The long-term significance of the 1965 federal health legislation lies in the development of new patterns of medical service and continuing education. These enactments also redefine the role and direction of the public sector. Federal legislation has necessarily entailed state action. At the same time the courts have clarified and reaffirmed the importance of the individual and his privacy, and the relation of such privacy to the public health.

1965: THE TURNING POINT IN HEALTH LAW—1966 REFLECTIONS

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NINETEEN hundred sixty-five was notable for health legislation, measured by the number and scope of health laws enacted. Twenty-nine important laws were passed by the 89th Congress relating to health, education, and welfare, 15 of which will have direct and far-reaching impact on the health services of the nation.[1] In addition, enactments of state legislatures and decisions of federal and state courts have gone far to clarify or define the status of health-related activities in relation to new technologies and changing socioeconomic conditions.

The federal and state legislative enactments set forth aggressive programs promoting health by utilizing revenue and regulatory powers to expand and integrate activities in planning, prevention, manpower development, continuing health education, research, services, equipment, and facilities. As these laws are implemented, preventive and curative health services will be vastly increased in both quantity and quality and will be made readily available to the general public.

During the same period, the courts reached decisions outlining criteria for the protection of fundamental personal freedoms in the light of modern technology, modern considerations of public policy, and modern trends in urbanization.

Now that there is opportunity to view the health law developments of 1965 in some perspective, it may be helpful to examine the actions of Congress, the state legislatures, and the courts.

Federal Legislative Developments

The 89th Congress during 1965 enacted the following significant health-related laws:

1. Drug Abuse Control Amendments of 1965 (PL 89-74).
2. Federal Cigarette Labeling and Advertising Act (PL 89-92).
3. Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965 (PL 89-105).
4. Community Health Services Extension Amendments of 1965 (PL 89-109).
5. Health Research Facilities Amendments of 1965 (PL 89-115).
6. Water Quality Act of 1965 (PL 89-234).

7. Heart Disease, Cancer and Stroke Amendments of 1965 (PL 89-239).
8. The Clean Air Act Amendments and Solid Waste Disposal Act of 1965 (PL 89-272).
9. Health Professions Educational Assistance Amendments of 1965 (PL 89-290).
10. Medical Library Assistance Act of 1965 (PL 89-291).
11. The Appalachian Regional Development Act of 1965 (PL 89-4).
12. The Older Americans Act (PL 89-73).
13. The Social Security Amendments of 1965 (PL 89-97).
14. The Vocational Rehabilitation Act Amendments of 1965 (PL 89-333).
15. The Housing and Urban Development Act of 1965 (PL 89-117).

Each of these statutes has important implications for the health of the nation. Some are designed to produce a reduction in environmental etiological agents of disease ranging from dangerous drugs to polluted air. Others are designed to provide financial support for raising the quality of health care and extending its reach. The Medicare portion of the Social Security Amendments, providing broad ranges of third-party-payment for hospital services and medical care, alone constitutes an important breakthrough in making new services and funds available.

The federal health legislation package of 1965 applies bold new concepts to attack "insoluble" problems in a systematic manner. It lays the foundation for initiating and utilizing the approach of systems integration in governmental attacks on health problems. These enactments provide new workable approaches to problems that were not amenable to traditional attempts at resolution.

The systems-integration method is a technic which examines and analyzes problems from input to yield or output. It approaches solutions by examining the goals to be accomplished (known as systems operational requirements), and determining the flow paths of planning, organization, money, manpower, equipment, and facilities inputs which must be processed and integrated to achieve these goals. This technic gives the decision-makers the opportunity to view a problem objectively in its entirety, seeing each component both as an absolute entity and as a unit (known as a subsystem), the functional importance of which is relative to its interaction with other components of the system.

The 1965 federal enactments represent a turning-point in health law because they now place the government in an important role in each of the components which must be integrated to achieve, with maximum effectiveness and minimal cost, our national goal of delivering to the American people the most advanced and highest quality health services.

The solutions to our nation's health problems ranging from basic manpower development to facilities, research, operational cost subsidies, services, and environmental and medical prevention programs can be viewed and handled systematically. In this vital area of growing concern to the public sector, in which approximately 6 per cent of the gross national product is expended yearly, effective and systematic short-term, intermediate, and long-term planning will now be possible. Appropriate factors necessary to fulfill the health needs of the nation now can be given thrust based upon their criticality and their relation to the entire public health effort. Logical quantitative decision-making will now be possible. The research, manpower, and facility requirements to make Medicare effective in delivering high-quality care at optimal cost can be made available. The optimal number of dollars can be expended to achieve optimal delivery of health services both qualitatively and quantitatively.

Specific discussion here will be limited to those significant federal statutes which give emphasis to: (1) organizational innovations, (2) precedents for future

legislative patterns, (3) production of increased manpower and new specialists. The federal legislation reviewed includes:

1. The Heart Disease, Cancer and Stroke Amendments—Regional Medical Programs —of 1965[2];
2. The Mental Retardation Facilities and Community Mental Health Centers Construction Act Amendments of 1965[3];
3. The Clean Air Act Amendments of 1965[4];
4. The Community Health Service Extension Amendments of 1965[5];
5. The Health Professions Educational Assistance Amendments of 1965[6];
6. Title II, The Child Health and Welfare Portion of the Social Security Amendments of 1965.[7]

In the following discussion attention will be given, where appropriate, to the systems approaches which are introduced in some of the enactments. However, the discussion will focus primarily upon the breakthroughs in: (1) organization, (2) patterns for future legislation, and (3) manpower development.

Organizational Innovations

In providing good health for every citizen to the limit of our nation's capacity, the public sector must strive to assure effective and dynamic organization and leadership in all components of the public and private sector's attack on health problems. In order to achieve and maintain this organization and leadership new relationships between all of the components in the national attack on health problems must be developed. In 1965, the Heart Disease, Cancer and Stroke Amendments constituted a highly significant initiation of these new relationships.

The Heart Disease, Cancer, and Stroke Amendments

Public Law 89-239 sets forth a program for education, research, training and demonstrations in the fields of heart disease, cancer, stroke, and related diseases. It amends the Public Health Service Act by encouraging regional cooperative arrangements among physicians and medical institutions to provide to patients the latest advances in the diagnosis and treatment of heart disease, cancer, and stroke at optimal places under optimal circumstances. Although these provisions are aimed primarily at combating the three major killers—heart disease, cancer, and stroke —the act will inevitably redefine patterns of medical services and the interrelations of the federal government with the university medical center and with the practicing physician. It sets forth a legislative pattern which will markedly affect the practice of medicine generally and the delivery of all health services in the United States.

Three basic features of the act make it a major innovation, which will set patterns for the future role of the federal government in medical services. The first innovative feature of the act is that it provides funding for regional programs irrespective of political boundaries. Whereas earlier comprehensive federal programs, such as the Hill-Burton program, verbally encouraged regionalization, those programs have provided for federal grant-in-aid funding for previously defined political units, namely the states. Regionalization was not achieved. This act by contrast, makes the funding available only to regions which define themselves on a functional basis. Definition of a functional region will take account of factors of population, geography, transportation, communication, physician-availability, demographic and epidemiological patterns, medical referral patterns, existing medical service facilities, and patient utilization patterns. Regions will be developed to carry out a systematic pattern of service and service-oriented educational and pilot programs. These regions, which will have developed on logical, systematic bases, will be a unit in what President Johnson has termed programs of "creative federalism."[8] "Creative federalism" pro-

grams envision making substantial federal funding available to functionally defined local units which can solve major problems effectively, utilizing the federal funds subject to local control and local initiative. The federal share in the funding of this program is 100 per cent for program planning activities and 90 per cent for operations. Implementing guidelines have been set forth which strive to ensure local professional and public and voluntary organizational program goals.[9]

The second innovative feature is the requirement for development of cooperative arrangements linking major medical centers—a medical school and affiliated teaching hospitals with clinical research, training, continuing education, and demonstration activities in patient diagnosis and treatment. Through these arrangements, the latest advances in research and technology can be translated into patient care. Programs of patient care, medical education, and continuing education will be carried out cooperatively under conditions utilizing the latest, most advanced equipment in the most appropriate settings. This regional program will serve continually to upgrade the skills and abilities of the practicing physician and will merge the "town and gown." It will make the university medical facility the base center in a centrifugal pattern of medical services, education, and continuing education and will reduce the gap between the university teaching facilities and the practicing physician on the firing line.

This regional medical program will create a new type of partnership between the federal government, universities, hospitals, practicing physicians, units of state and local government and even private industry to form a series of Manhattan project-like programs for attacking the killer diseases and delivering effective services to the public. It will attack health problems utilizing each of the components in the attack, such as universities for research, education, and training in a manner which will be most effective functionally. The pattern that is established for heart disease, cancer, and strokes will undoubtedly carry over to other disease categories. This carry-over will begin with "other related diseases" now authorized in PL 89-239.

The third feature of the law is the requirement for periodic evaluation and review of the initial operations of the program before further sums are allocated for its continuance or expansion. Operations research technics will be brought into use and careful cost-benefit analyses of the operations of the program and its components will be necessary.

The Heart Disease, Cancer and Stroke Amendments will serve to integrate health and medical practice with education and continuing education in a manner which can deliver the best in services to the patients of the nation. It can help to assure that the best kind of training is given to develop and maintain optimally effective professional manpower. It will also integrate services with research and basic and continuing education. Finally, by utilizing systems engineering and analysis technics, it will permit continuous effective operational review of the program so that periodic improvement can be made in services and education at proper places and times and under the proper circumstances. This act may well be the prototype for other federal health service projects supporting broad programs. Consequently, it can be construed both as an organizational innovation and as a pattern for future federal legislative programs.

Precedents for Future Legislative Patterns

In 1965 systematic realism was applied to federal health legislation. Although

there had been recognition that the health of the nation was a matter of great significance to the public sector and public monies were made available for health programs, many fictional restraints on public sector involvement were maintained. One of these restraints dealt with vital new but on-going service programs. The federal involvement was kept restricted to construction alone except in the case of research, demonstration, or pilot programs. Funds for staffing and operations were not provided for fear of constituting federal medical service programs. In preventive health service programs there had never been a service program directed toward the goal of complete eradication of a disease with federal funds and federal impetus. In regulatory programs control of health hazards caused by such an ubiquitous item as the automobile had been considered to be of proper concern only to the state and local government and to industrial self-policing because the automobile was considered strictly within the purview of the local police power and was susceptible of personal consumer inspection. Federal concern had been directed to ubiquitous items such as foods, drugs, and cosmetics because they could present "hidden hazards" not amenable to individual discovery and were generally packaged and sealed before starting on their journeys into interstate commerce.

The Community Mental Health Centers Amendments of 1965 (PL 89-105)

Congress authorized federal subsidy for initial staffing and operational expenses of community mental health centers. The project grants authorized by the law will assist in meeting operating and staffing costs for the first 51 months of the existence of comprehensive community mental health centers. Congress has thus recognized that, to implement bold new service programs, operational as well as construction funds must be supplied.

A major problem in the development of community mental health centers will be acquisition and use of effective, expensive professional and technical manpower. Without this manpower, no program can be developed, and a need deemed to be within the national interest cannot be fulfilled. Consequently, finances to help provide the needed manpower have been made available.

This act represents a turning-point of the greatest significance because it may be a model for future innovative and creative service programs. A new pattern in project grants-in-aid has been established which will include funds for operations and professional staff compensation.

The Community Health Service Extension Amendments of 1965 (PL 89-109)

Congress has added measles immunization to the community vaccination assistance program. Measles affects almost every infant or child, and one of 1,000 cases can result in neurological or other severe damage. By striking to eradicate, by prevention, a pediatric disease which can produce widespread, chronic, severe complications, Congress has placed its emphasis on eradication by prevention which requires minimal manpower, and on pediatric disease, which has a health return both in childhood and in later life. The measles vaccination program will permit a systematic evaluation of the role of a nearly absolute preventive health service on an almost universal childhood disease in quantitative terms. The lessons learned from experience with this act can then be applied to preventive and eradication programs for other widespread diseases.

The Clean Air Act Amendments of 1965

Title II of the Clean Air Act Amendments and Solid Waste Disposal Act of

1965 (PL 89-272) is designed to control air pollution from new motor vehicles. Standards for control will be developed by the Secretary of Health, Education, and Welfare and will be uniform in controlling a particular pollutant emitted via automobile exhaust. These standards will be enforced through civil and criminal legal sanctions against manufacturers and those entering vehicles into interstate commerce. The statute requires that the manufacturers keep records sufficient to indicate whether they are or are not complying with the law.

The significance of this legislation is that it aims at reaching a numerically large source of air pollution that is everywhere in the land—the automobile. It sets a pattern of imposing on the manufacturer controls and standards of an item essential to the existence of our present economy. The item—the automobile—presents health risks from exhaust emissions requiring technically and economically feasible emission control devices. This provision sets a clear precedent for proposed federal automotive and tire safety legislation proposals which are being considered in 1966. The 1965 clean air legislation provides a fixed point of reference for systematic evaluation of the effectiveness of regulating an ubiquitous, economically and socially necessary source of air pollution and for determining what other standards or controls would be necessary to reduce air pollution from automobiles. It also shows that regulation of items presenting overriding national problems such as the automobile can and should be within the federal purview rather than be left to local police power and principles of caveat emptor.

Manpower Development

Trained professional manpower, specialized professional manpower, and college-trained health manpower are required to carry out any health program. This manpower is in critically short supply. Since health programs are the concern of the federal portion of the public sector, so are health manpower and health manpower development. In 1965 Congress took great strides to express this federal concern in terms of programs to reduce the manpower gap.

Health Professions Educational Assistance Amendments

The 1965 amendments to the Health Professions Educational Assistance Act (PL 89-290) give the federal government a full and essential role at the base of all health programs. Through vastly increased support of educational institutions and their students, the federal government will be able to insure and stimulate the health manpower input which is the sine qua non for the complete array of programs of service and research for solving the health problems of the nation.

In 1963 the Health Professions Educational Assistance Act (PL 88-129) created an innovation in the government's role in promoting the nation's health by providing funds for expanding facilities for training health professionals. This was followed by the Nurse Training Act of 1965 (PL 88-581). The 1965 amendments mark a still further departure because they provide for federal scholarships and for basic and special improvement grants for medical schools and other schools in the health professions. The scholarship provisions, at long last, begin to place emphasis on health education and manpower development comparable to that given to education in mathematics, English, linguistics, and the physical sciences since the National Defense Education Act of 1958. Thus the federal government now can stimulate effectively the entrance of highly qualified students into the health professions, regardless of their financial situation. The basic and

special improvement grant portions of the 1965 act provide operational funds to health professional schools for faculty and curricular upgrading and maintenance. Legal recognition is given to the fact that construction, research grants, scholarships, and student loans do not make a comprehensive educational program. Expansion and strengthening of faculty, and improvement of and innovation in the curriculum, for the health professions programs have now been legally recognized as critical enough to good education to merit federal financial support. Consequently, national responsibility is beginning to be met in health professional manpower development by a pattern of attack which is adequate. This new pattern also permits a systematic analysis of the roles of: (1) construction and improvement of facilities; (2) scholarships and student loans; (3) research support; (4) operational improvement funds in the effective development and education of health professional manpower. The statute is sufficiently flexible to allow increased subsidy and support for aspects of education which prove most critical during the operation of the program.

The Social Security Amendments of 1965

Title II of the "Medicare Amendments" of 1965 (PL 89-97) deals with pediatric problems. One provision of Title II authorizes operational grants to universities engaged in special training programs for physicians, psychologists, nurses, dentists, and social workers for work with crippled children. This title recognizes that postdegree specialized training to produce skilled manpower is an essential ingredient in developing service programs. Moreover, it recognizes that these vital special training programs involve supervised on-the-job administering of expensive inpatient care and outpatient care programs and that the operational costs of these programs must be subsidized in order to induce institutions of higher learning to carry them out.

This program is also a new departure in that it attacks the special manpower problems related to pediatrics so that a competent array of skills will be on hand to service crippling disorders at birth, thereby minimizing their later costly ravages. Specialized manpower will also be available to carry out programs in prevention of all diseases which have their inception from the perinatal period throughout childhood.

The portion of Title II providing for special project grants for comprehensive medical and dental care for low-income school and preschool children is of great importance. These comprehensive programs, which cover health care from preventive services to aftercare and long-term follow-up services, stress the involvement of medical schools, dental schools, and teaching hospitals and require coordination with other health, education, and welfare programs. The striking feature of this provision is that the basic sources of health manpower—professional schools and teaching hospitals—are placed in the mainstream of comprehensive community pediatric medical service programs. The way is paved for these training resources to interdigitate with other community education and welfare services. This program will not only give comprehensive services of the kind which modern practice shows to be optimal, but will give professional training in this approach from the outset. Consequently, pediatric manpower skilled in early detection and correction of diseases and defects and in technics of comprehensive medical, educational, and welfare services will be developed to insure proper intervention at the earliest time in the natural history of disease.

Section 206 of Title II is of particular importance because it provides that the Secretary of the Health, Education, and

Welfare Department shall submit periodic evaluations of the program along with recommendations as to the continuance or modification of the Title II provisions. This section provides an opportunity to apply operations and systems analysis technics to this program in order to more effectively achieve the goals of manpower development and services.

With the manpower strides accomplished in 1965, the President was able in 1966 to recommend a three-year program to provide grants for training in allied health professions such as medical technology, biomedical engineering, and dental hygiene which, along with medicine, dentistry, and nursing, constitute the professional health team.[10]

Review of these six important federal statutes indicates that a new pattern in federal health legislation has emerged. A systematic and integrated approach rather than a piece-meal approach can be adopted now to ensure optimal contribution to the nation's health by the federal government. The system will include support of the total range of health services and resources: basic education, specialty training, research and service facilities, continuing education, preventive and curative programs, and service monies for vendor payment. Now, by involvement in the entire array of factors pertinent to the health of the nation, the federal government can approach health problems comprehensively, and thereby fulfill its public mandates more fully and effectively than in the past.

The new functions given to the Department of Health, Education, and Welfare and the United States Public Health Service in 1965 added to the already unprecedented growth of each, necessitated reorganization of the structure of the Public Health Service to improve the administration of federal health services. Pursuant to this need, in May, 1966, the President announced a reorganization program for the Public Health Service to make the service more efficient and to integrate its activities more fully into the Department of Health, Education, and Welfare.

The enactments of 1965 have opened the door to development of a truly comprehensive national health program, involving close intergovernmental collaboration, official and voluntary efforts and individual and organizational participation. Senate Bill 3008, "The Comprehensive Health Planning and Public Health Service Amendments of 1966,"* now before Congress, will advance this goal greatly. This bill provides for comprehensive statewide health planning for services, manpower, and facilities. It also includes project grants for regional, metropolitan, or areawide planning; for research and demonstrations in planning; and for grants to assist states in establishing and maintaining adequate public health services, including the training of manpower for state and local health work. This bill will advance significantly systematization, comprehensiveness, and improved management of health programs. Coordination of all parts of the public and private sectors will be improved, and solution of the most complex problems can be facilitated. New relationships will be pursued and health leadership will be strengthened at all levels in all sectors. The foundation for this bill was laid by the federal health legislation accomplishments of 1965.

In 1966, the concept of comprehensive planning for comprehensive programs was extended beyond the health field to the entire urban environment. In the proposed legislation entitled the "Demonstration Cities Act of 1966," comprehensive urban physical and human rebuilding and restoration are envisioned.[11] The programs set forth by this proposed legislation would encom-

* This was enacted by the Congress and signed by the President late in 1966.

pass, among other items, the housing, air and water pollution abatement, educational, health services, transportation, land use, recreational, sanitation, and adult education aspects of urban life. It would provide for federal subsidies to plan for urban development, taking the entire array of health programs into account as one aspect of a system of essential urban services.

State Legislation

The extensive federal enactments have necessarily impelled state action to accommodate state activities to the federal statutes.[12] The year 1965 also brought considerable state legislation to modernize health laws, e.g., the New York City Health Code[13]; to provide legislative authority for new health programs, e.g., the Connecticut law on statewide flouridation[14]; and to bring the law into line with scientific and therapeutic advances, e.g., the New York law governing mental hospitals admissions.[15] Here, still another state legislative change will be discussed, a change that spells a departure in concept of organization and regulation of personal health services.

Section 2800 et. seq. (1965) of the New York Public Health Law states in its policy declaration that hospital and related services of the highest quality, efficiently provided and properly utilized at reasonable cost, are of vital concern to the public health of the state of New York. The New York law provides that all new construction, renovation, modification, additions, or remodeling of new or existing public and private (including proprietary) hospitals and medical facilities must be approved by the state commissioner of hospitals based on conditions of public need. Public need requirements for the construction must be satisfied as to time, place, and circumstances. In determining public need, the commissioner must consider the availability of facilities which may serve as alternatives to or substitutes for the facility, the need for special equipment in view of comparable existing equipment utilization, possible economies and improvements in service to be anticipated from joint central services, and the adequacy of revenue resources.

This enactment recognizes that the hospital and the medical facility are essential elements of community health programs and determine, in large measure, the availability and cost of medical services to the community. The statute treats licensing these facilities appropriately as a form of franchise somewhat analogous to the treatment of public utilities or essential public services.[16] The controls apply even to existing proprietary hospitals because of the recognition that they are strongly affected with a public interest and are therefore subject to public regulation in each facet that affects the public health, safety, or welfare.

The statute gives legislative recognition to the judicial principle laid down by the New Jersey Supreme Court in Falcone v. Middlesex Co. Medical Society that private medical organizations, including hospitals, are an economic necessity affected with a public interest which must be safeguarded by the public sector.[17] The private character of the hospital or facility, including institutions already in existence, does not create immunity from public control.[18]

By applying the public service utility-public need concept to licensure of all physical changes in hospitals, the state government can ensure better distribution of facilities in response to need. It can effect economies and produce changes in operations, supplies, equipment, and facility interrelations to improve performance. It can provide a basis for application of operations and systems analysis technics to im-

prove distribution of patient care facilities for economic purposes and to improve the performance and economies of central facility operations. It removes these vital facilities from the uncertainties of private self-regulation and places them under public control. The application of the concept of public need to state governmental regulation of all medical care facilities is a force towards the development and orderly updating of all equipment and technologies. Obsolescence can be reduced and quality maintenance can be achieved more effectively.

Court Decisions

The important role and powers in public health and personal health service programs given to the federal and state governments by the 1965 legislation raise questions as to the extent and limitations of governmental power as applied to the individual. It is the role of the judiciary to define, interpret, and apply these statutes in cases and controversies over which they have jurisdiction. It is also the function of the courts to define the limits of governmental power, actions, and procedures affecting individual rights, balancing the value to society of individual freedoms against the value to society of limited restraints of these freedoms. This principle is valid except in cases of freedom of expression where there is a general, but rebuttable, presumption that all restraints are unwarranted. The individual freedoms are protected by testing the specific governmental actions against the overriding principles of the federal or state constitutions.

In two decisions in 1965, the courts enunciated general principles defining the extent of the governmental police power in regulating health when individual rights are affected. The principles derived from these two decisions present norms which can be utilized in considering the extent and limitations of governmental powers in other health-related situations.

Right of Privacy

In Griswold v. Connecticut, 381 U.S. 479 (1965), the United States Supreme Court issued a landmark decision on protection of the right of privacy from governmental intrusion. In this case the court held that physicians and voluntary agencies, such as the Planned Parenthood League of Connecticut, have standing to assert the constitutional rights of married people. It held that the Connecticut statute forbidding use of contraceptives violates the right of marital privacy which is within the penumbra of the specific guarantees of the Bill of Rights.

The statutes questioned were Sections 53-32 and 54-196 of the Connecticut General Statutes. They were invalidated because legitimate state exercise of the police power to prevent adultery, fornication, promiscuity, or disease may not be achieved by means which are unnecessarily broad and which invade the area of protected freedoms. The protected freedoms need not be spelled out specifically in the Bill of Rights but may be derived from the penumbra of the guarantees.

In a concurring opinion holding the statutes unconstitutional, three Justices concluded that the Connecticut statute in question violated the Ninth Amendment to the federal constitution. Personal rights should not be denied protection or disparaged in any way simply because they are not specifically listed in the first eight constitutional amendments (the Bill of Rights). The Ninth Amendment, the concurring opinion stated, lends strong support to the view that the "liberty" protected by the Fifth and Fourteenth Amendments is not restricted to rights specifically mentioned in the first eight amendments.

The court found that the law was unconstitutional because governnmental regulation restricting intimate personal situations and fundamental personal rights must be precise. If the legitimate policy goals of promoting health, safety, and welfare can be achieved by alternative means involving less or no interference with personal freedoms, then a more restrictive regulation will not be upheld. The court brought the right of privacy within the scope of constitutional protection and gave it the status of a fundamental personal right. Its holding will cover and is applicable to all federal and state health, safety, and welfare legislation and regulations restraining personal freedoms other than freedom of expression. It articulates a test for the validity of those regulations affecting purely personal and intimate activities which in themselves present no immediate danger to life or limb. Consequently, the overriding principles of the Griswold case must be heeded by all charged with both the substantive and procedural aspects of public health administration.

Power of Inspection versus Right of Privacy

In Camara v. San Francisco, 277 A.C.A. 136 (1965), the California District Court of Appeals held a city ordinance, civil in nature, authorizing an inspector of the municipal department of health to enter, at reasonable times on presentation of proper credentials, any building, structure, or premises in the city, was not a violation of the Fourth or Fourteenth Amendments of the United States Constitution. The court reasoned that the ordinance in question was part of a general regulatory scheme which was civil in nature, limited in scope, and could not be exercised except under reasonable conditions.

The plaintiff refused to permit a housing inspector to inspect his residence as part of a routine housing inspection. The inspection was pursuant to a provision of the San Francisco Housing Code, which was designed to assure minimum standards for the protection of life, limb, health, and safety of the general public and the owners and occupants of residential buildings erected or to be erected in San Francisco. No evidence of probable existence of a violation of the Housing Code provision was required; the inspections were designed to discover defects which, if found, could cause the owner to be directed to remedy them, with right of appeal of such directive to the Housing Appeals Board.

The court concluded that the constitutional guarantees of the right of privacy were not absolute in the case of civil inspections, citing Frank v. Maryland, 359 U.S. 360 (1958). It then set forth the conditions under which the right of privacy can be restrained under circumstances in which the regulation is designed to protect life or limb from a potential immediate physical danger, e.g., fire or epidemic disease.

If the inspection is for civil and not criminal purposes—to correct a violation rather than to prosecute for violation, if the inspection is reasonable, is part of a general regulatory program to protect human life, limb, and safety, occurs at reasonable times, is part of the general environmental health program in the megalopolis, and is not too broad, then an inspection without the necessity of showing probable existence of a violation is permissible. This kind of infringement of the right of privacy can be justified by the public interest in a safe environment. Health officers should heed the decision of the District Court of Appeals and the results of the subsequent appeals of this case because the issues raised will be of ever-increasing importance in maintaining adequate public health conditions in the megalopolis.

Clearly the courts are concerned with protecting the right of privacy in our age of technological advance, social interdependence, and urban living. They have given the right of privacy, which is not clearly spelled out in state or federal constitutions, the status of a constitutional guarantee. In those areas of exercise of the police power where the chance of immediate tangible harm is present, such as in premises which might present fire or communicable disease hazards, the right of privacy most probably will be accorded only that constitutional protection that is given to property or economic rights. In intimate or personal activities not at all likely to cause immediate danger to life or limb, the right of privacy will approach the more protected constitutional position of freedom of expression.

Summary

Each federal health statute enacted has significant potential for improving the health of the nation. Taken as a whole, the number of health programs established and the volume of dollar aid provided are epochal accomplishments. The deep and long-term significance of the 1965 federal health legislation, however, lies in the changing role of government in the direction of widening the responsibility of the public sector (as exemplified by the Medicare amendments) and in developing new patterns of medical service and continuing education (as exemplified by the Regional Medical Programs). The introduction of systems engineering and operations analysis into the total governmental health endeavor will permit the development of sound priorities, effective controls, and improved administration. Comprehensive legislation covering every facet of resources and services makes 1965 the turning-point in health legislation.

The federal legislation of 1965 has necessarily entailed state legislation to take advantage of federal support. In addition, new state laws have authorized new programs and modernized old statutes. Most significant is a pioneering statute establishing the authority for public regulation of medical facilities to assure optimal facilities at optimal places and time in response to public need.

In our age of big government, social interdependence, and the megalopolis, the courts have reaffirmed and clarified the importance of the individual and his privacy and have acted to give constitutional status to the protection of the right of privacy against governmental invasion. Both the judicial and the legislative actions to protect the public health are, fundamentally, a protection of the individual—of all individuals and of their right to the most healthful life that modern science makes possible.

ADDENDUM

Since the completion of this article, the following bills discussed in the text were passed by the 89th Congress and signed into law by the President:

1. PL89-749—(Senate 3008) The Extended Comprehensive Health Planning and Public Health Services Amendments of 1966
2. PL89-751—The Allied Health Professions Personnel Training Act of 1966
3. PL89-754—The Demonstration Cities and Metropolitan Development Act of 1966
4. PL89-563—The Traffic Safety Act of 1966.

REFERENCES

1. See generally, 1965: Year of Legislative Achievements in Health, Education, and Welfare. HEW Indicators Reprint April 1965-February 1966.
2. P.L. 89-239.
3. P.L. 89-105.
4. P.L. 89-272.
5. P.L. 89-109.
6. P.L. 89-290.
7. P.L. 89-97.
8. See also, Hearings on S-3008, Subcommittee on Health, Committee on Labor and Public Welfare, U. S. Senate, 89th Congress, 2nd session, 1966, p. 40. Testimony of Wilbur J. Cohen, Undersecretary, Department of Health, Education, and Welfare.
9. See Tentative Program Guidelines for Planning Grants. US Public Health Service (Mar. 23), 1966.
10. S. 3142 (1966).
11. S. 2842 (1966).
12. See A.B. 5, the California Medical Assistance Pro-

gram (1965), Chapter 7, Section 14,000 *et seq.*, Part 3 of provision 9 of the California Welfare and Institution code as amended.
13. New York City Health Code (1965).
14. An Act Concerning the Fluoridation of Public Water Supplies, Public Act No. 156. Special Session, Conn. General Assembly (Feb.), 1965.
15. New York Mental Hygiene Law, Article 5, Sections 70 ff. (Supp. 1965).
16. But see, Somers, Anne R. The Continuing Cost Crisis. Hospitals 40,12:44 (June), 1966, for a discussion of the New Jersey system utilizing voluntary rather than statutory "franchising" to seek to accomplish the same ends as New York State.
17. Falcone v. Middlesex County Medical Society, 24 N.J. 582, 170 A.2d, 791 (1961).
18. Greisman v. Newcomb Hospital, 40 N.J. 389, 192 A.2d, 817 (1963).

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Fellowship in the APHA

The attention of members of APHA is drawn to Association News in the February, 1967, issue of the Journal. This sets forth the eligibility requirements for Fellowship in the APHA, explains the procedure for applying (bank forms are available from the headquarters office), and describes the privileges conferred by Fellowship.

Members are encouraged to take the initiative in applying for Fellowship. Members so interested, and Fellows wishing to stimulate others to apply, are reminded that completed applications to be considered this year must be filed with the Membership Department, APHA, 1740 Broadway, New York, N. Y. 10019, no later than July 15.