



The Politics of Population Health

The Politics of Emergency Health Powers and the Isolation of Public Health

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The Model State Emergency Health Powers Act became a contentious document in more than 30 states in 2001 and 2002. Controversy has focused on recommendations by the authors of the Model Act that seemed to accord higher priority to collective action in emergencies than to protecting privacy and property.

This situation has several causes that derive from the characteristics of public health emergencies during the past half century and the relative isolation of public health officials from both their colleagues in government and many members of the public. (*Am J Public Health*. 2003;93:397–399)

FIerce ARGUMENTS SINCE

September 2001 about the powers of government, particularly state government, during health emergencies reveal fundamental problems for the field of public health. The most important problem is that many people—including many legislators, physicians, and hospital executives—accord higher priority to protecting privacy and property in a time of peril than to collective solidarity and the effective use of government authority.

This article relies mainly on our confidential conversations with policymakers in state and federal government. When an event we report left a partial trace on the public record, we offer a citation. Our generalizations about the relationship in recent decades between public health officers and the officials to whom they are accountable derive from our combined experience of almost half a century as participants in the politics of health policymaking. We regret the absence of credible, hence citable, secondary sources on the politics of policymaking for public health.

THE MODEL STATE EMERGENCY HEALTH POWERS ACT

In the spring of 2001, officials of the Centers for Disease Control and Prevention (CDC) asked the staff of the Center for Law and the Public's Health (based at Georgetown University and the Johns Hopkins University) to draft a Model State Emergency Health Powers Act. This Model Act would enable states to revise their public health statutes in order to take account of contem-

porary scientific knowledge, communications technology, and case law on the rights of individuals and the duties of government. Many states had not substantially revised their public codes for a half century or longer.

Drafting the Model Act accelerated after September 11th and especially after the first anthrax case was identified on October 4th. The Georgetown/Hopkins lawyers posted a draft on the World Wide Web in late October (and revised it in December).¹ Secretary of Health and Human Services Tommy G. Thompson enthusiastically endorsed the draft. Across the political spectrum, however, but especially among liberals and libertarians, attacks began immediately on the need for the act and its major provisions—especially on its recommendations for planning, surveillance, public information, taking property, directing the work of health professionals and immunizing them from liability, and interfering with the privacy and liberty of persons to prevent the spread of infectious disease.

Nevertheless, legislation inspired by the Model Act has been introduced in more than 30 states.² In some states, legisla-

tors and governors who supported the main thrust of the act decided that archaic provisions were better than anarchy. They feared that opening the entire public health code to amendment risked the repeal of substantial sections of it. In other states, lawmakers have used the Model Act as a checklist against which to review and revise their public health statute. No state, to our knowledge, has adopted the Model Act posted on the Web.

The Model Act has become a contentious document in a process of policymaking that is likely to continue as long as the threat of bioterrorism persists. This new fact of life is recognized in the new Department of Health and Human Services grant program to improve public health infrastructure for better defense against terrorism, which requires states to conduct ongoing review and revision of pertinent laws and regulations.

CONTROVERSIES

The debate over the Model Act is revealing that a large number of Americans question—and many even reject—the principles on which public health authority



has historically rested. Many people do not agree that the traditional police powers of government sanction intrusive action to protect the public's health. Many have asserted that privacy and liberty are too precious to compromise, even in response to bioterrorism. These people are too numerous, in all sections of the country, to be dismissed, as some of their opponents do, as "crazies," "wingnuts," "right wingers," or the "civil libertarian left."

Moreover, legislators across the political spectrum bristle at the phrase "model act." They prefer examples and suggestions to models thrust at them by outsiders. Organizations that have successfully sponsored model legislation—the National Association of Insurance Commissioners, for example—discuss it in detail with affected constituencies in advance of release.

In their understandable haste, the Georgetown/Hopkins group also produced a confusing document, posted first and discussed afterwards. Model acts are usually crafted to replace or fit easily into existing statutes. Because of the diversity in states' public health statutes, however, legislators could not consider this model until staff had prepared a lengthy memorandum comparing it with existing law. In Missouri, for example, this side-by-side comparison required 40 single-spaced pages.

Several proposed provisions have drawn particular criticism. Opponents of the Model Act do not want to give governors or health officers additional author-

ity to compel action by patients, potential patients, professionals, or providers. Many of them also object to language that requires immunization or isolation, commandeers private health facilities, and conscripts physicians. For example, a representative of the conservative American Legislative Exchange Council complained about "blatant disregard for personal privacy and individual liberties" and the erroneous "presum[ption] of the ignorance of the private sector and the American people and the superiority of the government."³ A prominent health lawyer, writing in the *New England Journal of Medicine*, agreed: the "argument that, in a public health emergency, there must be a trade-off between effective public health measures and civil rights is simply wrong."⁴ In fairness, we note that the American Legislative Exchange Council applies its strictures to all levels of government while the health lawyer asserts that "bioterrorism is primarily a federal, not a state issue."^(p134)

Language in the Model Act about defining, declaring, and managing a public health emergency has also produced controversy. The Georgetown/Hopkins lawyers propose a metaphorical on-off switch with which a governor could declare an emergency. But they do not suggest objective criteria for operating the switch and, in their first draft, severely limited legislative review. Their vagueness on this issue has stimulated fear that state health officers could panic governors into declaring emergencies prematurely. The ab-

sence of language in the Model Act about graduated response to an escalating threat reinforces the problem of when to throw the switch. Many health officers share this concern about what actions governors should be empowered to take when they are uncertain whether a small outbreak will become an epidemic.

THE CHALLENGE FOR PUBLIC HEALTH

Controversies over the particulars of the Model Act are less important than the underlying problem that there is, at best, a weak consensus in this country about who has authority to do what under the threat of a public health emergency. The issue of public health authority has not attracted sustained public attention since before the 1950s, when the success of antibiotics and vaccines against the most common infections began to create the illusion that the era of rapidly spreading diseases would recede. Some readers may object that considerable debate about public health authority took place during the first decade of the HIV/AIDS epidemic. But many Americans—most in some states—did not identify with the HIV/AIDS debate because they believed, however naively, that they were not at risk. Moreover, the success of campaigns against smallpox and, increasingly, measles offered contrary positive evidence that public health codes were fundamentally sound. September 11th and October 4th created a different political environment.

During the same half century in which the perceived threat of widespread epidemics diminished, public health agencies and their officials lost status among their colleagues at all levels of government. The apparent victory over rampant infections was only one reason for this diminished status. Other causes included the difficulty of explaining the complicated mission of public health in controlling chronic disease and the ascendancy of the widely shared belief that biomedical science, applied through personal health services, would produce the next major improvements in the length and quality of life.

As the status and moral authority of public health declined, many aspects of public health practice perplexed the governors and legislators to whom health officers are accountable. Many health officers, often because of frustration at not being heard, became articulate advocates of their cause within—and sometimes outside of—government. Because elected officials prize public employees' loyalty to them and generally regard advocates as persons with private agendas, many of them came to distrust health officers, or at least to distance themselves from them. Because public health professionals were increasingly isolated within government, at all levels, the theories and language they devised to advance the field became increasingly difficult for elected officials and members of their staffs to understand, and even more remote to the general public. And only public health pro-



professionals can describe their core competencies and recite the essentials of their practice.

Perhaps the current situation is not so different from that in the past. Historian James C. Riley claims that public health officials have deluded themselves about their authority for centuries. According to Riley, public health surveillance and control gained no consensus similar to the social contract on behalf of the institutions of representative government. He argues, for example, that 19th-century public health authorities “could sometimes command the power to enforce intrusive measures,” but he denies that they had “wide public support for the measures they advocated.”^{5(p69)}

Riley may be reading into the past the contemporary situation we have just described. Every state long ago placed the authority to act on behalf of the public's health among the police powers of government. A rich historical literature describes the successful assertion of solidarity as a higher priority than liberty during many epidemics since the 18th century; especially epidemics of yellow fever, cholera, diphtheria, influenza, and polio. On the other hand, historian Guenter B. Risse has recently argued that the authority of American public health officials in the past has varied greatly by jurisdiction.⁶

The controversy about the Model Act is unlikely to lead to repeal of existing public health statutes. However, it signals that many Americans, especially at either end of the current political spectrum, are deeply suspicious

about how government could use its power to coerce during health emergencies.

The current transfer of federal funds to the states to protect against bioterrorism could exacerbate this suspicion. Public health officials, as well as their colleagues who address the safety of food, water, air, and transportation, are likely to be described by critics as grabbing for power and resources, particularly at a time when states are facing the most dire fiscal situation since World War II.⁷ The anthrax outbreak in October 2001 did not enhance public confidence in government. A survey found that only 60% of Americans have confidence that the CDC will provide correct information to protect them from anthrax—and only 51.5% of residents in the Trenton/Princeton, NJ area, the site of one of the affected postal sorting facilities.⁸

The only available remedy for lack of confidence in governmental public health is concerted attention to reducing the isolation of public health within government and improving the public perception of government in general. For health officials, reducing isolation requires enhanced effort to collaborate with colleagues across government and improved communication with elected officials and members of their staffs.

Here is an example in point. At a recent meeting we attended, convened by elected officials, only a few of the state health officers from 9 states knew about the Emergency Management Assistance Compact on cross-border cooperation, agreed to by 49

states. Their lack of knowledge was the result of isolation from their counterparts in agencies responsible for public safety.

CONCLUSION

It is easier to manage uncertainty when experts and the persons to whom they are accountable trust each other and when the public shares that trust. Once lost, trust is difficult to restore. The history of public health offers many examples of trust between public health officials and the people to whom they are accountable. Restoring that trust is a significant precondition for effective protection against bioterrorism and other threats to public health. The reception of the Model Act demonstrates the precarious contemporary state of authority to protect the health of the public. ■

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