

## **Advancing Public Health Practice and Policy Solutions**

### **Building the Base for a Research Agenda On Local Public Health Legal Authority**

#### **Phase IV: Survey Synopsis: Developing and Enacting Municipal Public Health Ordinances.**

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**DISCLAIMER:** The purpose of the document is to describe regulatory authorities, priorities, concessions, and planning tools that municipalities use in promulgating public health ordinances. Due to the small number responses to the survey, only broad commonalities could be extrapolated. Municipalities might use some of these techniques as a starting point, but must consider the circumstances and specific needs of the town and its residents. Each ordinance should be tailored accordingly and in consultation with a public health attorney. The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the funding agency. The report has been reviewed by a panel of advisors to the project, but has not had a blind peer review.

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## Overview

As a part of a larger study of the scope, contents and range of local public health law, this phase explored how these laws are promulgated at the local level. The results of this phase of the research project will contribute to the public health system by providing a better understanding of the origins and variety of the law to build a foundation for future efforts to improve the quality of local public health law.

In order to examine how public health ordinances are devised, a national electronic survey of local public health authorities was conducted to examine regulatory authorities, priorities, concessions, and planning tools. Surveys were sent out to representatives of fifty-two local public health authorities in thirty-six municipalities via e-mail. The local public health authorities surveyed represented jurisdictions with populations ranging from 50,000 to 9.5 million in the United States and were selected to represent a range of organizational structures and geographic regions.

The e-mail solicited participation and provided an on-line survey link. Contacts and E-mail addresses were obtained through the National Association of County and City Health Officials (“NACCHO”).

The findings reveal the multitude of overlapping regulatory public health authorities that can exist within a single jurisdiction. While on the one hand regulatory powers provide input and regulations to promote public health efforts, a multitude of those powers conversely creates obstacles for public health efforts within a single jurisdiction. Additional findings point to a wide range of priorities among municipal public health entities when considering legislation action. Further results indicate public health authorities rely on a variety of sources, e.g., state, federal, local, and others, when seeking information and guidance to promulgate ordinances.

Public health ordinances are enacted and influenced by a number of variables beyond public health science, including: funding, regulatory authorities local priorities, and opposition to impending legislation.

## **Introduction**

The authority of a local government to enact ordinances is derived from the locality's state constitution, statutes, or through the legislative grant of a municipal charter. These ordinances deal with a vast array of topics that maintain public safety, health, and general welfare. The subject matter of any ordinance dictates the governing regulatory authority that will apply. Within the realm of public health topics, possible regulatory authority includes: local boards of health, local departments of health, health officers, city and county councils and special authorities (e.g., water districts).

Previously we have described the range of topics covered by local ordinance in 36 local areas. This paper examines factors that influence municipal authorities when enacting public health ordinances. These factors were identified through a national survey of the jurisdictions included in a prior study. In this article, the term "jurisdictions," "municipalities" and "localities" collectively refer to counties, cities, towns, and villages.

## **Methods**

The research team sent the survey to fifty-two local public health authorities in thirty-six municipalities. The contacts were obtained through the National Association of County and City Health Officials ("NACCHO") and were selected to obtain a geographically diverse sampling with populations ranging from roughly 50,000 to 9.5 million throughout the United States. The survey was distributed to the public health authorities via e-mail. The e-mail contained an introductory letter informing participants of the value of responding, the purpose of the survey, confidentiality protections, and a link to the survey. In addition, we encouraged personnel with knowledge of the regulatory process to complete the survey and collaborate with other staff as appropriate.

The survey questions focused on the decisive factors that influence public health ordinances. A web-based survey consisting of sixteen questions was developed as a collaborative effort between the *Center for Law and the Public's Health; A Collaborative at Johns Hopkins and Georgetown Universities*, Hunter College School of Nursing, NACCHO, National Association of Local Boards of Health, the Center for Public Health Practice at the University of Pittsburgh, and the Public Health Law and Policy Program at Arizona State University.

Public health authorities representing thirty-six percent (n=13) of the 36 jurisdictions responded to the survey. To determine if population size correlated with how the municipalities enacted ordinances, jurisdictions were identified as one of three categories: (1) small = seven municipalities with populations  $\leq 500,000$ ; (2) medium = three municipalities with populations between 500,001 and 999,999; and (3) large = three municipalities with populations  $\geq 1,000,000$ . In some instances, a non-response to a specific question occurred, thus varying response rates within the survey questions. The small number of initial requests and even smaller response number make statistical analysis difficult, so results are presented numerically. Interpretation is clearly limited by the small sample size, but is suggestive and points in the direction of useful further studies.

## **FINDINGS**

### **Regulatory Powers in Jurisdictions**

The majority of jurisdictions responding had multiple entities with regulatory powers to enact public health laws. Jurisdictions reporting only one regulatory authority all identified the State Health Department. Among the population categories, all large municipalities listed Health Officers, Local Health Departments, and City/County Councils; all medium municipalities listed Local Boards of Health and Health Officers; and half of the small municipalities cited Local Boards of Health, Local Health Departments, and City/County Councils as having regulatory authority in their jurisdiction. Mayors were four times more likely to have regulatory powers in large municipalities than in medium and small municipalities.

A commonality among municipalities with numerous regulatory authorities was the type of information considered when enacting an ordinance. Information sought by municipalities when determining whether to enact an ordinance included scientific data, public input, state health departments, and existing ordinances in other jurisdictions. Two federal agencies were specifically recognized for influential information: the U.S. Centers for Disease Control and Prevention (“CDC”) and the U.S. Environmental Protection Agency (“EPA”). Although small municipalities considered the same type of information as other population categories, all of the small municipalities consulted their own state health departments for information.

### **Obstacles, Education, and Concessions**

When a single jurisdiction had numerous agencies with regulatory powers, it also reported obstacles in enacting ordinances due to this arrangement. Multiple regulatory powers created obstacles of coordination among agencies when the subject matter involved several authorities.

Additional recurring obstacles encountered by authorities when enacting ordinances were: 1) stakeholder individuals and national advocacy groups opposing regulations, 2) interference from other government agencies, 3) lack of funding, 4) strong industry influence, or 5) lack of public support. Jurisdictions in all size categories experienced stakeholders opposed to regulations.

To overcome the opposition by individuals and groups to a specific public health ordinance and to educate the public, authorities utilized a host of media tools, including websites, public meetings, televised meetings, and press releases. The most frequent media tools used by all of the large municipalities were websites and public meetings. Between the medium and small population categories, public meetings also ranked the highest with a majority of medium municipalities, and half of the small municipalities relying on this discourse to inform their communities of the benefits of an impending ordinance. Specific ordinance topics that have been advanced by employing the above outreach practices ranged from noise pollution containment on highway construction sites, animals on patios at food establishments, and medical marijuana laws.

In addition to utilizing media tools on their own, jurisdictions collaborated with the media to advance health priorities. The media provided additional opportunities for authorities to educate the public and policy makers who influence public health priorities, as well as to provide specific public health information. An example of providing the public with specific information can be

found with the recent H1N1 vaccination campaigns, which provided necessity, dates, hours, and location of vaccinations via various media outlets.

In addition to using the media to advance ordinances, jurisdictions have used concessions to pass ordinances. Among all three population categories, the most frequent concessions included: 1) opt-out clauses, 2) grandfather clauses, 3) extended dates of compliance, and 4) compromising on a less comprehensive ordinance. A recent clean indoor air ordinance enacted by one municipality, for example, was less comprehensive than desired and also included a grandfather clause.

### **Public Health Priorities**

When setting public health priorities, municipal authorities employ multiple Federal and State planning tools. The most frequent tools used among all three population categories were Healthy People 2010 and State Public Health Plans, with 8 jurisdictions using these publications to set health priorities. Other tools utilized were: 1) NACCHO's and CDC's Mobilizing for Action through Planning and Partnership ("MAPP"); and 2) CDC's Planned Approach to Community Health ("PATCH"). In addition to state planning tools, municipalities consider public input and community evaluation impact studies. Among all three-population categories, 10 jurisdictions consider public input and 8 utilize community impact evaluations.

Jurisdictions reported a number of factors that influenced their selection of health priorities. Eight municipalities indicated that funding was the single most determining factor, followed by local concerns and community assessment.

Respondents were asked to list the top three public health priorities within their jurisdiction. The topic of chronic disease prevention was the most frequently identified. Topics closely following were communicable disease control, disaster preparedness, environmental health concerns, and food safety.

Municipal authorities perceived the most prevalent threat to their constituents' public health was communicable disease and food safety, with three-quarters of all municipalities ranking these two categories as a significant threat. The next frequent categories were: 1) Animals, 2) Housing, and 3) Nuisances. One of the major differences among the population categories was air quality, with 2 of the large municipalities reporting that air quality was a significant threat, followed by 1 of the medium municipalities and no small municipalities.

### **Recently enacted health ordinances**

The most commonly regulated topic recently enacted among all the municipalities was food, followed by animals. The subject matter within the food category was diverse and included fees, permits, menu labeling, and trans fat elimination. The diversity of food ordinances corroborated the researchers' findings in the initial phase of this study that identified the complexity of the food category with a vast array of subject matter ordinances. Subsequent topics that had been newly enacted were sanitation (motels and schools) ordinances, along with air (indoor and outdoor) quality.

## Discussion

This study examined influences that contribute to the promulgation of local public health ordinances. A major goal of the study was to explore the relationship between local public health laws and state and federal laws to determine whether smaller governments promulgated ordinances primarily to address local concerns or if smaller governments adhere to state and federal health regulations.

Survey responses indicated that regulatory authorities set local health priorities using community evaluation impact and input. In assessing criteria for developing local legislation, local governments look to regional (e.g., county boards), state (e.g., department of health) and federal (e.g., CDC, EPA) agencies, as well as existing ordinances in other jurisdictions. Additional evidence of local focus emerged when authorities answered specific questions on their jurisdictions' priority health issues and most recently enacted ordinances. Among all three categories, the top three priorities were preventing chronic diseases, curbing tobacco use, and reducing obesity. Recently enacted ordinances included trans fat elimination, menu labeling, smoking bans, and mandatory dissemination of information about the risks and benefits of dental amalgams. The newly enacted ordinances reflect the municipalities' priority of reducing chronic disease within its population.

Although local public health regulatory authorities seek guidance and information outside of their own jurisdictions, the external exploration is based on local priorities and, thus, a response to their own constituents' public health needs. This finding is contingent on the extent of the power that a state bestows upon a municipal authority to act in certain areas, commonly defined as home rule.

The findings in the first phase of this project revealed a vast array of public health topics varying in scope and depth among municipal codes. The same revelation was found in the second part of this project, i.e., authorities listed a complex array of public health topics within recently enacted ordinances. Extrapolating that the breadth and depth of local ordinances is not a random result, but rather responsive of local authorities to address local concerns by enacting public health ordinances.

Reduction in chronic disease was a priority among respondents, who employed scientific data and expert advice to develop legislation to lower the incidence rates in their communities. Similarly, municipalities outside the scope of our study anecdotally utilize the same techniques. For example, the City Council of Philadelphia augmented the traditional requirement to list calorie and fat percentages on restaurant menu items in an effort to reduce diabetes, heart disease, and obesity. After reviewing data on prevalence of chronic disease in Philadelphia residents and the impact of diet on this condition,<sup>i</sup> the city council passed an ordinance that requires chain restaurants to provide additional food and beverage nutrition information on menu items. The additional menu labeling requirements include grams of saturated fat, trans fat, carbohydrates, and milligrams of salt in each item sold.<sup>ii</sup>

A further example of public health officials' responsiveness to the use of data to reduce chronic disease in their communities can be found in Los Angeles County.<sup>iii</sup> The Los Angeles City Council passed a one-year moratorium prohibiting construction of new fast-food restaurants in a

32-square-mile area inhabited by low-income residents. The decision of the one-year ban was in part based on a 2008 report issued by the Los Angeles County Department of Public Health that found children in South L.A. were more likely to be obese, compared with children in other areas of the city.<sup>iv, v</sup>

Another goal of the study was to understand the partnership within the public health systems of various municipalities that are key in the decision making process to develop and promulgate public health ordinances. Findings suggest that a multitude of entities (e.g. Health Officers, Local Health Departments, City Council, and Mayors) have regulatory authority to enact public health ordinances in a single jurisdiction. Accordingly, this creates collaborative partnerships efforts in advancing public health initiatives; yet conversely creates collaboration obstacles when drafting specific ordinances to encompass the stipulations demanded by stakeholders' agencies.

The City of San Francisco provides an example of multiple agencies collaborating in reducing chronic disease in its population. The San Francisco Health Department ("SFDPH") states that a variety of health problems are associated with noise pollution including: heart disease, high blood pressures, and depression.<sup>vi</sup> The SFDPH took steps in 2007 to develop a digital local traffic model that identifies noise levels that exceed 60 Ldn on city streets.<sup>vii</sup> In areas that exceed this noise level, the requirement is that new construction on multifamily housing must be acoustically insulated.<sup>viii</sup> The enforcement responsibilities for the new ordinance require the SFDPH to coordinate, monitor and clarify requirements for the public.<sup>ix</sup> SFDPH must respond to all City agencies that regulate noise and deliver period recommendations to the Planning Committee regarding land use planning.<sup>x</sup>

## **Conclusion**

The goal of public health is to reduce disease, disability, and death, and to maintain the good health of the population.<sup>xi</sup> In some instances, the goal is to prevent disease from developing. Examples of these goals can be found in municipal health ordinances throughout the United States. Understanding and examining how local ordinances are enacted will help prevent and reduce disease throughout the country. The results of this project reveal that local public health authorities realize they are able to address community health status through enacting ordinances, which, in turn, affects the health of the nation as a whole.

## Introductory email

Dear XX:

With support from the Robert Wood Johnson Foundation and in collaboration with the National Association of County and City Health Officials (NACCHO) we are studying the range and nature of local public health laws and regulations. Within the scope of local public health laws we include any laws that support the protection of the population from conditions that lead to illness or injury, such as regulation of food services or water, safe disposal of waste or sewage, control of communicable or chronic diseases, or promotion of healthy habits. Our objective is to assess the breadth and scope of local public health laws nationally by focusing on select localities across the country. [Name of city or county will be inserted] has been included in this study.

**The National Association of County and City Health Officials (NACCHO) is pleased to support this Local Public Health Law Survey from Hunter College School of Nursing supported by Robert Wood Johnson Foundation. As local ordinances often fill gaps in federal or state public health laws by addressing critical public health concerns otherwise not regulated, this survey will provide important information to facilitate an understanding of relationships between local and state public health laws.**

In our current phase of the project, we are administering an electronic survey of the public health officials in the selected jurisdictions, and would very much like your assistance. Please see below a web link to the electronic survey, which includes additional explanatory information as well as the brief questionnaire. Please take the time to follow this link and consider participating. We estimate it may take no more than 15-20 minutes to complete the questionnaire online, and *your responses shall be kept confidential*. **Being respectful of your busy schedule, we would like to have your response by [specific date to be determined]**. Thank you in advance for your consideration and responses.

Sincerely,  
Kristine Gebbie, DrPH, RN, and Kathy McCarty, JD, MPH

## Introductory Screen

Dear Local Public Health Official:

With support from the Robert Wood Johnson Foundation and in collaboration with the National Association of County and City Health Officials (NACCHO), we are studying the range and nature of local public health laws and regulations in a sample of jurisdictions across the country. We are studying the role of law in local public health systems by documenting the scope, breadth, and content of local public health ordinances in key program areas. Within the scope of local public health laws we include any laws that support the protection of the population from conditions that lead to illness or injury, such as regulation of food services or water, safe disposal of waste or sewage, control of communicable or chronic diseases, or promotion of healthy habits. Through an analysis of these ordinances, we seek to develop a blueprint for drafting local health ordinances and propose an agenda for future research on local public health law.

We would like to complement the specific language of public health ordinances, which we have obtained from legal data bases, with additional, more detailed information about the adoption and use of these laws through this brief online survey. **You are being asked to participate in an online survey because your jurisdiction has been included in this study. The survey should take only 15-20 minutes. The study should post minimum risk to participant, and there is no direct benefit.** At the end of the survey, you have the option of providing contact information, which we would use only if we wanted to clarify any of your responses. *Your survey responses shall be kept confidential.* Reports or publications based on this survey will not identify you individually, though non-identifiable responses from your jurisdiction will be identified. None of the questions are personal. **You can choose to not answer any particular question if you like, and you may discontinue participation at any time without penalty or loss of benefits or services to which you are entitled.** .

**We are making every effort to ensure that no one knows what your responses were on the survey. Survey Monkey is a well known company that collects data for online survey research. We have purchased an encrypted version of their product to reduce the risk to subjects that their responses will be viewed by unauthorized persons. However, the study is not being run from a secure http server such as those used to handle credit card transactions, so there is a small possibility that responses could be viewed by unauthorized third parties, such as computer hackers.**

Your click to the next screen constitutes your informed consent to participate. If you have any questions **about the study**, you may contact any one of us. Thank you for your help with this project.

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## Survey Questions

1. Name of Jurisdiction:
2. Which local entities/bodies have regulatory powers regarding public health issues in your jurisdiction? (mark all that apply)
  - a. Local Health Department Y/N
  - b. Local Board of Health Y/N
  - c. City Council Y/N
  - d. County Commission Y/N
  - e. Health Officer Y/N
  - f. Mayor Y/N
  - g. County Executive Y/N
  - h. Other (Please List) \_\_\_\_\_
3. When did your jurisdiction last revise its' Public Health Code either through the reform of the entire Code or insertion of major new provisions? (Year or I don't know)
4. What public health topics were addressed in 5 recent health ordinances enacted in your jurisdiction?
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
  5. \_\_\_\_\_
5. When enacting a health ordinance for your jurisdiction, what type of information do the enacting body consider: (Mark all that apply)
  - a. Scientific Data Y/N
  - b. Expert Advice Y/N
  - c. Public Input Y/N
  - d. Evaluation Impact Y/N
  - e. Existing ordinances in other jurisdictions Y/N
  - f. Model ordinances or laws Y/N
  - g. Other government agencies recommendations Y/NIf so, please identify which ones:
  1. City Council Y/N
  2. State Health Department Y/N
  3. Other local governments Y/N
    - i. Within the state Y/N
    - ii. Outside of the state Y/N
  4. Specific other government agencies that were relied on for input:
6. The following 4 questions are focused on priorities of services and type of influences in enacting ordinances.

a. Please indicate 3 priority public health issues addressed by your jurisdiction? (e.g. reduction of chronic disease, improving health status, curbing tobacco use, environmental health concerns):

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

b. What approaches is your jurisdiction likely to use to achieve these priorities? (mark all that apply)

1. monitoring,
2. education,
3. assessment,
4. laws and regulations,
5. public health services
6. Other: \_\_\_\_\_

c. Please indicate **the** importance for responding to threats to the public health in your jurisdiction in the following topics by assigning the appropriate number from the scale to each: (1=very important, 2=somewhat important, 3= a little important, 4 = not important).

1. \_\_\_\_\_ Air Quality (e.g., offensive fumes emissions, regulating vehicles)
2. \_\_\_\_\_ Animals (e.g., disease transmission from animals, licensing, shelters)
3. \_\_\_\_\_ Communicable Diseases (e.g., reporting requirements, testing and screening, quarantine and isolation)
4. \_\_\_\_\_ EMS & Ambulances (e.g., regulating licensing, records of service)
5. \_\_\_\_\_ Housing (e.g., lead paint, steel guards on windows)
6. \_\_\_\_\_ Food (e.g., contamination, mobile services, inspections)
7. \_\_\_\_\_ Noise (e.g., regulating excessive noise, hours of noise)
8. \_\_\_\_\_ Nuisances (e.g., conditions that interfere with health or safety)
9. \_\_\_\_\_ Sewer Systems (e.g., installation, toxic pollutants)
10. \_\_\_\_\_ Smoking (e.g., regulating smoking and non-smoking areas)
11. \_\_\_\_\_ Tobacco (e.g., taxes, sales, licensing)
12. \_\_\_\_\_ Other (please identify)

From the list above please identify the three most important threats to public health in your jurisdiction:

- a. Most important \_\_\_\_\_
- b. Next most important \_\_\_\_\_
- c. Third most important \_\_\_\_\_

7. What planning tools, if any, **are used** to set your jurisdiction's health priorities? (mark all that apply)

- a. Healthy People 2010
- b. Community Health PATCH/CDC
- c. State public health plans, programs, or guidance
- d. Inter-county public health plans
- e. Other: \_\_\_\_\_

8. What factors influence the determination of health priorities in your jurisdiction? (e.g. new developments in research, other government agencies agendas, advocacy groups, funding allocations)
9. How does the media coverage of health issues affect your agency's health priorities? (e.g. coverage concerning the H1N1 virus) (Please list examples)?
10. If the subject of a new health ordinance is controversial in the community, what steps, if any, **does your jurisdiction** utilize to provide information to the public (e.g. town halls, fact sheets, media, and government officials)?
11. If your agency has attempted to amend or revise its public health laws in the past 2 years and was unsuccessful, what were some of the major obstacles? (Indicate all that apply)
  - a. National advocacy groups opposing regulatory changes.
  - b. State or local advocacy groups opposing regulatory changes
  - c. Key individuals opposing regulations
  - d. Other government agencies interference
  - e. Difficulty coordinating with other agencies
  - f. Conflict in goals and objectives among various actors
  - g. Conflict with federal, state, or local laws
  - h. Limited scientific evidence
  - i. Lack of funding
  - j. Lack of public support
  - k. Other \_\_\_\_\_ (please explain)
12. What concessions has your jurisdiction made to help pass local public health regulations? (indicate all that apply)
  - a. Opt-out clauses
  - b. Extending dates of compliance
  - c. Grandfather clauses
  - d. Liability protections
  - e. Funding exclusions/limitations
  - f. Agreements to collaborate with other jurisdictions
  - g. Adherence to national, state, or regional standards
  - h. Other \_\_\_\_\_ (please indicate)
13. What other information would help us better understand how local public health laws are prioritized, created, passed, or reformed in your jurisdiction?

Thank you for your assistance in this project. If you are willing, please provide your contact information below [*remember your identifiable information will be kept confidential*]:

- 
- <sup>i</sup> Don Sapatkin, What's on the menu? Food Facts. Philadelphia Inquirer, Jan. 31, 2010, available at: [http://www.philly.com/inquirer/health\\_science/daily/20100131\\_What\\_s\\_on\\_the\\_menu\\_Food\\_facts.html](http://www.philly.com/inquirer/health_science/daily/20100131_What_s_on_the_menu_Food_facts.html)
- <sup>ii</sup> Philadelphia, PA., Code. Title 6, Chapter 6-300, § 6.308 [cited 2010 March 1]. Available at: [http://www.amlegal.com/nxt/gateway.dll/Pennsylvania/philadelphia\\_pa/thephiladelphiacode?f=templates\\$fn=default.htm\\$3.0\\$vid=amlegal:philadelphia\\_pahttp://www.amlegal.com/nxt/gateway.dll/Pennsylvania/philadelphia\\_pa/thephiladelphiacode?f=templates\\$fn=default.htm\\$3.0\\$vid=amlegal:philadelphia\\_pa](http://www.amlegal.com/nxt/gateway.dll/Pennsylvania/philadelphia_pa/thephiladelphiacode?f=templates$fn=default.htm$3.0$vid=amlegal:philadelphia_pahttp://www.amlegal.com/nxt/gateway.dll/Pennsylvania/philadelphia_pa/thephiladelphiacode?f=templates$fn=default.htm$3.0$vid=amlegal:philadelphia_pa)
- <sup>iii</sup> Los Angeles City Clerk, Ordinance no. 180103, effective date: September 14, 2008. <http://cityclerk.lacity.org/lacityclerkconnect/index.cfm?fa=ccfi.viewrecord&cfnumber=07-1658&CFID=16489755&CFTOKEN=686e197f7dd7dcbd-19D7CFAD-0EA9-EA77-56761128488172BA&jsessionid=f030382ec33aad55db794a3c841465e23462>
- <sup>iv</sup> Los Angeles County Health Survey 2007, *Childhood Obesity: Tipping the Balance Toward Healthy, Active Children*, Issue date 07/01/2008. Available at: <http://publichealth.lacounty.gov/phcommon/public/reports/rptsbygroup.cfm?ou=ph&prog=hae&unit=ha&categoryid=125>
- <sup>v</sup> Molly Hennessy-Fiske and David Zahniser, *Council bans fast-food outlets*, LA Times, July 30, 2008, <http://articles.latimes.com/2008/jul/30/local/me-fastfood30>
- <sup>vi</sup> San Francisco, Cal., Code Article 29, § 2912. [cited 2010 March 1] Available at: <http://www.municode.com/content/4201/14140/HTML/ch029.html>
- <sup>vii</sup> Id.
- <sup>viii</sup> Id.
- <sup>ix</sup> San Francisco, Cal., Code, Article 29, § 2912. [cited 2010 March 1] Available at: <http://www.municode.com/content/4201/14140/HTML/ch029.html>
- <sup>x</sup> San Francisco, Cal., Police Code, Article 29; Article 1, § 49. 2008 <http://library.municode.com/index.aspx?clientId=14140&stateId=5&stateName=California>
- <sup>xi</sup> Rothstein MA., *Public Health Law, Society, and Ethics: Rethinking the Meaning of Public Health.*, , 30 J.L. Med. & Ethics 144 (Summer 2002)