Public Health Law: Past & Present

Full Script

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Welcome to the Public Health Law Academy's training, **Public Health Law: Past & Present**, brought to you by ChangeLab Solutions and the Centers for Disease Control and Prevention's Public Health Law Program.

Public health practitioners who work in state, tribal, local, and territorial (STLT) health departments play a critical role in protecting and promoting public health. Two important yet often underutilized tools available to health departments are law and policy. Laws and policies can stop the spread of communicable disease, ensure that our food is safe for consumption, shape our transportation infrastructure, and establish guidelines and codes for safe housing. Yet public health officials and policymakers – who are responsible for designing, implementing, and enforcing these laws and policies – must also balance those actions with the rights of affected individuals.

How can health departments protect the public's health and promote health equity without running into constitutional or other legal barriers? How can health departments use the tools of law and policy to address the social determinants of health and advance health equity? What are some important lessons that we can learn from historical events that helped shape how public health law is practiced today? By answering these questions, this training will help public health practitioners recognize how law affects public health practice and equip them with the ability to apply this knowledge to improve the practice of public health.

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Before we begin, we want to remind you that the information provided in this training is for informational purposes only and does not constitute legal advice. ChangeLab Solutions does not enter into attorney-client relationships.

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Further, while every effort has been made to verify the accuracy of these materials, legal authorities and requirements may vary from jurisdiction to jurisdiction. Always seek the advice of an attorney or other qualified professional with any questions you may have regarding a legal matter.

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Today, we will provide an overview of public health law's past and present.

- First, we will offer some context, defining what public health law is and explaining why it is important.
- Then, we will examine how legal history has shaped today's public health practice.
- Next, we will center today's conversation in health equity and explore how law and policy affect health equity.
- We will then identify who holds the power to make public health law and policy.
- And finally, we will discuss constitutional limitations on public health powers.

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To get started, let's start with a few key definitions.

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First, what is public health? Here's language on the CDC website from C. E. A. Winslow, founder of the Yale School of Public Health: Public health is "the science and art of preventing disease, prolonging life, and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."

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When it comes to public health law, we turn to a definition from Lawrence Gostin, a law professor and public health expert, who describes public health law as "the study of the legal powers and duties of the state...to assure the conditions for people to be healthy...and the limitations on the power of the state to constrain the...legally protected interests of individuals for the common good." Legally protected interests include things like the individual right to autonomy, privacy, and liberty.

Public health law reflects the effort to balance the goal of protecting the health and well-being of the larger society against the goal of upholding individuals' and communities' rights to autonomy, privacy, and freedom from unfair or oppressive restrictions by the state. One example of this is the requirement to vaccinate children before enrolling them in school; this effort has imposed a responsibility on families to vaccinate their children in the interest of preventing the spread of diseases like smallpox, polio, tuberculosis, and measles among children.

As we'll discuss throughout today's training, understanding these legal powers and duties and how to balance them against individual rights is foundational to the practice of public health law and critical to ensuring the success of governmental public health interventions.

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We want to take a minute to clarify what we mean when we say "law" and "policy." Because of the close connection between law and policy, the terms are used interchangeably by many people. Law includes ordinances, statutes, and regulations that codify and institutionalize a government policy. Policy is a bit broader in scope; it includes laws, regulations, procedures, administrative actions, incentives, and voluntary practices of governments and other institutions. All laws are policies, but not all policies are laws.

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Public health interventions at all levels can include public health policies and laws. The five-tiered pyramid shown on this slide is based on the framework developed by Tom Frieden, when he served as director of CDC, to describe the impact of different types of public health interventions.

While implementing interventions across all tiers is necessary to achieve the greatest possible public health benefit, interventions on the two lowest tiers have the greatest potential impact.

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Let's start with the bottom tier: socioeconomic factors.

Interventions to address the socioeconomic determinants of health can include things like reducing poverty and improving education and housing. As we will discuss later in this training, socioeconomic factors are shaped by structural forces in society such as systemic racism and disparities in opportunity and political power.

Changes at this level have the greatest potential impact – that is, they tend to be most effective – because they reach broader segments of society and require less individual effort.

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The second tier is changing the context to make individuals' default decisions healthy.

This tier includes interventions that change the environmental context to make healthy options the default choice.

Examples of such interventions include fluoridation of water; removal of trans fats from foods; elimination of lead and asbestos exposures; and improvements in road and vehicle design.

The idea here is that regardless of education, income, or other factors, individuals would have to try very hard to not benefit from such interventions. However, as we'll discuss in a moment, laws and policies that attempt to change the context may not always decrease negative health outcomes for all if they're not designed with equity in mind.

We use the definition of health equity from Dr. Paula Braveman. She and her colleagues state that "health equity means that everyone has a fair and just opportunity to be as healthy as possible." We will expand on the concept of health equity a little later in this presentation.

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The third tier – long-lasting protective interventions – represents one-time or infrequent protective interventions that do not require ongoing clinical care. One example would be immunization. Another would be smoking cessation programs.

Because these interventions operate by reaching people as individuals – rather than collectively – they typically have less impact than those from the bottom two tiers.

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The fourth tier represents ongoing clinical interventions or direct clinical care.

Evidence-based clinical care can reduce disability and increase life expectancy. For example, clinical care for preventing cardiovascular disease has many benefits.

However, such interventions are often limited by lack of access (for example, in countries without universal health care) or non-adherence (for example, when patients do not take medications as advised).

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And finally, the top tier represents health education. This type of education could include the type of medical advice received during clinical visits – for example, when a doctor tells an individual to eat healthier foods or quit smoking.

This tier is often the least effective type of intervention, largely because without addressing the bottom two tiers (socioeconomic factors and making the healthy choice the easy choice), education efforts can be less effective.

However, when applied consistently and repeatedly, education interventions can have a considerable population impact. One example is behavioral counseling to reduce HIV risk.

Again, keep in mind that while the bottom two tiers have the potential for greatest impact, a combination of interventions from all of these tiers generally is the most effective way to address any given public health problem. The tiers are not mutually exclusive.

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With this framework in mind, we can begin to understand that law and policy are important vehicles for public health intervention because they operate at the societal rather than the individual level.

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Before moving on to the next section, let's pause for a quick question to check our knowledge:

A policy to increase the minimum wage is an example of what tier of the pyramid of public health interventions?

A. Long-lasting protective intervention

B. Counseling and education

C. Changing socioeconomic factors

D. Making the default decision healthy

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If you chose "C," changing socioeconomic factors, you are correct. Increasing the minimum wage would affect levels of income and poverty. This type of change is in the bottom tier and has potential for significant impact on people's health.

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Now that we know what public health law is and the levels at which it can affect public health, let's discuss a few examples from history that illustrate the origins and foundation of the legal powers and limitations that shape the practice of public health today.

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Remembering back to your American history or civics class, recall the Mayflower Compact. In 1620, before the settlers of Plymouth Colony disembarked from the Mayflower, they agreed in writing to bind themselves into a society to preserve order and further their goals.

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To secure the common good, they also agreed to create offices, laws, and constitutions that would place restraints on the personal freedom and property rights of individuals.

The excerpt on this slide illustrates their covenant to, quote "enact, constitute, and frame, such just and equal laws, ordinances, acts, constitutions and offices, from time to time, as shall be thought most meet and convenient for the general good of the colony" unquote.

So here we have a concept that we mentioned earlier when we discussed Gostin's definition of public health law – the balancing of personal freedoms and the common good. This concept was established early in our country's history.

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Next, we turn to a foundational moment in the history of public health law. Pictured on this slide is the Broad Street pump.

The story of this pump dates to the middle of the 19th century, when London's Soho was an insanitary place of filth due to a large influx of residents and a lack of proper sanitary services. On August 31, 1854, after several outbreaks of cholera elsewhere in the city, a major outbreak struck Soho. Within the first three days of the outbreak, 127 people on or near Broad Street died, and by the end of the outbreak, 616 people had died.

John Snow, the British physician who eventually linked the outbreak to contaminated water, later called it "the most terrible outbreak of cholera which ever occurred in this kingdom."

Snow did not know how the disease was transmitted, but evidence led him to believe that it was not spread by pollution or breathing bad air, as was the popular belief at the time.

By talking to local residents about their water supply and creating dot maps comparing deaths to sources of water, he identified the source of the outbreak as the public water pump on Broad Street. Although Snow's chemical and microscopic examination of a water sample from the Broad Street pump did not prove its danger, his studies of the pattern of the disease were convincing enough to persuade the local board of health commissioners to disable the well pump by removing its handle. In other words, Snow had to use legal tools and persuasive arguments to make the environmental changes needed to improve public health.

Snow's study was a major event in the history of public health. His methodology and subsequent findings led to fundamental changes in the water and waste systems of London, which led to similar changes in other cities and a significant improvement in general public health around the world. Snow is therefore regarded as one of the founding fathers of modern epidemiology.

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Understanding the causes of disease was also instrumental in shaping public health efforts in the United States. If you think that filth accumulated just in London, here is a picture of trash piled up on Varick Street in New York City in 1893, before sanitation reform!

Prior to New York City's sanitation reforms of the 1890s, street cleaning and regular trash collection were not widely available; only affluent residents paid for these services. Garbage and filth were allowed to accumulate on the streets and alleyways in the rest of the city's neighborhoods, as this photo shows.

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This is the same corner of Varick Street, two years and a massive cleanup later, due to the passage of the first municipal sanitation law in the United States.

It was not until the late 19th to early 20th century that public health reformers recognized the common thread in their work: what some scholars have described as "a shared understanding of the causes of disease and the ambitious, sweeping action that would be required to promote the public's health."

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Now we turn to a foundational court case from the early 20th century: Jacobson versus Massachusetts. This landmark Supreme Court case reviewed the constitutionality of mandatory public health control measures.

In 1902, during a smallpox outbreak sweeping through the northeastern United States, the city of Cambridge, Massachusetts, passed an ordinance making vaccinations mandatory. A minister in the community, Pastor Henning Jacobson, who asserted that he and his son had experienced adverse side effects from vaccines in the past, refused to be vaccinated. Under the mandatory vaccination law, individuals who refused to be vaccinated were fined $5, the equivalent of roughly $130 today. Pastor Jacobson refused to pay the $5 fine and challenged the constitutionality of the vaccination law in court.

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The US Supreme Court upheld the mandatory vaccination law in 1905, saying, "There are manifold restraints to which every person is necessarily subject for the common good."

The Court stated that the government may enact "reasonable regulations" to protect public health and safety. These "reasonable regulations," however, must balance and recognize the individual rights established and protected under the US Constitution.

This case is significant because it provides support for the government to intervene to protect the public's health, and it marks the beginning of the application of modern constitutional analysis to disease control law. Even though the case involved mandatory vaccination, it articulates the general principles and authority behind the state's contemporary public health powers. The important takeaway is that Jacobson represents the balancing of collective actions – or public health interventions – for the common good against the rights of individuals.

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Here's a quick quiz, based on what you learned from Jacobson:

The government can regulate individual behavior to protect health. True or false?

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The answer is "True." While there are some important nuances, states generally have the authority to take reasonable actions to promote public health as part of their police powers, which we will discuss later in this training.

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As a result of mass vaccination campaigns, aided by laws like the one upheld in Jacobson, smallpox – one of the world's most devastating and deadliest diseases – was completely eradicated by the 1970s. But while history reveals many such successes in the use of law and policy to promote public health, it also illuminates the dangers of failing to center health equity, as public health interventions often have in the past.

Before diving into this history, let's take a moment to further define health equity, a concept we briefly defined earlier in this presentation.

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As we noted earlier, Dr. Paula Braveman, one of the nation's leading experts on health equity and health disparities, put it very simply when she said, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." It means everyone has access to the resources and opportunities they need to thrive, regardless of characteristics like race, ethnicity, gender, or sexual identity. At the core of equity is a focus on fairness, justice, and opportunity.

Having a shared understanding of health equity is critical. We can't improve health for everyone without taking an equity approach. How organizations and teams talk about inequities will shape the approaches they use to advance health equity. A project explicitly focused on improving health equity might take a very different direction from one that's focused more generally on improving health for everyone.

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To move toward true equity, we must understand the difference between equity and equality.

This illustration, based on the Robert Wood Johnson Foundation's "Visualizing Health Equity: One Size Does Not Fit All" infographic, shows the difference. The top section illustrates equality. An intervention focused on equality would apply the same one-size-fits-all solution to everyone, irrespective of need. Here this idea is illustrated by giving four individuals the same bicycle. That sounds pretty good so far. But let's examine the situation more closely. The bicycle may be a good fit for the two individuals in the middle, but what about the child in the wheelchair on the left? And how about the person on the right, who struggles to reach the pedals? This scenario shows how an equal approach – even a well-intentioned one – doesn't necessarily benefit everyone equally. The two individuals in the middle might be well on their way, while those on either side are left behind.

The bottom section, on the other hand illustrates equity. An equitable approach means that we're focused on ensuring that people have what they need to thrive. And beyond that, it acknowledges the reality that not everyone starts at the same place. What one person or population needs might be different from what another needs.

When we fail to design projects or interventions with equity in mind, there is potential for our efforts – again, even well-intentioned ones – to not only maintain inequities but, in some cases, actually widen them. Providing the same bike to everyone will give the two individuals in the middle the means to take off, while those on either side are left even farther behind.

Furthermore, this example – which suggests that giving each person a bike suited to their individual needs achieves equity – has some significant limitations. First, while bicycles can be built for some people who use wheelchairs, for many other people with disabilities, even modified bicycles are not an inclusive or accessible form of transportation. A more equitable intervention would allow each person to choose from an array of vehicles and determine the one that works best for their needs. Additionally, this example has left out the broader structural conditions within which each individual is traveling. Do they have access to a bike lane? Does their neighborhood have a lot of car traffic? What about air pollution? And how far do they have to travel to get where they need to go? Equitable interventions must address these questions, not just providing an accessible vehicle but aiming to change the conditions that make it unsafe or more difficult for some individuals to get on a bike or travel in the first place.

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For a real-world illustration of concepts related to equity, let's consider tobacco control, widely regarded as a major public health success story in the United States. As scientific evidence on the links of disease, tobacco use, and environmental exposure to tobacco accumulated, substantial public health efforts in the second half of the 20th century brought about significant reductions in the prevalence of tobacco use.

Public health efforts to protect people from the harmful effects of tobacco use and exposure included policy interventions such as legislation restricting smoking in public places. But smokefree air laws that failed to center equity have contributed to continuing tobacco-related health disparities. For example, California's 1994 Smokefree Workplace Act created numerous exemptions for workplaces where low-wage workers and people of color tend to be overrepresented, such as hotels, long-term health care facilities, and outdoor worksites. As a result, 1 in 7 Californians face secondhand smoke exposure at work. The exemptions in the law are part of a system that, despite reducing tobacco use overall, makes it easier for some of California's most affected populations to start smoking, makes it more difficult for them to quit smoking, and makes them more likely to die from diseases associated with tobacco use. This example shows how our legal and policy responses can fail to address inequities and can, at times, reinforce systems of injustice.

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As the tobacco example demonstrates, laws and policies have played – and continue to play – a central role in creating the health disparities that exist today. On the flip side, when approached intentionally with an equity mindset, law and policy can also be powerful tools for mitigating and transforming health inequities.

The five fundamental drivers of health inequity are a tool for addressing current and historical inequities through law and policy, using these five lenses:

- Are we accounting for the historical and structural harms in our systems that perpetuate racial or other forms of discrimination?
- Who has access to wealth or wealth-building opportunities?
- Who has access to other resources and opportunities that promote health and equity – such as food, education, parks, and healthy environments?
- Who has access to what types of power?
- How are our governance structures set up to amplify or take away the voices of which people?

We have a lot more ground to cover in today's training, so I won't go into depth on each of the five drivers of inequity, but the key takeaway here is that although law and policy have been central to creating today's health disparities, the very same law and policy tools can also be used to create positive change by addressing these drivers of inequity.

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Here's an example of how laws and policies can be used to address the drivers of health inequity:

Some states and localities have adopted policies that support families by addressing the income inequality driver of inequity – for instance, requiring employers to provide paid family leave.

Given the complexity and interrelatedness of the fundamental drivers of inequity, the pursuit of health equity requires collaboration between public health practitioners and partners from a wide range of disciplines, sectors, and communities.

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Now, let's pause for a true-false question:

True or false? Structural discrimination is a fundamental driver of health inequity.

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If you picked "True," that's correct! Achieving health equity will require laws and policies that address the fundamental drivers of health inequity, including structural discrimination.

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Now that we have a basic understanding of what public health law is, including how it has been shaped by history and how it relates to health equity, I'm going to introduce a scenario that will help illustrate how public health law informs the use of law and policy in the practice of public health today.

For purposes of this hypothetical situation, let's meet Wendy, the deputy health commissioner for a small city. The city council has asked the health department to identify potential policy interventions to address persistent high rates of childhood lead poisoning in the community. Wendy has been assigned to lead this project.

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To identify possible solutions, Wendy convenes a community coalition of diverse stakeholders, including housing advocates, parents of children who have had lead poisoning, landlord advocates, doctors, academic partners, and county public health officials. Through conversations with coalition members, Wendy learns that traditional complaint-based code enforcement policies can discourage renters from exercising their right to safe housing because renters fear losing their housing or experiencing other forms of retaliation if they make a complaint. The current enforcement system strains relationships among renters, landlords, housing advocates, and city officials, eroding all of these parties' belief that government can be impartial and responsive to their needs. The group identifies proactive rental inspection (PRI) programs as a promising strategy to prevent lead poisoning. PRI programs institute periodic lead dust inspections rather than relying on tenant complaints.

In terms of the drivers of inequity framework we discussed earlier, PRI programs are, essentially, a policy intervention designed to confront the fifth fundamental driver of health inequity: governance that limits meaningful participation. PRI programs avoid the pitfalls of complaint-based enforcement and can promote trust, fairness, and transparency so that all community members can meaningfully benefit from enforcement of rental housing codes.

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Based on what we've learned about public health law so far, Wendy believes that it is within the scope of governmental authority to establish a PRI program to prevent childhood lead poisoning, just as the government acted within the scope of its authority by establishing a mandatory vaccination program to stem the smallpox outbreak in Jacobson. Before going any further with this proposal, however, Wendy needs to understand who has the power to mandate proactive rental inspection and what limitations the Constitution places on such authority.

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Now that we understand more about how laws and policies can be used to advance health equity, let's explore the powers of different levels of government to establish such laws and policies.

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Who has the power to shape public policy to improve public health?

To determine who has this power, we must go first to the US Constitution, which distributes power between the different levels of government – federal, state, and local – and provides a framework for balancing public health and individual interests.

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The federal government has only the powers listed in the Constitution; these are referred to as enumerated powers. Some of these are express powers, which means that they are explicitly mentioned by the Constitution. Others are implied powers, which means that they are necessary to carry out the express powers.

The federal government's powers can be exclusive – that is, only the federal government is allowed to execute them – or they can be concurrent – that is, shared with the states. All the remaining governmental powers – those not outlined by the Constitution, including the majority of core public health powers – are reserved for the states. As we'll discuss shortly, states often delegate at least some of those powers to local governments.

Examples of federal power include the authority to levy taxes and to spend for the common welfare. These powers are granted in the Taxing and Spending Clause of the US Constitution. Most of the federal government's public health authority comes from that simple grant of power.

Another source of the federal government's public health power comes from its authority to regulate interstate commerce. For example, the federal government can be involved in responding to communicable disease outbreaks because disease can travel across state borders. The federal government can be involved in school lunch programs because it provides crops and funding for the free and reduced-price meal programs.

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To recap what we just covered, here's a short quiz:

Which of the following are examples of the federal government's enumerated powers?

A. Taxing

B. Interstate commerce

C. Zoning

D. A and B

E. A and C, or

F. A, B, and C

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If you picked "D," you're correct!

The federal government has the power to levy taxes and to regulate interstate commerce.

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True or false? If the federal government shares a power with the states, that is an exclusive power.

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If you answered "False," you are correct. A power shared with the states is a concurrent power. A power that only the federal government has is called an exclusive power.

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The federal government may use its enumerated powers to shape public health in other indirect ways.

Federal regulations can incentivize local action by setting standards for federal funding or programs that might have a trickle-down effect. The minimum drinking age in the United States is an example of this kind of incentivization through funding. In 1984, Congress passed the National Minimum Drinking Age Act, which withheld 10% of federal highway funding from states that did not maintain a minimum drinking age of 21.

The law was challenged by the state of South Dakota but upheld by the Supreme Court in 1987. The Court explained that Congress had validly exercised its authority under the Spending Clause and therefore did not infringe upon the rights of the states.

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The federal government can also affect public health laws and policies through preemption – in other words, by limiting state or local action. Preemption is the sole focus of Part Two of this three-part training series, but it is also central to this discussion.

The US Constitution states that federal laws are the "supreme law of the land." This statement means that federal laws can sometimes prohibit or supersede state or local action. State regulation of aircraft safety and operations, for example, is preempted by statute. Under the Federal Aviation Act, the US government has the exclusive authority to control all navigable airspace in the United States. As a result, state regulation of aviation is preempted because Congress occupies the entire regulatory field.

Plus, think about it: Would we want a patchwork of state-level regulations requiring pilots to remember the unique aviation laws of every state that they might land in or cross while flying from coast to coast? No! It makes great sense to have a single unified body of law governing airline operations and safety.

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Despite the powers of the federal government to address public health, it is state and local governments that have the most power to pass laws to protect the public's health. Under the Constitution, states have all of the powers not reserved for the federal government. This means that the Constitution gives states primary power over public health.

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This power – known as police power – is granted to states through the Tenth Amendment. Courts generally allow the exercise of police power as long as it is for the purpose of promoting the general health and well-being of the community.

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Here are some requirements that apply to police power. The government intervention . . .

- Must be reasonably designed to correct a condition adversely affecting the public good;
- Must be rationally related to promoting the public health, safety, or general welfare;
- Cannot violate any state or federal laws or constitutions; and
- Cannot be arbitrary or oppressive.

Courts have generally been deferential to the exercise of this power as long as the interventions have been carefully designed to meet these requirements.

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States can delegate their police power to local governments.

The authority to protect the health, safety, and welfare of the community is acknowledged throughout court cases, also called case law, in every state. In other words, protecting public health is one of the core purposes of state and local government. Accordingly, state and local governments have very broad and flexible authority.

However, the scope of a local government's police power varies from state to state. Some states, like Florida and Illinois, give local governments extensive police power authority. Others, like Arkansas, greatly limit the ability of local governments to exercise police power.

The excerpt on this slide is from California's state constitution, which says, "A county or city may make and enforce within its limits all local, police, sanitary, and other ordinances and regulations not in conflict with general laws." As a result, local governments in California have relatively broad police powers.

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Native American tribes have a special status. Federally recognized tribes are sovereign nations, which means that they have the authority to govern themselves. They maintain a nation-to-nation relationship with the United States.

As sovereign nations, tribes have the power to do what's necessary to control their internal affairs and preserve their self-government. While federal law places certain limits on the tribal exercise of political sovereignty, courts and legislatures interpret the language on tribal control very broadly. Tribes have the power to create their own health laws and regulations to protect the health, safety, and welfare of their communities – for example, by establishing quarantine or isolation provisions or creating disease reporting requirements. The allocation of public health authority varies by tribe, and public health powers can reside with entities such as tribal governments, tribal organizations designated by tribal governments, and inter-tribal consortiums.

While tribes have the authority to create their own laws and policies for public health and safety, they also often work with federal and state agencies on public health.

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Let's review with a few questions.

Here's the first question: Local governments have legislative independence apart from states. True or false?

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The answer is "False." Local governments generally act within the authority delegated to them by states. While some states grant local governments extensive authority to act independently, others greatly limit those powers.

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The second question is: The federal government can control all aspects of state and local laws. True or false?

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The answer again is "False." The Constitution divides control between the federal and state governments. The federal government may only exercise the authority specifically granted to it by the Constitution.

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In the realm of public health, state and local governments' police powers can apply to a wide array of government actions. Let's review a few.

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One of the best-known examples of local police power is the power of local health officials to invoke isolation and quarantine orders to protect the public's health. If you are interested in learning more about isolation and quarantine powers, we encourage you to check out our training **Public Health Threats & the US Constitution: What Responders Need to Know About Equity, Law, and Public Health Authority**.

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State and local governments can also set minimum wage requirements for employers.

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Local governments also have considerable discretion when enacting zoning regulations or land use classifications. This power can be used to require or encourage new housing developments to include affordable units.

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Another valid use of state and local governments' police power is the enactment of LGBTQ-inclusive anti-bullying protections for students.

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One final example is that state and local governments can protect the safety of children by requiring them to wear bicycle helmets.

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Now, let's return to Wendy, who is working on policy interventions to address childhood lead poisoning. Based on the coalition's recommendations, Wendy is working to institute proactive rental inspections. Consulting the city attorney's office, she learns that code enforcement is a valid exercise of the city's police power. Therefore, establishing a proactive rental inspection program falls within the scope of the police power delegated by the state to the city.

Wendy runs into a roadblock, however, when the community coalition drafts a policy identifying its aim to address racial inequities in childhood lead poisoning by targeting Black and Latinx communities for proactive rental inspections. The city attorney's office says that this policy raises serious constitutional concerns and can't be passed. How can Wendy's team craft a policy that centers health equity and addresses the disproportionate impact of childhood lead poisoning in their community? What constitutional constraints and legal considerations does Wendy need to keep in mind while drafting this proposal? We'll explore the answers to these questions when we talk about the constitutional limitations on public health powers.

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Although public health powers are broad, they are not without limits. Even if a government entity has the authority to enact a certain law to protect the public's health, there may be other reasons why that authority is limited.

There are three main limitations. The first is preemption, which we have already touched on in this training and which is also discussed extensively in Part Two of this series.

The second limitation is separation of powers. There are three branches of government: legislative, executive, and judicial. Generally, the legislative branch passes laws, the executive branch enforces laws, and the judicial branch interprets laws. This structure of government ensures a system of checks and balances, so that no single branch has too much power. To learn more about this system, check out our **Structure of Government** training, the third training in this series.

The third limitation is constitutional protection of individual rights, which is the focus of this presentation and which we will discuss in depth shortly.

It's also important to note that in addition to constitutional limits on public health authority, political feasibility can be a challenging hurdle to overcome.

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Again, the major takeaway – and recurring theme – from this section (and this entire training) is that the government's authority to protect the public's health must be balanced against the rights of affected individuals. This balance is what the Constitution requires.

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To determine the scope of the limits on government authority, we can turn to the Bill of Rights.

In 1791, shortly after ratifying the Constitution, Congress amended the new constitution with the Bill of Rights, which consists of the first 10 amendments that set forth the liberties we have as individuals. The purpose was to protect individuals from government overreach and undue control.

So we have a real tension at the heart of our core legal documents that pulls in two directions: on one hand, toward protection of the common good (recall the Mayflower Compact) and on the other, toward protection of individuals. This tension plays out in the field of public health every single day.

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Many of the individual liberties established by the Bill of Rights will be very familiar to you. A few are listed on this slide.

The first three – in grey text – will not be discussed in this training. They are . . .

- Freedom of speech and religion under the First Amendment
- The right to bear arms under the Second Amendment, and
- The right to be free of unreasonable searches and seizures under the Fourth Amendment

The last two – In blue – will be the focus of discussion for the remainder of this training. They are . . .

- The right to not be deprived of life, liberty, or property without due process of the law under the Fifth Amendment
- The right to equal protection of the laws – also under the Fifth Amendment

The Bill of Rights, although it is part of the federal Constitution, also applies to the states due to the Fourteenth Amendment. So, for instance, the Fifth Amendment provides the right to not be deprived of life, liberty, or property without due process of law, and the Fourteenth Amendment prohibits states from depriving individuals of life, liberty, or property without due process of law. The Supreme Court previously had interpreted the Fifth Amendment as applying only to the federal government, so the Fourteenth Amendment explicitly extended that application to the states.

For a deeper dive into how these constitutional rights apply in the context of public health emergencies, check out our training **Public Health Threats & the US Constitution: What Responders Need to Know About Equity, Law, and Public Health Authority**.

Slide 68

Due process is a central concept when we're talking about individual rights in the context of public health laws and interventions, so it's important to understand.

As mentioned in the previous slide, the Fifth and Fourteenth Amendments of the US Constitution say that the government cannot deprive individuals of life, liberty, or property without due process of law. What does "due process of law" mean? Due process is about the fairness and reasonableness of government actions that deprive individuals of life, liberty, or property.

There are two types of due process: procedural and substantive. We'll discuss both in the upcoming slides.

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Procedural due process means that the government has to follow certain procedures to protect our rights. These procedures include things like honoring the right to an attorney and the right to a fair hearing.

The key question when considering procedural due process is whether the government has honored the right to fair and impartial legal proceedings before depriving someone of life, liberty, or property.

For example, if someone is receiving a benefit from the government – say, disability benefits – the government cannot just terminate that benefit whenever and however it wants to. Before termination is allowed, the Constitution requires the government to provide written notice explaining that the benefit will be terminated and why, an opportunity to challenge the decision to terminate, and a hearing to review that decision. These are all procedural requirements to protect the individual's rights.

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In contrast, substantive due process examines not the procedures the government uses but whether the government has a good enough reason for depriving someone of life, liberty, or property.

To decide whether the government action is justified, a court will evaluate the relative importance of the individual versus governmental interests at stake.

The Jacobson case we discussed earlier – in which the pastor challenged the constitutionality of a vaccine mandate law – was a case about substantive due process and the deprivation of liberty. The Supreme Court had to decide whether the government had a good enough reason to implement a law mandating vaccines.

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The criteria required of the government become more stringent as the individual interest at stake becomes more significant. So, as we'll discuss further in a moment, government actions that interfere with intimate personal choices (for example, marriage, procreation, or privacy within the home, to name a few) receive the greatest constitutional protection. The burden on the government to provide a good reason for such interference is much higher.

Slide 72

So, we start with issues that do not constitute fundamental liberty interests, like . . .

- The ability to smoke in public
- The ability of a restaurant to cook with trans fats
- The ability to drink and drive or to drive a polluting car

Slide 73

When fundamental liberties are not involved – which is the case for most police power regulations – the government action must pass a lenient test, called rational basis, if challenged in court.

This test asks whether the government action is reasonably related to a legitimate government goal. This is a relatively easy test for the government to pass. In fact, the government generally doesn't even have to offer evidence to prove that an action is reasonably related to a legitimate government goal; any plausible reason will do.

Take, for example, a local ordinance prohibiting smoking in restaurants and bars.

- Is there a fundamental right to smoke in restaurants? No.
- Does the government have a legitimate goal when seeking to prohibit smoking in restaurants and bars? Sure. The government is trying to protect patrons and employees from secondhand smoke.
- Finally, is that goal reasonably related to the means? Of course. Prohibiting smoking is a simple way to protect people from secondhand smoke exposure.

Accordingly, if an ordinance like this were to be challenged, a court would almost certainly uphold it.

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Now consider the photos on this slide, which show some examples of what the US Supreme Court has deemed fundamental liberties. Fundamental liberties receive the greatest level of protection because they are essential to a person's autonomy or personal dignity. Although this area of the law is still evolving, the kinds of individual interests that the Supreme Court has deemed to fall within this category include marriage, bodily integrity, and parenting.

Slide 75

This "greatest level of protection" that is used to protect the fundamental liberties we just talked about is known in legal terms as the strict scrutiny test.

Strict scrutiny has two parts. For a government action to be constitutional, it must meet the following criteria:

- First, intend to achieve a compelling goal – that is, something necessary or crucial, not simply preferred
- Second, be narrowly tailored or be the least restrictive alternative to achieve that goal

In the realm of public health law, think of this test in the context of quarantining a patient with a communicable disease. Applying the two-part strict scrutiny test, you must first ask whether the government has a compelling interest in quarantining the patient. The answer would almost certainly be "Yes," since protecting the public's health by stopping the spread of a contagious, dangerous disease is critical to protecting the common good.

Second, you must assess whether the intervention – in this case, quarantine – is narrowly tailored. In other words, would quarantining the patient effectively stop the spread of disease, and is there a less intrusive way? The answer to this second question probably depends on the facts of the case, but it's possible that a quarantine order would be upheld for a serious and very contagious disease.

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This chart summarizes the rational basis and strict scrutiny tests we just discussed.

The important point is that the government has a lot of power to take actions to protect public health most of the time, but it has to tread very carefully if it wants to enact a regulation that affects a core set of fundamental liberties.

If an individual's interest is minimal – for example, the ability to smoke in a restaurant – a court will use the rational basis test to determine whether the government's goal is legitimate and reasonably related to the regulation.

On the other hand, if the individual has a fundamental interest (one that is related to their autonomy or personal dignity – for example, to be free from a quarantine order), then the strict scrutiny test is used to determine whether the government has a compelling goal and whether the regulation is narrowly tailored or the least restrictive alternative.

It is also worth noting that there are other tests that judges may use, so it is important to consult a lawyer if you have any questions.

Slide 77

Let's explore the concept of fundamental liberties a bit more with an example on mandatory vaccination.

Can the government require parents to vaccinate their children in order for the kids to attend public school? As you might know, the answer is "Yes." Under their police powers, states have the authority to require children to undergo mandatory treatment or vaccination, even in the absence of a public health emergency or pandemic. Indeed, all 50 states have state immunization laws requiring students to receive a standard set of vaccines prior to entering school. At the same time, states have the power to carve out exceptions to vaccine requirements – for example, for medical reasons or for religious or philosophical beliefs.

Slide 78

What about vaccination in order to attend private school? Does that change the analysis? It doesn't, and again, the answer is "Yes." States have the authority to apply the same vaccination requirements to private schools, for the same reasons – to protect the health of the community.

Slide 79

Finally, what about all children? Could the government, for example, require all children to be vaccinated, totally independent of whether they are attending school? This is a trickier question. Under the Constitution, parents have a fundamental liberty right to determine "the custody, care and nurture" of their children. At the same time, the government has a compelling interest in protecting the child and the broader community from infectious disease and death. Therefore, a court reviewing this requirement would have to balance the two interests and determine whether mandatory vaccination is the least restrictive means of achieving the government's goal. Many states include children who are homeschooled in school vaccination requirements, which means they are effectively reaching all school-age children.

However, a broad requirement that all children of any age be vaccinated, regardless of any connection to school attendance, likely would not happen in the absence of an outbreak. Remember the Jacobson case we talked about earlier; in that case, the Supreme Court determined that protecting the common good and ending the smallpox epidemic warranted mandatory vaccination. At the same time, it's important to note that the analysis here, unlike in Jacobson, applies specifically to children. The government will have more leeway to require things like vaccination and treatment for children – even without an outbreak – than it will for adults, who have more autonomy to make decisions about their health care and their body.

Slide 80

Based on what you've just learned, which of the following is required for the government to prohibit unvaccinated children from attending public school?

A. A compelling government interest

B. A public health emergency

C. Exceptions for personal beliefs

D. A and B, or

E. A, B, and C

Slide 81

If you picked "A," you're correct! The government must have a compelling interest in order to prohibit unvaccinated children from attending public school.

Slide 82

Here's another multiple-choice question:

Which of the following is needed for the government to require children to wear bicycle helmets?

A. A compelling government interest
B. A public health emergency
C. A legitimate government interest
D. A and B
E. A, B, and C

Slide 83

The correct answer is "C" – A legitimate government interest.

If challenged in court, a government would just need to show that its action – requiring children to wear a bicycle helmet – is reasonably related to a legitimate government goal – here, protecting children's safety.

Because fundamental liberties are not involved, the government would not need to demonstrate a compelling government interest (answer A), nor would it need a public health emergency to justify government action (answer B).

Slide 84

Under the Fifth and Fourteenth Amendments of the US Constitution, individuals have equal protection under the law. As you may remember, these are the same amendments that require due process. Some amendments do more than one thing.

The term equal protection makes us think of treating different people fairly, but does this mean that the government always has to treat one group the same way as another?

Equal protection, in short, prohibits discrimination against someone because that person belongs to a particular group. Similar to the issue of fundamental liberties, government actions that treat certain groups of people differently must pass certain standards like rational basis or strict scrutiny if challenged in court. Certain categories such as race, ethnicity, national origin, and gender receive special protection under the law and therefore are labeled protected classes.

Slide 85

Governmental public health actions affecting only groups that don't receive special protection under the Equal Protection Clause (that is, groups that aren't protected classes) only need to pass a rational basis test.

The top two pictures of this slide might lead us to think about how kids and adults are treated differently in many ways under the law. There is no strict scrutiny for laws that require children to wear bicycle helmets but not adults, or for laws that ban minors from buying alcohol or tobacco or grant special health insurance only for seniors.

In considering the bottom two pictures, we note that the concept of equal protection also applies to economic and business regulations. For example, can we treat certain executive, administrative, and professional employees (often called white-collar employees) differently from other types of employees in overtime pay regulations?

The answer again depends on whether such a regulation would pass the rational basis test.

Slide 86

The rational basis test is the same in the equal protection context as it is in the due process context: the government action must be reasonably related to a legitimate goal. This test is generally easy to pass, and most government regulations reviewed under this test are upheld.

Slide 87

Based on what you've learned about the rational basis test, can the government pass an overtime pay law that specifically exempts certain executive, administrative, and professional employees?

Slide 88

Yes, because a law that applies to certain types of employees but not others only needs to be reasonably related to a legitimate government goal. The government could argue that executive, administrative, and professional employees have greater access to other forms of compensation – like benefits and opportunities for advancement – which warrants different treatment under the Equal Protection Clause. And that it – the government – has a legitimate interest in promoting public health by protecting workers from exploitation by employers, and therefore it can impose overtime pay requirements for only certain employees.

Slide 89

There are other instances in which the government will have to meet a higher standard than rational basis. With respect to equal protection, the strict scrutiny test applies if the protected class of race, ethnicity, or national origin is affected. There is a slight variation on this test that applies to gender discrimination; we call that one "intermediate scrutiny."

Slide 90

Remember that under strict scrutiny, the government action must be narrowly tailored to achieve a compelling goal.

Narrowly tailored in an equal protection context means that the government cannot single out groups of a specific race, ethnicity, or national origin when trying to accomplish its goal. If challenged, it is very difficult for a government regulation to be upheld under the strict scrutiny test.

Slide 91

Here are a few more equal protection scenarios to consider:

- Can the government quarantine citizens of another country who are suspected of having been exposed to a viral respiratory disease?
- What about limiting the number of fast-food restaurants in certain parts of a city?
- And finally, what about putting an age restriction on buying harmful products?

Slide 92

We start with the first question: Can the government quarantine citizens of another country who are suspected of having been exposed to a viral respiratory disease?

The answer is "No." The government must have a valid justification for distinguishing between members of certain protected categories – such as race, ethnicity, and national origin – and such a law must pass the strict scrutiny test. Since anyone traveling to or living in the country with a viral respiratory disease outbreak would be just as likely to have contracted the virus (regardless of their race, ethnicity, or national origin), the quarantine cannot unjustifiably single out citizens from that country.

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What about limiting the number of fast-food restaurants in certain parts of a city?

The answer is "Yes." Zoning codes can restrict the number of fast-food chains in certain parts of a city. Remember, however, that the distinctions between different parts of the city cannot be based on the race, ethnicity, or national origin of a community. The restrictions on fast-food restaurants should instead be based on other classifications such as geographic location – for example, neighborhoods with higher rates of diet-related diseases than the citywide average.

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Finally, the answer to putting an age restriction on buying harmful products is also "Yes." Unlike people of different races, for example, minors do not receive special protection under the equal protection clause. Therefore, laws that treat them differently from adults need only be reasonably related to a legitimate government goal. In this example, that goal would be protecting children and youth, who are particularly vulnerable to harmful products like nicotine, tobacco, and alcohol.

Slide 95

Now, let's return to Wendy and apply what we have learned about governmental public health powers and the constitutional limitations on those powers. Based on discussions with members of the community, Wendy wants to institute proactive rental inspections to reduce childhood lead poisoning. The community coalition's initial draft policy focused on Black and Latinx communities, and the city attorney raised constitutional concerns.

The city attorney's office rejected Wendy's original proposal to write a law that explicitly stated that its aim was to address racial inequities and that designated neighborhoods for the program based on their racial characteristics, focusing on racial disparities as the reason that the ordinance could make sense from a public health point of view, given that such disparities are a core public health issue. However, from both a legal and practical standpoint, race-based distinctions should be avoided because they not only raise serious constitutional concerns but also can lead to unintended consequences.

Wendy's team can still develop a policy that addresses the race-based disparities in childhood lead poisoning. Another way to approach the issue is to write a law that singles out certain neighborhoods using race-neutral criteria such as epidemiological data on rates of childhood lead poisoning. This approach will be a lot less risky from a constitutional perspective because it addresses health disparities without singling out any racial groups for different treatment.

Another constitutional consideration that Wendy's team needs to keep in mind is the Fourth Amendment, which guarantees the right to be free of unreasonable searches and seizures by the government. In designing a proactive rental inspection program, the city will need to include adequate Fourth Amendment safeguards, such as processes for obtaining tenants' consent prior to entering their home and processes for obtaining warrants to enter the property when necessary and appropriate.

Slide 96

Now that the relevant legal issues have been considered, Wendy and her team can start preparing a proposal for a PRI program for the city council and begin thinking ahead to next steps. As part of this process, they identify several key equity considerations.

The first is ensuring that community education efforts and any educational materials about the PRI program reach all segments of the population. For example, are educational materials in languages other than English needed? Addressing any language barriers and providing clear communication about the program is critical to getting buy-in from key accountability partners. Because Wendy convened a community coalition early in the policy development process, her team will be one step ahead in generating community support for the program.

The second consideration relates to centering equity in the implementation and enforcement of the PRI program. Wendy and her team want to ensure that the program is producing the intended effects and not creating unintended consequences. The team recognizes that in order to accomplish this objective, they need to include policy mechanisms for collecting data and evaluating the policy, and they need to allocate funding to support these efforts. The city should also be sure to devise equitable penalties – such as fines adjusted for the severity or impact of a violation – to avoid needlessly displacing tenants, removing rental units from the market, or forcing foreclosure on property owners.

Wendy's small city and health department can also learn from cities across the country that have successfully implemented PRI programs. For example, one potential hurdle for new PRI programs is addressing concerns raised by small-scale landlords or tenants who are uncomfortable with the PRI process. When Boston implemented its PRI program, the city addressed this challenge by convening regular workshops to help landlords learn about the code enforcement process and rules. Relatedly, Cleveland's PRI program builds community buy-in by and hiring housing inspectors from within the local community. This strategy helps generate trust among residents in neighborhoods where people don't trust the government due to past disinvestment and harm.

By centering equity and facilitating cross-sector collaboration (for example, among health officials, housing code inspectors, and community members), Wendy can help the city design a program that will not only protect the public from lead and other health hazards in their homes but also reduce health disparities and empower community members to meaningfully participate in the rental housing code enforcement system.

Slide 97

In closing, here is a recap of what we discussed.

- We began by defining public health law and explaining its importance.
- Next, we examined the legal history that has shaped modern public health practice in the United States.
- Then, we centered the conversation in health equity and introduced the structural drivers of inequity framework for public health intervention.
- We also discussed who holds the power to make public health law and policy.
- And finally, we highlighted constitutional limitations on the exercise of public health powers.

We encourage you to watch the second and third parts of this series, which cover **Preemption & Public Health** and **Structure of Government**.

Slide 98

Before we conclude, here's some brief background information on the content providers.

ChangeLab Solutions is a nonpartisan nonprofit organization that uses the tools of law and policy to advance health equity. They partner with communities across the nation to improve health and opportunity by changing harmful laws, policies, and systems. Their interdisciplinary team works with public health lawyers; state, tribal, local, and territorial health departments; other government agencies; community organizations; and local institutions to design and implement equitable and practical policy solutions to complex health challenges.

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The mission of CDC's Public Health Law Program – PHLP – is to advance the use of law as a public health tool.

The program creates resources that can be used to influence public health outcomes – for example, through…

- Legal epidemiology, including legal mapping and evaluation
- Workforce development opportunities, including webinars, trainings, training materials, fellowships, internships, and externships

and, finally, through

- Partnerships and outreach.

PHLP does all of this to serve CDC programs as well as state, tribal, local, and territorial communities.

To submit a request or to learn more about public health law, you can visit the program's website at www.cdc.gov/PHLP.

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Individuals who work as public health practitioners, lawyers, and policy experts in state, tribal, local, and territorial (STLT) health departments need measurable skills to move their careers forward. The CDC's Public Health Law Program developed the Public Health Law Competency Model to help guide practitioners in career trajectories. This module of the Public Health Law Academy covers the four competencies listed on this slide, to build skills for public health practitioners in public health law. We want to note that these are not the objectives for this course but are general public health law competencies suitable for the workforce and public health students.

The four competencies are…

- Defining basic constitutional concepts that frame the everyday practice of public health
- Describing public health agency authority and limits on that authority
- Identifying legal tools and enforcement procedures available to address day-to-day (non-emergency) public health issues
- Distinguishing public health agency powers from those of other agencies, legislatures, and the courts

This training is intended for public health professionals at all levels of their career, from students to entry-level staff to supervisors and executive-level managers.

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This slide acknowledges that this training was made possible, in part, by a cooperative agreement with CDC and that the views expressed in the training do not represent the official policies of the US Department of Health and Human Services.

Slide 102

<Credits>

Slide 103

Thank you for attending our training!