Law and Ethics in a Public Health Emergency

by Lawrence O. Gostin

In 1974, the Surgeon General informed Congress that it was time to "close the book on infectious diseases." So sure was the United States that modern biomedicine would solve the problem of infectious diseases that government was already cutting funding from state and local public health agencies and beginning a massive build-up of biotechnology research and development. Having declared victory over infectious diseases, the new war would be waged against diseases of modern western civilization, principally cardiovascular disease and neoplasms.

The United States was also unconcerned about bioterrorism. To be sure, America had experienced bioterrorism in 1984 when the Rajneeshee cult contaminated salad bars in rural Oregon, causing over 750 cases of Salmonella poisoning. But the government and citizenry felt that America's geographic isolation meant it would be relatively immune from upheavals abroad.

Of course, the perception of safety and security evaporated on 11 September 2001. And then on 4 October, authorities confirmed the first case of inhalational anthrax in Florida, beginning a period in which five people died, hundreds were treated, and thousands treated. Although the method of delivery through the postal service was inefficient, the anthrax outbreak exposed the nation's vulnerability.

A sustained debate ensued about the public health system's preparedness to detect and respond quickly and effectively to bioterrorism and naturally occurring infectious diseases. Do public health agencies have sufficient laboratory capacity, information systems, and work force? Are there sufficient stockpiles of safe and effective vaccines and treatments? Do health and safety agencies efficiently share information and coordinate activities? Is communication to the public clear and authoritative? Unfortunately, the answer to these questions, and many others, is that the United States is ill prepared.

Crumbling Foundations

The lack of preparedness for bioterrorism and naturally occurring infectious diseases is due primarily to insufficient financing. Before the recent influx of funding for homeland security, traditional population-based public health services received approximately 1 percent of all health dollars, with the rest going to health care and biotechnology. At the federal level, over 95 percent of the health budget went to nondiscretionary spending, principally Medicaid and Medicare. Congress allocated half of the remaining 5 percent to the National Institutes of Health, whose budget has been approximately doubling in each of the last several years. The Public Health Service agencies together shared the remainder. Even in the president's new bioterrorism budget for homeland security, biotechnology and health care take the lion's share, leaving relatively little for prevention.

What is wrong with this picture? Expenditures on biotechnology and health care are not improper, but they are now out of proportion to the benefit derived.

Biotechnology and health care contribute to only a small percentage of the population's health (estimated at less than 5 percent), but receive an inordinately high percentage of health funding (more than 95 percent). On the other hand, population-based services (such as sanitation, pure food and water, safe products and roads) contribute much more to health and longevity, but have been starved of resources.

Individual health care services dominate federal and state budgets because of the values dominant in America. Both ends of the political spectrum celebrate personal freedom and choice—the political left emphasizes civil liberties while the political right focuses on markets and free enterprise. In this political climate, the public sees government as inefficient and burdensome. People would rather see ever-increasing advances in clinical medicine and freedom of choice in health care than stable and well-funded agencies regulating for the public welfare. The nation has lost the tradition of classical republicanism that valued the collective benefits of health, safety, and security.

Public Health Law Reform

Another important reason for the lack of preparedness is that public health laws are antiquated. Many of these laws date back to the early twentieth century and predate modern science, medicine, and constitutional law. Consequently, these laws do not provide a clear mission, essential services, or powers necessary for public health agencies to be effective. These antiquated laws are often unconstitutional since they lack clear standards and procedural safeguards. Vague public health laws may be challenged in a crisis, adding to indecision and delay; more fundamentally, existing laws do not provide a hedge against arbitrary action and unfairness in the exercise of public health powers.

To rectify the problems of antiquity, inadequacy, and unfairness, the Robert Wood Johnson "Turning Point" program funded the development of a model public health law in collaboration with a consortium of states. The "Public
The Model Law

MSEHPA (available at www.publichealthlaw.net) is intended to support the vital functions of public health agencies while safeguarding personal and proprietary interests: planning, surveillance, management of property, and protection of persons. The planning and surveillance functions would be implemented immediately, but the measures affecting property and persons would be triggered only after a state's governor declares a public health emergency.

Declaration of a Public Health Emergency. A public health emergency is narrowly defined in the model law as involving an imminent threat caused by bioterrorism or a new or re-emerging infectious agent or biological toxin that poses a high probability of a large number of deaths or serious disabilities. Civil libertarians objected to a previous draft of the definition on two grounds: that it would permit compulsory powers against persons living with HIV/AIDS, and that state governors would have too much discretion. In response, the definition of a public health emergency was modified to exclude endemic diseases such as HIV/AIDS and to place checks on the governor. The legislature may, by majority vote, discontinue the state of emergency at any time. Similarly, the judiciary may overturn an emergency declaration if the governor has not complied with the standards and procedures in the model law. This reflects a preference for constitutional checks and balances, providing a role for each branch of government.

Emergency Planning. The governor must appoint a Public Health Emergency Planning Commission to design a plan for coordination of services: procurement of necessary materials and supplies; housing, feeding, and caring for affected populations; and vaccination and treatment. The planning requirement is important because most states do not have a systematic design for handling a public health emergency. Planning raises significant ethical issues, notably the proper criteria for allocating vaccines, medicines, and health care services. On what basis should scarce resources be allocated: need, benefit, age, or utility? The model law does not resolve the numerous ethical or policy issues but insists that a rational plan be devised through a deliberative process.

Surveillance. MSEHPA addresses measures necessary to detect and monitor infectious disease outbreaks. It requires prompt disease reporting, interviewing, and contact tracing. Existing law often does not facilitate, and may even hinder, surveillance. For example, most states do not require reporting of many of the critical agents of bioterrorism. Conversely, if a case of smallpox or hemorrhagic fever is known or suspected, there is no assurance that public health authorities will be promptly notified. MSEHPA also facilitates exchange of health information if necessary to prevent, identify, or investigate a public health emergency. Existing state laws, due to privacy concerns, often prohibit the sharing of health information between public health and law enforcement agencies, between public health agencies and health care organizations, and among public health agencies in different states. While individuals have the right to expect a certain amount of privacy to prevent harms and embarrassment, a balance needs to be struck to ensure public health and safety. Consider the potential impact of a case of bioterrorism in New York City; if a health officer could not exchange data with the public safety officer, monitor hospitals and pharmacies for unusual clusters of symptoms, or obtain health records from New Jersey or Connecticut.

Management of Property. MSEHPA authorizes the public health authority to close, decontaminate, or procure facilities and materials to respond to a public health emergency; dispose of infectious waste safely; perform appropriate burials; and obtain and deploy health care supplies. These powers are necessary to ensure sufficient availability of vaccines, medicines, and hospital beds, and sufficient power to regulate, close, or destroy dangerous facilities. The political right has engaged in a sustained attack on these provisions, claiming that they interfere with the freedom to own and
control personal property. Indeed, the drafters have been lobbied by virtually every major corporate sector, including the food, transportation, hospital, and pharmaceutical industries, some of which have hired large law firms to help press their case.

Although the right to possess and enjoy private property is important, owners have always been subject to the restriction that property not be used in a way that poses a health hazard.\(^1\) MSEHPA provides a right of compensation to owners only if the government “takes” private property for public purposes—i.e., if, for example, it confiscates private stocks of drugs to treat patients or takes over a private hospital to quarantine persons exposed to infection. No compensation would be provided for a “nuisance abatement”—closing a facility that poses a public health threat or destroying property contaminated with smallpox or anthrax. Although entrepreneurs may complain that such private losses are unfair, MSEHPA fully comports with modern constitutional law and enlightened public policy.\(^3\) If government were forced to compensate for all nuisance abatements, it would significantly chill public health regulation.

**Protection of Persons.** MSEHPA permits public health authorities to physically examine, test, vaccinate, or treat individuals to prevent or ameliorate an infectious condition, and to isolate or quarantine individuals to prevent or limit the transmission of an infectious disease. Civil libertarians have argued that individuals should be neither confined nor compelled to receive vaccines or treatment. But this view has never been accepted even in the most liberal societies. It is generally accepted that persons who pose a significant risk to the public may be subject to restraint. MSEHPAs’ powers of vaccination, treatment, and civil confinement are not new, but have been part of public health law since the founding of the republic. The exercise of these powers has also been upheld by the courts on grounds of community health and security: “There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organ.

### The Future of Public Health

In many ways, America has the public health system it deserves—underfunded, ill prepared, and dispirited. The government has starved public health agencies of resources, allowing the public health infrastructure to deteriorate. The public has valued high-glamer generics and high-technology biomedicine over basic prevention and population-based services. And the legislature has neglected the legal foundations of public health. The law lacks a coherent vision of an appropriate mission, essential services, powers, and safeguards for public health agencies.

The Institute of Medicine Report on Public Health Preparedness, due to be published this year, will set out the intellectual critique of the public health system. The events of 11 September and 4 October will provide the impetus for change. Now it is time to change the nation’s values, priorities, and funding to recognize the overwhelming importance of assuring the conditions in which the people can be healthy, safe, and secure.

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