VIRGINIA PUBLIC HEALTH LAW- REVIEW AND RECOMMENDATIONS

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> *The mission of public health is fulfilling society's interest in assuring the conditions in which people can be healthy.*[2]

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 Because law enables government to exercise public health powers, outdated laws may thwart public health goals.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, statutory, and administrative laws supporting the public health system in the Commonwealth of Virginia and identifies potential areas for statutory reform. Virginia'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 Virginia Department of Health (VDH), the Department of Environmental Quality (DEQ), and the Department of Agriculture and Consumer Services (VDACS)), and local governments (including counties, cities, towns, and other municipalities).

The report is part of Virginia's Turning Point Initiative, *Collaborating For A New Century in Public Health*, supported by a grant from the Robert Wood Johnson Foundations [*www.vdh.state.va.us/tpoint/index.htm*]. This initiative provides technical support for state and

community public health partnerships. Through its Coordinator, Jeffrey L. Wilson, at the Virginia Department of Health, and his colleague, Christopher Bailey, Senior Vice-President of the Virginia Hospital and Healthcare Association, the Virginia Turning Point 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 Project seeks greater understanding of the current constitutional and legal structure of public health powers in Virginia, 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, statutory, administrative, and case-based public health laws toward the preparation of this report which thoroughly examines public health law in Virginia. This report provides both a general and sometimes specific review and analysis of constitutional, statutory, administrative, and case-based public health law. The substance of the report is not intended to be exhaustive, but rather demonstrative of various facts of Virginia public health law.

The report first reviews the concept and definition of public health law, including issues of federalism, to provide some context for a discussion of Virginia public health law. Second, it examines the current status of Virginia 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 a high-level panel of governmental officials, public health experts in the public and private sectors in Virginia, state legislators, academics, and

members of the Virginia Turning Point Committee and one of the report's authors [James Hodge]. Mr. Hodge will discuss the substance of the report with these individuals through phone conferences to gain valuable input concerning public health practice in Virginia.

After completing the report, Mr. Hodge will present the findings to Virginia Turning Point officials and other interested individuals during a one-day meeting in Richmond, Virginia. This consultation will focus on proposed changes concerning Virginia 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.[3] 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[4] 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:[5] "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).[6] 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.[7]

If the Constitution is a fountain from which governmental powers flow, federalism represents a partition in the fountain which separates federal and state powers.[8] 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.[9] 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.").[10]

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,[11] 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 are 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.[12] 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 predominant role in providing population-based health services.[13] States still account for the majority of traditional spending for public health services (not including personal medical services or the environment).[14] 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 reduce 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[15] to sanitation and water and air pollution.[16] Police powers exercised by the states include laws authorizing vaccination,[17] isolation and quarantine,[18] inspection of commercial and residential premises,[19] abatement of unsanitary conditions or other health nuisances,[20] regulation of air and surface water contaminants as well as restriction on the

public's access to polluted areas,[21] standards for pure food[22] and drinking water,[23] extermination of vermin,[24] fluoridization of municipal water supplies,[25] and licensure of physicians and other health care professionals.[26]

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 have 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*[27] 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.[28] 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,*[29] along with several non-commerce clause cases, is reflective of the judicial trend.[30] In *Lopez*, the Court held that Congress exceeded its Commerce powers by making gun possession within a school zone a federal criminal offense.[31] 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,[32] 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[33] or loosely preemptive federal laws[34] which invade core state concerns in public health.

Virginia Public Health Law

The Virginia Constitution

Like the federal Constitution, the Virginia Constitution sets limits on the powers of the state while providing affirmative grants of governmental powers. The Commonwealth of Virginia's 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,[35] equal protection,[36] freedom of religion[37] and speech,[38] and a prohibition against unreasonable searches and seizures.[39] Unlike some states, however, the Virginia Constitution does not explicitly provide for additional protections such as an individual's right to privacy, although the Commonwealth's legislature (the General Assembly) has acted where the constitution is silent (see *Virginia Public Health Information Privacy Laws* below).

While the Virginia constitution does not explicitly grant the General Assembly the power to promote or protect public health or to provide for public welfare, the General Assembly is given broad authority to act in areas not otherwise restricted.[40] The omission of specific grants of authority shall not be construed to deprive the legislature of such authority.[41] As a result, Virginia public health law and regulations are largely defined by the General Assembly.

The Virginia constitution also authorizes the legislature to create political subdivisions, subject to few limits.[42] Pursuant to this concentration of lawmaking power, the legislature has organized the Commonwealth into 95 counties and hundreds of cities, towns, and other regional governments. The Virginia constitution, unlike some states' constitutions, does not expressly empower local governments with "home rule" powers. Virginia operates under the *Dillon Rule*

which states that local governments have no powers other than those expressly or impliedly granted them by the state.[43] As a result, Virginia 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.[44]

The General Assembly may specifically assign local governments the power to create ordinances or other laws in the interest of public health. Occasionally, local enactments pursuant to these delegations of public health powers may interfere or overlap with state law. When this occurs, the authority of the state to act prevails, though Virginia courts try to reconcile such overlap wherever possible.[45]

Virginia Public Health Statutes

Unlike many states,[46] Virginia has statutorily enacted a comprehensive and fairly sophisticated mission statement regarding the protection of the health and safety of its citizens:

> The General Assembly finds that the protection, improvement and preservation of the public health and of the environment are essential to the general welfare of the citizens of the Commonwealth. For this reason, the State Board of Health and the State Health Commissioner, assisted by the State Department of Health, shall administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, educate the citizenry in health and environmental matters, develop and implement health resource plans, collect and preserve vital records and health statistics, assist in research, and abate hazards and nuisances to the health and to the environment, both emergency and otherwise, thereby improving the quality of life in the Commonwealth.[47]

Pursuant to this broad, tripartite mission, the Virginia General Assembly has declared public health to be a fundamental, governmental responsibility[48] and has subsequently enacted an array of statutes creating and authorizing various state and local governmental agencies and departments to regulate and carry out public health functions.

Many of these agencies are overseen in the executive branch by Mr. Claude A Allen, Secretary of Health and Human Resources.[49] The Secretary, appointed by the Governor and subject to confirmation by the General Assembly, carries out a host of duties regarding multiple state health agencies[50] at the discretion of the Governor. These duties include (1) resolving administrative, jurisdictional, operational, or policy conflicts between state health agencies; (2) formulating a comprehensive budget for health-related programs; (3) holding agency heads accountable for their administrative, fiscal and program-related responsibilities; and (4) developing goals, objectives, and policies toward the effective and efficient operation of government.[51]

State agencies which contribute to public health objectives include the ***Department of Emergency Services*** (which coordinates the state's emergency preparedness and response efforts for a variety of disasters); the ***Department of Labor and Industry*** (primarily responsible for occupational safety and health); the ***Department of Health Professions*** (which provides for the licensure of physicians and nurses); the ***Department of Rehabilitative Services,*** the ***Department for Rights of Virginians With Disabilities,*** and the ***Council on Human Rights*** (which assist individuals with disabilities concerning issues of abuse, neglect, and discrimination); the ***Department for the Aging*** (responsible for planning, coordinating, funding, and evaluating some health-related programs for older Virginians); the ***Department of Mental Health, Mental Retardation and Substance Abuse Services*** (concerned with mental health issues, including research and surveillance); the ***Department of Medical Assistance Services*** (which administers the state's Medicaid services to the Commonwealth's low-income population); the ***Joint***

Commission on Health Care (a legislative commission which studies, reports, and makes recommendations to the General Assembly on multiple health-related areas); and the ***Virginia Tobacco Settlement Foundation*** (recently established to allocate money from the Virginia Tobacco Settlement Fund to programs and initiatives that seek to limit minor's access to tobacco products).

Most traditional public health functions in Virginia are centrally administered, if not performed directly, by one of three state agencies: the ***Virginia Department of Health*** (VDH) (*www.vdh.state.va.us*),[52] the ***Department of Environmental Quality*** (DEQ) (*www.deq.state.va.us*), [53] and the ***Virginia Department of Agriculture and Consumer Services*** (VDACS) (*www.state.va.us/~vdacs/vdacs.htm*). [54] As summarized below, the respective duties and functions of these state agencies, though at times overlapping, are distinguished by the general legislative intent underlying the agency's establishment. VDH is primarily responsible for regulating public health matters related to the control of communicable diseases, administration of public health care, and some issues of public safety. DEQ is delegated the authority to regulate environmental threats to health. VDACS is responsible for the control of some public health nuisances, although many of its duties intersect with those of VDH and DEQ.[55]

Virginia Department of Health (VDH)[56]

VDH and its many sub-commissions and sub-offices are headed by Dr. Anne Peterson, State Health Commissioner,[57] advised by the State Board of Health[58] (a multi-disciplinary group, including the Commissioner,[59] whose mission includes leadership, planning, and policy development concerning VDH's health programs)[60] and responsible to the Secretary of Health

and Human Resources.[61] While many of VDH's health-related responsibilities are focused on the provision of individual health care services, it is also primarily responsible for numerous core public health functions. Most traditional public health duties and functions are broadly delegated to VDH through legislative authorizations by the General Assembly.

VDH is statutorily authorized in general to (1) administer and provide a comprehensive program of preventive, curative, restorative and environmental health services, (2) educate the citizenry in health and environmental matters, (3) develop and implement health resource plans, (4) collect and preserve vital records and health statistics, (5) assist in health-related research, (6) abate hazards and nuisances to the health and environment, both emergency and otherwise, and (7) generally improve quality of life among citizens in the Commonwealth.[62]

Public health duties of VDH also include the administration of state public health regulations, programs, and initiatives concerning (1) disease prevention and control,[63] (2) compilation of vital health records through the State Registrar of Vital Records,[64] (3) maternal and child health and welfare services[65] (including, for example, reporting information about children with health problems or disabling conditions),[66] (4) preventive medical services (e.g. immunizations), (5) nutrition services, (6) health education, and (7) development,[67] regulation,[68] and management of medical care facilities.

These and other public health functions of the Department are legislatively set forth in sections of the VIRGINIA ANNOTATED CODE, primarily Title 32:1, Health. VDH is authorized, among other things, to coordinate the creation of a statewide emergency medical services system;[69] establish a comprehensive program for the control of tuberculosis,[70] HIV/AIDS, and

other infectious diseases; regulate the delivery of services in hospitals;[71] monitor and control radioactive materials;[72] regulate public water supplies;[73] and administer the Virginia Children's Medical Security Insurance Plan.[74] VDH also works in conjunction with VDACS to set sanitation standards for a variety of commercial businesses (e.g. food handling and manufacturing establishments, industrial plants, restaurants, and bars) and non-commercial establishments (e.g. schools and other similar establishments in which lack of sanitation may create a condition that causes disease).[75]

Accompanying these and other public health duties of the Department and the Board of Health is the legislative authorization to enact administrative regulations which more precisely define the scope and extent of these powers.[76] These administrative regulations may have the binding force and effect of statutory law, but are subservient to federal and state constitutional and statutory laws.[77] Many public health responsibilities assigned to VDH are further clarified through these regulations, including human subject research,[78] newborn screening and treatment,[79] various regulations concerning disease reporting and control,[80] and child immunizations.[81]

Department of Environmental Quality (DEQ)

The Virginia Department of Environmental Quality (DEQ) has primary authority concerning additional, significant public health efforts.[82] DEQ is the Commonwealth's primary environmental protection agency. Unlike many state environmental agencies, it has also been assigned responsibility for abating some public health nuisances. Specific duties of DEQ include coordinating and developing state-wide environmental policies; setting standards governing air, water, surface, and subcutaneous pollution; and preventing public health nuisances.[83]

Concerning this latter duty, DEQ regulates sanitary practices in the interest of public health. Various divisions within DEQ are responsible for implementing programs consistent with these broad legislative criteria, including monitoring air and water pollution; administering laws and regulations concerning, among other things, solid waste management,[84] environmental sanitation,[85] and regulating areas of environmental contamination.[86] Like VDH, DEQ has the delegated authority to establish and enforce administrative regulations.

Department of Agriculture and Consumer Services **(VDACS)**

The Virginia Department of Agriculture and Consumer Services advocates on behalf of Virginia's agricultural industries and regulates areas related to public health, consumer goods, and food safety through its Commissioner and Board of Agriculture and Consumer Services.[87] VDACS' regulatory authority extends into areas including pesticides,[88] consumer tobacco quality,[89] food and beverages generally,[90] milk products and dairies,[91] and livestock and poultry production.[92] VDAC's **Office of Meat and Poultry Services** focuses on safe production and truthful labeling of meat and poultry products. Its regulations are equivalent to or more stringent than those promulgated by the U.S. Department of Agriculture. The **Office of Food Safety and Dairy Services** monitors the safety of milk and dairy products as well as eggs, apples, and vinegar. Working with industry representatives, the U.S. Food and Drug Administration, and the U.S. Department of Agriculture, this Office also helps to regulate non-restaurant food establishments and food warehouses.

Some public health functions undertaken by government agencies in Virginia overlap to some degree. For example, the broad authority of VDH to control public health diseases

intersects with DEQ's and VDAC's responsibility for monitoring and preventing food and water-borne contaminants in the interests of public health. Some infectious diseases, such as hepatitis A and crypto sporidium, may be spread through contamination of food or water supplies, thus requiring potential action from both agencies to monitor and prevent their spread. In addition, though milk and milk products are regulated by VDACS, the State Health Commissioner is authorized to oversee permitting and enforcing regulations promulgated by VDACS. While dual responsibility may in some cases work to better the public health, inevitable conflicts of agency authority and action may arise. These conflicts present opportunities for inefficient or incomplete responses to legitimate public health threats. The limits of this organizational division of power in Virginia's public health system are further addressed in subsequent sections of this report.

Municipal/Local Public Health

As mentioned above, Virginia has constitutionally provided for the establishment of counties, cities, towns, and regional governments.[93] Virginia statutory law further classifies these divisions of local government and clarifies their powers. Among other public health powers,[94] municipal corporations (counties and cities)[95] can regulate in the interests of (1) abating public nuisances;[96] (2) requiring trash removal;[97] (3) removing or repairing dilapidated buildings;[98] (4) requiring security fences surrounding swimming pools;[99] (5) requiring the installation of smoke detectors in certain buildings;[100] and (6) prohibiting certain forms of discrimination beyond that prohibited by federal or state law.[101] State law also conveys the general power to municipalities to promote the general welfare, safety, and health.[102] Local ordinances may not offer less protection than that afforded by Virginia state law or administrative regulations.[103]

While counties and cities are allowed some discretion in the exercise and passage of public health ordinances via authorization pursuant to state law, most public health functions are undertaken through local departments of health which are contractually overseen by the Virginia Department of Health. Each county and city in Virginia is statutorily required to "establish and maintain a local department of health which shall be headed by a local health director,"[104] who must be a licensed physician in Virginia. Counties and cities may enter into contracts with the State Board of Health to assist, financially and otherwise, with the operation of the local health departments.[105] The State Health Commissioner has broad discretion in managing such health departments, is responsible for appointing a local health director, and may consolidate these departments into district health departments to allow for the performance of their functions in a more efficient and economical manner.[106] There currently exist 35 local health districts in Virginia.[107]

Counties and cities which choose not to enter into such contracts with the Board of Health are authorized to operate independent local health departments and appoint their own health directors,[108] although the Commissioner retains significant oversight over these departments as well.[109] Only the Cities of Richmond and Arlington, and Fairfax County, have established independent health districts. The Board of Health is authorized to perform the duties of local health directors and departments for those counties and cities which do not enter into contracts with the Board or which do not establish independent health departments.[110]

Local boards of health are statutorily and contractually bound to administer many public health in accordance with state requirements. While this dual relationship could be seen as de-

emphasizing the role of local governments in public health, the state and local relationship is more cooperative in practice. VDH officials recognize the need for a strong local presence in public health and seem willing to listen to local concerns. Local health officials understand the need for state oversight, expertise, and funds to conduct public health programs and initiatives. As a result, public health goals are ideally achieved through a mutually-respectful working relationship between state and local public health officials.

Virginia Public Health Information Privacy Laws

Absent an explicit state constitutional right to privacy, the Virginia legislature has enacted multiple laws to protect the confidentiality of personal medical and public health records. The Privacy Protection Act of 1976 requires government agencies that maintain information systems containing personally-identifiable information (including medical information) to ensure safeguards for personal privacy.[111] However, the Privacy Act is more procedural than substantive.[112] Substantive health information privacy protections are generally set forth in the Medical Records Privacy Act.[113] This law recognizes a patient's right of privacy in the content of his or her medical record and generally prohibits medical providers from disclosing (or others from redisclosing) such records without a patient's informed consent. The Supreme Court of Virginia has held that the unauthorized disclosure of medical records by a medical provider constitutes medical malpractice.[114] However, the general rule against disclosures is subject to multiple exceptions. It does not apply to worker's compensation claims or the medical records of minors. Disclosures without consent are allowed for over two dozen statutory reasons, including, for example, (1) pursuant to subpoena or legal testimony; (2) where necessary to care for the

patient or collect a provider's fee; (3) "to communicate a patient's specific and immediate threat to cause serious bodily injury or death of an identified or readily identifiable person;"[115] or (4) "[a]s required or authorized by any other provision of law including contagious disease, public safety, and suspected child or adult abuse reporting requirements."[116]

Though the Commonwealth has declared information held by state agencies to be public records open to inspection pursuant to its Freedom of Information Act, it specifically exempts from disclosure "[m]edical and mental records."[117] This exception, however, does not prohibit a state agency from releasing confidential health or safety information to the subject person whose health or safety is affected, or to a physician of the subject person's choice.[118] For minors (under age eighteen), such access to medical records must be asserted by a parent or guardian.[119]

Like most states, Virginia has not implemented broad *public health* information privacy protections through the passage of a single statute. The legislature has instead enacted a series of privacy provisions relating to specific public health information, including vital records and health statistics,[120] HIV/AIDS data,[121] communicable disease information,[122] infant screening for certain genetic and metabolic diseases or congenital anomalies,[123] data gathered by the statewide cancer registry,[124] medical research data,[125] and insurance records.[126]

On a statewide level, the legislature has created a Center for Health Statistics which collects health-related records, vital records, and other data in conjunction with the Board of Health and VDH under the supervision of the Commissioner.[127] Concerning vital records and statistics, county and city health directors are authorized to serve as registrars of vital records and health statistics and collect personally-identifiable health records in their respective jurisdictions.

Some data services, including compilation, storage, analysis, and evaluation are performed on a contract basis by non-profit entities.[128] Though the aggregate data gathered by the Center for Health Statistics are publicly available, the specific identities of patients, physicians, and employers may be released only for research purposes and only if such data are encrypted and cannot reasonably be expected to reveal patient identities.[129] Further, no report published by the non-profit organization or by the Commissioner may present personally-identifiable information.[130]

The State Commissioner of Health is given broad authority to examine medical and health records, and may examine those records of "every practitioner of the healing arts and every person in charge of any medical care facility" in investigating, researching, or studying diseases "of public importance."[131] Though the Commissioner is required to preserve the anonymity of such records, she may divulge the identities of relevant patients and practitioners in the course of an investigation, research, or study.[132]

Specific privacy provisions vary with respect to certain diseases. The records of children suffering from congenital anomalies, for example, may be released only to their physicians, parents, and for studies which do not identify the individuals. HIV test results submitted for laboratory analysis may not be disclosed except: (1) to the health care provider ordering the test; (2) to the person who is the subject of the test; (3) to the spouse of the subject of the test; (4) to VDH; (5) to parents or legal guardians of minors; (6) to any facility which procures, processes, distributes or uses blood, bodily fluids, tissues, or organs; (7) by court order; (8) to medical or epidemiological researchers for statistical use only; (9) to departments of health outside the

Commonwealth for disease surveillance and investigation; and (10) to other persons authorized by law to receive such information.[133]

The Benefits of a Public Health Law Improvement Process

> *The field of public health is firmly grounded in law and could not exist in the manner in which we know it today except for its sound legal basis.*[134]

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. We recognize the law as merely one tool toward the improvement of public health. Many of the problems observable in public health are remedied not primarily though law reform but, rather, through better leadership and training, improved infrastructure for surveillance and epidemiological investigations, comprehensive counseling and health education, and innovative prevention strategies. In making policy, public health authorities will have to consider prevailing social values and respect multiple constituencies, including scientists, politicians, and community leaders.

The Role of Public Health Law

There are at least four possible roles for the law in advancing public health. Law can define the objectives of public health and influence its policy agenda, authorize and limit public

health actions, serve as a tool of prevention, and facilitate planning and coordination of governmental and non-governmental health activities.

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

Public health law must provide broad authority for the exercise of public health powers and coextensively limit that authority where necessary for the protection of individual rights. In considering law reform, it is important to distinguish between duties and powers in public health. The legislature should impose duties on health departments[135] to initiate a broad range of activities relating, for example, to surveillance, communicable disease control, environmental protection, sanitation, and injury prevention. It is important that health officials retain *flexibility* in the powers used to achieve public health purposes.

While providing for a flexible range of public health powers, the law must also place appropriate limits on those powers to protect human rights. This is best accomplished by adhering to certain strategies:

- Establishing clear criteria for the exercise of compulsory powers by requiring health authorities to use scientific evidence of a significant risk to the public health;
- Providing procedural due process for all individuals who face serious constraints on their liberty; and
- Safeguarding the privacy of individuals and preventing or punishing invidious discrimination.

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

The following benefits could be achieved through a public health improvement process.[136]

Update Antiquated Laws

Most public health laws in the United States have been passed piecemeal in response to specific disease threats such as tuberculosis, sexually-transmitted diseases, and HIV/AIDS. The law has thus developed, layer-upon-layer, from one time period to another. Certainly, older laws are not necessarily bad laws. A well-written statute may remain useful, efficacious, and constitutional for many decades. However, older laws are often outmoded in ways that directly reduce their efficacy and conformity to modern legal standards. Older laws may not reflect contemporary scientific understanding of disease, current medical treatments of choice, or

constitutional limits on the state's authority to restrict individual liberties. They may fail to allow public health agencies the discretion to modernize such enactments through administrative regulation.

Comply with Modern Constitutional and Other Legal Requirements

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

At the constitutional level, the United States Supreme Court now has more exacting standards for equal protection of the laws, substantive due process, and procedural due process. Public health powers that affect liberty (e.g., quarantine and directly observed therapy), privacy (e.g., reporting and partner notification), and autonomy (e.g., compulsory testing, immunization, or treatment) may undergo more careful scrutiny under the federal Constitution. At the same time, the Constitution may require more rigorous procedural safeguards before exercising compulsory powers.

Federal disability law prohibits discrimination against persons based on their health status, such as an infectious disease. This may require health officials to adopt a standard of "significant risk" before resorting to compulsion. A significant risk may be defined as a direct threat to the health or safety of others that cannot be eliminated by modification of policies, practices, or procedures. Thus, under this standard, adverse treatment, such as a decision to use compulsory powers, would only be permitted if the person posed a significant risk to the health or safety of

others. A significant risk regarding communicable diseases would be determined through an individualized assessment of the mode of transmission, probability of transmission, severity of harm, and the duration of infectiousness.[137]

Clarify the Law

General or overlapping 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 approach of 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 is an important goal. 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 sometimes 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. 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. Coextensively,

legislators may see a need for clear criteria and procedures under which public health officials can operate.

Legislators and public health authorities must listen to one another through discussions which are motivated on the sole issue of improving Virginia'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.

(ii) Federal and State

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

(iii) State and Local

State and local dialogue on public health is critical in Virginia given the size and diversity of the State and its urban, suburban, and rural populations. Maintaining channels of communication between state and local public health authorities is important. A lack of regular communication between these authorities could carry serious implications for the public health. If the Commonwealth, 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 funded or provided by the state, but early

communication may facilitate local resource allocation and perhaps avoid public health repercussions from sudden discontinuances of programs.

(iv) City and Rural

Closely related to State and local relationships are the different perspectives of city and rural dwellers. State legislators from urban areas have distinctly different visions of public health and financial responsibilities than persons from rural communities. Each constituency may lack some trust in the other. A constructive and systematic dialogue process may improve relationships.

(v) Public Health Authorities and the Private Sector

Increasingly government public health authorities have aligned with private sector health care providers, insurers, managed care companies, and nonprofit and religious organizations to provide, directly or indirectly, various public health services. The private sector can play a valuable role in public health, especially where government funding for public health programs remains static, if not in decline. Establishing and nurturing these relationships between public and private sectors may serve to improve the public health.

Guidelines for Reforming Virginia Public Health Law

Through active reform over the past several decades, Virginia has re-organized its public health system at the state and local levels, updated its statutory code in many instances, and aggressively implemented effective state administrative regulations. Most public health experts in the Commonwealth suggest that the state's public health system is well-designed, thorough, and functioning. The public health is well-regarded for its ability to attend to most traditional public health functions, including communicable disease control, health prevention activities, licensing and inspection, public health education, and environmental issues. Virginia is well ahead of other less-populated and less-wealthy jurisdictions which may struggle to provide even basic public health services to their entire populations because of a fundamental lack of organizational structure and deficient public health laws. Despite these observations, the Commonwealth's public health laws can be improved.

Whether Virginia should reform its substantial and, at times, sophisticated public health law remains open. Law reform is not the inevitable result of the public health law improvement process pursuant to the Turning Point Project (although it could be). While this report discusses many of the benefits of law reform, there are also risks. First, once a bill is introduced in the legislature, it can become politicized. Second, enacted laws can tie the hands of public health officials. For this reason, many public health professionals emphasize the need for flexibility. Finally, once the relationships among various groups are delineated in legislation, it could result in great distrust. Despite these evident risks, it is important to see the benefits of public health law

improvement. With this in mind, we propose the following guidelines for public health law improvement in Virginia, not necessarily in order of their priority.

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. Virginia public health law largely reflects these observations in its attempt to classify communicable diseases under limited headings. The elimination of some existing laws which apply differing standards to certain diseases or conditions will contribute toward the implementation of a single set of standards and procedures, clarify legal regulations, and might diminish politically-motivated disputes about existing and newly-emergent diseases.

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

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

Virginia 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. And where scientific evidence may not provide suitable public health responses, public health authorities should have a flexible range of powers to address such instances.

Provide Fair Procedures

Public health officials need ample and flexible powers to protect the common welfare. Coextensively, the community needs to have confidence in the fairness of public health practice. Virginia public health law may generally delineate the powers of public health authorities without suggesting the manner in which they may be exercised. For example, Virginia statutory law authorizes the Commissioner ". . . to require quarantine, vaccination or treatment of any individual when [she] determines any such measure to be necessary to control the spread of any disease of public health importance." [138]

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.

In Virginia, some of these procedures are legislatively set forth in the State Administrative Procedure Act[139] which requires standard fair procedures to be followed in the production of administrative regulations as well as the hearing of cases pursuant to the exercise of public health authority by state agencies. These requirements provide a workable framework, but may require additional supplementation in cases where sensitive personal health information is involved or individual liberties may be restrained in the interests of the public health.

State law concerning isolation hearings provides some standard due process protections, including (1) conducting the hearing before an impartial tribunal in a timely manner; (2) the individual's right to information about the public health action, right to an appeal, and the right to counsel; and (3) the declaration of findings to be made before isolation may be ordered.[140] While these protections collectively represent fair procedures, it is important to note that the authority to isolate individuals extends to anyone who the Commissioner determines may be knowingly engaging in at-risk behaviors which threaten the public health in relation to all communicable diseases.[141] The potential for inappropriate public health responses to certain communicable diseases exists, although statutory law and administrative regulations concerning isolation suggest that the least restrictive course of action be taken in any given case.[142]

Improving Relationships and Resolving Disputes

Regular and meaningful exchange of information between state and local public health agencies is critical. As discussed above (see *Benefits of a Public Health Improvement Process*), the relationships between federal, state, and local public health authorities are critical. Prior leadership issues and reported failures to work effectively between officials at the state's two primary public health agencies (VDH and DEQ) as well as some distrust of state government among local governments provide ample reasons for increased communication in the future. While Virginia public health relies on core relationships between state public health agencies and local health departments, there exist few legislative requirements that these entities regularly engage in public health discussion. State public health agencies may tend to see their missions narrowly and attempt to avoid certain issues that do not fit neatly under their responsibilities to the detriment of the public health. Local governments may resent what are viewed as unfunded mandates streaming down from state public health agencies where local involvement in the decision-making process is non-existent or not respected.

Rather than rely on public health communication stemming from an emergency or crisis, state and local public health officials should conduct formalized, meaningful, and ongoing discussions with each other and members of the private sector. This could have several beneficial effects. First, it helps to plan in advance to avoid conflicts. Second, it provides a mechanism for responding to crises when they arrive. Third, and most important, it enhances familiarity and trust among different groups in the public health infrastructure.

Balancing Benefits Across the Commonwealth

Virginia's public health system is built around highly-organized, centralized state agencies, primarily VDH and DEQ, that distribute their expertise and resources through state-mandated local departments of health. This system may be commended for stretching its protections to each segment of the population. In other states, many individuals may lack access to and the benefits of any meaningful public health services. While Virginia canvases the state with public health coverage, public health services vary across local health districts for reasons which are both financial and political. Such variances are understandable. They are also ethically problematic where some state citizens enjoy less public health protections depending upon their locale. Where millions of people nationwide cannot afford, or otherwise choose not to obtain, adequate health insurance in the United States' market-based health care system or through Medicare/Medicaid, public health services may be one of few sources of primary care for under-privileged individuals (although nonprofit hospitals, religious organizations, and other private sector entities often provide such care). While the Commonwealth has not assumed a duty to provide individual health care for these persons,[143] it seems incumbent upon the state to ensure that public health benefits are as evenly distributed as possible where it's public health mission includes improving the quality of life for all citizens.

The uneven distribution of public health services is resolvable. Through legal reform or otherwise, Virginia should strive to balance the coverage of public health services and resources across the state for the betterment of its less-fortunate citizens and the improvement of public health outcomes generally.

Private Sector and the Public Health

Public health has always envisioned the cooperative efforts of the public and private sectors. Increasingly states are turning to the private sector (e.g. medical providers, hospitals, health insurers, managed care companies, nonprofit organizations) for assistance with public health goals. While government must remain primarily responsible for the public health, the private sector may serve important roles (e.g., population-based disease screening, provision of indigent care, surveillance assistance). Like the relationships between governmental public health agencies, the relationships between public and private sectors can be formalized through state law. As the potential collaboration between public and private sectors becomes a core facet of public health planning, these formal relationships may work overall to strengthen the public health system. While public health officials in Virginia support collaboration between the public and private sectors, there exists little to any law supporting or requiring these joint pursuits.

Data Protection: Public Health Data Needs and Privacy Considerations

The collection, storage, maintenance, and use of vast amounts of information about the health of populations is one of the core functions of public health. Surveillance is among the most important functions of public health, permitting early identification of health threats, targeted delivery of prevention services, and links to treatment and other services. Public health law must enable, encourage, and fund a strong public health information infrastructure.

While Virginia law generally supports the privacy and confidentiality of personally-identifiable, government-held health information, these statutes and regulations singularly and collectively raise some privacy concerns. These statutes may exceptionalize some data to the exclusion of other, equally-sensitive health information, fail to provide meaningful privacy

protections, and tend to imprecisely define privacy protections which are provided (although administrative regulations may remedy some of this imprecision). The latter two of these points are perhaps demonstrated concerning Virginia's administrative regulations concerning contact tracing [or as commonly known, partner notification].

Although partner notification is an accepted component of public health surveillance concerning communicable disease, it involves the exchange of sensitive, personally-identifiable information about infected individuals and their partners.[144] Local health departments in Virginia are required to conduct contact tracing in cases involving HIV infection, infectious syphilis, and tuberculosis, and may perform contact tracing for the other diseases ". . . if deemed necessary to protect the public health."[145] The affirmative requirement that local health departments perform partner notification for HIV, syphilis, and tuberculosis suggestively rejects the ethic of voluntarism underlying its practice and may offend the privacy interests of infected individuals. While administrative regulations prohibit the release of names of informants or infected persons to contacts by the health department and otherwise requires all information obtained to be kept "strictly confidential," they do not attempt to clarify the extent and meaning of these protections.

In the absence of a structured statutory approach to protecting public health information privacy, certain privacy infringements and breaches may occur which could have deleterious effects on public health. Several public health experts in the Commonwealth acknowledge the need for public health information privacy reform.

Statutory provisions governing data collection and privacy must seek to satisfy two goals that will, at times, conflict: ensuring up-to-date information for public health purposes and

protecting that information from inappropriate disclosure. Balancing these competing goals can only be accomplished through the implementation of policies and practices consistent with set guidelines. The guidelines below concern only personally identifiable data which pose the most significant privacy concerns.

(i) Justification for Data Collection

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

(ii) Community Access to Information

A community should be generally informed about aggregate data collection by public health departments and its purposes. Even where information is non-identifiable, people should generally be aware of the sorts of data collection undertaken by public health departments. Aggregate public health data should be made accessible by community members for virtually any purpose.

(iii) Fair Information Practices

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

(iv) Privacy Assurances

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

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

The Model State Public Health Privacy Act

Some 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 protect 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.

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

Conclusion

Virginia's public heath system is commendable in many ways. The Commonwealth's public health laws often reflect sophistication unseen in other jurisdictions. However, there remains opportunities for improvement. The preceding Recommendations, supported by our study of public health law in Virginia, present guidelines for legal reform. Specific statutory language needed to accomplish these reforms 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 and outcomes. Ultimately, this is the overriding goal of the Turning Point Project in Virginia.

ENDNOTES

1. The authors would like to acknowledge the research assistance of Jeffrey Huang (J.D. Candidate, Georgetown University Law Center), and others as part of the Georgetown/Johns Hopkins Program on Public Health and the Law.
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47. VA. CODE ANN. § 32.1-2 (Michie 1999).
48. *See* Roanoke Mem. Hosps. v. Kenley, 352 S.E.2d 525 (Va. 1987); Lohr v. Larsen, 431 S.E.2d 642 (Va. 1993).
49. VA. CODE ANN. § 2.1-51.13 (Michie 1999).
50. VA. CODE ANN. § 2.1-51.15 (Michie 1999) (these agencies presently include the Department of Health, Department for the Visually Handicapped, Department of Health Professions, Department for the Aging, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department of Rehabilitative Services, Department of Social Services, Department for Rights of Virginians With Disabilities, Department of Medical Assistance Services, the Council on Indians, Governor's Employment

and Training Department, Child Day-Care Council, Virginia Department for the Deaf and Hard-of-Hearing, and the Virginia Council on Coordinating Prevention).
51. VA. CODE ANN. § 2.1-51.14 (Michie 1999).
52. VA. CODE ANN. §§ 32.1-16 *et seq.* (Michie 1999).
53. VA. CODE ANN. §§ 10.1-1183 *et seq.* (Michie 1999).
54. VA. CODE ANN. §§ 3.1.1 *et seq.* (Michie 1999).
55. VA. CODE ANN. §§ 32.1-163 *et seq.* (Michie 1999).
56. VA. CODE ANN. § 32.1-16 (Michie 1999).
57. VA. CODE ANN. § 32.1-17 (Michie 1999).
58. VA. CODE ANN. § 32.1-5 (Michie 1999).
59. VA. CODE ANN. § 32.1-9 (Michie 1999).
60. VA. CODE ANN. § 32.1-9 (Michie 1999).
61. VA. CODE ANN. § 32.1-16 (Michie 1999).
62. VA. CODE ANN. § 32.1-2 (Michie 1999).
63. VA. CODE ANN. §§ 32.1-35 *et seq.* (Michie 1999).
64. VA. CODE ANN. §§ 32.1-249 *et seq.* (Michie 1999).
65. VA. CODE ANN. § 32.1-77 (Michie 1999).
66. VA. CODE ANN. § 32.1-78 (Michie 1999).
67. VA. CODE ANN. §§ 32.1-122.01 – 32.1-122.08 (Michie 1999).
68. VA. CODE ANN. §§ 32.1-123 – 32.1-137 (Michie 1999).
69. VA. CODE ANN. §§ 32.1-111.1 – 32.1-111.15 (Michie 1999).
70. VA. CODE ANN. §§ 32.1-49 – 32.1-54 (Michie 1999).
71. VA. CODE ANN. §§ 32.1-123 – 32.1-137 (Michie 1999).
72. VA. CODE ANN. §§ 32.1-227 – 32.1-238 (Michie 1999).
73. VA. CODE ANN. §§ 32.1-167 – 32.1-176 (Michie 1999).
74. VA. CODE ANN. §§ 32.1-351 – 32.1-353 (Michie 1999).
75. VA. CODE ANN. §§ 3.1-361 *et seq.* (Michie 1999).
76. VA. CODE ANN. §§ 32.1-12, 32.1-13 (Michie 1999).
77. Carbaugh v. Solem, 302 S.E.2d 33 (Va. 1983).
78. 12 Va. Code. Reg. 5-20-10 *et seq.*
79. 12 Va. Code. Reg. 5-70-10 *et seq.*
80. 12 Va. Code. Reg. 5-90-10 *et seq.*
81. 12 Va. Code. Reg. 5-110-10 *et seq.*
82. VA. CODE ANN. §§ 10.1-1182 *et seq.* (Michie 1999).
83. VA. CODE ANN. §§ 10.1-1186, 10.1-1300 *et seq.*, 10.1-1425.10 *et seq.* (Michie 1999).
84. VA. CODE ANN. §§ 10.1-1401 – 10.1-1413 *et seq.* (Michie 1999).
85. VA. CODE ANN. §§ 10.1-1425.10 *et seq.* (Michie 1999).
86. VA. CODE ANN. § 10.1-1426 (Michie 1999).
87. VA. CODE ANN. §§ 3.1-8 *et seq.* (Michie 1999).
88. VA. CODE ANN. §§ 3.1-249.27 – 3.1-249.78 (Michie 1999).
89. VA. CODE ANN. §§ 3.1-297 *et seq.* (Michie 1999).
90. VA. CODE ANN. §§ 3.1-361 *et seq.* (Michie 1999).

91. VA. CODE ANN. §§ 3.1-420 *et seq.* (Michie 1999).
92. VA. CODE ANN. §§ 3.1-723 *et seq.* (Michie 1999).
93. VA. CONST. Art. VII, § 2.
94. VA. CODE ANN. §§ 15.2-900 *et seq.* (Michie 1999).
95. VA. CODE ANN. § 15.2-102 (Michie 1999).
96. VA. CODE ANN. § 15.2-900 (Michie 1999).
97. VA. CODE ANN. § 15.2-901 (Michie 1999).
98. VA. CODE ANN. § 15.2-906 (Michie 1999).
99. VA. CODE ANN. § 15.2-921 (Michie 1999).
100. VA. CODE ANN. § 15.2-922 (Michie 1999).
101. VA. CODE ANN. § 15.2-965 (Michie 1999).
102. VA. CODE ANN. §§ 15.2-1102, 15.2-1200 (Michie 1999).
103. VA. CODE ANN. § 32.1-34 (Michie 1999).
104. VA. CODE ANN. § 32.1-30 (Michie 1999).
105. VA. CODE ANN. § 32.1-31 (Michie 1999).
106. VA. CODE ANN. § 32.1-31(C) (Michie 1999).
107. These local health districts are as follows: Alexandria, Alleghany, Arlington, Central Shenandoah, Central Virginia, Chesapeake, Chesterfield, Crater, Cumberland Plateau, Eastern Shore, Fairfax, Hampton, Hanover, Henrico, Lenowisco, Lord Fairfax, LoudounCounty, Mount Rogers, New River, Norfolk Peninsula, Piedmont, Pittsylvania/Danville, Portsmouth, Prince William, Rappahannock, Rappahannock/Rapidan, Richmond, Roanoke, Southside, Thomas Jefferson, Three Rivers, Virginia Beach, West Piedmont, and Western Tidewater.
108. VA. CODE ANN. § 32.1-32(A) (Michie 1999).
109. VA. CODE ANN. § 32.1-32(B) (Michie 1999).
110. VA. CODE ANN.§ 32.1-33 (Michie 1999).
111. VA. CODE ANN. §§ 2.1-377 – 2.1-386 (Michie 1999).
112. Hinderliter v. Humphries, 224 Va. 439, 297 S.E.2d 684 (1982) (Privacy Protection Act of 1976 does not render personal information confidential and does not generally prohibit the dissemination of information. Rather it requires certain procedural steps to be taken in the collection, maintenance, use, and dissemination of such data).
113. VA. CODE ANN. § 32.1-127.1:03 (Michie 1999).
114. Fairfax Hospital v. Curtis, 492 S.E.2d 642 (1997).
115. VA. CODE ANN. § 32.1-127.1:03(D)(19) (Michie 1999).
116. VA. CODE ANN. § 32.1-127.1:03(D)(6) (Michie 1999).
117. VA. CODE ANN. § 2.1-342.01 (Michie 1999).
118. VA. CODE ANN. § 2.1-342.01 (Michie 1999).
119. VA. CODE ANN. § 2.1-342.01 (Michie 1999).
120. VA. CODE ANN. § 32.1-271 (Michie 1999).
121. VA. CODE ANN. § 32.1-36.1 (Michie 1999).
122. VA. CODE ANN. § 32.1-40 (Michie 1999).
123. VA. CODE ANN. § 32.1-67.1, §§ 32.1-69 – 32.1-69.2 (Michie 1999).
124. VA. CODE ANN. § 32.1-71 (Michie 1999).

125. VA. CODE ANN. § 32.1-276.9 (Michie 1999).
126. VA. CODE ANN. §§ 38.2-608 – 38.2-609 (Michie 1999). Provisions relating to the privacy of genetic information exist under the insurance laws of the Commonwealth, *see* VA. CODE ANN. § 38.2-508.4 (Michie 1999) ("No person proposing to issue, re-issue, or renew any policy, contract, or plan of accident and sickness insurance... shall on the basis of any genetic information obtained concerning an individual or on the individual's request for genetic services, with respect to such policy, contract, or plan: terminate...cancel...exclude...establish differentials in premium rates for coverage.").
127. VA. CODE ANN. § 32.1-276.1 (Michie 1999). The statue governing such health care data reporting expires on July 1, 2003 to allow the General Assembly an opportunity to assess and examine whether the Center for Health Statistics is effective at carrying out its stated purposes.
128. VA. CODE ANN. § 32.1-276.4 (Michie 1999).
129. VA. CODE ANN. § 32.1-276.9 (Michie 1999).
130. VA. CODE ANN. § 32.1-276.9 (Michie 1999).
131. VA. CODE ANN. § 32.1-40 (Michie 1999).
132. VA. CODE ANN. § 32.1-41 (Michie 1999).
133. VA. CODE ANN. § 32.1-36.1 (Michie 1999). Where a provider is directly exposed to the blood or bodily fluid in a manner which may transmit HIV/AIDS there is deemed consent to testing for HIV/AIDS and the release of such test results to the person exposed under VA. CODE ANN. § 32.1-45.1 (Michie 1999). *See, e.g.*, Adams v. Drew, 906 F. Supp. 1050 (E.D. Va. 1995).
134. FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL (2d ed. 1990).
135. The term "health" department is used in the generic sense to include all public health functions carried out by the Commonwealth.
136. *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).
137. *See* Lawrence O. Gostin, Chai Feldblum, & David W. Webber, *Disability Discrimination in America*, 281 JAMA 745, 746 (1999).
138. VA. CODE ANN. § 32.1-43 (Michie 1999).
139. VA. CODE ANN. §§ 9-6.14:1 *et seq* (Michie 1999).
140. VA. CODE ANN. § 32.1-48.04 (Michie 1999).
141. VA. CODE ANN. § 32.1-48.01 (Michie 1999). Pursuant to 12 Va. Code Reg. 5-90-80, this includes the following reportable diseases: Acquired Immunodeficiency Syndrome (AIDS), Amebiasis, Anthrax, Arboviral infections, Botulism, Brucellosis, Campylobacter infection, Chancroid, Chickenpox, Chlamydia trachomatis infections, Cholera, Cryptosporidiosis, Cyclosporiasis, Diphtheria, Ehrlichiosis, some E. coli infections, Giardiasis, Gonorrhea, Granuloma inguinale, Haemophilus influenzae infection, invasive Hantavirus pulmonary syndrome, Hemolytic uremic syndrome (HUS), Hepatitis A, Hepatitis B, Hepatitis C, Other acute viral Hepatitis, Human immunodeficiency virus (HIV) infection, Influenza, Kawasaki syndrome, Lead-elevated blood levels, Legionellosis, Leprosy (Hansen disease), Listeriosis, Lyme disease, Lymphogranuloma venereum, Malaria, Measles (Rubeola), Meningococcal infection, Mumps, Ophthalmia neonatorum, Outbreaks, all (including foodborne, nosocomial, occupational, toxic substance-related, waterborne, and other outbreaks), Pertussis (Whooping cough), Plague, Poliomyelitis, Psittacosis, Rabies, human and animal, Rabies treatment, post-exposure, Rocky Mountain spotted fever, Rubella (German measles), including congenital rubella syndrome, Salmonellosis, Shigellosis, Streptococcal disease, Group A, invasive, Syphilis, Tetanus, Toxic shock syndrome, Toxic substance-related illness, Trichinosis (Trichinellosis), Tuberculosis, Typhoid fever, Typhus, Vancomycin-resistant Staphylococcus aureus,

Vibrio infection, and Yellow Fever.
142. 12 Va. Code. Reg. 5-90-10.
143. VA. CODE ANN. § 32.1-11 (Michie 1999).
144. *See* Lawrence O. Gostin and James G. Hodge, Jr., *Piercing the Veil of Secrecy in HIV/AIDS and Other Sexually Transmitted Diseases: Theories of Privacy and Disclosure in Partner Notification*, 5 DUKE J. OF L. & GENDER 9 (1998).
145. 12 Va. Code. Reg. 5-90-80[H].