The Legal Basis of Public Health

An Individual or Group Study Course in Ten Modules

Module 3

Service Delivery

SS0003

CDC

The Legal Basis of Public Health

SS0003 - Module 3, Service Delivery

Continuing Nursing Education (CNE)

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The Legal Basis of Public Health

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Course Contents

This course consists of the following ten modules and a Coordinator Guide, which includes suggestions for using the course materials.

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About this module

Overview

Service delivery is the mainstay of public health, especially for the poor, the elderly, and children.

Module Three discusses one major area of health department activity—service delivery. The modules that follow this one will discuss the more intrusive health department activities—enforcement actions surrounding licensing, inspections, and the imposition of corrective actions and sanctions. In this module, the focus is on activities distinctly different from either surveillance or enforcement; namely, the delivery of services.

Service delivery programs have long been a mainstay of public health. In recent years, these programs have increased in size and number as health departments have become the provider of last resort for vulnerable populations such as the poor and the elderly.

Health service delivery raises liability issues

In the past, service delivery programs—such as senior wellness or well child care programs—have by and large been free of legal controversy. This may be changing. Immunization programs, confidentiality issues surrounding HIV testing and counseling, and legal complications involving equal access to public health programs have all raised legal liability issues. Health departments may need to review and update their practices in these areas.

Module components

This module consists of the following components:

- Text and self-study exercises to be completed individually or discussed with your learning community. These exercises are meant to help you absorb what you have just read and immediately apply the concepts.
- A self-check review, found at the end of the text, will help you assess your understanding of the material.
- Group exercises to undertake with your learning community, found at the end of the text.

Goals

This module is intended to help public health professionals carry out the provision of direct services with a clear understanding of their own legal responsibilities and the legal rights of their clients.

Learning objectives

At the end of this module, you should be able to:

1. Describe the measures that should be taken to reduce your agency's potential liability arising from immunization and other programs.

2. Describe the basis of public health agencies' legal authority to carry out their activities.

3. Describe how the requirements for due process apply to implementing service programs.

4. Describe how the concept of equal protection applies to access to public health services.

Start by networking...

Because laws and regulations vary from state to state, you need access to much more information than this module provides if you are to understand the legal basis for the activities of your agency. Networking with knowledgeable people is one way to get this information.

As you begin this module, think about who may be able to provide you with some of the information you need. Think about friends who might help you gain access to others you want to meet. Each of these contacts can lead you to *other* knowledgeable people and sources of information

Introduction

Public health departments are responsible for assessment, policy development and assurance.

State and local public health departments carry out a broad variety of functions. The core functions of public health identified in *The Future of Public Health* report—assessment, policy development, and assurance—are aimed at "fulfilling society's interest in assuring conditions in which people can be healthy."

The third function—assurance—suggests that public health agencies have an inherent responsibility "to assure their constituents that services necessary to achieve agreed-upon goals are provided, either by encouraging action by other entities (private or public), by requiring action through regulation, or by providing services directly."

Public health departments are service providers for many vulnerable groups.

In recent years, the assurance function has increasingly been carried out through the direct delivery of services by public health agencies. Changes in government funding patterns have made public health departments the provider of last resort for persons unable to afford or access the fee-for-service system. Although this trend may be changing to some extent due to federal cut-backs and competition from managed care providers, health departments now provide a broad range of health services, which include:

Examples of public health direct services

Immunization programs
STD clinics
AIDS testing and counseling
TB services
Screening programs (e.g., lead levels, vision, hearing)
Clinic services/physical & dental examinations
Nutrition services and education (including WIC)
Family planning services
Prenatal clinics and care
Well child care
Services for physically handicapped children
School health programs
Senior wellness/health maintenance programs
Home care visits
Employee health programs (including health education)
Health education services
Alcohol and drug abuse services
Mental health services

Some of these services are purely public-sector functions, but others parallel services offered in the private, for-profit sector.

Bringing it home...

List the services your agency provides.

Does your agency provide these services directly or does it do so by contracting with non-governmental service providers?

How many of these services are also offered by the private sector?

Each program has unique legal requirements, but five legal issues are common to all.

The services provided by public health agencies make up a disparate array of programs, each with its own specific legal concerns. Some are backed up by laws requiring screening and/or treatment. Alcohol and drug abuse services, for example, must comply with federal confidentiality regulations, while immunization programs must adhere to state statutory and administrative requirements. However, the following legal issues apply to all programs: legal authority, due process, equal protection, compliance with federal regulations, and avoidance of negligence and liability. The remainder of this module focuses on these five common legal areas.

Legal authority

Laws authorize public health services that reflect community needs.

The delivery of services by public health agencies must be specifically authorized under state statute or local ordinance. The source of this authority derives from the states' inherent police powers (discussed in Module 1, Introduction) or, in some cases, from a state's constitution. There is no *federal* constitutional right to public health services nor to health care generally. Indeed, the word "health" is not mentioned in the U.S. Constitution.

Authority for services may be specifically granted by statute, as in Illinois, where the state health department is given statutory authority to "establish a program for the care and treatment of persons suffering from chronic renal disease," or authority may be based on a health department's general authority to protect the public health, as provided for in statute or ordinance. Exercise of general authority is most likely to come into play in protecting against epidemics of contagious disease or in dealing with emergency threats such as toxic spills, rather than in delivering ongoing services. Whether the authority is specifically granted or general in nature, the main legal requirement is that the health department be able to demonstrate how its efforts are relevant to the public health needs of the community it serves.

Compulsory public health requirements may override individual rights.

Some health department programs—such as immunization and screening—include major compulsory requirements. The authority for public health agencies to carry out these programs and enforce compliance from the public was discussed in Module 1, Introduction. Public health agencies have broad authority to act, even when individual autonomy may be intruded upon. For example, although some people have religious objections to immunizing their children, the courts have been firm in holding that First Amendment freedom to practice religion does not block the state from insisting upon such protective measures as immunization.

State constitutional authority

The Constitution limits the authority of the federal government.

At the time the U.S. Constitution and the Bill of Rights were written, foremost in the minds of the framers was the desire to sharply circumscribe the power and authority of the newly created federal government. The resulting document reflects this bias. The U.S. Constitution is a carefully drawn text which establishes the structure and operating procedures for the federal government while at the same time conferring significant liberties upon U.S. citizens. The liberties ensure that citizens of the United States will be protected from the intrusive reach of a strong federal government. In keeping with this sentiment, the U.S. Constitution does not assign any active role to the federal government for assuring positive, substantive rights of its citizens.

State constitutions tend to give government a more active role.

In contrast, many state constitutions carve out a more active role for their state governments. For example, the Illinois constitution recognizes the right to a healthy environment and mandates that the State General Assembly provide by law for the implementation and enforcement of this right (Article XI, Illinois State Constitution). The Montana Constitution recognizes a right to health, to a clean and healthful environment, and a right to pursue basic necessities of life (Article II, Section 3., Montana State Constitution.) and the New York State Constitution recognizes that the protection of health and the support of the needy are public concerns for which the state shall make provisions.

What, if any, practical effects do such constitutional rights have? From time to time the public has tried to use state constitutional rights to challenge a limited entitlement program or to force the government to provide additional services—sometimes successfully and sometimes not.

Stop and think...

New York State's Constitution provides:

"The aid, care and support of the needy are public concerns and shall be provided by the state and by such subdivisions, and in such manner and by such means, as the legislature may from time to time determine.

The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision thereof shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine" [N.Y. Constitution, Article XVII, Sections 1 and 3].

Does your state constitution recognize the health of its citizens and/or care of the state's needy as public concerns?

New York State's constitution recognizes duty to care for health of citizens and support of the needy

The "aid to the needy" provision was used successfully to challenge a law imposing arduous legal requirements upon needy children under the age of 21 and living independently of their parents and guardians, before they could receive public assistance. The state's highest court struck down a law requiring such children to file support proceedings against their parent or guardian before receiving public assistance. The Court held that such legal proceedings, which often take months to reach a decision and are usually futile, created an unconstitutional barrier to obtaining needed state support. As the Court noted, "In this State, assisting the needy is a matter of constitutional command, not legislative grace" [*Tucker v. Toia*, 43 NY2d 1, at 7].

In a later lawsuit plaintiffs challenged the State of New York's Prenatal Care Assistance Program arguing, among other things, that the program violated the State constitutional provisions quoted above. The program provides women at 185% of the poverty level with various pregnancy-related services but excludes funding for medically necessary abortions. The plaintiffs alleged that the program impermissibly withholds such coverage without regard to the financial or medical needs of the participants.

Courts will generally defer to a legislative determination of "needy."

The State's highest court rejected the plaintiffs' arguments. The Court deferred to a legislative determination that the category of women excluded from coverage (those at 185% of the poverty level) are not generally indigent or in need of public assistance to meet their medical needs; that is, the legislature presumed their ability to afford an abortion. It distinguished the Prenatal Care Assistance law from the law in *Tucker v. Toia* where the legislation caused public assistance to be withheld from a category of persons the legislature had otherwise deemed to be "needy" [*Hope v. Perales*, 83 NY2d 563].

Bringing it home...

How is the community's health protected by services your agency provides?

Do you know the specific statutes or ordinances that authorize your agency to provide services to your clients? If not, do you know where you can find them?

Due process

Due process protects vulnerable groups by requiring clear and fair procedures

Legislation creating a public health program may require an agency to undertake specific actions, but more often public health agencies have considerable discretion to decide whether to operate service delivery programs and, if so, what procedural rules will apply. An agency's discretion is limited by the rather vague notion of procedural "due process." Due process is of particular concern in public health programs that focus on the most vulnerable segments of society, such as children, the elderly and the poor, groups whose legal rights are too easily disregarded.

Fairness entails guaranteed notice, a chance to be heard, and written records

State and local governments must exercise their constitutional authority to legislate and regulate properly if their actions are to be legally valid. This includes using clear procedures and affording basic fairness in administering the law or a program. In the administrative law context, "fairness" means that all those affected by the regulatory process are guaranteed:

- notice
- a chance to be heard
- and a written record for use in judicial appeals.

Notice must be given of an intended action and of the opportunity to challenge that action

"Notice" refers to informing a recipient of an intended agency action, such as termination, suspension or a change in benefits *and* informing him or her of a chance to be heard to challenge the proposed action. Prior notice of an adverse action is generally required, except in emergency situations. If a hearing cannot be given before action is taken, then a prompt post-action hearing must be allowed.

In the leading case in this area, *Goldberg v. Kelly*, 397 U.S. 254 (1970), the U.S. Supreme Court held that New York could not terminate welfare benefits under the federally-assisted Aid to Families with Dependent Children (AFDC) without first affording the recipient the right to an evidentiary hearing.

This second element, the opportunity to be heard, raises several questions:

- Need the hearing be held *before* the agency makes a final binding determination?
- Must the recipient be given an opportunity to present evidentiary material?
- Does the recipient have the right to present witnesses and cross-examine those of the government?
- May the recipient bring an attorney to the proceeding?
- Must the hearing be recorded?
- Who should preside over the hearing?

The courts will uphold safeguards to ensure a proper decision is reached.

Many of these questions are addressed in Module 6, Enforcement. The short answer to almost all of these questions is that "it depends."

Whether the recipient must be given the right to present evidence, to question witnesses and/or to have an attorney present at the hearing will depend on whether these safeguards are necessary to ensure that a proper decision is reached. For example, if questions of "credibility or veracity" are at issue, then such rights should in most instances be given. However, when the issues involved are relatively straightforward or objective in nature, such protections are of less importance. If the issues involve purely legal rather than factual questions, the courts have held that an evidentiary type hearing is not required.

Safeguards that are overly burdensome may be modified.

A third factor the courts will look at is how burdensome the procedural safeguards are for the agency, both fiscally and administratively. Thus, if requiring extensive procedural safeguards before suspending or reducing services would substantially hamper the agency's effectiveness, the courts would balance the recipient's interests with those of the agency, and would likely impose some lesser degree of formality, one protecting both the recipient and the agency's ability to function.

Whether the hearing must be recorded (using a tape recorder or by court stenographer) will again depend on the nature of the interests involved and the type of hearing required. There is less need to record a hearing based on legal argument than one based on conflicting factual evidence. Regardless of whether the hearing is formally recorded, the final decision should identify the hearing officer's findings of fact and conclusions of law.

The decision-maker must be impartial

In all instances the hearing should be presided over by an impartial decision-maker. As the following example illustrates, impartiality means at a minimum that the decision-maker was not involved in an earlier stage of the controversy.

This latter issue was examined in the case of *Crescent Convalescent Center v. Washington State Department of Social and Health Services*, 942 P.2d 981 Wash.App.Div 3 (1997). A state licensed nursing home caring for Medicaid recipients received a citation for failing to complete dietary assessments for two patients. Crescent Nursing Home challenged the citation in a letter to the agency's acting district manager. In the letter, the nursing home disputed the factual basis for the citation and requested that it be deleted.

The acting district manager denied the request. Crescent Nursing Home then filed an appeal with the agency's Office of Administrative Hearings. This appeal was denied based on a determination that Crescent Nursing Home had "no regulatory, statutory or constitutional right to a hearing." Crescent Nursing Home appealed that decision to the Washington civil courts.

Due process is required when property interests are involved

The appellate court held that Crescent Nursing Home had a significant property interest to protect based on the mandatory consequences which follow the issuance of a citation and that the informal review process offered by the agency after the nursing home disputed the citation did not satisfy due process requirements.

With regard to Crescent's property interest, the court found that the practical consequences of a citation are not inconsequential. First the nursing home must post notice of the citation in a prominent location in its facility. Second, the agency publishes an annual public report identifying nursing homes receiving citations and the nature of the citations. Third, the nursing home is excluded from an annual list of "citation-free" nursing homes. The list is circulated to all public agencies that refer patients to nursing homes. By law, public agencies must give priority to citation-free nursing homes when referring publicly assisted patients.

Because of the property interests involved, the court determined that the informal review of Crescent's letter by the acting district manager did not satisfy due process. In particular, the court noted that the acting district manager was not an impartial decision-maker because she was also responsible for the initial issuance of the citation.

Bringing it home...

How does your agency decide who will be provided services and who will be denied services? How are they notified?

Can denial of service be appealed? What is the appeal process?

When your agency terminates services, are persons entitled to a hearing? Before terminating the service? Afterward?

What kinds of written records are kept?

Is anyone ever forced to accept your services? How are these decisions made?

If you were given the task of developing due process guidelines for your agency, what would you want to be sure to include?

See Group exercise 3.1 at the end of the module.

Equal protection

Public health agencies may not arbitrarily discriminate against individual persons.

Equal protection means even-handed application of law; the law cannot arbitrarily discriminate. This applies to both statutory law and to regulatory laws promulgated by administrative agencies. The Fourteenth Amendment to the U.S. Constitution provides that "[n]o State shall...deny to any person within its jurisdiction the equal protection of the laws." While the Constitution does not contain a comparable provision explicitly prohibiting the denial of equal protection by the federal government, the Supreme Court has interpreted Fifth Amendment due process as implicitly including such an equal protection requirement.

Agencies may treat special groups differentially if necessary to protect the public's health and safety or if there is compelling interest.

The principle of equal protection does not necessarily require identical treatment under the law. Government often has legitimate reasons for classifying people into groups and treating the various groups differently. For example, it is legitimate for government to recognize the special needs of persons with physical disabilities. The fact is that government can and does differentiate between individuals and groups *when it has good reason to do so.*

The critical question, therefore, is what constitutes a legally acceptable reason for applying a law in a different way to people who are similar, or in a similar way to people who are different. The courts have developed a two-tier analysis which they apply in deciding this question.

Differential application of the law must be reasonable.

In the overwhelming majority of cases, the most important criterion is that the application of the law is *reasonable* in terms of protecting the public's health and safety. If, for example, a government agency that has been challenged for discrimination can offer a plausible basis for a law and its application, and can show that the challenged law or action bears some reasonable relationship to the governmental interest involved, the courts will generally defer to the agency's determination and uphold the law.

Compelling interest must be shown in cases affecting suspect classes or fundamental rights.

However, legislation or regulation which differentially impacts persons based on race, nationality or alienage, i.e., "suspect classes," will be held to a higher level of scrutiny, as will laws which impact a person's rights to privacy, to vote, to marry and to travel, some of the "fundamental rights" guaranteed by the U.S. Constitution. In these cases, the courts will require the government to show a "compelling interest" in the law being challenged, and will rigorously scrutinize both the underlying need for the law and whether the state's purpose can be fulfilled in a less discriminatory manner.

Scrutiny of cases involving age, gender or mental retardation is aggressive

The courts apply a third level of scrutiny for cases involving age, gender and mental retardation. While stopping short of including them as "suspect classes," the courts will take a fairly aggressive look at the rationale for laws which disparately impact people in one of these categories.

The following examples illustrate how the courts treat a situation where a "suspect class" or "fundamental right" is not affected.

The New York Court of Appeals upheld a law assessing a tax on gross receipts of a nursing home. The law was challenged by the owner as a violation of state and federal equal protection laws because the law did not tax all nursing homes equally. Nursing homes totally financed by charitable contributions and dedicated solely to the care of low income patients, as well as homes dedicated solely to the care of police personnel, firefighters or emergency personnel, were exempt from the tax. The Court upheld the classification scheme, allowing the differential treatment of nursing home categories. [*Miriam Osborn Memorial Home v. Chassin, Commissioner, New York Department of Health, et al.*, 658 N.Y.S. 2nd 156 (Sup. 1996)].

Similarly, a federal court upheld an Ohio county board of health regulation prohibiting smoking in public places except "bowling alleys, pool halls and bars if such establishments post signs stating that no smoking areas are available." A coalition of adversely impacted business owners challenged the regulation as a violation of equal protection. [*Badlaw, Inc. v. Licking Co. General Health District Board of Health, et al.,* 866 F.Supp 1059 S.D.Ohio (1992)].

Courts look for plausible reasons for differential treatment

In each case the court found that neither a "suspect class" nor a "fundamental right" was involved. Having made that finding, the court then searched for a plausible explanation to uphold the differential treatment recognizing that "when social or economic legislation is at issue, the equal protection clause allows states wide latitude." In the first case, the court found the state had a rational basis for encouraging the provision of health care to the indigent and to those who risk their lives for the public. In the latter case the court surmised that the county board could rationally have chosen to treat smokers in some establishments differently than smokers in other public places on the belief that attendance at some establishments is more a matter of voluntary choice than at other public places or on the belief that smoking bans would more severely impact the clientele and profitability of some establishments.

In contrast, the United States Supreme Court struck down a zoning ordinance which required a proposed operator of a group home for the mentally retarded to obtain a special use permit, finding that such requirement violated the equal protection clause. It found no rational basis for the city's belief that a group home for the mentally retarded would pose any special threat to the city's legitimate interests. The Court concluded that the law appeared to rest on an irrational prejudice against the mentally retarded. While it did not find that mental retardation was a "suspect class," the Court seemed to imply that it would require greater proof to uphold a law based on this distinction [*Cleburne v. Cleburne Living Center, et al.*, 105 S.Ct. 3249 (1985)].

Bringing it home...

Who uses your services? Who are your constituents? Are they classified into categories for the purpose of service delivery, such as poor, children, elderly, Medicare/Medicaid, schools, immigrants?

Think of examples where categories of individuals are treated differently in your agency. How can this differential treatment of distinct categories of people be justified?

Stop and think...

What are some proper and improper classifications of groups? When (if ever) can you justify differential treatment according to race, gender, age, citizenship, economic status?

What situations might trigger classifications and differences in treatment of people? What about provision of scarce vaccines? What are some other possible situations?

See Group exercise 3.2 at the end of the module.

Compliance with federal regulations

Federally funded programs must comply with federal laws and regulations.

State and local programs financed either in whole or in part by federal monies must attain compliance with federal regulations, which are often quite extensive in scope. For example, the Medicaid program, created by Congress in 1965 as Title XIX of the Social Security Act, establishes a comprehensive set of rules governing nursing home facilities that accept Medicaid patients (*Social Security Act, 42 U.S.C. 1396 et seq.*). While a full discussion of the federal laws affecting specific health department programs is beyond the scope of this module, there are two federal laws which affect the delivery of *all* agency services, the Americans with Disabilities Act of 1990 and the Civil Rights Act of 1964.

Americans with Disabilities Act of 1990

Under the Americans with Disabilities Act of 1990 (ADA), which prohibits public entities from discriminating on the basis of disability, health departments must assure that their services, policies and practices, essentially every aspect of their service delivery programs, meet the extensive requirements of the ADA. The regulations cover activities of the health department, whether provided directly or through contractual, licensing or other arrangement. The ADA requires, among other things, that public entities:

Persons with disabilities must have access to the same services and information as others.

- Provide qualified disabled individuals the opportunity to participate in the same services, programs or activities as others; separate and distinct programs are not acceptable.

- Operate each service, program and activity in locations that are readily accessible to and useable by individuals with disabilities.

- Take steps to ensure that communications with applicants, participants, and members of the public with disabilities are as effective as communications with others.

(*See ADA regulations*, 28 C.F.R. Part 35)

The ADA requires services to be provided in a manner appropriate to individual needs and consistent with human dignity.

In a 1995 case, a Federal Appellate Court found that the Pennsylvania Department of Public Welfare violated the ADA by requiring a woman who had contracted meningitis and was paralyzed to receive care services in a nursing home rather than in her own home through the Department's Attendant Care Program. Finding the woman qualified for the Attendant Care Program, the Court held the State agency violated the ADA's mandate that public entities "administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities" [*Helen L. v. DiDario*, 46 F.3rd 325 (CA.3)(1995)].

As the Court said,

> "The ADA was enacted to ensure that qualified individuals receive services in a manner consistent with basic human dignity rather than in a manner which shunts them aside, hides and ignores them."

Civil Rights Act of 1964, Title VI

The Civil Rights Act of 1964 prohibits discrimination based on race, color or national origin. Section 601 of the Act states:

The Civil Rights Act prohibits discrimination based on race, color, or national origin.

> "No person in the United States shall, on the grounds of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

Recently health departments have been challenged for discrimination based on national origin and limited English proficiency. A complaint was filed with the U.S. Office of Civil Rights by an Illinois resident on behalf of himself and other non-English-speaking and limited-English-speaking persons, alleging that an Illinois county health department discriminated against them based on national origin. The complaint specifically alleged that the county denied and/or delayed their receiving services, required them to provide their own interpreters, and treated them in a discriminatory manner. As evidence of the latter, the complainants asserted that county officials made negative comments, had a hostile attitude and assigned them to Spanish-speaking clinics.

As a result of the complaint, the Illinois county worked with the complainants and the Office of Civil Rights to hire interpreters, conduct sensitivity training for their staff, and to reorganize delivery services so as not to segregate Spanish-speaking persons.

Federally funded health departments must meet language needs of persons entitled to use their services.

A Guidance Memorandum prepared by the Office of Civil Rights addresses the kind of language assistance which may be required to comply with Title VI for federally funded health and social service programs. It warns that where language barriers limit a person's access to critical public health, hospital and other medical and social services to which they are legally entitled, or limit their ability to receive notice of or understand what services are available to them, such exclusions, delays or denials violate Title VI.

To comply with Title VI, health departments need to systematically examine their points of contact with persons who may need language assistance and identify the resources available to fulfill their responsibilities under the Act. In particular, agencies must consider whether to translate written material and information into a language other than English, and how to provide oral language assistance where needed.

For example, the rules prohibit agencies from requiring clients to use their own family and friends as interpreters. Such requirement could cause a breach of confidentiality. Clients may also be reluctant to reveal personal information critical to their situations. However, if a client requests to use a friend or family member as an interpreter, this is allowed as long as it does not compromise the effectiveness of services *and* the client is informed that the agency can provide a free interpreter.

The Guidance Memorandum is available from the United States Office of Civil Rights, Regional Managers. Regulations implementing Title VI can be found at 45 C.F.R. Part 80 and 28 C.F.R. Part 42.

Stop and think...

Does your agency serve non-English or limited English-speaking clients? If so, what, if any, arrangements have been made to accommodate their special needs?

In your opinion, do the accommodations comply with the Civil Rights Act of 1964?

Avoidance of negligence/liability

Public health clinics face the same liability potential as private doctors.

In *The Future of Public Health*, the authors note, "Once immersed exclusively in population-wide and community-based efforts, health departments have rapidly become de facto family doctors for millions of Americans."[1] As local and state health departments take on more and more clinical services, public health physicians, nurses, and others who provide those services become exposed to potential legal liability much the same way as their private-sector counterparts.

For example, a public health clinic and its employees were sued by parents who alleged their child's death was caused by an adverse reaction to an immunization shot administered at the clinic. In another case, a State Department of Mental Health staff psychiatrist and registered nurse were defendants in a lawsuit alleging that the negligence of department employees resulted in the death of a thirty-two-year-old patient living in a residential care facility maintained and operated by the department. The decedent's parents alleged that the defendants failed to monitor the patient's drug intake and his compliance with a medication plan.

To what extent are agencies and their staff liable for injuries resulting from the delivery of services?

Traditionally, government was only liable for its proprietary functions.

Under traditional common law, the government was granted immunity from tort liability for actions that were purely "governmental functions," that is, actions which only the government could undertake. Immunity did not extend to governmental activities that were "proprietary" in nature. Proprietary activities are those which are not uniquely carried out by the government, such as providing health care services. In the latter instance, the government could be found liable if it failed to carry out its activities with the same degree of care required of private parties.

The common law distinction between "governmental" and "proprietary" functions has been blurred by the enactment of State Tort Immunity Statutes and the courts' interpretations of those acts. The laws establishing governmental immunity and liability now vary significantly among the states.

[1] Future of Public Health, p. 52.

For example, the Illinois Tort Immunity Act of 1965 eliminated the governmental/proprietary distinction and instead adopted the principle that local governmental units are liable in tort except where the General Assembly expressly grants immunity by specific statutory enactment. The Illinois General Assembly then limited the government's liability by granting an extensive list of immunities based on specific governmental activities [*Corral v. Chicago Park District*, 660 N.E.2d 89 (Ill.App. 1 Dist 1995)].

In contrast, the Tennessee Governmental Tort Liability Act (T.C.A. Sections 23-3301, *et seq*.) retains the distinction between "governmental" and "proprietary" functions, but extends the traditional governmental immunity to cover proprietary functions as well [*Crowe v. John W. Harton Memorial Hospital*, 579 S.W.2d 888 (1977)].

Immunity of individuals differentiated from that of agencies

In yet another variation, a Georgia court found that the administration of a city medical center was a "governmental function" entitling the center and its director to claim a "qualified immunity from liability," but the physician who administered the allegedly negligent medical care which resulted in the death of a two-year-old was *not* entitled to claim immunity. The court reasoned that the physician's duty was simply that of one providing medical care, i.e., a non-governmental function, and the doctor's primary duty was to the patient, not to the state or the city [*Jackson v. Miller*, 335 S.E.2d 438 (1985)].

A similar result was reached by a Utah court, but for different reasons. In the case of *Frank v. State of Utah*, the court held that the Utah Governmental Immunity Act expressly grants states and localities immunity from suit for injuries relating to public ownership and operation of a hospital, nursing home or other health care facility [*U.C.A. 1953, 63-3010(1)*]. But the court also found that the Utah Act did not confer immunity upon *employees* of the governmental unit. [*Frank v. State of Utah*, 613 P.2d 517 (1980)].

Finally, in some jurisdictions, the courts have determined that the state waived its claim of sovereign immunity by purchasing insurance covering the relevant activities. In this line of thinking, the state has implicitly granted the public the right to sue it for negligence.

To make sense of all of this, you must look to the particular laws governing your jurisdiction. Some of the relevant questions to ask include:

- Does your state law recognize a difference between "governmental" and "proprietary" functions?
- Do your state's sovereign immunity laws extend to municipalities?
- Are employees who conduct traditional "proprietary" functions entitled to claim a qualified immunity?
- Are employees who conduct "mandatory" rather than "discretionary" functions immune from suit? The latter category of functions is uniformly entitled to a "qualified immunity."
- If the state agency purchases insurance coverage, do your state laws assume the government has waived its claim to sovereign immunity?

Where employees performing "proprietary" functions are *not* entitled to immunity, the harm resulting from their allegedly negligent care can lead to malpractice actions.

Malpractice actions are difficult to prove.

Malpractice is not easily established. A plaintiff must prove the following of the professional who provided treatment: (1) that the care provided was performed at a level below the standard of care in the profession *and* (2) that this failure was the cause of significant harm to the plaintiff. If both are proven, the professional who treated the plaintiff will probably be found guilty of negligence, that is, of malpractice. However, only in the more flagrant cases of negligence can a plaintiff expect to succeed in a malpractice action. Nevertheless, the threat and reality of such liability can have significant effects, financial and otherwise, on a public health agency.

Summary of Key Legal Terms... What They Mean and How They Affect Agencies

Governmental functions

"Governmental functions" are those a state or local health department carries out for the benefit of the public welfare generally. Such functions, including licensing, enforcement and inspections, can only be carried out by government. Historically government could *not* be sued for carrying out "governmental functions" in a negligent

Proprietary functions

"Proprietary functions" are not uniquely carried out by a state or local health department, such as the delivery of health care services. While government may provide these services, they are not "governmental functions." Historically, government *could* be sued for carrying out "proprietary functions" negligently.

Mandatory duties

"Mandatory duties" are imposed on government by law and must be perform. For example, the 1990 Clean Air Act Amendments impose a mandatory duty on the United States Environmental Protection Agency to set emissions standards for a long list of hazardous air pollutants. Generally speaking the government *can* be sued for failing to carry out a "mandatory duty." If USEPA fails to set hazardous air pollutant standards, it may successfully be sued in

Discretionary duties

"Discretionary duties" are those which the government may or may not elect to undertake. Discretionary duties are also those which give the government room to exercise judgment in determining how best to carry out a function. For example, while the USEPA *must* set emissions standards for hazardous air pollutants, the *permissible level* of emissions is a judgment call to be made by the USEPA Administrator. (Roughly worded, the law requires the Administrator to set standards that achieve the maximum degree of reduction which she deems achievable after taking into account a host of factors.) Generally speaking, the government *cannot* successfully be sued for the manner in which it carries out a discretionary duty. Thus, a person challenging an emission level would not win a lawsuit against USEPA as long as the agency followed proper procedures and took into account the required factors when setting the permissible level.

Qualified immunity

"Qualified immunity" generally means that public health officers who carry out their duties in a competent manner cannot be sued for any resulting harm or damages. However, if the harm resulted from gross and willful carelessness, from malicious or corrupt conduct or from actions taken which were beyond the scope of the officer's authority, the officer *can* successfully be sued for damages.

For a more in-depth discussion of legal liability see Module 10, Responsibility and Liability.

Childhood Vaccine Injury Act of 1990

With enactment of the federal Childhood Vaccine Injury Act of 1990, the number of lawsuits brought against state and local health departments for injuries arising from immunizations has significantly dropped.

The Act establishes a federally administered compensation scheme for persons who sustain injuries as a result of childhood immunizations. While the Act does not preclude victims or their families from suing an agency or drug manufacturer in a traditional civil suit, the law does require such persons to elect whether to proceed through the court system or under the compensation system established by the Act.

By simplifying the evidentiary proof required and creating an administrative mechanism which affords more prompt relief than the civil court system, most victims and their families elect to receive compensation through the administrative program.

(*Childhood Vaccine Injury Act of 1990, 42 U.S.C. Sections 300aa 1-34*)

Stop and think...

In your work, are you considered a health care provider or a public health officer—or both?

How might these roles be interpreted differently in a court of law?

How might the principles discussed in this module affect the way you conduct your work?

Review of terminology...

The preceding pages used a number of legal terms that may have been unfamiliar to you. Some of the terms used are listed below. You may find it useful for review to define them now in your own words; doing this will also give you a glossary that is specific to this module. Feel free to add more terms.

compelling state interest

discretionary duties

due process

equal protection

fundamental rights

governmental functions

liability

malpractice

mandatory duties

negligence

notice

opportunity to be heard

proprietary functions

qualified immunity

service delivery

sovereign immunity

standard of care

suspect class

Self-check review

Check your knowledge of the preceding material by answering the questions below. Circle the letter of the correct response.

1. Legal authority can be based on

    A. Statutes
    B. Regulations
    C. Local ordinances
    D. State constitution
    E. All of the above

2. Which of the following governmental actions are proprietary in nature?

    A. Restaurant inspections
    B. Licensing nursing homes
    C. Prenatal clinics and care
    D. Data collection
    E. Hazardous waste enforcement

3. Government may treat groups differently:

    A. If it can show there is a compelling interest
    B. If no civil liberties are denied
    C. If it is authorized by specific statutes
    D. Only if they are not vulnerable groups

4. In order to prove malpractice, the plaintiff must show:

    A. Harm to patient was intentional.
    B. Treatment was below professional standard of care.
    C. No consent form was signed.
    D. Client paid for services.
    E. Discrimination
    F. Civil liberties were denied.

5. Due process requires everything below except:

   A. Written consent
   B. Notice
   C. A chance to be heard
   D. A written record
   E. An impartial hearing officer

Answers:

1.E, 2.C, 3.A, 4.B, 5.A

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Turnock, B.J. *Public Health: What It Is and How It Works*. Aspen Publishers, 1997.

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Group exercises

Exercise 3.1 Case Study #1

Cases of measles among children living and attending school in Onion County have increased dramatically. The Board of Health is considering various options to force parents to get their children immunized against this deadly childhood disease. One such proposal is to automatically cut off food to mothers participating in the federal Women, Infants and Children (WIC) program who cannot prove their children have received the measles immunization. Under the WIC program, Onion County Health Department distributes food and provides nutrition education to low-income pregnant and post-partum women, lactating mothers, infants and children up to five years of age who are determined to be at nutritional risk under WIC criteria.

Would this proposed action violate due process requirements? Why or why not?

How could the Board structure the proposal to accomplish its objectives in a legally acceptable manner?

Exercise 3.2 Case Study #2

Granite State Health Department operates a radon testing program for residents. Upon request, a state official will test a resident's home to determine radon levels. If elevated levels are detected, the resident is responsible for undertaking remedial actions necessary to bring the radon levels to within acceptable limits.

The Health Department maintains a list of "qualified and equipped" radon abatement contractors. When elevated radon levels are detected, the list of qualified contractors is furnished along with the test results to the homeowner.

To be considered a "qualified" contractor, the Granite State Health Department determined that a company must have at least one year of experience in the environmental abatement field (radon, asbestos, lead, underground storage tank removal, etc.) ***or*** successfully complete a rigorous two-week department approved training course on radon abatement techniques.

Does the criterion deny new abatement contractors equal protection under the law?

To register for continuing education credit and to evaluate this module

Registering for Continuing Education Credit

To receive credit for this module you must submit course enrollment forms and the answers to the **Evaluation and Test** (located on the following pages) to CDC. There are several ways to complete this registration process:

Complete the forms online.

- **U** Go to the PHTN website **www.cdc.gov/phtn** and complete the registration and evaluation online. Directions will be given at the website.

Complete the forms on paper. There are two ways to obtain the forms from CDC. (If you plan to study additional modules, you may want to request enrollment materials for those modules also at this time.)

- **U** Request the enrollment materials online by going to the following URL at the PHTN website **http://www.cdc.gov/phtn/legal-basis/req-form.htm** and completing the online request form. After the online form is submitted, an enrollment packet will be mailed to you with instructions.

- **U** Request the enrollment materials by calling **1-800-41-TRAIN** (1-800-418-7246). At the prompts, press 1, then 3. Please clearly speak your name, mailing address, daytime phone number, and the correct module name and number. The enrollment materials will be mailed to you with instructions.

If you are unable to register online, you will have to wait several weeks until your course enrollment materials arrive in the mail. If this is the case, you might want to complete the Evaluation and Test immediately after you finish the module by marking your answers directly on the following pages (or make a photocopy) and then, when the enrollment materials arrive, transfer your answers to the answer sheet included with the materials.

Evaluating the Module

If you are registering for continuing education credit, you will be asked to complete an evaluation as part of that process.

If you are not interested in receiving continuing education credit, we ask that you please take time to evaluate the module. Follow the procedure specified above for getting continuing education credit, but indicate in the first question on the **Evaluation and Test** that you do not wish to receive continuing education credit. Although this is not required, your opinion of the module is important to us. By letting us know if this module was effective for you, we can improve future editions, as well as other PHTN courses.

Evaluation and Test
The Legal Basis of Public Health
Module 3, Service Delivery
COURSE #SS0003

Objectives for *Module 3, Service Delivery*

- Describe the measures that should be taken to reduce your agency's potential liability arising from immunization and other programs.
- Describe the basis of public health agencies' legal authority to carry out their activities.
- Describe how the requirements for due process apply to implementing service programs.
- Describe how the concept of equal protection applies to access to public health services.

NPlease use the red *CDC Answer Sheet* included in the enrollment materials to complete the following questions.

Tell us about yourself...

1. What type of continuing education credit do you wish to receive?

A. (CME) *Not Available for this Course*
B. Continuing Nursing Education (CNE)
C. Continuing Education Units (CEU)
D. do not want continuing education credit

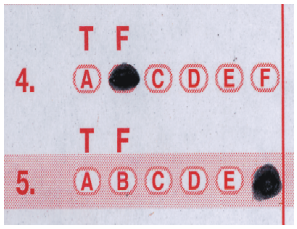
2. Have you previously completed *Module 1, Introduction*?
(Completion of Module 1 is required before taking any of the other modules.)

A. yes
B. no
C. I have just completed ***Module 1, Introduction***.

3. Are you a

A. Nurse
B. Physician
C. None of the above

Please note: Question 5 is a continuation of question 4. Please answer each question, but choose only **ONE** occupation. Your answer to one of the these questions will be **F. None of the above**. For example, a Health Educator would answer as follows:



4. Which of the following best describes your current occupation?

A. Epidemiologist
B. Health Educator
C. Laboratorian
D. Pharmacist
E. Physician Assistant
F. None of the above

5. Which of the following best describes your current occupation?

A. Field Inspector (nursing homes, restaurants, etc.)
B. Manager/Supervisor
C. Environmental Health Worker/Sanitarian
D. Lawyer/Attorney
E. Other public health professional
F. None of the above

6. Which of the following best describes the organization in which you work?

A. Academic
B. Private health care setting
C. Federal government
D. State government
E. Local government
F. Other organization

Tell us about the module...

7. How did you first learn about this module

A. State publication (or other state-sponsored communication)
B. MMWR
C. CDC website (not including PHTN website)
D. PHTN source (PHTN website, catalog, e-mail, or fax announcement)
E. Colleague
F. Other

8. How did you obtain this module?

A. Purchased from the Public Health Foundation
B. Downloaded from the PHTN website
C. Borrowed or copied materials from someone else
D. Other

9. What was the most important factor in your decision to obtain this module?

A. Content
B. Continuing education credit
C. Request from supervisor
D. Previous participation in PHTN training(s)
E. Ability to take the course at my convenience
F. Other

10. I completed this module

A. As an individual learner
B. As part of a learning group that organized itself
C. As part of a learning group that was organized by someone outside of the group

11. My completion of this module included interaction(s) with an expert(s) (or reasonably experienced person) on the topic?

A. Yes
B. No

12. My interaction(s) with the expert(s) on this topic could be described as follows

A. I had no interactions with an expert
B. One or more sessions organized by someone outside of the group
C. One or more sessions organized by someone within my group
D. One or more informal consultations that I initiated on my own

13. How long did it take you to complete this module?

A. 1 - 2 hours
B. 3 - 4 hours
C. 5 hours or more

14. How many of the ten modules comprising the *Legal Basis of Public Health* have you completed?

A. 1 or 2 modules
B. 3 to 5 modules
C. 6 to 9 modules
D. All 10 modules

15. How many of the ten modules comprising *The Legal Basis of Public Health* do you plan to complete?

A. 1 or 2 modules
B. 3 to 5 modules
C. 6 to 9 modules
D. All 10 modules

16. Please rate your level of knowledge prior to completing this module.

A. Had a great deal of knowledge about the content
B. Had a fair amount of knowledge about the content
C. Had limited knowledge about the content
D. Had no prior knowledge about the content
E. No opinion

17. Please estimate your knowledge gain due to completing this module.

A. Gained a great deal of knowledge about the content
B. Gained a fair amount of knowledge about the content
C. Gained a limited amount of knowledge about the content
D. Did not gain any knowledge about the content
E. No opinion

18. If this module is further evaluated through the use of focus groups or other methods (e.g., follow up questionnaires) would you be willing to participate?

A. Yes
B. No

Please use the scale below to rate your level of agreement with the following statements about this module.

A. Agree
B. No opinion
C. Disagree
D. Not applicable

19. The objectives were relevant to the purpose of the course.

20. I would recommend this module to my colleagues.

21. I believe completing this module will enhance my professional effectiveness.

22. The content in this module was appropriate for my training needs.

23. Reading the text on my own was an effective way for me to learn this content.

24. The self-study questions contributed to my understanding of the content.

25. The group exercises contributed to my understanding of the content.

26. The Coordinator Guide contributed to my ability to have a learning experience appropriate to my (or my group's) needs.

27. Downloading the materials from the PHTN website was user-friendly.

28. Ordering the materials through the Public Health Foundation was user-friendly.

29. Ordering the materials through the 1-800-41-TRAIN phone number was user-friendly.

30. I am confident I can describe the measures that should be taken to reduce my agency's potential liability arising from immunization and other programs.

31. I am confident I can describe the basis of public health agencies' legal authority to carry out their activities.

32. I am confident I can describe how the requirements for due process apply to implementing service programs.

33. I am confident that I can describe how the concept of equal protection applies to access to public health services.