

"Public-Private" Health Law: Multiple Directions in Public Health

Nan D. Hunter

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>



Part of the [Health Law Commons](#), and the [Public Health Commons](#)

Recommended Citation

Nan D. Hunter, *"Public-Private" Health Law: Multiple Directions in Public Health*, 10 J. Health Care L. & Pol'y 89 (2007).
Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol10/iss1/6>

This Conference is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

“PUBLIC-PRIVATE” HEALTH LAW: MULTIPLE DIRECTIONS IN PUBLIC HEALTH

NAN D. HUNTER*

No public law is more public than public health law. Its defining subject is the use of state power to control and prevent death and disease.¹ Its primary institutions are a cluster of state actors, the governmental agencies that comprise the American public health “system.”² The system grew out of the eighteenth century boards of health that produced the beginnings of administrative law.³ Public health law is grounded on statutory provisions that authorize various forms of state action and on judicial decisions that resolve constitutional challenges to those actions.⁴

In some respects, this field is moving even closer to the core of governmental functions. Since September 11th and the 2001 anthrax attacks, public awareness of the danger of bioterrorism has heightened.⁵ Contingency planning for widespread

Copyright © 2007 by Nan D. Hunter.

* Professor of Law and Director, Center for Health, Science and Public Policy, Brooklyn Law School (Brooklyn, NY). This article is adapted from the author’s lecture at the Association of American Law Schools’ Annual Meeting in Washington, D.C., *Empirical Scholarship: What Should We Study and How Should We Study It?*, which was co-sponsored by the AALS Sections on Law, Medicine and Health Care; Socio-Economics; and Torts and Compensation, entitled *Public Health in Law* (January 2006). The author appreciates the research assistance of Clara Altman and editing suggestions by Scott Burris, Chai Feldblum, Peter Jacobson, and the editors of this journal.

1. Lawrence O. Gostin, *A Theory and Definition of Public Health Law*, 10 J. HEALTH CARE L. & POL’Y 1, 1 (2007). Within the broad scope of promoting population health, approaches vary among nations. David P. Fidler, *A Globalized Theory of Public Health Law*, 30 J.L. MED. & ETHICS 150 (2002).

2. Hugh Tilson & Bobbie Berkowitz, *The Public Health Enterprise: Examining Our Twenty-First-Century Policy Challenges*, 25 HEALTH AFF. 900, 904 (2006) (“[T]he building blocks for the public health system are the network of nearly 3,000 local public health agencies and . . . public health departments.”).

3. WILLIAM J. NOVAK, *THE PEOPLE’S WELFARE: LAW & REGULATION IN NINETEENTH-CENTURY AMERICA* 202 (1996).

4. BERNARD J. TURNOCK, *PUBLIC HEALTH: WHAT IT IS AND HOW IT WORKS* 133-37 (3d ed. 2004). See generally LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* (2000) (discussing the relationship between government power and public health and discussing the executive, legislative, and judicial roles in public health endeavors).

5. JEANNE GUILLEMIN, *BIOLOGICAL WEAPONS: FROM THE INVENTION OF STATE-SPONSORED PROGRAMS TO CONTEMPORARY BIOTERRORISM* 167 (2005). Within the federal government, greater awareness of and funding for anti-bioterrorism efforts began in the 1990s. JONATHAN B. TUCKER, *SCOURGE: THE ONCE AND FUTURE THREAT OF SMALLPOX* 191-95, 244-45 (2001).

infectious disease, whether resulting from a natural outbreak or the hostile release of a pathogen, has mushroomed.⁶ Should such an outbreak occur, federal law provides for the declaration of a national emergency or disaster.⁷ Beyond formal declarations, the conceptual framework of emergency preparedness and response subsumes ever larger segments of the field of public health. Authorizations of funding for public health activities underscore the need to prepare for emergencies,⁸ and contingency planning has been folded into an all-hazards framework that channels public health policy and programs.⁹ As of July 2006, thirty-eight legislatures and the District of Columbia had adopted, at least in part, state-level health emergency statutes.¹⁰

Emergency planning has become an important discourse of governance, one which reveals a great deal about the operations of state power. The field of emergency public health planning comprises much more than a set of procedures for who should do what in extraordinary situations. The need to control a serious infectious disease outbreak, for example, creates opportunities for the enlargement of the government's coercive powers and for potential abuses that can leave permanent scars on the body politic. It also raises important questions about whether emergency responses and protections by government are too weak, especially for disempowered communities. Debates over the use of military personnel for law enforcement exemplify these dilemmas.¹¹

Paired with this reinvigoration of command and control models for public health is a new trend toward enlarging the influence of the private sector in health emergency planning. The reach of public health law is extending beyond the state at the same time that it is intensifying the power of the state. Increasingly, private sector entities are implicated in the state's matrix of collaborative institutions.

In this article, I identify three approaches to governance embedded in today's public health law and policy. These approaches align with internal tensions within the public health field that pull it in multiple and conflicting directions. Three distinct reconfigurations of law and policy are developing.

6. See, e.g., Homeland Security Act of 2002, Pub. L. No. 107-296, § 304, 116 Stat. 2165 (codified at 6 U.S.C. § 184 & 42 U.S.C. § 233); Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. No. 107-188, 116 Stat. 594 (codified in scattered sections of 42 U.S.C.); see also Bill Frist, *Public Health & National Security: The Critical Role of Increased Federal Support*, 21 HEALTH AFF. 117, 120-21 (2002).

7. 42 U.S.C. §§ 5170, 5191 (2000 & Supp. 2003).

8. Kristine M. Gebbie & Bernard J. Turnock, *The Public Health Workforce, 2006: New Challenges*, 25 HEALTH AFF. 923, 925-27 (2006) (describing the increases in federal funding to support the public health workforce while noting that state and local funding may be "replace[d] or supplant[ed]" by this federal funding, resulting in a net reduction of the number of public health positions).

9. Tilson & Berkowitz, *supra* note 2, at 905.

10. CTR. FOR LAW & THE PUB.'S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., THE MODEL STATE EMERGENCY HEALTH POWERS ACT (MSEHPA): STATE LEGISLATIVE ACTIVITY (2006), <http://www.publichealthlaw.net/MSEHPA/MSEHPA%20Leg%20Activity.pdf>.

11. See *infra* text accompanying notes 57-60.

The first approach to governance that is evident in public health law is the most traditional and conventional one, that of dominant state authority. What is notable is how this approach is being strengthened by a trend toward greater centralization and hierarchy in infectious disease control, pushing public health into a tighter command and control structure. This trend is counter to virtually every other development in the world of civilian government or governance, where arguments for devolution and horizontal management dominate the best practices literature. Operating alone, this trend would lead to the traditional government model of public health becoming even more state-centric than it is already. Two other developments counteract it, however.

The second governance construct in the public health field is the public-private model for administrative governance, which constitutes the most commonly examined branch of new governance theory.¹² Public-private models for administrative governance are relatively new to public health. They are more common in other areas of law that are concerned more with large-scale regulated industries.¹³ Today, however, calls for partnerships with the private sector for the purpose of achieving population health goals are growing.¹⁴

The third governance model now evident in the public health field illustrates governmentality theory, a critical theory cousin to the administrative governance literature. Governmentality theory incorporates the recognition that the state already permeates the private sector even without formal authority.¹⁵ What is key is not whether the state occupies a position of command or of partnership, but the insight that power flows back and forth between public and private entities through a multiplicity of channels and technologies.¹⁶ Both sectors generate and enforce policies that govern the health of a population and that govern a population through its health.¹⁷ One current trend that illustrates this dynamic of governance is an emerging branch of public health emergency policy that would utilize indirect and

12. Lester Salamon first used the phrase "new governance," which he described as a new paradigm distinct from traditional public administration and relying on systematic collaborative public and private sector approaches to policy issues. Lester M. Salamon, *The New Governance and the Tools of Public Action: An Introduction*, in *THE TOOLS OF GOVERNMENT: A GUIDE TO THE NEW GOVERNANCE* 1, 1-14 (Lester M. Salamon ed., 2002). See *infra* Part II for elaboration of what "new governance" connotes.

13. See, e.g., NEIL GUNNINGHAM ET AL., *SMART REGULATION: DESIGNING ENVIRONMENTAL POLICY* 145-372 (Keith Hawkins ed., 1998) (discussing the regulatory nature of the chemical and agriculture industries).

14. See *infra* Part II.B.

15. See generally MITCHELL DEAN, *GOVERNMENTALITY: POWER AND RULE IN MODERN SOCIETY* (1999).

16. *Id.*; ALAN HUNT & GARY WICKHAM, *FOUCAULT AND LAW: TOWARDS A SOCIOLOGY OF LAW AS GOVERNANCE* 22-23 (1994); JANET NEWMAN, *MODERNISING GOVERNANCE: NEW LABOUR, POLICY AND SOCIETY* 22-25 (2001).

17. DEAN, *supra* note 15, at 20-21; NEWMAN, *supra* note 16, at 42-44; Sarah Nettleton, *Governing the Risky Self: How to Become Healthy, Wealthy and Wise*, in *FOUCAULT: HEALTH AND MEDICINE* 207-22 (Alan Peterson & Robin Bunton eds., 1997).

non-coercive governance methods, channeled through workplace management, to control the spread of infectious disease.¹⁸

I am intentionally drawing the distinction between these three models in somewhat exaggerated form. Governments in the twenty-first century operate in sophisticated ways, blurring the line between public and private. In a complicated world of interlinked institutions, my categories cannot be pristine. But they point to distinct approaches that complexify the traditional understanding of public health law as a medicalized form of administrative procedure.

Part I of this article analyzes the meanings and dangers that accompany the first trend, the shift of public health authority for coercive interventions deeper into the national security state. Both the proposed new regulations for federal quarantine authority and a series of emergency planning documents are directed toward the goal of maximizing the power of government. They evidence little concern for checks against arbitrary uses of that power and reflect broader attempts to instantiate the principles of a unitary executive philosophy.

Part II describes my taxonomy of new governance theory in greater detail and analyzes specific examples of each in current public health policy. I describe how new administrative governance models for public-private sector partnerships are growing in public health generally and in emergency planning specifically. Applying the governmentality frame, I argue that proposals for “modern quarantine,” which would institute quarantine restrictions by relying on voluntary compliance, illustrate a complex use of both institutional and individual choices to advance state goals.

Part III uses modern quarantine proposals as a case study for examining how the workplace could function as a venue for health governance. Paradoxically, this approach, based on the enablement of voluntary, self-protective instincts, cannot succeed absent an array of legal supports emanating from the state, a reality that is being overlooked in official policy documents.

In conclusion, I consider the consequences of these simultaneous and partially contradictory developments for our understanding of a public health “system.” I argue that these three trends taken together illustrate the complexities found throughout contemporary American government: how the same apparatus can be intensifying as a security state while at the same time, on the same set of issues, deploying new governance rhetoric. Part of the intellectual richness of public health is that it is a field in which scholars have the opportunity to analyze and critique examples of new governance models as they develop in a traditionally public law field.

18. See *infra* Part II.C.

I. HEALTH SECURITY AS A DISCOURSE OF GOVERNANCE

The oldest traditional function of public health has been the control of communicable disease.¹⁹ The police powers authority, as applied to public health, originated in the adoption of self-protective policies by which localities sought to defend themselves against the spread of infection.²⁰ Early public health efforts were framed in the language and imagery of self-defense and national security, allusions that rang starkly true before antibiotics and vaccines offered medical alternatives to a traditional reliance on the exclusion of disease carriers.²¹ Boards of health, local or state legislatures, and police departments were the sources and enforcers of public health policy.²²

Public health is thus an archetype of traditional government as a mode of governance. It has relied almost exclusively on the public sector to channel individuals and resources toward the achievement of broad social goals. The structure, functions, and professional culture of public health all signify a dominant state apparatus for directing the distribution of public goods. Public health policymaking and implementation exemplify the use of traditional regulatory mechanisms rather than the decentralized, often privatized structures and procedures associated with new governance theory.

During the last five years, one major trend in public health has been to become even more government centric. Contemporary public health policymaking occurs within the broader context of emergency planning and an undefined, undeclared war. Security and self-defense furnish the dominant tropes for the cultural register of this governance narrative. Federal public health discourse is returning, at least metaphorically, to its quasi-military roots in the Marine Hospital Service, established for merchant seamen, which became the uniformed Public Health Service, a civilian officer corps.²³

The phrase "health security" itself also illustrates the change. Advocates of universal access to health care used the phrase "health security" in the promotion of reform proposals; the allusion was to a completion of the social insurance project begun with Social Security.²⁴ Today, "health security" most often refers to a form

19. TURNOCK, *supra* note 4, at 3-7. For a spirited argument that battling communicable disease should remain the sole activity of public health, see Richard A. Epstein, *In Defense of the "Old" Public Health: The Legal Framework for the Regulation of Public Health*, 69 BROOK. L. REV. 1421 (2004).

20. NOVAK, *supra* note 3, at 197.

21. *See, e.g.*, *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905) ("Upon the principle of self-defense, of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members."); *see also* NOVAK, *supra* note 3, at 211-13.

22. NOVAK, *supra* note 3, at 198-202; *see, e.g.*, *Jew Ho v. Williamson*, 103 F. 10, 17, 21-22 (N.D. Cal. 1900).

23. FITZHUGH MULLAN, *PLAGUES AND POLITICS: THE STORY OF THE UNITED STATES PUBLIC HEALTH SERVICE* 14-31 (1989).

24. WHITE HOUSE DOMESTIC POLICY COUNCIL, *HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE* 2, 17-18, 33-34, 93-94 (1993); WHITE HOUSE DOMESTIC POLICY COUNCIL, *THE*

of national defense.²⁵ This linguistic change marks a shift in the public imagery regarding what constitutes protective health policy, away from a concern with assuring access to a public good and toward a concern with guarding against disaster. It also marks the melding of public health and the security state. As then Secretary of Health and Human Services Donna Shalala told the press in 1999, “[t]his is the first time in American history in which the public health system has been directly integrated into the national security system.”²⁶

The most frightening point of overlap between the threats posed by a hostile attack and those resulting from naturally occurring health emergencies may become manifest in the event of an emerging infectious disease for which available medical treatments are inadequate. Many of the pathogens most likely to be deployed as weapons in a bioterrorist attack would be frightening, not only because of the revelation that an enemy has control of such weapons, but also because effective treatments and prophylactics either do not exist or cannot be produced quickly enough and in sufficient quantity to immediately protect the population.²⁷ Similarly, if a naturally occurring mutant influenza virus produced pandemic disease, pharmaceutical responses would likely become available significantly behind the curve of transmission.²⁸

Command and control, in some form, is surely an indispensable mode for governmental response to an emergency. The efficiency and speed of top-down responses in moments of crisis have obvious attractions. But in a form of mission creep and professional norm migration, all aspects of health emergency policy have shifted toward the framework of enhanced executive authority. Especially when no intentional hostile act caused the emergency, this perspective crowds out the possibility of using alternative approaches such as a human rights framework.²⁹

PRESIDENT’S HEALTH SECURITY PLAN 3, 5-6, 14 (1993). Some use of the phrase in this way continues. See, e.g., The Health Security Campaign, <http://www.healthsecurity.org> (last visited Dec. 19, 2006).

25. Frist, *supra* note 6, at 118-19; Eileen Salinsky & Elin A. Gursky, *The Case for Transforming Governmental Public Health*, 25 HEALTH AFF. 1017, 1022, 1025 (2006).

26. GUILLEMIN, *supra* note 5, at 235 n.65.

27. RICHARD A. FALKENRATH ET AL., AMERICA’S ACHILLES’ HEEL: NUCLEAR, BIOLOGICAL, AND CHEMICAL TERRORISM AND COVERT ATTACK 151-54 (1998); Lawrence O. Gostin, *When Terrorism Threatens Health: How Far Are Limitations on Personal and Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1170 (2003); Barry Kellman, *Biological Terrorism: Legal Measures for Preventing Catastrophe*, 24 HARV. J.L. & PUB. POL’Y 417, 432-37 (2001).

28. U.S. HOMELAND SEC. COUNCIL, NATIONAL STRATEGY FOR PANDEMIC INFLUENZA: IMPLEMENTATION PLAN 198 (2006), available at http://www.whitehouse.gov/homeland/nspi_implementation.pdf [hereinafter HOMELAND SEC. COUNCIL] (“A specific pandemic influenza vaccine cannot be produced until a pandemic influenza strain emerges and is identified. Once a pandemic influenza virus has been identified, it will likely take 4-6 months to develop, test, and begin producing a vaccine.”).

29. Wendy K. Mariner, *Law and Public Health: Beyond Emergency Preparedness*, 38 J. HEALTH L. 247, 270-76 (2005).

A. Legal Powers

The tendency to expand the public health power of government toward coercive ends is reflected in proposed federal regulations for the imposition of quarantine orders.³⁰ The proposed regulations provide for sweeping powers to detain individuals based on the Centers for Disease Control’s (CDC) “reasonable belief” that an individual may have been exposed to a particular disease when the individual has moved or is about to move interstate, or when the individual is a probable source of infection to persons moving interstate,³¹ a description that fits vast numbers of people in a highly mobile society.

If they become final, the proposed regulations would permit extraordinary controls by legitimizing a dense concentration of power in federal health officials. The CDC Director or the Secretary of Health and Human Services would have the power to determine that a public health emergency exists, upon finding a “significant potential” for interstate spread of an infectious disease.³² This declaration would trigger immediate authority to detain persons subject to minimal oversight. The regulations would provide for both “provisional quarantine” and “quarantine.” Provisional quarantine may last up to three business days, while quarantine may last for a significantly longer period of time.³³

The proposed regulations are framed to allow actions to interrupt transmission without requiring certainty that disease spread is likely to occur. Individuals who are thought to have only a “pre-communicable” stage of the disease may be restricted through either “provisional quarantine” or “quarantine.”³⁴ The standard for both quarantine orders suggests, but does not require, that the CDC Director have actual evidence of clinical manifestations or test results.³⁵ That is, both quarantine and provisional quarantine orders may be based on “other evidence of exposure or infection available to the Director at the time.”³⁶

Although such immediate actions may be effective in eliminating risk, careful attention to individual rights is missing from the proposed regulations. The proposed regulations would allow provisional quarantine to be imposed simply by a written or verbal order or by “actual movement restrictions.”³⁷ A person under

30. Control of Communicable Diseases, 70 Fed. Reg. 71,892 (proposed Nov. 30, 2005) (to be codified at 42 C.F.R. pt. 70).

31. *Id.* at 71,932-33. Part 70 of the proposed regulations concerns persons moving in interstate commerce; Part 71 addresses persons entering the United States from another country. For the sake of simplicity, my discussion is limited to the interstate travel context. Comparable provisions exist for international travel. *See, e.g., id.* at 71,942.

32. *Id.* at 71,930.

33. *Id.* at 71,932-33.

34. *Id.* at 71,930. There is no definition provided for “pre-communicable.” *Id.*

35. *Id.* at 71,933.

36. *Id.*

37. *Id.*

regular quarantine may request a hearing, but no hearing is available for persons in provisional quarantine.³⁸

Moreover, many of the most fundamental indicia of due process are missing from the proposed system of hearings for quarantine. The CDC Director would designate the hearing officer.³⁹ There is no requirement of an independent judge at any point in the administrative review procedure even though this is a bedrock component of due process.⁴⁰ Although a person can designate a “representative” for the review hearing,⁴¹ there is no provision for counsel to be appointed if the individual cannot afford an attorney. The proposed regulations do not address what the evidentiary burden would be or who would bear it. The hearings are limited to “genuine and substantial issues of fact.”⁴²

The overall scheme embodied in the regulations fails to satisfy constitutional due process requirements. The Department of Health and Human Services argues that the existence of habeas corpus will serve the function of providing for a meaningful hearing.⁴³ But requiring an individual to initiate habeas corpus is a significant decrement from the constitutional norm for reviewing deprivations of liberty based on the individual posing a risk to the public’s health.⁴⁴ In addition, a critical omission throughout the proposed regulations is the absence of a requirement that less restrictive alternatives be preferred to greater infringements on liberty.⁴⁵ In sum, the balance struck is overwhelmingly in favor of state power.

B. Planning and Response Policy

Beyond the parameters of regulatory law, the conceptual model for public health emergency response situations is also moving in subtle ways toward a national security or quasi-military norm. Federal public health emergency policies are part of the National Response Plan (NRP), an “all-hazards” framework for

38. *Id.* at 71,895.

39. *Id.* at 71,934.

40. *Cf.* *Hamdi v. Rumsfeld*, 542 U.S. 507, 533 (2004) (identifying a neutral decision-maker as necessary for hearings of persons detained as enemy combatants).

41. Control of Communicable Diseases, 70 Fed. Reg. at 71,934.

42. *Id.*

43. *Id.* at 71,896.

44. For example, persons facing civil commitment on mental health grounds for posing a risk of harm to others receive judicial review of such orders without having to invoke the power of habeas corpus. *See, e.g., Kansas v. Crane*, 534 U.S. 407, 412-13 (2002); *Kansas v. Hendricks*, 521 U.S. 346 (1997).

45. The mandate to exhaust less restrictive alternatives exists under state law. *E.g., City of New York v. Antoinette R.*, 630 N.Y.S.2d 1008, 1009 (N.Y. 1995) (upholding a statute permitting involuntary detention of a woman with active tuberculosis in a hospital setting where the statute provided “due process safeguards,” including “review of less restrictive alternatives which were attempted or considered”); *City of Newark v. J.S.*, 652 A.2d 265, 272 (N.J. Super. Ct. Law Div. 1993) (requiring that, in order to involuntarily commit a homeless man diagnosed with tuberculosis, “[t]he terms of confinement must minimize the infringements on liberty and enhance autonomy” and “[l]esser forms of restraint must be used when they would suffice to fulfill the government interests”).

governmental action in emergencies.⁴⁶ Adopted in 2004, the NRP delineates triggers for types of governmental responses, the roles and responsibilities of different actors, and the operational functions to be implemented when Incidents of National Significance (INS) are declared.⁴⁷ The operations system designed by the NRP to go into effect when a crisis occurs is the National Incident Management System (NIMS).⁴⁸ When an INS occurs, the agency "with appropriate jurisdictional authority" is to designate "a single Incident Commander with overall incident management responsibility."⁴⁹ When, as would often be the case, multiple agencies would be involved, the agency Incident Commanders form a Unified Command. "At the [Incident Command Post], the Unified Command develops the NIMS incident command organizational structure in a top-down, modular fashion based on the [s]ize and complexity of the incident [and the s]pecifics of the hazard environment caused by the incident[.]"⁵⁰

Local health agencies have replicated the federal approach, creating a consistent set of models and operational principles. In New York City, for example, the Health Department's response to pandemic flu would be carried out under the auspices of the Citywide Incident Management System (CIMS), led by the Office of Emergency Management.⁵¹ New York City's CIMS uses the same Unified Command principles as the federal government's NIMS.⁵² Internally, the New York City Health Department uses the Incident Command System.⁵³

The exigencies of a disaster such as Hurricane Katrina illustrate the benefits of an approach relying on a militarized model of structure and functions. There, more rapid deployment of governmental resources almost certainly would have saved lives and mitigated human suffering.⁵⁴ But top-down command models come with a cost. They can produce quick responses, but they also silently align all civilian emergency relief efforts, in any kind of emergency, with a military approach.

46. U.S. DEP'T OF HOMELAND SEC., NATIONAL RESPONSE PLAN i (2004), available at <http://www.dhs.gov/xlibrary/assets/NRPbaseplan.pdf>.

47. *Id.* at i, 1-5.

48. *Id.* at i, 17-21.

49. U.S. DEP'T OF HOMELAND SEC., QUICK REFERENCE GUIDE FOR THE NATIONAL RESPONSE PLAN 21 (4.0 version 2006), available at http://www.dhs.gov/xlibrary/assets/NRP_Quick_Reference_Guide_5-22-06.pdf.

50. *Id.*

51. N.Y. CITY DEP'T OF HEALTH & MENTAL HYGIENE, PANDEMIC INFLUENZA PREPAREDNESS AND RESPONSE PLAN 1 (2006), available at <http://www.nyc.gov/html/doh/downloads/pdf/cd/cd-panflu-plan.pdf>.

52. Compare *id.*, with U.S. DEP'T OF HOMELAND SEC., *supra* note 49, at 21.

53. N.Y. CITY DEP'T OF HEALTH & MENTAL HYGIENE, *supra* note 51, at 1.

54. See David L. Feinberg, *Hurricane Katrina and the Public Health-Based Argument for Greater Federal Involvement in Disaster Preparedness and Response*, 13 VA. J. SOC. POL'Y & L. 596 (2006); Joseph B. Treaster & Deborah Sontag, *Despair and Lawlessness Grip New Orleans as Thousands Remained Stranded in Squalor*, N.Y. TIMES, Sept. 2, 2005, at A1.

Systems like the NRP internalize serious shortcomings that flow from literal command and control. Built-in assumptions mask important issues, such as the absence of mechanisms for input and critique. Reliance on this paradigm sets in motion a constellation of unspecified understandings. Potentially, the ramifications extend beyond immediate needs, as new routines and different professional norms channel the development of public health policymaking beyond emergency situations. The structure reflected in the vocabulary of the NIMS, CIMS, and INS systems may not be intrinsically problematic, but it bespeaks much bigger issues.

On purely instrumental grounds, a top-down, militarized, command and control structure that fails to incorporate ground-up concerns and the divergent material realities of differing communities can exacerbate the harms of a public health emergency.⁵⁵ Social science research has found that substantial portions of the population express concerns that could dissuade them from following the directions of public health officials, especially given significant levels of distrust toward government.⁵⁶ More active citizen engagement in identifying and working through the barriers that impede public cooperation with emergency response efforts might lead to more effective programs.

Overall, one must read the NRP for its silences as well as its mandates. Hierarchical command can crowd out alternative mechanisms that would better incorporate democratic practices and norms. The public health emergency context presents a concrete example of the questions raised in debates on how to preserve democratic values in a dangerous world. The headline value of pandemic flu planning may not compare to debates over detainees in extraterritorial prisons, but the former's quotidian nature should not cause us to overlook the possible gaps that may occur in the practices essential to a democracy.

C. *Problematizing Emergency To What Ends?*

Disease outbreaks and natural disasters are real recurrent events, but how they are conceptualized in government policy is changing. "Health emergency" is becoming a powerful frame, a funding magnet for programmatic initiatives, and a rapidly enlarging subfield of knowledge within public health. Both the evolving legal architecture of health security, exemplified in the proposed quarantine regulations, and the NRP-NIMS operational systems reflect this new discourse of health emergency.

The key process underway is the reframing of preparedness for and response to emergencies into an issue of health security. This process itself can redefine the acceptable scope of state power and reshape bureaucracy. It has affected policy on

55. Thomas A. Glass & Monica Schoch-Spana, *Bioterrorism and the People: How to Vaccinate a City Against Panic*, 34 *CLINICAL INFECTIOUS DISEASES* 217, 219-22 (2002); ROZ D. LASKER, N.Y. ACAD. OF MED., *REDEFINING READINESS: TERRORISM PLANNING THROUGH THE EYES OF THE PUBLIC* (2004), available at <http://www.cacsh.org/pdf/RedefiningReadinessStudy.pdf>.

56. LASKER, *supra* note 55, at ii-iv, 10-12, 49.

the use of federal troops for domestic law enforcement purposes, generally forbidden.⁵⁷ In 2006, in reaction to Hurricane Katrina and possibly in anticipation of creating an option for military personnel to enforce quarantine,⁵⁸ Congress enlarged the permissible scope of troop deployment to include threats to normal law enforcement stemming from “natural disaster, epidemic, or other serious public health emergency.”⁵⁹

The expanded leeway provided by the 2006 amendment for federalizing the police function and locating it within the military may in the future save lives or enable oppressive uses of power or both. Calls to repeal it have noted that it was enacted as part of a budget bill, with little congressional debate, although all fifty state governors opposed it.⁶⁰ If it stands, it will have established a new marker for the borders of authorizing military command.

Within and among agencies of government, the reframing of health emergency and the new structure of preparedness systems have reshaped bureaucracy. When the Department of Homeland Security (DHS) was established, it absorbed both the lead agency for responding to emergencies and disasters—the Federal Emergency Management Agency (FEMA)—and the border patrol and rescue functions of the Coast Guard.⁶¹ In this reorganization model, security trumps rescue.

What these examples signify is the building of health emergency as a new frame for an old set of problems. The new frame itself creates new authorities, new powers and the reassignment of power to new locations, and subtly altered ways of thinking about the appropriate role of government. Social understandings of what “public health” means and what its proper scope should be are part of what is behind these changes.

II. NEW GOVERNANCE IN PUBLIC HEALTH LAW

Given the definitively public sector nature of public health and its accentuation by a trend toward greater top-down command authority and culture, the remarkable development in the public health field today is that new governance models are simultaneously taking root. In contrast to the traditional government model, new governance theory stresses collaborative public and private efforts to

57. The Posse Comitatus Act forbids deployment of military troops for law enforcement purposes unless authorized by Congress or the Constitution. 18 U.S.C. § 1385 (2000).

58. David Brown, *Military's Role in a Flu Pandemic; Troops Might Be Used to "Effect a Quarantine," Bush Says*, WASH. POST, Oct. 5, 2005, at A5.

59. John Warner National Defense Authorization Act for Fiscal Year 2007, Pub. L. 109-364, § 1076(a)(1), 120 Stat. 2083, 2404-05 (2006) (to be codified at 10 U.S.C. § 333).

60. Editorial, *Making Martial Law Easier*, N.Y. TIMES, Feb. 19, 2007, at A18.

61. See U.S. Dep't of Homeland Sec., History: Who Became Part of the Department?, http://www.dhs.gov/xabout/history/editorial_0133.shtm (last visited Mar. 2, 2007).

address public policy issues.⁶² The fact that both moves—toward public and toward private—are happening simultaneously within public health illustrates the dynamism of this field and makes it a particularly rich one for theoretical analysis.

In the following part, I sketch the parameters of the growing body of new governance scholarship. I suggest that it is useful to identify two distinct branches of new governance theory that offer different analyses and insights into state and private power. I then describe how each branch of new governance theory is currently finding expression in certain trends in public health law and policy. Finally, I use the specific case of public health and the workplace to explicate how the governmentality branch of new governance theory can help us better analyze and critique the public-private power dynamics inherent in public health regulation.

A. *Dynamics Within New Governance Theory*

“New governance” includes an extended epistemological family of conceptual and operational understandings.⁶³ All of these understandings address the power exchanges between government and the private sector. The vernacular of new governance is most evident in administrative and environmental law scholarship.⁶⁴ In these academic areas, new governance has emerged as the promotion of mediated self-regulation, interlaced with ongoing feedback between industry and agency.⁶⁵

What is largely absent from most legal scholarship in this area, however, is the governmentality branch of governance theory. Michel Foucault first used the term “governmentality” in 1978 to demarcate differences between government and the state or, alternatively stated, to drive home the point that a range of institutions outside of government interact with it to control and channel human behavior.⁶⁶

62. Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Governance in Contemporary Legal Thought*, 89 MINN. L. REV. 342, 345-50 (2004).

63. See the exchange between Bradley C. Karkkainen, *Reply: “New Governance” in Legal Thought and in the World: Some Splitting as Antidote to Overzealous Lumping*, 89 MINN. L. REV. 471, 496 (2004) and Lobel, *supra* note 62, at 348, for a discussion of whether new governance is “not a single model, but a loosely related family of alternative approaches to governance,” as Karkkainen argues, or is more fittingly described by Lobel as a “new legal model” with “dimensions . . . operating together.”

64. Both fields contain an enormous amount of work in new governance theory. Samples of discussions of the theory’s relevance in administrative law include: Alfred C. Aman, Jr., *Globalization, Democracy, and the Need for a New Administrative Law*, 49 UCLA L. REV. 1687 (2002); Jody Freeman, *Collaborative Governance in the Administrative State*, 45 UCLA L. REV. 1 (1997). For comparable discussions in the area of environmental law, see GUNNINGHAM ET AL., *supra* note 13; CHARLES SABEL ET AL., *BEYOND BACKYARD ENVIRONMENTALISM* (2000); Eric W. Orts, *Reflexive Environmental Law*, 89 NW. U. L. REV. 1227 (1995).

65. *E.g.*, Jody Freeman, *Private Parties, Public Functions and the New Administrative Law*, in *RE-CRAFTING THE RULE OF LAW: THE LIMITS OF LEGAL ORDER* 331, 346-50 (David Dyzenhaus ed., 1999).

66. See Michel Foucault, *Governmentality*, in *THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY* 87, 102-03 (Graham Burchell et al. eds., 1991).

One finds governmentality analysis more often in the work of political sociologists⁶⁷ and less often in the writings of legal scholars.⁶⁸

I identify and explicate below those two distinct branches of governance theory, administrative governance and governmentality, not because they are completely independent. Both concern "the range of activities, functions, and exercise of control by both public and private actors in the promotion of social, political, and economic ends."⁶⁹ But there is a spectrum of ideas in the new governance literature that is worth categorizing into these two distinct branches, even at the risk of some simplification. The scholarship around administrative governance tends to focus on structural forms and policy applications, while the governmentality literature tends to focus on theories of power and the attendant roles and identities of public and private actors. Exploring how each of these theories plays out today in public health law and policy can illustrate some of the different ramifications of using one construct, rather than another, to analyze the operations of the state.

1. *Administrative Governance*

The administrative and regulatory wing of new governance theory rejects the traditional public management approach of hierarchical command design with centralized control. Instead, it embraces collaborative ventures that require facilitation rather than coercion to achieve desired goals.⁷⁰ It relies upon a network of stakeholders working together to achieve outcomes, management by negotiation, and dispersed networks rather than traditional methods of command and control.⁷¹ Its common themes include an increase in partnerships, flexibility, and negotiation. It is a form of regulatory governance, albeit with a great deal of anti-regulatory rhetoric.

Two books published in 1992 provided the groundwork for new administrative governance theory in the United States. *Responsive Regulation*

67. NIKOLAS ROSE, POWERS OF FREEDOM: REFRAMING POLITICAL THOUGHT 48-50 (1999); Nikolas Rose & Peter Miller, *Political Power Beyond the State: Problematics of Government*, 43 BRIT. J. SOC. 173, 174 (1992).

68. Scott Burris and Jonathan Simon are two legal theorists who have drawn explicitly on governmentality principles. See, e.g., Scott Burris, *Governance, Microgovernance and Health*, 77 TEMP. L. REV. 335 (2004) (applying a theory of nodal governance to health policy); Jonathan Simon, *Driving Governmentality: Automobile Accidents, Insurance, and the Challenge to Social Order in the Inter-War Years, 1919 to 1941*, 4 CONN. INS. L.J. 521 (1998) (analyzing the effects of automobile-related liability on risk regulation).

69. Lobel, *supra* note 62, at 344. Indeed, I would identify a third branch, concerned primarily with the functioning of institutions, in the democratic experimentalist school of constitutional theory. See, e.g., Michael C. Dorf & Charles F. Sabel, *A Constitution of Democratic Experimentalism*, 98 COLUM. L. REV. 267, 314-23 (1998).

70. Freeman, *supra* note 65, at 341-45.

71. SALAMON, *supra* note 12, at 13-15.

sought to “transcend the intellectual stalemate”⁷² between old-line regulators and market advocates by advocating a “trust but verify” regime in which agencies would delegate much of their enforcement function to private actors, but retain oversight and the capacity to step in with “big gun” mechanisms if industries rejected change.⁷³ A second book, *Reinventing Government*, written primarily for a general audience, made a more limited argument for introducing market discipline and efficiency into the public sector.⁷⁴

Advocates of administrative governance celebrate anti-linearity and plasticity, describing these new processes as “open-textured, participatory, bottom-up, consensus-oriented, contextual, flexible, integrative, and pragmatic.”⁷⁵ Administrative governance is presented more as methodology than ideology: “a centrally coordinated and monitored system of parallel local experiments, networked and disciplined through structured information disclosures and monitoring requirements, subject to rolling minimum performance benchmarks but otherwise free to experiment in a continuous and ceaseless effort to improve, learn, and revise.”⁷⁶

In technology and in vocabulary, the goal stated within much administrative governance literature is to jettison categories of regulators and regulatees in favor of multi-stakeholder decision-making.⁷⁷ Not surprisingly, the rhetorical construct of new governance is anti-bureaucratic and anti-hierarchical, as well as dismissive toward traditional boundaries between public and private sectors.⁷⁸ Power flows not only downward to the level closest to implementation, but also outward, to both the for-profit and public interest branches of the private sector.⁷⁹ Transparency and coordination predominate over mandates, and at any regulatory moment, a strong preference attaches to the least prescriptive, efficacious alternative.⁸⁰ At the core of new administrative technologies are multiple forms of public-private hybridization.

A central feature of administrative governance is integrating stakeholders and communities to resolve complex public problems. Administrative governance, unlike traditional government, is not organized around a single entity responsible for public problem solving. Rather, it is a systemic concept that integrates organization, policy-making, and network theories and utilizes an amalgamation of tools and people for addressing social problems.

72. IAN AYRES & JOHN BRAITHWAITE, *RESPONSIVE REGULATION: TRANSCENDING THE DEREGULATION DEBATE* 3 (1992).

73. *Id.* at 35-49.

74. DAVID OSBORNE & TED GAEBLER, *REINVENTING GOVERNMENT: HOW THE ENTREPRENEURIAL SPIRIT IS TRANSFORMING THE PUBLIC SECTOR* (1992).

75. Karkkainen, *supra* note 63, at 474.

76. *Id.* at 485.

77. Lobel, *supra* note 62, at 371-79.

78. GUNNINGHAM ET AL., *supra* note 13, at 4-10.

79. Lobel, *supra* note 62, at 345.

80. GUNNINGHAM ET AL., *supra* note 13, at 391-94.

2. *Governmentality Theory as an Alternative Lens*

The strand of governance least discussed in legal literature is “governmentality.” If “new governance” generally celebrates a networked structure, then its Foucauldian antecedent can be seen as a network theory of state power, focused on a circulatory system rather than a set of defined partnerships. The operative principle of governmentality is more that of inter-penetration than of participatory administration. In general, governmentality scholarship has a sharper critical edge than the new administrative governance writings in the public policy literature.

Governmentality approaches constitute “governing at a distance,”⁸¹ an idea not captured by either the concepts of public-private partnership or self-regulation. Rather, it refers to the utilization of private entities, through ongoing operations, to channel and instantiate government policies. Governing at a distance involves indirect forms of control, for which state and non-state entities establish a series of norms as well as rules, ultimately leading individuals to guide themselves in certain directions, toward certain ends. There is no sharp demarcation between political entities and non-state spheres, such as the market or civil society. Rather,

Liberal rule is inextricably bound to the activities and calculations of a proliferation of independent authorities—philanthropists, doctors, hygienists, managers, planners, parents and social workers. It is dependent upon the political authorization of the authority of these authorities [and] upon the forging of alignments between political aims and the strategies of experts⁸²

Taken together, the scholarship on administrative governance and governmentality mark a major shift in understandings of the role and functions of the state. The field of public health—that quintessentially public sector venue for the exercise of power—provides an excellent arena for testing and applying these ideas.

B. *New Administrative Governance in Public Health*

The administrative governance concepts of multi-stakeholder involvement and decision-making can be seen in public health policy trends today. In 2003, the Institute of Medicine (IOM) recommended that the United States envision its public health system as including partners from across society, including businesses and other private actors.⁸³ The IOM report highlighted employers’ interest in healthy

81. Rose & Miller, *supra* note 67, at 173; see ROSE, *supra* note 67, at 48-50.

82. ROSE, *supra* note 67, at 49. Some scholars, including Rose, would include state-private partnerships as an example of governing at a distance. See Nikolas Rose, *Government and Control*, 40 BRIT. J. CRIMINOLOGY 321, 323-24 (2000). I develop administrative governance and governmentality separately because I think that, especially for legal studies, the distinction serves to more fully highlight the dimensions of each.

83. INST. OF MED., *THE FUTURE OF THE PUBLIC’S HEALTH IN THE 21ST CENTURY* 2-3 (2003).

workers as sponsors of health insurance plans and their concern with occupational and environmental health issues.⁸⁴ In response to, and in recognition of, the need for “multisector actions that address the broad determinants of health,” policymakers are starting to call “for the business sector’s participation in . . . [the] public health system.”⁸⁵

In both planning and operations, public health departments are starting to utilize new governance techniques. An example of the planning mode in action is “Take Care New York,” New York City’s development of a set of target population health goals for 2008.⁸⁶ The City selected its goals based on the extent of disease burden caused by each targeted health problem, each problem’s amenability to intervention, and whether each problem could “be best addressed through coordinated action by City agencies, public-private partnerships, health care providers, businesses, and individuals.”⁸⁷ “Take Care New York” reiterates the point made by the IOM: “[t]he public sector cannot and should not address these health problems alone.”⁸⁸ On the operations side, Sarah Gollust and Peter Jacobson found public health department outsourcing of functions such as clinical testing and primary care services.⁸⁹

Policy-making for public health emergencies heightens some of the dynamics that propel new governance initiatives. Public health emergencies highlight the strong needs shared by government and business for the maintenance of important resources such as communications and transportation.⁹⁰ For example, the DHS pandemic influenza planning guide for private businesses calls for “fundamentally integrated partnerships” between government agencies and the owners and operators of businesses linked to infrastructure and other critical resources.⁹¹ DHS describes its “Sector Partnership Framework” as “built on an unprecedented level of public-private cooperation.”⁹²

84. *Id.* at 268-300.

85. Paul A. Simon & Jonathan E. Fielding, *Public Health and Business: A Partnership That Makes Cents*, 25 HEALTH AFF. 1029, 1030 (2006).

86. N.Y. CITY DEP’T OF HEALTH & MENTAL HYGIENE, TAKE CARE NEW YORK: A POLICY FOR A HEALTHIER NEW YORK CITY 5 (2004).

87. *Id.* at 4.

88. *Id.* at 18; INST. OF MED., *supra* note 83, at 2-3.

89. Sarah E. Gollust & Peter D. Jacobson, *Privitization of Public Services: Organizational Reform Efforts in Public Education and Public Health*, 96 AM. J. PUB. HEALTH 1733, 1735 (2006).

90. The catastrophic consequences of infrastructure breakdown became abundantly evident in a planning exercise centered on a possible outbreak of pneumonic plague. See Thomas V. Inglesby et al., *A Plague on Your City: Observations from TOPOFF*, 32 CLINICAL INFECTIOUS DISEASES 436 (2001).

91. U.S. DEP’T OF HOMELAND SEC., PANDEMIC INFLUENZA PREPAREDNESS, RESPONSE, AND RECOVERY: GUIDE FOR CRITICAL INFRASTRUCTURE AND KEY RESOURCES 66 (2005), available at <http://www.fcc.gov/pandemic-flu-guide.pdf>.

92. *Id.* at 67.

Indeed, public health emergency planning discourse and "smart regulation" arguments have merged. A Century Foundation analysis of homeland security epitomizes the harmonization:

The development of an appropriate security posture for each of the sectors that need to be defended hinges on a detailed understanding of industry operations and risk management practices. Owners and operators are in a better position than the government to know how to translate homeland security goals and objectives into specific standards and operating procedures for their industries and companies. Close collaboration and coordination between the sectors and government are therefore indispensable.

....

Smart regulation focuses on results or end-states rather than dictating how those results should be achieved.⁹³

Anticipating the specific dynamics of an infectious disease emergency, public health leaders have started developing models for collaboration with businesses. The CDC Foundation commissioned a "lessons learned" study of how public health and business leaders in Toronto dealt with Severe Acute Respiratory Syndrome (SARS). The study concluded that "the patterns of business/government leadership are significantly altered during a public health emergency due to the economic consequences of the events. The business community became directly involved in the resolution of the public health situation. This leadership shift can be planned for in advance"⁹⁴ The United Nations System Coordinator for influenza concluded, after a pandemic flu simulation at the 2006 meeting of the World Economic Forum, that "[e]ngaging business from the start is not a luxury—it is essential and perhaps the most important factor of all."⁹⁵

These collaborative efforts illustrate a trend which will surely grow.⁹⁶ Although new public-private collaborations are more advanced in the remainder of the health care industry,⁹⁷ the trend toward incorporating business community participation in governance, in part to expand the reach of public health interventions, is likely to increase. The premium placed on emergency preparedness will only accelerate this process.

93. RICHARD A. CLARKE & RAND BEERS, CENTURY FOUND., *THE FORGOTTEN HOMELAND* 67-68 (2006).

94. GENE MATTHEWS, CDC FOUND., *THE PUBLIC/PRIVATE RESPONSE TO SUDDEN DISEASE OUTBREAK 6* (2005), available at <http://www.cdcfoundation.org/sitefiles/TorontoReport.pdf>.

95. BOOZ ALLEN HAMILTON, *INFLUENZA PANDEMIC SIMULATION: IMPLICATIONS FOR THE PUBLIC AND PRIVATE SECTORS 5* (2006).

96. In an example that presumably will be replicated, New York City's planning for an influenza outbreak has included meetings "with all . . . critical infrastructure partners." Isaac B. Weisfuse et al., *Pandemic Influenza Planning in New York City*, 83 J. URBAN HEALTH 351, 352, 354 (2006).

97. See, e.g., Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 139, 148, 156 (2006).

These developments signify the arrival of administrative governance principles and reforms based on public-private partnerships in public health. Their utilization will synchronize the management of public health programs with programs in other fields which also use these approaches.

C. Governmentality in Public Health

The experiences of various countries with SARS, and the fears of a possible pandemic flu, have generated policy proposals from different sources that go beyond proposing simply structural private-public partnerships, and engage in more focused, although indirect, governing at a distance. These public health policy ideas illustrate governmentality in action through the assumption of new roles and identities for private actors.

During 2003, waves of SARS struck Hong Kong, Shanghai, Taipei, and Toronto, resulting in 8,098 probable cases and 774 deaths.⁹⁸ In Toronto, 30,000 individuals lived under quarantine.⁹⁹ Almost all of these individuals complied voluntarily with quarantine recommendations, and in only twenty-seven cases was it necessary for courts to issue enforcement orders.¹⁰⁰ These figures suggest that a widespread instinct to protect oneself by seeking shelter at home during a disease outbreak provided the basis for close to total “compliance.” Public health officials realized that although exhortations to stay home were not enforceable, they effectively curbed the spread of the disease. Using a model based on voluntary actions had the additional advantage of not requiring health officials to obtain and implement legally binding orders.¹⁰¹

This form of “modern quarantine,” which depends on voluntary action rather than coercive state action, has been further developed in the public health literature since the SARS outbreak. David Heyman, a political scientist at the Center for Strategic and International Studies, has promoted the concept of “disease exposure control,” designed to maximize voluntary actions of social distancing.¹⁰² Heyman argues that not only will the public be more accepting of such an approach, but that it will be essential in situations in which society confronts an infectious disease

98. Reg'l Office for the W. Pac., World Health Org., SARS, http://www.wpro.who.int/health_topics/sars/ (last visited Dec. 20, 2006).

99. Martin Cetron & Pattie Simone, *Battling 21st-Century Scourges with a 14th-Century Toolbox*, 10 EMERGING INFECTIOUS DISEASES 2053, 2053 (2004). Approximately the same number of persons were quarantined in Beijing and more than 131,000 persons were placed under quarantine in Taiwan. *Id.* at 2053-54.

100. *Id.* at 2053.

101. WORLD HEALTH ORG., WHO PANDEMIC INFLUENZA DRAFT PROTOCOL FOR RAPID RESPONSE AND CONTAINMENT 14 (draft May 30, 2006), available at http://www.who.int/csr/disease/avian_influenza/guidelines/protocolfinal30_05_06a.pdf.

102. CTR. FOR STRATEGIC & INT'L STUDIES HOMELAND SEC. PROGRAM, MODEL OPERATIONAL GUIDELINES FOR DISEASE EXPOSURE CONTROL (draft Nov. 2, 2005), available at http://www.csis.org/media/isis/pubs/051102_dec_guidelines.pdf [hereinafter MODEL OPERATIONAL GUIDELINES].

outbreak without adequate pharmaceutical resources for vaccinations or treatments to curb transmission.¹⁰³

In policy documents, although not in formal regulations, the CDC has also been developing the concept of "modern quarantine," under which the coercive orders set forth in its proposed regulations would become largely irrelevant.¹⁰⁴ "Modern quarantine" does not abandon the authority to issue involuntary quarantine orders,¹⁰⁵ but its primary thrust is a form of soft law. It prioritizes a voluntary approach to quarantine, suggesting implicitly that the kind of powers sought in the proposed regulations will apply in limited instances.¹⁰⁶

The modern quarantine approach has also led the CDC to consider resource questions that it elided in the traditional coercive approach set forth in its proposed regulations on quarantine. In its policy document, the CDC explains that modern quarantine should be used only when several preconditions are met.¹⁰⁷ One of these preconditions is that "[r]esources are available to care for quarantined people."¹⁰⁸ The policy document also states that "[q]uarantined individuals will be sheltered, fed, and cared for They will also be among the first to receive all available medical interventions"¹⁰⁹

By contrast, the CDC's proposed regulations on quarantine contain no commitment to those individuals who may be subject to coercive state orders. The proposed regulations state that persons subject to coercive orders "may receive care and treatment" at the CDC's expense,¹¹⁰ but that such provision is discretionary and subject to the availability of appropriations.¹¹¹

The CDC's approach to modern quarantine also differs from Heyman's on one key point. The CDC's influenza plan states that "[i]n the event voluntary measures are not successful, it may be necessary to implement mandatory containment measures,"¹¹² but the agency does not commit itself to the principle that less restrictive alternatives should be exhausted before officials resort to

103. *Id.* at 19, 25-26.

104. U.S. DEP'T OF HEALTH AND HUMAN SERVS., HHS PANDEMIC INFLUENZA PLAN S8-27 to -28 (Supp. 8 2005), available at <http://www.hhs.gov/pandemicflu/plan/pdf/HHSPandemicInfluenzaPlan.pdf> [hereinafter U.S. DEP'T OF HEALTH AND HUMAN SERVS.].

105. *Id.* at S8-10.

106. *Id.* at S8-29. In its answers to Frequently Asked Questions, the CDC states that it defines quarantine "when used clinically or programmatically" to include persons who voluntarily sequester themselves. *Id.* "[E]ven when . . . restrictions are voluntary, the person is said to be under quarantine." *Id.*

107. *Id.* at S8-27.

108. *Id.*

109. *Id.*

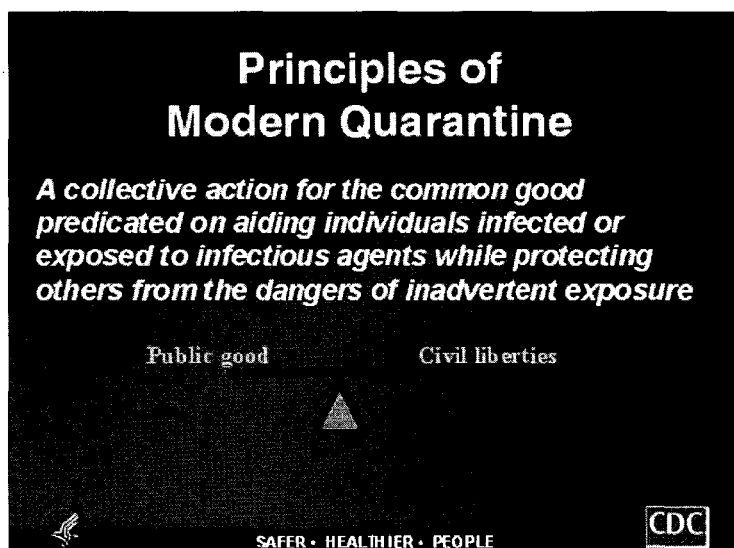
110. Control of Communicable Diseases, 70 Fed. Reg. 71,892, 71,934 (proposed Nov. 30, 2005) (to be codified at 42 C.F.R. pt. 70).

111. *Id.* at 71,934.

112. U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 104, at S8-29.

coercion.¹¹³ By contrast, the fourth principle of Heyman's model is that "[d]isease exposure control programs should be designed using the least restrictive means necessary to control the spread of disease."¹¹⁴

Whatever its internal ambivalences, the CDC has proposed a set of "modern quarantine" principles that serve a powerful political end, proffering a way to harmonize community needs and individual rights. They present an opportunity for government officials to shed a legacy of abusiveness and bigotry related to quarantine¹¹⁵ and instead to build efficacy on public acceptance of measures seen as protective rather than restrictive.¹¹⁶ The conflict between public health and civil liberties has bedeviled public health officials, such that the tension became a standard refrain during the 1980s phase of AIDS.¹¹⁷ "Modern quarantine" is meant to resolve the conventional liberty versus community debate by producing a happy equilibrium, as this CDC PowerPoint™ slide¹¹⁸ illustrates:



113. See *supra* note 44 and accompanying text.

114. MODEL OPERATIONAL GUIDELINES, *supra* note 102, at 23.

115. Historical examples of the misuse of public health powers abound. Two of the most frequently cited instances of officials using ethnic identifiers rather than scientific principles to designate parts of a city for restrictions are the quarantine of San Francisco's Chinatown during a plague epidemic and the use of quarantine against immigrants in New York City's Lower East Side. *E.g.*, MARILYN CHASE, *THE BARBARY PLAGUE: THE BLACK DEATH IN VICTORIAN SAN FRANCISCO* (2003); HOWARD MARKEL, *QUARANTINE!: EAST EUROPEAN JEWISH IMMIGRANTS AND THE NEW YORK CITY EPIDEMICS OF 1892* (1997).

116. "Experiences with the use of quarantine during the SARS outbreaks of 2003 suggest that public acceptance of quarantine may be greater than previously thought." U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 104, at S8-30.

117. *E.g.*, Wendy E. Parmet, *Legal Rights and Communicable Disease: AIDS, the Police Power, and Individual Liberty*, 14 J. HEALTH POL. POL'Y & L. 741 (1989).

118. Div. of Global Migration & Quarantine, Ctrs. for Disease Control & Prevention, Quarantine: Community Response and Containment for SARS, <http://www.cdc.gov/ncidod/sars/ppt/quarantineslides110303.ppt> (last visited Dec. 20, 2006).

“Modern quarantine” discourse illustrates governmentality in action. Its ramifications extend beyond the calls for new forms of regulation that characterize much of the administrative governance wing of new governance scholarship. Its planning documents do not seek to establish ongoing public-private partnerships. It is not a more collaborative form of regulating particular industries overseen by an agency. Instead, “modern quarantine” principles would operate by indirection. Their efficacy would depend on inducement and enablement. Calls for “social distancing” and self-quarantine seek to elicit voluntary behaviors, but ones which nevertheless would occur in the shadow of the law. Specific practices experienced as autonomous would align with the objectives of a regulatory strategy. Modern quarantine provides a contemporary example of the governmentality dynamic in action.

III. WORKPLACES AS PART OF THE PUBLIC HEALTH SYSTEM: INSIGHTS FROM GOVERNMENTALITY THEORY

Public health policies such as modern quarantine and disease exposure control would be announced and put into place by government officials. But the effectiveness of these public policies would require active facilitation by various institutions and social systems, including, most importantly, by employers. Using the insights of governmentality theory, we can explore the role that employers would assume in response to an outbreak of infectious disease that could not be quickly curbed by medications as a case study of how governing at a distance would operate in an epidemic. The complex interrelationships and interpenetrations of power required to make “modern quarantine” work provide a good example of the power dynamics revealed by a governmentality analysis. I conclude that such an analysis reveals a paradox: to make the role played by employers effective to achieve health goals will require more active intervention by the state in areas of law other than public health law.

A. The Role of Employers

The CDC has acknowledged that its modern quarantine approach cannot succeed without adequate material support for individuals who will be asked to remain at home voluntarily rather than continue working. In the “Recommendations for Quarantine” appendix to its pandemic flu plan, the CDC includes the following caution for public health agencies: “[p]rovide persons in quarantine with all needed support services Financial issues, such as medical leave, may also need to be considered.”¹¹⁹

The role of the state vis-à-vis employers has also been explored by the CDC. A report commissioned by the CDC on lessons learned from the responses of various countries to SARS noted that “[b]ecause the success of quarantine

119. U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 104, at S8-31.

depended on compliance by the affected individuals, all of the countries we studied took some steps to provide for income replacement and employment security of individuals in quarantine."¹²⁰ For example, during the SARS outbreak, the Canadian province of Ontario enacted legislation that provided material compensation to individuals under formal or even recommended quarantine conditions. Individuals who could not work because they were ill, under medical supervision, or providing care to someone with SARS, were entitled to job protection in the form of leave without pay.¹²¹ Individuals who self-quarantined were required to obtain a medical certificate within two days of being quarantined in order to receive benefits.¹²² Health care workers unable to work because of SARS received unemployment benefits and financial assistance with tax and mortgage payments.¹²³

Ontario was not the only jurisdiction to adopt enabling legislation for public health purposes. Hong Kong, Singapore, and Taiwan enacted legislation providing unemployment benefits for persons who were unable to work during the SARS epidemic and death benefits for the families of those who died from SARS.¹²⁴

While SARS offers the most recent example of using workplace benefits as a health mechanism, the idea itself has earlier origins in international law. The Convention on Medical Care and Sickness Benefits outlines basic requirements expected from signatory nations with regard to medical care and sickness benefits.¹²⁵ In 1969, the International Labour Organization (ILO), which is affiliated with the United Nations and the World Health Organization, adopted a Recommendation that sickness benefits should include cash awards to compensate for loss of earnings caused by obtaining medical care or because an individual has been quarantined.¹²⁶ In 2004, the ILO's permanent secretariat, the International Labour Office, prepared an analysis of workplace issues related to SARS. In that report, the ILO reiterated its conclusion that individuals who fail to seek medical care or fail to remain at home when appropriate for them to do so can vastly increase the velocity of transmission of an infectious disease and, therefore, some

120. MARK A. ROTHSTEIN ET AL., QUARANTINE AND ISOLATION: LESSONS LEARNED FROM SARS: A REPORT TO THE CENTERS FOR DISEASE CONTROL AND PREVENTION 14 (2003), available at <http://archive.naccho.org/documents/Quarantine-Isolation-Lessons-Learned-from-SARS.pdf>. The countries studied were Canada, China, Hong Kong, Singapore, Taiwan, and Vietnam. *Id.* at 6.

121. SARS Assistance and Recovery Strategy Act, S.O., ch. 1, § 6(1) (2003) (Can.).

122. *Id.* at § 6(2).

123. ROTHSTEIN ET AL., *supra* note 120, at 58.

124. *Id.* at 139.

125. INT'L LABOUR ORG., C130 MEDICAL CARE AND SICKNESS BENEFITS CONVENTION, 1969, available at <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C130>. For a list of signatories to the convention, visit <http://www.ilo.org/ilolex/cgi-lex/ratifice.pl?C130>. The United States has not ratified the Medical Care and Sickness Benefits Convention.

126. INT'L LABOUR ORG., R134 MEDICAL CARE AND SICKNESS BENEFITS RECOMMENDATION Art. 8 (1969), available at http://wallis.kezenfogva.iif.hu/eu_konyvtar/Projekt/Vocational_Rehabilitation/instr/r_134.htm. Recommendations are not binding on signatory nations in the manner of a Convention.

forms of “social protection” are necessary for health purposes.¹²⁷ The 2004 report also defined “quarantine” as a form of preventive health care, thus bringing it within the scope of its original Convention—and not simply the ILO’s 1969 Recommendation—on Medical Care and Sickness Benefits.¹²⁸

Since SARS, the largest public health planning exercise in the United States has been in anticipation of pandemic influenza. In May 2006, the United States Department of Homeland Security (DHS) published a comprehensive “implementation plan” for its national strategy of preparedness.¹²⁹ The DHS Pandemic Influenza Implementation Plan (DHS Plan) recognizes that “the development of public-private partnership is paramount to securing our Nation’s [critical infrastructure] assets.”¹³⁰

As the DHS Plan notes, pandemic flu would not affect physical facilities or infrastructure, but it would nonetheless threaten critical functions because of its impact on the population. According to the DHS Plan, up to forty percent of workers could be sick for up to two weeks at the height of the pandemic, with lower absentee levels for shorter periods during the weeks before and after the peak.¹³¹ As a result, the DHS Plan declares that “effective continuity planning including protection of personnel . . . is a ‘good business practice’ that must become part of the fundamental mission of all . . . private sector businesses and institutions”¹³²

However, the DHS Plan only weakly acknowledges the basic lesson of SARS: workplace policies are critical to preventing disease transmission and are not merely an afterthought or aside. In discussing protection of personnel, the DHS Plan identifies “infection control measures” that would minimize workplace exposure to influenza, including “allowing unscheduled and non-punitive leave for employees with ill household contacts.”¹³³ Another section of the DHS Plan discusses “social distancing,” advising that “businesses should prepare for the possibility of measures that have the potential to disrupt their business continuity.”¹³⁴

Neither portion of this infection control advice in the DHS Plan addresses how or by whom emergency leave policies would be financed. The DHS Plan is somewhat more specific in its preparedness checklist section for employers, but

127. JACQUELINE HARDIMAN ET AL., INT’L LABOUR OFF., SARS: PRACTICAL AND ADMINISTRATIVE RESPONSES TO AN INFECTIOUS DISEASE IN THE WORKPLACE 31 (2004), available at <http://www.ilo.org/public/english/protection/safework/accidis/sars.pdf>.

128. *Id.* at 21. The Convention states that the “contingencies covered shall include . . . under prescribed conditions, need for medical care of a preventive nature.” *Id.* (emphasis added).

129. HOMELAND SEC. COUNCIL, *supra* note 28.

130. *Id.* at 168.

131. *Id.* at 165.

132. *Id.*

133. *Id.* at 171.

134. *Id.*

implicitly assigns responsibility to each private entity. The DHS Plan urges employers to “[e]stablish policies for employee compensation and sick leave absences unique to a pandemic (e.g., non-punitive, liberal leave), including policies on when a previously ill person is no longer infectious and can return to work after illness.”¹³⁵

Other sections of the DHS Plan are similarly vague. The DHS Plan identifies population groups who might be at higher risk of severe or fatal infections, and recommends that employers consider reassignment of such persons to jobs with less risk of exposure or “flexibility (where appropriate) in terms of worksite or work hours.”¹³⁶ Finally, the DHS Plan discusses the “social risk” of employees without health insurance:

Some employees may be at increased personal risk during a pandemic because of limited access to health care services or other special needs Risk reduction planning for such employees should be individualized.¹³⁷

The CDC, in addition to the 2005 plan on pandemic flu described above,¹³⁸ has also issued a “planning guidance” document directed primarily to state and local health officials.¹³⁹ This 2007 document describes voluntary quarantine as part of a mitigation strategy that “would, in all likelihood, be implemented in most communities at some point during a pandemic.”¹⁴⁰ Mitigation through the use of nonpharmaceutical interventions (NPIs) such as voluntary quarantine, designed to reduce the opportunities for exposure and transmission, would be necessary because officials expect that effective vaccines would not become available for four to six months.¹⁴¹

CDC’s planning guidance document calls for health officials to “[e]nable institution of workplace leave policies that align incentives and facilitate adherence with” NPIs.¹⁴² It recognizes that “the requirements for success” for NPIs include the “commitment of employers to support the recommendation” for voluntary quarantine¹⁴³ as well as “the ability to provide needed support to households that are under voluntary quarantine.”¹⁴⁴

135. *Id.* at 183.

136. *Id.* at 174.

137. *Id.*

138. See U.S. DEP’T OF HEALTH AND HUMAN SERVS., *supra* note 104, at S8-27.

139. U.S. DEP’T OF HEALTH & HUMAN SERVS., INTERIM PRE-PANDEMIC PLANNING GUIDANCE: COMMUNITY STRATEGY FOR PANDEMIC INFLUENZA MITIGATION IN THE UNITED STATES—EARLY, TARGETED, LAYERED USE OF NONPHARMACEUTICAL INTERVENTIONS (2007), http://www.pandemicflu.gov/plan/community/community_mitigation.pdf (last visited Mar. 9, 2007) [hereinafter HHS PLANNING GUIDANCE].

140. *Id.* at 20.

141. *Id.* at 17, 19.

142. *Id.* at 19.

143. *Id.* at 37.

144. *Id.* at 38.

The CDC planning guidance contains a franker acknowledgment than the DHS Plan of the financial commitments that would be required for modern quarantine to be feasible. It anticipates widespread absenteeism from work for twelve weeks,¹⁴⁵ six times longer than the DHS estimate.¹⁴⁶ In doing so, the plan reflects a more thorough sense of the dynamics of channeling both public and private action toward a public health good.

The shallowness of the DHS Plan illustrates how a superficial use of administrative governance rhetoric can amount to an attempt to do new governance on the cheap. The DHS Plan uses the administrative governance language of partnership but engages *sub silentio* in an attempted outsourcing of financial responsibility to the private sector. It highlights a focus on enlisting private businesses as planning partners but implicitly rejects any shared responsibility between the state and private businesses in terms of enabling employees to adhere to social distancing plans.

Ultimately, however, both agencies blink. Neither addresses how either employers or the government would ensure that the necessary resources would be available to those who comply with modern quarantine. It is to those details that I now turn. Explicating the limitations of existing law can help demonstrate the potential need for state intervention in areas other than public health law.

B. Making Modern Quarantine Work

The effectiveness of modern quarantine relies on the public’s willingness to remain at home voluntarily to avoid exposure and possible transmission of an infectious disease. Public opinion poll data document that a common popular concern about quarantine during an infectious disease outbreak pertains to how persons would maintain themselves and their families if they could not work.¹⁴⁷ A poll commissioned by the CDC found that seventy-six percent of respondents believed that they would have serious financial problems if they had to miss work for three months.¹⁴⁸ Even exposed or infected workers without sick leave benefits would likely report for work when they could not afford the loss of income, just as persons without health insurance might continue to work and engage in other activities without seeking medical care.

In thinking about the practical details of quarantine, it is useful to categorize three types of individuals who might be at risk of losing essential material support during an emergency. The first group, which I call the Under Order (UO) group, includes persons who are *under a formal order* to remain away from work. This

145. *Id.* at 51.

146. *See supra* text at note 131.

147. Robert J. Blendon et al., *Attitudes Toward the Use of Quarantine in a Public Health Emergency in Four Countries*, HEALTH AFF. W15, W21-22 (2006), <http://content.healthaffairs.org/cgi/content/abstract/25/2/w15>.

148. HHS PLANNING GUIDANCE, *supra* note 139, at 50.

may be an order to remain in isolation because these individuals are already ill from an infectious disease, to remain in quarantine because these individuals are known to have been exposed to an infectious disease, or to remain in quarantine because of a possibility of having been exposed. The second group, which I call the Self-Protective (SP) group, includes persons who are engaged in *self-protective, voluntary separation* from others, so as to avoid possible exposure to an infectious disease or because they have self-identified possible exposures that have already occurred. Finally, the third group, which I call the Care-Taking (CT) group, includes persons *engaged in caretaking activities* for persons who need assistance and who remain at home for any of the reasons noted above.

The success or failure of modern quarantine would turn on the degree of cooperation by persons in the SP and CT groups. As a result, three topics within employment law carry enormous import for public health emergencies. Job protection, income replacement, and access to health care would make or break CDC's plan. Its 2007 planning guidance acknowledges the first two issues in one paragraph,¹⁴⁹ but fails to engage the questions in a serious way. Each example illustrates the dense connections between workplace law and policy questions and the public health system's capacity to curb disease transmission.

1. Job Protection

In the United States, no federal law and very few state laws guarantee that an individual's job will be preserved if he or she must be absent during an emergency. Some modernized statutes, resulting from a retooling of public health law to incorporate due process standards, focus on individually ordered isolation or quarantine.¹⁵⁰ This scope provides neither assurance to persons who respond to official requests to limit their activities, but who are not under any formal order, nor to persons in the SP or CT groups. Yet another model uses labor law to protect jobs for persons who follow emergency orders such as evacuation.¹⁵¹ However, these laws leave important questions regarding coverage unanswered.

The DHS Plan recommends that employers provide "non-punitive, liberal leave" but provides no further details on how such leave would be provided or the conditions accompanying such leave.¹⁵² The only existing federal leave law that might be used as a model, the Family Medical Leave Act (FMLA),¹⁵³ is too

149. *Id.* at 52.

150. New Mexico's relevant provision, for example, specifies that protection extends to "a person who is placed in isolation or quarantine pursuant to the provisions" of state law. N.M. STAT. ANN. § 12-10A-16 (LexisNexis Cumulative Supp. 2003). The statute establishes a process by which health officials would identify particular individuals and seek a court order of isolation or quarantine. *Id.* at § 12-10A-7.

151. A Texas state law makes it unlawful to fire or discriminate against employees who leave their places of employment to obey a general public evacuation order issued during an emergency. TEX. LAB. CODE ANN. § 22.002 (Vernon 2006).

152. HOMELAND SEC. COUNCIL, *supra* note 28, at 183.

153. 29 U.S.C. § 2601 *et seq.* (2000).

incomplete to serve a population health function. The FMLA guarantees up to twelve weeks of unpaid leave for persons who have a “serious health condition” or persons who need the time off to care for a newborn or newly adopted child, or for a child, spouse or parent with a serious health condition.¹⁵⁴ A “serious health condition” is defined as one involving inpatient care or continuing treatment by a health care provider.¹⁵⁵ However, it applies only to employers with fifty or more employees, leaving very small workplaces and self-employed workers uncovered.¹⁵⁶ Workers must also have been employed for at least one year and must meet minimal hour per week standards.¹⁵⁷ Caring for anyone not included in the statutory list—such as a grandchild, domestic partner, or neighbor—would disqualify the worker from using leave under the FMLA. Thus, while an already-infected person would meet the criteria for having a “serious health condition,” someone who had merely been exposed but was not ill, or who was taking precautions against exposure by staying at home, would not qualify. A few state leave laws provide more coverage,¹⁵⁸ but workers in most states are governed by the federal law.

Other legal mechanisms may redress or compensate for inequities after the fact, but do not provide the advance assurance that would provide optimal incentives for people to change their behavior in the midst of an emergency. The Americans with Disabilities Act (ADA) would prohibit firing an individual because he or she has a disability, or once had a disability, or is perceived to be disabled, or associates with someone who is disabled.¹⁵⁹ The ADA could apply if an employee was fired because of a serious injury or illness resulting from an emergency if the general statutory criteria were met. Given the limited scope of the coverage of the ADA, however, based on the recent Supreme Court interpretations, the utility of the ADA in this regard would be severely limited.¹⁶⁰

An even less likely source of protective law is the public policy exception to the employment-at-will doctrine, which rarely succeeds. Courts generally uphold an employer’s right to discharge workers, absent a specific statutory barrier,

154. *Id.* § 2612(a).

155. *Id.* § 2611(11).

156. *Id.* § 2611(4)(A).

157. *Id.* § 2611(2)(A).

158. *E.g.*, CAL. UNEMP. INS. CODE § 3300 *et seq.* (West 2007).

159. 42 U.S.C. § 12101 *et seq.* (2000).

160. *See Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 198 (2002) (noting that disability must affect activities of central importance to daily life and must be permanent or long term in duration); *Sutton v. United Airlines, Inc.*, 527 U.S. 471, 487 (1999) (suggesting that corrective and mitigating medical devices may eliminate applicability of the ADA); *Murphy v. United Parcel Serv., Inc.*, 527 U.S. 516, 521 (1999) (suggesting the same for medications); *Albertson’s, Inc. v. Kirkingburg*, 527 U.S. 555, 565-66 (1999) (suggesting the same for organic processes).

allowing only narrow exceptions.¹⁶¹ Judicial reluctance to invalidate a job termination has carried over to emergencies.¹⁶²

2. *Income Replacement*

The principle of income replacement for persons who cannot work during a health emergency is well established in the abstract. The ILO's 1969 Recommendation provided for income replacement to individuals under quarantine.¹⁶³ All of the countries most affected by the SARS outbreak in 2003 adopted laws that provided some form of monetary compensation to persons who were under quarantine or who had been advised to remain at home.¹⁶⁴ In the United States, as with the issue of job protection, some laws already exist which could be used to provide income replacement, but they are incomplete.

One model for income replacement in existing American law is the unemployment compensation benefits system. As a threshold matter, however, individuals who did not lose their jobs, but who received unpaid leave, would not qualify for unemployment compensation.¹⁶⁵ These individuals would be protected in the sense that they would have a job to return to when they became able to work again, and their membership in a workplace health insurance plan, if their employer sponsored one, would continue.¹⁶⁶ But they could not receive unemployment benefits.

A special set of unemployment benefits does exist for persons who lose their jobs because of an emergency. The Stafford Act, a federal disaster response law, provides for but does not require federally ordered unemployment compensation benefits if a national disaster is declared.¹⁶⁷ In addition, the President has broad authority under the Stafford Act to provide financial assistance to individuals for "necessary expenses or serious needs" including property and transportation expenses.¹⁶⁸ Federal gap-filling legislation amending the Stafford Act could provide a mechanism for addressing the current absence of income protection

161. *See, e.g.*, *Burk v. K-Mart Corp.*, 770 P.2d 24, 29 (Okla. 1989); *Berube v. Fashion Centre, Ltd.*, 771 P.2d 1033, 1049 (Utah 1989); *Brockmeyer v. Dun & Bradstreet*, 335 N.W.2d 834, 840 (Wis. 1983).

162. *Weyenberg Shoe Mfg. Co. v. Seidl*, 410 N.W.2d 604, 607 (Wis. Ct. App. 1987); *contra Gardner v. Loomis Armored, Inc.*, 913 P.2d 377, 386 (Wash. 1996).

163. INT'L LABOUR ORG., *supra* note 126.

164. ROTHSTEIN ET AL., *supra* note 120, at 58-59, 139.

165. *See, e.g.*, CAL. UNEMP. INS. CODE § 1252 (1986); *State Street Bank & Trust Co. v. Dep. Dir., Div. of Unemployment & Training*, 845 N.E.2d 395, 400 (Mass. App. Ct. 2006) (concluding that an employee must have been discharged or forced to leave by such urgent reasons as to render the departure involuntary). States may impose a waiting period during which the applicant must be unemployed and seeking work before benefits can begin. *See, e.g.*, CAL. UNEMP. INS. CODE § 1253(d) (1986 & West 2007). *See generally* Alan J. Jacobs & Lisa Zakolski, *Unemployment Compensation*, 76 AM. JUR. 2D *Unemployment Compensation* § 1 (2006).

166. 29 U.S.C. § 2614(c)(1) (2000).

167. 42 U.S.C. § 5177 (2000).

168. *Id.* § 5174(e)(2).

guarantees for persons on unpaid leave in any of the three categories (UO, SP, or CT) of vulnerable workers. However, emergency planning documents do not indicate that this option is being considered.

3. *Access to Health Care*

Medical care is an especially complex question. Virtually all Americans younger than sixty-five who have health insurance receive it through a workplace group plan,¹⁶⁹ another reason why preserving one’s job is essential, because termination from employment also means termination of health insurance. More than forty million Americans, however, have no health insurance, nor are they covered by public programs such as Medicare or Medicaid.¹⁷⁰ An emergency-specific response is possible. In the wake of September 11th, federal, state, and New York City officials liberalized the eligibility criteria for Medicaid for those affected by that disaster.¹⁷¹ The Stafford Act allows, but does not require, the federal government to provide financial assistance “to meet disaster-related medical, dental, and funeral expenses.”¹⁷² Again, current planning documents do not indicate that any thought has been given to such possibilities.

The point of this brief review of employment law is not to identify oversights or suggest fixes, but to make a deeper point about the structure of this kind of administrative policy. The CDC and DHS documents reflect different levels of engagement with new governance approaches, but neither fully confronts the issue of how much government intervention in employment law would be required in order to make a voluntary modern quarantine system work. If employers are effectively to facilitate quarantine—not because of some explicit partnership structure with the state, but because of how a policy like voluntary quarantine would operate—it will not be sufficient for government to simply exhort employers to be good citizens. This enlistment of employers to carry out state functions would necessitate the state becoming more interventionist in employment law. A genuinely workable emergency public health law will require comparable emergency employment and income protection law.

169. INST. OF MED., *supra* note 83, at 269.

170. *Id.* at 215. Recent data indicate that the number of individuals in the United States with no health insurance is close to 47 million. Robert Pear, *Without Health Benefits, A Good Life Turns Fragile*, N.Y. TIMES, Mar. 5, 2007, at A1.

171. Kathryn Haslanger, *Radical Simplification: Disaster Relief Medicaid in New York City*, 22 HEALTH AFF. 252, 253 (2003).

172. 42 U.S.C. § 5174(e)(1) (2000). The Model State Emergency Health Powers Act recommends that states enact laws providing that isolated and quarantined persons shall receive “adequate food, clothing, shelter, . . . medication and competent medical care.” CTR. FOR LAW & THE PUB.’S HEALTH AT GEORGETOWN & JOHNS HOPKINS UNIVS., THE MODEL STATE EMERGENCY HEALTH POWERS ACT 28 (2001), available at <http://www.publichealthlaw.net/MSEHPA/MSEHPA2.pdf>. New Mexico law contains a comparable provision. N.M. STAT. ANN. § 12-10A-8(B)(5) (LexisNexis Cumulative Supp. 2003). As with the state’s job protection provisions, this protection extends only to persons against whom a formal public health order has been issued. *Id.* § 12-10A-8(B).

CONCLUSION: RETHINKING THE PUBLIC HEALTH “SYSTEM”

Traditionally, we have assumed that the law of public health is essentially the cluster of issues revolving around the operations of the government agencies that comprise the public health system. The changes in the foundational strata underlying the public health field that I have identified in this article call that assumption into question. The architecture of governance in the public health field is in flux, with trends moving in multiple and sometimes contradictory directions. Some government authorities are proposing sweeping authorities for detention and surveillance and pressing for tighter command procedures in responding to all forms of emergencies. Other policy-making bodies are generating infrastructure partnership models, and yet others are advocating indirect modes of disease control that will ultimately depend as much on employment law as public health law. The increasing role of trans-national governance structures further complicates the field.¹⁷³

The changes happening today in public health have broad resonance. Some open up a new angle of vision into the national security state. Other aspects of emergency planning illustrate subtle technologies of governance that operate at multiple points of public-private intersection. An employer can, in a subtle way, take on the functions of a quarantine agent, even as individual citizens incorporate new disciplines of health into their daily lives. In these ways, health emergency planning adds another layer to the biopower of the state, in its potential to shift how we understand the identities associated with citizenship and regulation.

In both branches of the new governance discourse emerging in public health, economic issues are central. New governance approaches within the health emergency framework explicitly foreground the principle that a key component of population health and national security is a healthy and secure economy. Throughout discussions of infectious disease emergencies, biological incapacity at the individual level aligns with economic incapacity at the collective level. The prescriptions of economic health policy are directed to employers, who are advised to review what their legal obligations are for providing leave,¹⁷⁴ and individuals, who are told to “[c]onsider maintaining a cash reserve.”¹⁷⁵

Using a new governance lens to think about the multiple directions for policy-making operating within public health provides a richer sense of how this field is increasingly knit together with broader trends in American government. There has not yet been substantial crossover between new governance theory and national security analysis. Public health emergency policy presents both sets of issues.

The sum of these developments should also encourage us to rethink how we define the boundaries of a public health system or of public health law. If public

173. Fidler, *supra* note 1, at 158.

174. HHS PLANNING GUIDANCE, *supra* note 139, at 80-81.

175. *Id.* at 107.

health law consists of the legal doctrine most fundamental to the operation of the public health system, then its scope will change as the system itself changes, becoming reconfigured as emergency and security law and expanding into the private sector. Regulating population health is multi-faceted and multi-sectoral and, increasingly, the product of government-private sector partnership. It is also wired into aspects of law that, on their face, do not address health.

Today's changes in the field of public health take us back in some ways, to fears associated with infectious diseases that lacked effective cures or vaccines. But these changes also move us ahead toward new understandings of what practices constitute government and governance. This dynamism creates challenges for those who analyze and teach public health law, as well as for our students. In the future, practitioners of what constitutes public health law in these redefined terms will include not just lawyers for traditional public health agencies and public health care systems, but also attorneys who work in a wide array of private law fields as well. Focusing on theories of governance is one important way to link the public health field to broader understandings of society, to convey its intellectual richness, and to prepare students for critical practice.

From a more theoretical perspective, public health law offers the opportunity to study the interaction of varying models of governance as they develop, in real time. Policy texts and the practices they signify constitute a portion of that law, if we understand law to encompass the full range of discourses and institutions that regulate behavior. Perhaps most significantly, public health policy has become a venue for insinuating the normalization of emergency discourse into non-emergency governmental policy-making.

