since that time, South Carolina has experienced a surge in activism and leadership for national public health reform efforts. Spearheaded by officials at DHEC and complemented by close ties to faculty at the Arnold School of Public Health at the University of South Carolina, actors had considered public health law reform as a needed step in South Carolina’s public health modernization. For several South Carolina actors, their specific interest in public health law reform derived from an October 1997 conference at the New York Academy of Medicine, which was convened by Professor Kristine M. Gebbie of the Columbia University School of Nursing. Professor Gebbie had just completed an analysis of state enabling statutes for public health—comparing each statute to the paradigm of essential public health services in *Public Health in America*¹⁰—and she convened this conference to share her results and provide information and resources for those seeking improvements in public health through changes in state health systems statutes. Although South Carolina actors had not previously considered the strengths and weaknesses of the state’s statutory authority for public health, Professor Gebbie’s analysis highlighted many gaps in South Carolina public health law, surprising those state actors who worked on these issues and who felt that their laws were

¹⁰ See KRISTINE M. GEBBIE & INSEON HWANG, PREPARING CURRENTLY EMPLOYED PUBLIC HEALTH PROFESSIONALS FOR CHANGES IN THE HEALTH SYSTEMS (1998) (on file with lead author).; see also PUBLIC HEALTH FUNCTIONS STEERING COMM., PUBLIC HEALTH IN AMERICA: VISION, MISSION, AND ESSENTIAL SERVICES (1994).

sufficiently general to cover any unforeseen circumstance. While at this conference, state public health agency leadership also heard from Professor Lawrence O. Gostin of Georgetown University, who discussed with them possible bases for public health law reform. These actors returned from New York with newfound awareness of the limits and possibilities of their legal authority.

Concurrent with the New York conference, the Robert Wood Johnson Foundation requested proposals from states to take part in its new project, “Turning Point: Collaboration for a New Century of Public Health” (Turning Point). Based upon interest from officials at DHEC and a state legislator who had attended the New York conference, South Carolina decided to apply for the first round of the Turning Point grant awards. With many actors continuing to believe that South Carolina had “very strong public health law,” even if it was not specifically addressed to the contemporary concept of essential public health services, South Carolina DHEC staff opted not to apply to the Turning Point collaborative on Public Health Statute Modernization, applying instead to three of the remaining four sections.¹¹ In the second round of Turning Point grant awards, South Carolina was accepted to two of these multi-state collaboratives, Leadership Development and Information Technology.¹² Thus, despite the newfound

¹¹ The DHEC public health staff initially took charge of the application process; however, with several key DHEC staff leaving the bureaucracy and joining the Arnold School of Public Health, all Robert Wood Johnson projects would eventually be administered from the School of Public Health, where administrators would have far more budgetary flexibility in distributing funds to local Turning Point partners.

¹² Although South Carolina was not selected for either these sections in the first round, DHEC provided \$150,000 in funds on its own to continue the work that actors had begun in applying for the Robert Wood Johnson Turning Point Grants, and as a result of these initial funds, South Carolina received funding in the second round of Turning Point grant awards, awarded a two-year \$300,000 Turning Point Planning Grant in 1998 and a five-year \$500,000 Turning Point Implementation Grant in 2000. *See generally* University of South Carolina, South Carolina

emphasis of South Carolina actors on public health modernization, this emphasis did not extend to public health law reform.

Public health law reform took precedence again following the terrorist attacks of September 11, 2001 and the anthrax dispersals that same Fall. In responding to this new threat, the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities was asked by the Centers for Disease Control and Prevention (CDC), multiple states, and a host of public and private sector entities to prepare a legislative model that states could use in reviewing their existing laws on public health emergency preparedness and response. The Center for Law and the Public's Health finalized the Model State Emergency Health Powers Act in December 2001,¹³ and immediately thereafter South Carolina's legislators and DHEC officials worked to prepare state legislation based on the Model State Emergency Health Powers Act. In House Bill 4416, several legislators jointly introduced the "Omnibus Counter-Terrorism and Homeland Defense Act of 2002," a bill amended to adopt every provision and almost all of the language of the Model State Emergency Health Powers Act. Within six months, this bill received the unanimous support of the legislature without any significant amendment and was signed into law on June 4, 2002.¹⁴

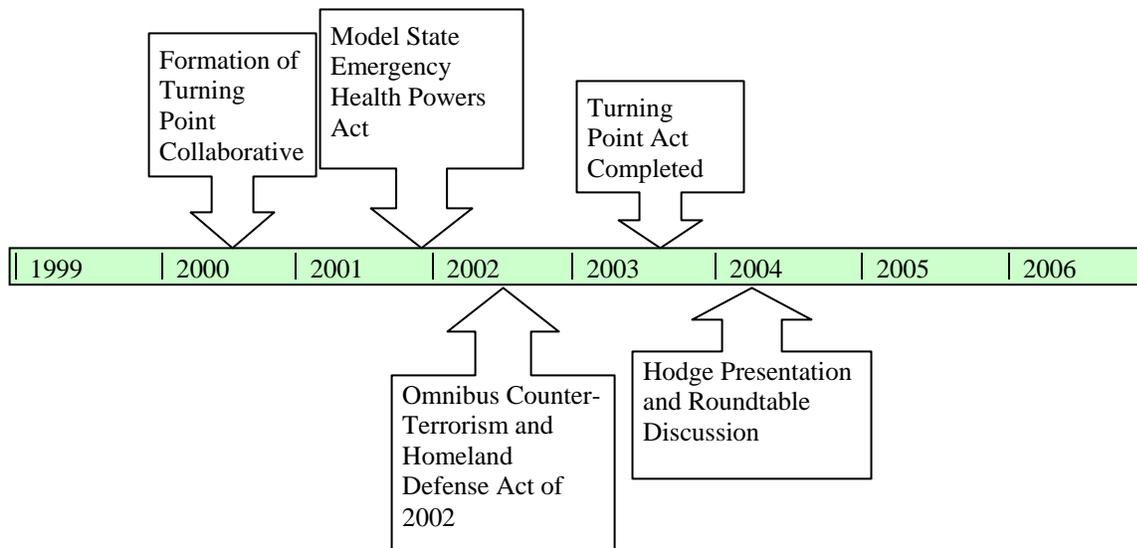
Turning Point Background, at <http://www.sph.sc.edu/turningpoint/tpbackground.htm> (last accessed Sept. 2, 2006).

¹³ Model State Emergency Health Powers Act (2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>. For additional information on the Model State Emergency Health Powers Act, see Lawrence O. Gostin, et al. *The Model State Emergency Health Powers Act: Planning for and Response to Bioterrorism and Naturally Occurring Infectious Diseases*, 288 JAMA 622 (2002).

¹⁴ 2002 S.C. Acts A339 (Omnibus Terrorism Protection and Homeland Defense Act).

II. South Carolina Considers the Turning Point Act

Attempts to reform South Carolina public health law were made informally in the Fall of 2003 and Spring of 2004, as illustrated in the figure below. This Part discusses the events that surrounded South Carolina actors' consideration of the Turning Point Act.



South Carolina actors stayed apprised of the Turning Point Act through their affiliation with other Turning Point collaboratives. The Turning Point program held periodic comprehensive meetings, at which one of the collaboratives would update the other four on its efforts. In the case of the Public Health Statute Modernization Collaborative, representatives from the state of Alaska, as the chair of that collaborative, presented (with Professors Lawrence O. Gostin and James G. Hodge, Jr. of the Center for Law & the Public's Health) on the progress of state representatives in developing the Turning Point Act. Following this early presentation on the Turning Point Act, members of DHEC met with several academics and policymakers in South Carolina to get a better understanding of how public health law reform would take shape.

Although no one in South Carolina made any immediate efforts to consider a comprehensive reform of state public health law, several DHEC staff with interest in policy—those who had taken part in other aspects of the Turning Point Collaborative and maintained a Turning Point Office—took interest in the Turning Point Act’s clear and concise enumeration of the essential functions of public health, believing that the Turning Point Act’s framing of public health functions would improve the legislature’s understanding of DHEC’s role. These actors believed that it would be helpful to invite representatives from the Center for Law & the Public’s Health to come to South Carolina to discuss the Turning Point Act with DHEC staff shortly after its release in Fall 2003. Faculty at the Arnold School of Public Health, who had interest in teaching students about public health policy, agreed, feeling that a discussion of the Turning Point Act would be ripe for academic discussion¹⁵ and would catalyze discussion of the Turning Point Act among DHEC program staff. Although academics had hoped to “cast a pretty broad net” in inviting participants to discuss the Turning Point Act—including representatives of the Governor’s Office, legislators, and public health, hospital and physician groups—DHEC administrators requested that invitations be extended only to a narrow group of DHEC staff.

To accommodate DHEC requests while providing for a more open discussion, faculty decided to invite Professor Hodge to present on consecutive days, February 19 and 20, 2004: first, in an open lecture as part of the School of Public Health’s Policy Seminar Series and second, in a closed DHEC roundtable discussion. Despite the first

¹⁵ The Arnold School of Public Health had previously sponsored discussions on the Model State Emergency Health Powers Act. The close relationship between DHEC and the School of Public Health on the Turning Point Act was fostered by the move of a senior public health official (and also a Turning Point collaborator) from DHEC leaving the agency to take a faculty position at the School of Public Health.

lecture being open to the university community, no effort was made to publicize the event to public health actors outside of the university and DHEC. Consequently, the event was attended almost universally by DHEC staff and select public health faculty and students.¹⁶ With few questions, no attendees took up Professor Hodge's call to respond to his comments on the applicability of the Turning Point Act to South Carolina.

The roundtable discussion, lasting approximately two hours, was attended by approximately twenty DHEC staff members (including program officers, members of the DHEC Legal Office, the Deputy Commissioner for Health Services, and the DHEC Chief of Staff) and several faculty from the School of Public Health.¹⁷ Professor Hodge began the discussion by repeating many of his comments from the previous day on the development of the Turning Point Act before turning to a discussion of the steps taken by other states in reforming their public health law. DHEC representatives questioned Professor Hodge aggressively about the actions of other states, trying to understand the political advantages and disadvantages of pursuing comprehensive public health law reform.

Although several academics expressed support for the Turning Point Act, no DHEC member discussed either the need for public health law reform or the application of the Turning Point Act to South Carolina. Feeling unqualified to discuss the legal benefits of the Turning Point Act, in particular its due process protections and the balance struck between individual rights and public health, DHEC members felt compelled to

¹⁶ DHEC program staff frequently attend the School of Public Health's seminar series as a way of forging ties between the university and practical public health communities.

¹⁷ Many informants were surprised that no elected officials attended the meeting, although it is unclear whether any were invited.

defer to the advice of DHEC’s Chief Counsel for Health Services,¹⁸ who noted repeatedly that “public health law was in pretty good shape,” expressing skepticism in the benefits of the Turning Point Act, cautioning that “there wasn’t any sense in raising issues when you didn’t need to,” and concluding that “it was not in the best interest of our state and our agency to push through an overhaul of the public health laws.”

The participants left this roundtable discussion without any plan as to what would happen next or any mechanism for continued discussion. Even among those who had initiated the roundtable discussion, it was felt that DHEC’s lack of support and initiative would make any attempt to garner further support for public health law reform within the larger public health community or sympathetic legislators unworkable. With no subsequent meetings scheduled and no actors taking an independent initiative to pursue the Turning Point Act, nothing happened.

III. Analysis

Concluding with what many informants described as an “underwhelming” response from DHEC actors to the promise of the Turning Point Act, this Part analyzes the two interdependent reasons that appear to underlie the reluctance of South Carolina actors to pursue state public health legislation based on the Turning Point Act: the lack of an external galvanizing force for public health law reform, given the preference for vague statutory authority and a lack of commitment from the DHEC Legal Office, and the expansiveness of the agency posing a greater risk for legislation to become regressive rather than progressive. These interviews left the research team with the conflicting

¹⁸ Although many DHEC program staff members were at the roundtable discussion, the DHEC legal office was represented only by the chief legal counsel and a new associate in the office, with only the chief legal counsel speaking during the course of the meeting.

impression that the Turning Point Act was both too comprehensive (given the limited, tailored needs of the Department of Health Services) and not comprehensive enough (given the expansive purview of DHEC as a whole). This part seeks to analyze this conflict and develop generalizable conclusions applicable to other states seeking to translate the Turning Point Act into state law.

A. Lack of an External Galvanizing Force

South Carolinians are pleased with the perceived comprehensiveness of their public health laws. Unlike the experiences reported by other states facing the existence or threat of an infectious disease epidemic (or South Carolina itself at the beginning of the HIV epidemic), DHEC has not perceived gaps in South Carolina’s public health authority. Under the belief that South Carolina “had never been confronted with a public health issue that couldn’t be dealt with [under] existing public health law,” actors saw no pressing need to engage in comprehensive law reform, preferring small tailored policy changes as threats arise.

By promulgated much of the language of the Model State Emergency Health Powers Act, South Carolina actors felt that they had adequately prepared for public health emergencies while politics favored such reform immediately after September 11, 2001.¹⁹ In comparison to those reforms, many actors within the DHEC Legal Office viewed the Turning Point Act merely as a matter of public health “housekeeping,” streamlining and strengthening regulations with little perceived public health benefit. Where these actors felt that their laws were already sufficiently close to the prescriptions of the Turning Point Act, there was less incentive to act to make large changes for an incremental gain.

¹⁹ As noted bluntly by a senior member of DHEC, “but for September 11th, [the Model State Emergency Health Powers Act] probably wouldn’t have happened...The timing was everything.”

These results suggest that as the perceived policy distance between the status quo and the model legislation decreases, a state less likely is to amend its laws.

1. Preference for Vague Statutory Authority for Public Health

South Carolina, like several Southeastern states, expresses its public health laws through very traditional broad and intentionally vague statutory authority, with both the legislature and judiciary deferring to agency preferences in implementing public health regulations. As noted by a senior communicable disease official in describing the harm of specific statutory authority, “[e]very time it’s specific, you close possibilities and then you come across an unpleasant situation where you really need to do that and you have foreseen that. And by being specific, you’ve closed off the possibility of using some essential power.” Given the Turning Point Collaborative’s over-reliance on Midwestern and Western states with modern public health statutes, the specificity of the Turning Point Act may act to the detriment of its implementation in Eastern states.

In this case, DHEC’s Chief Counsel found the Turning Point Act to be “more procedural than what we need in statute,” with South Carolina public health actors preferring expansive statutory language with interpretive authority delegated to the executive agencies responsible for implementing the legislation. Several informants illustrated this through South Carolina’s legislation governing disease reporting, wherein DHEC designates the reportable diseases every year, as compared with other states, which were criticized by a senior health official for “making the mistake of putting into the statute...the actual reportable conditions, which means that every time they need to change it, they have to change the statute or change the regulation, which is a big job.” Given this preference for expansiveness, there was no discussion of later 20th century

case law suggesting that procedural specificity has become the norm for assuring protection of individuals even while protecting the overall public's health.

In the absence of an external public health crisis, it was felt that the need for public health law reform consistent with the Model Act could only be highlighted through an internal gap analysis, a side-by-side comparison of provisions of the Turning Point Act and South Carolina Law,²⁰ and many critiqued the absence of such an analysis in clarifying the debate. However, no South Carolina actor ever did a formal gap analysis or comparison of South Carolina laws with Turning Point Act provisions, nor was the Center for Law and the Public's Health ever asked to prepare one. Academics commented that the University of South Carolina then lacked a professor in public health law who could have undertaken such a project. Many DHEC program staff faulted their own legal office for failing to invest the time and resources in preparing such a document.²¹ It is this latter group, the DHEC legal staff, who many actors believe would have been crucial in lending their support to this reform initiative.

2. Lack of Commitment from State Legal Staff

The legal staff of a state's health department is pivotal to generating the initiative and gathering the expertise to pursue public health law modernization. Specifically, it is often the legal office that must be enlisted to draft a proposed bill for introduction by

²⁰ For a discussion of the Turning Point Act's use in gap analysis, see M. Jane Brady et al., *How States Are Using The Turning Point Model State Public Health Act*, 32 J.L. MED. & ETHICS 97 (2004).

²¹ As expressed most forcefully by one senior DHEC public health official, "I always get peeved at this a little bit because, again, I really think, I really wish, we had done a formal analysis. I really wish we had spent some proactive time."

sympathetic legislators.²² Where the legal office lacks support for such an initiative, other public health actors will be hard pressed to push such reforms without the detailed legal analyses necessary to support them. From this experience, it appears crucial that public health law modernization efforts arise from, or come with the strong support of, legal actors within the state public health bureaucracy.

In the present case, DHEC legal officials commented on the lack of staff and a lack of desire to take on a project that they believed, based upon their experience with the Model State Emergency Health Powers Act, would overwhelm an office already taxed by excessive litigation responsibilities.²³ In the case of the Model State Emergency Health Powers Act, although the legal office was reluctant to open up its statutes, legislators pressed legislation upon them, seeking a rapid policy response from DHEC in response to the attacks of September 11, 2001. As argued by the Chief Counsel, “we [the legal office] had been reviewing our public health laws and looking at ways that we could strengthen our powers within our public health agency or make them more user-friendly, or cost-effective, or comprehensive [but] we have enough language in there now that we felt that we had the powers that we needed to have for most situations.”

The Model Act was not being ignored. The DHEC Legal Office had stayed apprised of the Turning Point Act’s development and had discussions several times on the Turning Point Act prior to Professor Hodge’s presentation. While several attorneys

²² In South Carolina, it is not the legal office that takes draft legislation directly to legislators but rather one of the legislative liaisons for DHEC that educates and consults with legislators, lobbyists, and prospective stakeholders in moving a bill forward.

²³ Although these litigation responsibilities often involve environmental control regulations, the same legal office handles both the environmental and health components of DHEC.

made an informal assessment of different portions of the Turning Point Act,²⁴ no one from the DHEC Legal Office, as discussed earlier, provided a written analysis of the Turning Point Act's application to South Carolina or drafted a gap analysis. Even had outside consultants prepared such a gap analysis, DHEC attorneys, expressing a distrust for outside voices, felt that such efforts from a "non-stakeholder" would have been in vain, as "if the result is going to be legal advice to the department, we're going to have to do it ourselves anyway."²⁵ They did not.

Because this was not believed to be a critical reform that would improve the standing of the DHEC Legal Office, its staff saw no need to invest its energies in what was perceived to be an "academic exercise," driven only by scholars at the School of Public Health.²⁶ Having decided in advance that they would not support such a comprehensive legal initiative, representatives from the DHEC Legal Office attended Professor Hodge's presentation only to dissuade those at the School of Public Health

²⁴ In describing this informal analysis, a lawyer with DHEC commented that "I don't think it was ever sort of a systematic...putting clerks on it and you know making charts and things like that. . . . I remember at one point reading the Model Act and thing about, you know, what is useful in this? What could we use? Does it serve any purpose for us? Is there anything in here that we need? But it was never really anything formal like a committee or anything like that."

²⁵ When pressing the informant on this distrust for independent analysis and seeking constructive criticism of the process, the informant offered that "[i]f the purpose [of Turning Point] is to really try to get changes done state by state, then it probably would be better to fund people in the state, the people that are actually going to do it." As a senior public health official described this, "there's always a certain amount of stubbornness in South Carolina. It's sort of like...we'll just do it our own way. . . . It's sort of like a streak, a cultural streak, that runs through the state."

²⁶ Despite the perception that academics at the School of Public Health were seeking to impose the Turning Point Act on a reluctant DHEC legal office, interested academics and the DHEC lawyers had not met about the Turning Point Act prior to the roundtable discussion at the School of Public Health.

from moving forward without DHEC support.²⁷ Without the legal staff pushing it, other DHEC actors felt no need to intervene.²⁸ These DHEC program staff deferred to the DHEC Legal Office in matters of legal concern, with a member of the Legal Office noting that “we never got any kind of push-back or feedback [from DHEC staff] saying ‘why haven’t you guys gone about trying to amend the Model Act?’.” Although some actors outside of DHEC considered enlisting support outside of the Legal Office for law reform, it was determined that any legislation drafted without collaboration from the legal office “would be something imposed on them from without and that would be the worst possible thing [for getting a law passed].”²⁹

B. Bureaucratic Expansiveness and the Risk of Backsliding

South Carolina DHEC is a comparatively large bureaucracy, both vis-à-vis other state agencies and other health departments nationally, encompassing public health, direct provision of health services, waterway safety, and environmental regulation, with the latter (because of industry involvement in regulation) viewed as the most politically volatile.³⁰ The expansiveness of the agency notwithstanding, the Turning Point project was largely viewed as something emanating from and benefiting only the Department of

²⁷ Many in the legal office felt that they could decide such issues before Professor Hodge’s presentation, believing that they were already familiar with the Turning Point Act from previous presentations at public health law conferences.

²⁸ By way of counterfactual, one senior public health official posited that “if they [legal counsel] really felt it was necessary, I think it would have happened.”

²⁹ As one public health scholar lamented, “if you get the agency, which is your public health authority in this state, saying ‘we don’t need comprehensive reform,’ where’s the constituency for it? . . . Just because it’s the right thing to do is never enough.”

³⁰ As explained by a senior DHEC program official, “the EPA [environmental control] functions are more controversial than the health functions, in general, because it’s [environmental control] very regulatory. It’s very industry. There’s big bucks.”

Health Services.³¹ In this particular case, senior DHEC actors were “concerned that if we opened up some of the laws for change that we might be in a situation where some of our [current] powers were eroded rather than either expanded or clarified.” According to a DHEC lawyer, the expansiveness of the agency “changes the cost/benefit risk,” with what a public health scholar described as “opportunity costs,” wherein “the good that we would get from opening it [legislation] up for more changes outweighed by the potential harm that could be done.” With so much under its purview and so few legislators perceived to be in favor of any government programs, DHEC faces far greater risk of the legislature moving backward in many unrelated areas should it ever open up any public health legislation to reform. Given the number of states that house health and environmental protection under the same agency, the Turning Point Act’s limitation to covering only public health authority may prove an impediment to those states that necessitate greater breadth of subject matter in any “comprehensive” reform for their enabling statutes.³²

The current government of South Carolina, controlled overwhelmingly by the Republican party, has committed itself in party platform and legislative action to reducing the size of the state bureaucracy and function, a goal perceived to be inconsistent generally with the expansive authority of DHEC and specifically with public health law reform. For many, this propensity to limit the size of government stemmed from the antebellum culture of South Carolina, with an unwillingness to consider policy

³¹ Noting the “dysfunctional” and “counterproductive” relationship between the various DHEC departments, many informants suggested that the agency needed to be legislatively balkanized, grouping the environmental departments and health departments in separate agencies.

³² Because of its size and the subject matter of its programs, many public health actors posited that DHEC was not amenable to national models and that the Turning Point Act was not designed for an agency of DHEC’s size and breadth.

innovation “permeating everything.” Although no current government or non-government employees would discuss such issues on the record or for attribution, a former DHEC staff member noted, “we were—and still are—at a point where the Governor would like to downsize government, decrease power within the state government and so forth, that we might have a net loss of the strength of public health law if we were to open it [the laws] up.” This reduction in the size of the bureaucracy had been an issue several times in the legislature over the last decade, with legislators frequently cutting funding for existing DHEC programs and denying many incremental developments in the creation of new programs. With what informants felt to be a weak state public health association and “status quo oriented” DHEC leadership, a legislature ill-informed on health issues and slow to amend legislation, and no prominent Republican championing the causes of public health,³³ public health actors felt constrained in what a senior public health official described as “policy entrepreneurship,” risking political support with the hope of reaping policy rewards through innovative public health law reforms.

In addition to the general ‘small is better’ attitude, certain public health actions remain deeply unpopular among legislators, with legislators frequently threatening to cut DHEC’s budget further and DHEC administrators perennially counseling not to take

³³ This lack of a Republican champion for public health is one of many distinguishing factors between South Carolina and Alaska, both heavily Republican states that reached divergent results in translating the Turning Point Act into state law. In the case of South Carolina, because the Commissioner of Health and Environmental Control is not appointed directly by the Governor, a senior public health official noted that “the Governor doesn’t get directly involved” to enact the independent priorities of the Commissioner, denying public health reform the clout and resources of the Governor’s Office. This was explicated by another senior public health official, who noted that “obviously the Governor has influence, but it’s not like, it’s not a cabinet agency kind of thing where you’re there at the behest of the big boss, in this case the Governor, and if her or she decides tomorrow that you’re no longer in that role, you’re no longer in that role. This is much more of a diffuse relationship.”

actions that will offend recalcitrant legislators. DHEC holds authority over several major areas that are contrary to preferences of individual legislators, among them environmental protection, family planning, and certificates of need. In this latter instance, DHEC must certify that any new hospitals or medical facilities will meet the needs of the communities they serve without reducing physician/patient ratios below levels that have been shown to lead to suboptimal health outcomes. By denying certificates to build medical facilities in those communities wanting them—accomplished largely by way of evaluative needs assessment, using a formula that leaves little room for bureaucratic or legislative discretion—DHEC has garnered the fiscal retribution of affected legislators, who have gone so far as to try to block any legislation emanating from DHEC.³⁴ This has resulted in what some described as a “buffer mentality,” wherein DHEC is institutionally defensive about its contacts with the state legislature. As a result of these unpopular actions, DHEC has resisted any opening of health legislation in the past few years for fear that legislators will amend any legislation to deny DHEC authority over these controversial programs.³⁵ “They’re [DHEC] not trying to persuade legislators that, you

³⁴ An example of this was seen in successful legislative efforts to block legislation (through the addition of unrelated and unpopular amendments) that would have amended the Omnibus Counter-Terrorism and Homeland Defense Act of 2002, the South Carolina law based on the Model State Emergency Health Powers, to include public health authority for emergencies caused by natural disaster. As explained by the DHEC chief legal counsel, “[p]erhaps in some peoples’ minds it wouldn’t have mattered what the agency was supporting for this year’s legislative agenda because it would have been overridden by the people who were upset with that decision [needs assessment certification].”

³⁵ Some non-state informants interpreted DHEC’s legislative squeamishness as indicative of DHEC cowardice in explaining the benefits of public health to ignorant legislators. As expressed in the regret of one informant, “unless we can explain it [public health] in a way that makes sense to people and have both the reason for it, the constraints to it, the due process part of it and the protection of individual rights, then we are walking on thin ice anyway because we just haven’t done that part of our job of reminding people...about what public health law is about anyway.” However, because the authors have no independent way of confirming or denying the sincerity of DHEC actors’ beliefs, this report remains silent on this point.

know, public health is a . . . public good,” noted a public health scholar. “They’re into minimizing damage, and the less most of their laws are discussed by the legislature, the happier they’d be.”

Further, based on South Carolina’s experience in legislating public health powers surrounding AIDS, specifically confidentiality of health information surrounding HIV, there was a fear that a comprehensive redrafting of public health legislation would encourage legislators to reevaluate laws regulating HIV disclosure.³⁶ In the “unpredictable” legislative environment then in existence, senior public health officials found that “there are areas of our public health laws that could be strengthened and improved, but it’s not worth the risk at this time of eroding the powers that we do have.” Based upon this individual “cost/benefit balancing,” DHEC officials decided that it was not worth the risk to attempt regulatory reform that was not immediately essential.³⁷

Thus, DHEC actors would prefer to invoke a vague public health authority than risk its current public health authority, perceived to be sufficiently expansive, in the pursuit of legislative specificity. It has become axiomatic in South Carolina that legislation is best left out of the hands of legislators, with informants attributing to past commissioners of health expressions ranging from “let sleeping dogs lie away from the legislature” to “don’t open a can of worms you can’t close” to “you don’t want to go to the well too often” to “never put your hand in a hornet’s nest.” Rather than humorous

³⁶ In the case of losing HIV confidentiality protections, the chief legal counsel noted that “one of the concerns that we had was that if we opened up our public health laws to completely re-writing them, that we might lose some of that—the confidentiality protections that we do have, which encourage people to come in and get tested.

³⁷ In contrasting the Turning Point Act with the Model State Emergency Health Powers Act, many actors felt that the latter could more easily ward off amendments—and thus avoid the risk of legislative backsliding—because the urgency of responding to terrorism necessitated a focus in shepherding through legislation.

asides, these appeared to be real concerns of all public health actors, who feared that any legislative debate on public health would result in the weakening, not strengthening, of current law. As described by a DHEC attorney:

You've gotta make the sale. You've got to sell it to the legislators. You know, you have to convince them that the law is necessary. That you need it. You have to have a reason why you need it. You know, you're going to appear before subcommittees, before committees. You've got to get a sponsor. You've got to convince the sponsor that it's necessary. You've got to have program people on board that are, you know. . . . You've got to have program folks: doctors, epidemiologists, administrators or whatever on board saying, "I, as implementer of public health law in South Carolina, think this is necessary." So they can go before committees and subcommittees and testify about the need. . . . And it's resources too. I mean you gotta get your lobbyist on board, you know. Take staff time. It takes attorney time. It takes time in legislature. It takes time during subcommittee and committee meetings also. It's a pretty involved process. And so just by virtue of that, you only want to do it when it's absolutely necessary. . . . So you gotta make damn well sure you need what you say you need and you're willing to take the chances of it being changed or defeated, or something being tacked on to it at the end. You know, you just don't know.

For those legislators sympathetic to public health—who shepherded the Model State Emergency Health Powers Act through the legislature and with whom DHEC has assiduously cultivated relationships throughout the years—it was felt that their efforts (and the political capital that comes from them) should not be needlessly expended on health legislation not deemed absolutely essential for a tangible public health benefit.

Conclusion

South Carolina's consideration of the Turning Point Act offers a cautionary tale to activists and practitioners in other states seeking to enact modernization of public health law. South Carolina actors did not move forward with comprehensive public health law reform legislation, but all of the actors involved were grateful to have had the opportunity to meet with experts on the Turning Point Act and consider internally, in an informal

setting, its application to South Carolina. If anything, many actors thought that this conversation should have been expanded, with additional speakers (from both academic institutions and public health agencies) and the inclusion of legislators and staff from the relevant legislative committees. Although they did not introduce legislation for public health law modernization, leaving many of its original South Carolina proponents disappointed, many actors remain convinced of the need to pursue reform, hoping that the political winds would someday shift to allow such reform.

Even with political change, many actors feel that underlying circumstances and exigencies for public health reform would also have to change, creating a circumstance where DHEC's authority is no longer perceived to cover all conceivable circumstances and forcing a reluctant legislature to regulate in areas that are already felt to be overregulated. In this instance, South Carolina actors largely agreed that they would not pursue public health reform comprehensively, but rather would take from the Turning Point Act "cafeteria style," where "you can cherry pick out of this and maybe this would be useful to you to solve whatever problems you have."

Appendix: Research Methods

This study used process tracing to examine the chain of events and decision-making processes by which case outcomes (in this case, the enactment or failure of a proposed bill) are dictated by yet-unknown independent variables. By examining evidence at each step, the investigators can present a plausible causal chain of actions which failed to lead to the enactment of modernized state public health laws.

The specific steps of the method involve identification of key actors from all segments of public life in the state likely to have been involved in the specific activities of interest. Information is gathered from identified individuals through semi-structured interviews augmented by the collection of contemporary documents, including draft legislation and legislative commentary, correspondence among participants, newsletters or other communication vehicles and organizational position papers. Careful content analysis of interview transcripts and documents allows construction of a case timeline, and identification of the dynamics of the process. To assure that no key actors have been inadvertently overlooked, selected interviewees are asked to identify other participants in the legislative process under study. Finally, draft findings are shared with key interviewees for clarification and verification of accuracy. While complete anonymity in reporting data would have been ideal in avoiding design effects, the results have validity only by virtue of the status of the actors informing the interviewer. In this analysis, informants generally are identified by job title or a generic description of his or her activities.

The present case study is based on eight semi-structured qualitative interviews with South Carolina actors from the public health bureaucracies at the state and local level, public health advocacy groups, and academia. Table 1 identifies the interviewees by category.

Informant Role	No. of Informants
DHEC Staff	4
Academics	2
Nongovernmental Advocates	2

The semi-structured interviews covered the:

- role of the informant in the proposed legal/regulatory changes;
- public health problems addressed by the changes; and
- obstacles to changes in state law and strategies used to overcome these obstacles;

Based upon notes and transcripts of these interviews, and careful reading of the documents, a narrative description of the legislative process was drafted and themes were identified for analysis.