abstract

The rising epidemic of childhood and adolescent obesity is placing a heretofore unprecedented physical and fiscal burden on individuals and communities. Federal and state government officials who seek to determine the scope of the problem are using a spectrum of tools that include reporting, screening, and surveillance initiatives. The extent of authority to use these public health tools is yet to be determined, especially in the area of data use, privacy, and liability as government officials balance the need to improve public health with individual freedom and autonomy. *Pediatrics* 2009;124:S83–S88
Acute public health threats of the 20th century, such as communicable diseases and poor sanitation, have been addressed and, in large measure, brought under control. These significant improvements in the public’s health have arisen through the simultaneous documentation of impairments in public health, development of appropriate evidence-based tools, and use of legally authorized public health interventions. Examples include substantively reducing tropical disease vectors in the United States through publicly financed pest eradication and addressing communicable childhood diseases through public school-entry immunization mandates. Under the authority of law supporting public health policy makers, a matrix of public health threat targeted interventions were developed and successfully implemented; as a result, the acute public health threats of the last century have been addressed and, in large measure, brought under control.

In contrast, present-day public health threats are largely nonacute and related to chronic diseases and modifiable behaviors, and at least 1 of these, obesity, is regarded by most researchers and opinion leaders as being unprecedented in its potential negative impact on the physical health and fiscal well-being of adults and children in the United States. To better understand the scope of the obesity issue and create and evaluate evidence-based interventions, academics, policy makers, and government leaders are increasingly turning to BMI-assessment initiatives.

The authors of the other articles in this supplement to Pediatrics present a thorough overview of the scientific evidence regarding development and implementation of BMI-reporting, -screening, and -surveillance programs. Although ongoing and targeted evaluations of these programs remain essential, in the aggregate, these authors provide a compelling case that such programs have merit in the effort to understand and address the issue of child and adolescent obesity.

Despite the growing body of scientific evidence in support of BMI programs, questions have arisen regarding the extent of governmental authority to mandate such programs and the issues that surround their implementation and operation. In this article I discuss the legal authority of the state to implement these types of programs generally and, more specifically, to undertake school-based BMI-assessment and -reporting programs. Next is a brief review of issues related to BMI-surveillance, -screening, and -reporting programs, focusing on data confidentiality, consent to screen and release data, and application of competing statutes (eg, Health Insurance Privacy and Accountability Act [HIPAA] and Family Educational Rights and Privacy Act [FERPA]). Finally, the article is concluded with a discussion of likely next steps related to BMI screening as policy makers continue to struggle with arriving at an acceptable balance between improving public health and maintaining respect for individual confidentiality and autonomy.

DISCUSSION

Background

At the individual level, obesity and overweight result from a seemingly simple equation: calorie intake exceeds calorie expenditure. Yet, when considered from a population-based perspective, the causes of this chronic condition are multifactorial and not readily ameliorable. However, obesity research has indicated that there are key leverage points at which interventions can be more optimally applied. Because overweight children have a higher probability of becoming obese adults with increased adult morbidity (when compared with their normal-weight peers), many recommendations have focused on prevention of child and adolescent overweight.

Incorporating concepts from these and other recommendations, several municipalities and states have begun development of age-targeted interventions. One state, Arkansas, passed legislation in 2003 that mandated a multipronged, statewide child and adolescent obesity and nutrition initiative, with a focus on increasing parental awareness and school- and community-based interventions. Key requirements of the act included establishment of state- and community-level child health advisory committees; limiting access to vending machines and nonnutritive foods; mandated disclosure of competitive food contracts between schools and food and beverage vendors; and annual assessment of BMI for age of all kindergarten through 12th-grade public school students (with results, explanation of health effects of overweight, and resources available reported confidentially to parents). Analytic results reported by the Arkansas Center for Health Improvement have indicated that Arkansas has halted the upward progression of child and adolescent obesity since implementation of Act 1220 of 2003.

Legal Authority to Survey, Screen, and Report Children’s BMI

In the US federalist system of government, the power to undertake public health interventions primarily resides not with the federal government but with the states (and, by delegation, to intrastate entities such as communities and schools). These state- and substate-level actions are supported through exercise of either police power (legal authority to act in areas of health, welfare, safety, and morals)
or *parens patriae* power (authority to act to safeguard minors and those who are not able to care for themselves). These twin powers reside with the states as plenary entities (authority to act), who are not able to care for themselves. These twin powers reside with the states as plenary entities (authority to act), who are not able to care for themselves.

Both sources of authority are implicated when considering state mandates related to BMI activities (eg, police power authorizes state interventions that address the public health threat of obesity, and *parens patriae* power allows state actions that maintain a safe school environment for students through the state’s *in loco parentis* role).

State governments have a long history of conducting public health programs that involve assessment and reporting, screening, and/or surveillance activities. There is general agreement that states’ actions in these areas are supported through application of their police power authority and that these programs are legally valid, especially if individuals consent to participate and allow their collected data to be analyzed (or if parental consent is obtained for minors).

However, the extent of the state’s authority regarding these programs is as yet untested and gives rise to numerous questions. For example, what is the state’s ability to mandate participation in these programs absent express or implied consent from participants and/or parents of participants? Can states require that students undertake BMI assessments as a public school-entry requirement? Does liability potentially attach to states when these programs are conducted improperly or, in the alternative, not conducted at all? Is there federal authority that supersedes state laws regarding confidentiality of BMI data collected in school settings and the parameters controlling how these data may be used? This last question is discussed first.

**BMI Data Confidentiality**

As noted above, state authority to implement BMI-assessment programs in schools (or other venues) and confidentially report this health-related information to parents who have consented to the process is readily supportable (eg, Arkansas Act 1220 of 2003, which states that BMI information collected in schools is to be “reported confidentially to parents.”). In a seemingly analogous manner, states have implemented other school-based health care delivery and screening programs with broad-based impact (among these are childhood immunization school-entry mandates and exemption reporting, scoliosis, vision and hearing screenings, BMI-for-age surveillance, school-based health clinics and other initiatives); there is evidence supporting the merit of these programs for both individual children and the community.

State laws that require that BMI-screening information collected in schools be reported to state entities for surveillance and analytic purposes may come into conflict with certain federal statutes. Federal laws primarily on point in this area include the HIPAA and subsequent standards for privacy of individually identifiable health information (“privacy rule”) and the FERPA and the ongoing regulations and guidance promulgated from each.

It is as yet unclear to what extent these type of programs can inform public health initiatives and interests. Laws that mandate nonconsented reporting of sensitive personal health information collected in health care settings may find authorization in the public health exemption of the HIPAA privacy rule. However, for data collected by school employees through school-based BMI programs (and other school-sited screening and surveillance programs), some hold that controlling authority is found in the federal FERPA statute, which at present does not have a similar exemption that allows for nonconsented release of personal health information for public health purposes. Questions posed to the US Department of Education (DOE) Family Policy Compliance Office have usually been answered in the negative regarding whether personal health information collected in schools can be released to comply with state reporting mandates.

At present, efforts are underway to resolve this dilemma. The Association of State and Territorial Health Officials and the Council of State and Territorial Epidemiologists recently issued position statements highlighting the importance of school health data for public health surveillance and calling for the DOE to either issue guidance allowing state departments of education to designate other state agencies as authorized representatives under the FERPA and receive personal health intervention (PHI) and/or requesting that Congress amend the FERPA to include a public health exception similar to the HIPAA allowing public health authorities access to student health information without consent.

In March 2008, the DOE issued a notice of proposed rule making for the FERPA intended to, in part, “clarify permissible disclosures to parents of eligible students and conditions that apply to disclosures in health and safety emergencies; clarify permissible disclosures of student identifiers as directory information; allow disclosures to contractors and other outside parties in connection with the outsourcing of institutional services and functions.”

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This document is a supplement to the *Pediatrics* journal and contains information on private health information collected in schools and the parameters controlling how these data may be used. The text discusses the legal frameworks governing these programs, including state and federal statutes such as HIPAA and FERPA, and explores the challenges of data confidentiality and reporting.
Resolving this issue is important. For policy makers considering adoption of BMI programs and those charged with implementation in the school, applicable but discrepant competing laws promote confusion and lessen the chance of widespread use of this important tool.

More broadly, although public health interventions such as BMI screening are traditionally and generally viewed as falling within state police power authority, the outcome of a specific legal challenge brought regarding the validity of state screening and surveillance laws that mandate reporting of student health data are by no means predetermined. Courts may hold that such programs represent impermissible exercises of state authority and that federal statutes on point should control through application of the Supremacy Clause of the US Constitution.* In the alternative, courts may hold that these programs are proper exercises of governmental power intended to advance public health goals and may even go as far to rule if asked that federal efforts to control this area are impermissible usurpations of police power reserved to the states through the 10th Amendment.

Mandatory Participation in Reporting, Screening, and Surveillance Programs

As discussed above, the legally authorized ability of states to implement consensual school-based BMI-assessment/parent reporting programs and the accompanying mandate that the collected information be handled in a safe and secure manner would seem to be well settled. It is less clear how far this state authority reaches.

For example, does state police power authority extend to the support of mandates that require BMI assessment as a condition of school attendance (analogous to school-entry childhood vaccination requirements)? If so, would such a mandate requiring participation in a nonmedical (or at least noninvasive) BMI-assessment program still have to incorporate an exemption clause (similar to the medical exemption judicially required for immunization mandates)?28

Liability

The boundaries of states’ liability related to BMI programs are also unclear. Potential claims may arise if BMI data are released in an unauthorized or improper manner, or if school personnel or volunteers in the assessment process improperly interact with students. Finally, it is clear that states have a discretionary authority to act in undertaking government actions to improve public health. However, do states have an implied affirmative duty to act to implement evidence-based interventions to improve public health (eg, BMI-screening programs), a failure to act in the presence of such duty then constituting “public health malpractice”?29–31

Officials will have to consider resolution of these and other issues as more states seek to address the burgeoning obesity epidemic through innovative and evidence-based solutions.

CONCLUSIONS

As has been shown, the government’s authority to intervene in pursuit of public health goals is well developed and readily supportable. As regards BMI, it can be assumed that a state program (school-based or otherwise) that mandates assessment of children’s BMIs and confidential reporting of that information directly to parents is safely within the ambit of state authority and, in the face of a judicial challenge, would be upheld as a supportable exercise of state police power. This type of program is likely especially valid if parental consent for the assessment is obtained.

Because of the school-based setting in which these programs are usually situated and the age status of the population, the authority to implement programs that are either screening and/or surveillance oriented in nature is not as clearly delineated. Of course, if parental consent for their children to participate and/or personal health information to be released is obtained, then the need for a discussion of authority becomes moot.

It is unclear and as yet judicially untested what the extent of this power is in situations in which either parental consent is not obtained and/or the program has a screening or surveillance goal. Questions also arise as to the outer limits of state police power in this area as discussed above related to participation mandates and the impact of federal data statutes such as the HIPAA and FERPA.

In the alternative, it can be argued that state laws that mandate BMI screening and/or surveillance programs to monitor the threat of obesity are appropriate executions of state police power through application of the 10th Amendment and that federal laws and interpretations that block that exercise of authority are impermissible usurpations of the states’ authority to intervene in pursuit of public health. It is not clear at this point how the courts will rule if faced with this thorny issue.

Child and adolescent BMI screening is demonstrating its merit as an “arrow in the quiver” of interventions that have been implemented to combat the epidemic of obesity. It is in-
cumbent on scientists and researchers to develop reporting, screening, and surveillance protocols that are rigorously tested and evidence based.

It is equally important that government officials, policy makers, and public health stakeholders create programs that incorporate 2 guiding principles often difficult to balance: protection and advancement of public health and safeguarding of individual rights and autonomy.

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Surveillance, Screening, and Reporting Children's BMI in a School-Based Setting: A Legal Perspective

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