Public Health Law: Past & Present

Full Script

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Welcome to the training on Public Health Law: Past & Present. The content for this training was originally developed by ChangeLab Solutions and the Centers for Disease Control and Prevention's Public Health Law Program for the Public Health Law Academy.

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During this training we're going to talk about the government's authority to protect the public's health. We'll first start by looking at the legal history, which provides the origins of and the foundation for the practice of public health law today. We'll then talk about how this history shapes the government's modern-day authority by exploring the parameters of the government's public health powers. Finally, we'll examine constitutional limitations on the ability of the government to enact public health regulations.

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To understand the history and role of public health law and policy, let's start by going back in time …

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Traveling 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 aims.

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

The excerpt on this slide illustrates their covenant to, quote unquote, "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."

This concept – the balancing of personal freedoms and the common good ---which was established so early in our country's history, will be a central and recurring theme throughout this training.

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Next we turn to another foundational moment in the history of public health law. As you might recognize, this is the Broad Street pump.

This story dates back to the middle of the 19th century, when London's Soho was an unsanitary place of filth due to a large influx of people living there and a lack of proper sanitary services. On August 31st, 1854 a major outbreak of cholera struck Soho. Within the first three days of the outbreak, 127 people on or near Broad Street had 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 didn't know how the disease was transmitted, but evidence led him to believe it was not spread by pollution or breathing "bad" air, as was the popular perception 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, he 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. He is thus 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 U.S. Lest we think that filth accrued just in London, here is a picture of New York City!

Prior to New York City's sanitary 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 shown in this photo.

This slide shows the trash piled up on Varick Street in New York City in 1893 – before sanitation reform.

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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 was a landmark Supreme Court case that reviewed the constitutionality of mandatory public health control measures.

In 1902 there was a smallpox outbreak in Cambridge, Massachusetts. The defendant, Jacobson, refused to be vaccinated, as the law required. He was fined $5, which would be the equivalent of roughly $130 today. He refused to pay the 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: "[T]here 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 U.S. Constitution.

This case is significant because it provides support for the government to intervene to protect the public's health, and marks the beginning of the application of modern constitutional analysis to disease control law. Even though this was a mandatory vaccination case, it articulates the principles and authority behind the state's contemporary public health powers. As we'll discuss later, this applies to areas such as injury prevention, tobacco control, and quarantine and isolation orders.

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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Now let's fast forward to the present day, where we'll see remarkable similarities between past and present public health interventions and laws.

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For example, compare New York City before sanitation reform – where trash all over the streets was the norm – with smoking, which also used to be a regular part of daily life. Even in the recent past, you wouldn't have looked twice at people smoking in workplaces, restaurants or bars, or other public places. But smoking today is much less common than it had been even in the latter part of the last century.

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This chart provides some more context for that trajectory. It shows the unintended consequences of a public policy – giving free cigarettes with mess kits during World War II – which led to tobacco addiction of returning GIs and eventually their spouses and families, and consequently a dramatic rise in smoking rates after World War II.

Then, looking further along the spectrum, it shows the *intended* consequences of various public health policy changes that have driven the decline of tobacco use over the past two-plus decades. The combination of public education (like the Great American Smokeout) with public policy changes led by the nonsmokers' rights movement (including a focus on increasing taxes and securing smokefree public places) has provided a dramatic benefit to population health.

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A further example of the potential of public health policy change to improve health is the efforts of the California Tobacco Control Program, or "C-T-C-P," which was established in 1989 within the California Department of Public Health. The C-T-C-P uses a comprehensive approach that was designed to change social norms to denormalize smoking through media and policy change, particularly by promoting smoke-free environments.

As a result of its efforts, the number of lives saved, the positive cost savings for the health care industry, and the negative cost impact on the tobacco industry have been tremendous.

From 1989 through 2008:

- There were 25% fewer tobacco-related diseases in California, compared to the rest of the U.S.,
- 6.7 billion fewer packs of cigarettes were sold, which represents $28.5 billion in pre-tax sales for the tobacco industry, and
- $134 billion dollars were saved in personal health care expenditures, representing a 50-fold return on a $1.8 billion dollar program investment.

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As director of the CDC, Tom Frieden developed the five-tiered pyramid on this slide, which provides a framework for how to address tobacco use, as well as a wide spectrum of other public health issues, like transportation infrastructure and healthy housing, which we'll talk more about shortly.

We'll spend a couple of minutes explaining the individual tiers, but what's important to remember is that implementing interventions at *each* level of the pyramid helps achieve the greatest possible public health benefit.

Starting 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.

These changes 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.

The second tier is: Changing the Context to Make the Individual's Default Decisions Easier.

This includes interventions that change the environmental context to make healthy options the default choice. Examples of such interventions include smokefree environments; the elimination of lead and asbestos exposures; improvements in road and vehicle design; removal of trans-fats from foods; and fluoridation of water.

Regardless of education, income, or other factors, individuals would have to try very hard to not benefit from such interventions.

The third tier – Long-Lasting Protective Interventions – represents one-time or infrequent protective interventions that do not require ongoing clinical care. So, immunization would be an example. Or smoking cessation programs.

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

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

Evidence-based clinical care can reduce disability and increase life expectancy. For example, we've seen the benefits of clinical care for preventing cardiovascular disease.

However, such interventions are often limited by lack of access (like in countries without universal healthcare) or nonadherence (such as patients who do not take medications as advised).

And finally, the top tier represents health education. This type of education could include the type of medical advice received during clinical visits, such as when one's doctor tells him or her to lose weight or quit smoking.

This is often the least effective type of intervention, largely because without establishing contexts in which healthy choices are the default options, such education can be fruitless.

However, when applied consistently and repeatedly, such interventions may have a considerable population impact. An example of this is behavioral counseling for reducing HIV risk.

Again, keep in mind that a combination of interventions at all of these tiers generally is the most effective way to address any given public health problem. By no means are they mutually exclusive.

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Now that we've talked about the various types of interventions public health officials can utilize, let's look at all the ways in which law and policy can help improve public health.

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Laws and regulations have shaped our transportation infrastructure. For example, the federal transportation reauthorization can direct funds to incentivize healthy or dis-incentivize unhealthy modes of transportation.

Creating healthy modes of transportation also has important implications for: obesity (from lack of physical activity), climate change, asthma, mental health, aging in place, and more.

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Law and policy are also critical for developing and enforcing housing guidelines and codes, implementing "Healthy Homes" programs to improve indoor environmental quality, assessing housing conditions, and advocating for healthy, affordable housing.

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State policies can save lives by monitoring prescription information and increasing access to naloxone – the opioid overdose medication often used to reverse the effects of narcotic drugs.

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Laws and policies can also protect public health by strengthening and ensuring the safety of the food system. For example, the Food Safety Modernization Act (signed into law by President Obama on January 4, 2011) enables the Food and Drug Administration to focus more on preventing food safety problems, rather than reacting to the problems after they occur. And state and local laws can set out specific guidelines to improve food safety, and create inspection programs to enforce those guidelines and inform the public about compliance.

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The government can use laws and regulations – especially local land use and economic development policies – to shape the development of the retail environment, which has significant health implications.

For example, laws and policies that improve access to healthy foods are particularly important since healthy food options are often less prevalent in low-income communities and communities of color.

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And finally, laws and policies equip government agencies with the tools and processes necessary to effectively and appropriately respond to public health emergencies. Every state, for example, has laws outlining the scope of state quarantine and isolation powers within its borders.

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We've talked about the history of public health law, and the role of law and policy in modern day public health, such as by lowering smoking rates and addressing issues such as transportation, housing, food access and safety, and emergency preparedness.

Next, we'll discuss who has the power to pass laws affecting public health.

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To answer this question, we must look first to the U.S. 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 those powers listed in the Constitution. These are referred to as "enumerated powers." Some of these powers are express – meaning they are explicitly mentioned by the Constitution, and others are implied – meaning they are necessary to carry out the express powers.

The federal government's powers can be exclusive – that is, only the federal government has the ability to execute them – or they can be concurrent – which means they are 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 talk about shortly, states often delegate at least some of that power to local governments.

Examples of federal power include the authority to levy taxes and to spend for the common welfare. This is known as the Taxing and Spending Clause. 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; it can also be involved in school lunch programs because it provides commodity crops and funding for the free and reduced meal programs.

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

Federal regulations can incentivize local action, most commonly through funding, by setting standards for federal programs that might have a trickle-down effect. The minimum drinking age in the U.S. is an example of this. 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 prohibiting state or local action. Preemption is the sole focus of another Public Health Law Academy training module, but it is also central to this discussion.

The U.S. Constitution provides that federal laws are the "supreme law of the land." That 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 U.S. government has the exclusive authority to control all navigable airspace in the U.S. As a result, state regulation of aviation is preempted because Congress intended to occupy 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 in which he or she may land or cross while flying from coast to coast? NO! It makes great sense to have a single and unified body of law governing airline operations and safety.

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In general, however, 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 the "police power" – is granted to states through the 10th 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 the 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, of course, be arbitrary or oppressive.

Courts are generally deferential to the exercise of this power as long as they meet these requirements.

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States can delegate – or share – this police power with local governments.

The authority to protect the health, safety, and welfare of the community is acknowledged throughout 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 to do so.

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 government to exercise the 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 that maintain a nation-to-nation relationship with the United States.

Tribal sovereignty provides Tribes with the inherent authority to govern themselves, including by promoting public health. However, federal law places certain limits on the Tribal exercise of political sovereignty.

Regardless, on their tribal lands – officially known as Indian Country – Tribes have the power to do what's necessary to *control their internal affairs* and *preserve their self-government*. Courts and legislatures interpret this language very broadly. This includes the power to create their own laws and health regulations to protect the health, safety, and welfare of their communities – for example, by establishing quarantine or isolation provisions or outlining disease reporting requirements.

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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 look at a few . . .

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.

Local governments also have considerable discretion when enacting zoning regulations or land use classifications. This power can be used to permit land uses like farmer's markets.

Protecting the safety of children by requiring them to wear bicycle helmets is another valid use of state and local governments' police power.

And finally, under its police powers, a state or local government can regulate the *sale* of unhealthy products, such as by limiting the portion size of sugary drinks, as New York City tried to do. I should clarify that the reason why New York City's Sugary Drinks Portion Cap Rule was eventually struck down by a court had to do with how the law was enacted, not with any lack of police power authority to pass such a law.

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These government powers 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 two main limitations. The first is preemption, which we have already touched upon here but which is also discussed extensively in a different training module.

The second is the 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 the constitutional limits on public health authority, political feasibility can be a challenging hurdle to overcome.

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The major take-away – and recurring theme – from this section is that the government's authority to protect the public's health must be balanced against the rights of affected individuals.

That 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 our individual liberties. The purpose was to protect individuals from government over-reach and undue control.

So we have a real tension baked right into our core legal documents that pulls in two directions: on the one hand, toward the protection of the common good and on the other toward the 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.

The first three items on this slide will not be discussed in this training, and include:

- The freedom of speech and religion under the 1st Amendment,
- The right to bear arms under the 2nd Amendment, and
- The right to be free of unreasonable searches and seizures under the 4th Amendment.

The last two *will* be the focus of discussion for the remainder of this training and include:

- The right not be deprived of life, liberty, or property without due process of the law under the 5th Amendment, and
- The right not to be denied equal protection of the laws – also under the 5th Amendment.

The Bill of Rights, though part of the federal constitution, also applies to the states through the 14th Amendment. So, for instance, the 5th Amendment provides the right not to be deprived of life, liberty or property without due process of law, and the 14th Amendment prohibits states from depriving individuals of life, liberty, or property without due process of law. The Supreme Court previously had interpreted the 5th Amendment as applying to the federal government, so the 14th Amendment explicitly extended that application to the states.

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

As mentioned on the previous slide, the 5th and 14th Amendments of the US Constitution say that the government cannot deprive individuals of life, liberty, or property without *due process* of law. What does that mean … due process of law? Due process looks at 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 on the following slides.

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Procedural due process means the government has to follow certain procedures to protect our rights. This includes things like the right to an attorney or a fair hearing.

The key question when considering procedural due process is whether the government has allowed 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 when 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 looks not at the *procedures* the government uses but instead at whether the government has a good enough *reason* for depriving someone of life, liberty, or property.

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

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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 talk about more 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 interferences is much higher.

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So, starting 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, or
- The ability to drink and drive or to drive a polluting car.

These may feel very important to someone who wants to do what the government wants to forbid, but as a society, we've decided that these types of activities don't fall into that small category of core, fundamental liberties that deserve special protection.

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When fundamental liberties are not involved – which is the case for the most basic 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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The Court has determined that each of individual interests – marriage, bodily integrity, parenting, and family values – receive the greatest level of protection because they are essential to a person's autonomy or personal dignity. The US Supreme Court has deemed them "fundamental liberties."

Here is a quote from the Supreme Court's 2015 *Obergefell versus Hodges* decision, allowing same sex marriages, that describes fundamental liberties:

> "Under the Due Process Clause of the Fourteenth Amendment, no State shall 'deprive any person of life, liberty or property, without due process of law.' The fundamental liberties protected by this Clause include most of the rights enumerated in the Bill of Rights. In addition, these liberties extend to certain *personal choices central to individual dignity and autonomy, including intimate choices that define personal identity and beliefs*.
>
> Identification and protection of fundamental rights is an enduring part of the judicial duty to interpret the Constitution. That responsibility, however, 'has not been reduced to a formula. Rather, it requires courts to exercise reasoned judgment in identifying interests of the person so fundamental that the State must accord respect.'"

In this quote we not only learn more about current interpretations of liberty related to individual dignity and autonomy, but we also learn that our interpretation of fundamental liberties can evolve over time. Our liberties are not stuck in history but can grow with our understanding of humanity.

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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.

There are two parts to strict scrutiny. For a government action to be constitutional, it must:

- First, intend to achieve a *compelling* goal – that is, something necessary or crucial; not simply preferred. AND
- Second, be *narrowly tailored* or 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 (for example: tuberculosis, ebola, or measles). 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 health by stopping the spread of a contagious, dangerous disease is critical to protecting the common good.

Next, 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 or is there a less intrusive way? The answer to the latter 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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Are you going to remember the nitty gritty of each of these tests? Probably not.

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

If an individual's interest is *minimal*, such as 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, such as 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.

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

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Can the government require parents to vaccinate their children in order to attend public school? As most of you probably 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. And 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 also have the power to carve out exceptions to vaccine requirements, such as for religious or philosophical beliefs, or for medical reasons.

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What about 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.

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Finally, what about for *all* children? Could the government, for example, require all five-year old 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 in determining "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 or death. So, to answer the question – whether the government can require all parents to vaccinate their children – a court would have to balance the two interests as well as determine whether mandatory vaccination is the least restrictive means to achieving the government's goal. Theoretically, states could have immunization requirements for all children, and many do include children who are homeschooled in the school vaccination requirements, which means they are effectively reaching all children.

However, a broad requirement that all children, regardless of any connection to school attendance, be vaccinated likely would not happen in the absence of an outbreak. Remember the *Jacobson* case we talked about earlier – there, the 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 bodies.

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And, now we'll talk about how equal protection enters into the discussion of public health. The term equal protection makes us think about treating different people fairly, but does this mean that the government always has to treat one group the same way as another?

Under the 5th and 14th Amendments, the government may not "deny to any person within its jurisdiction the *equal protection* of the laws." In case you are wondering – yes, these are the same amendments that require Due Process. Some amendments do more than one thing.

Equal protection, in short, prohibits discrimination against someone because that person belongs to a particular group. To put it another way, the government must have a valid justification if it's going to distinguish between members of certain protected categories, such as race or gender.

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Groups that aren't race, ethnicity, or gender based don't get special protection under the Equal Protection Clause, even when the government passes a public health-related law that applies to one group but not another.

For example, we can 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.

The concept of Equal Protection also applies to economic and business regulations: For example, can we treat chain restaurants differently than a mom and pop restaurant in our menu labeling regulations?

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

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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 is generally an easy test to pass, and most government regulations reviewed under this test are upheld.

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So referring back to the slide asking whether the government can treat chain restaurants differently than mom and pop restaurants … Let's spend a couple minutes answering this question. Based on what you've learned about the rational basis test, can the government pass a law that imposes menu labeling requirements on large chain restaurants but not on smaller chains or independents?

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Yes, because a law that applies to bigger but not smaller businesses only needs to be reasonably related to a legitimate government goal. The government could argue that chain restaurants' ubiquity and accordingly greater impact on public health warrant different treatment under the Equal Protection Clause. And that it – the government – has a legitimate interest in promoting public health by reducing diet-related diseases and encouraging healthier eating, and therefore can impose menu labeling requirements on large chain restaurants even if smaller restaurants are not included in the law.

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

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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 a racial or ethnic group when trying to accomplish its goal. If challenged, it is very difficult for a government regulation to be upheld under the strict scrutiny test.

For example, let's say a local city council member is concerned about the disproportionate rates of diet-related disease a predominantly Latino and African American neighborhood that lacks access to fresh foods. That council member wants to draft an ordinance providing incentives for increasing the number of grocery stores in the area.

One way to approach this is to write a law that explicitly says its aim is to address racial inequities and that defines the neighborhood in terms of its racial characteristics. Honing right in on racial disparities as the reason for 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.

Another way to approach the issue is to write a law that singles out the neighborhood by epidemiological data on chronic disease rates regardless of race. This approach will be a lot less risky from a constitutional perspective because it gets the same job done without singling out any racial groups for different treatment.

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Here are a few more equal protection scenarios to consider:

- Can the government quarantine South Koreans suspected of being exposed to Middle East Respiratory Syndrome, or MERS?
- What about limiting the number of fast food restaurants in certain parts of the city? And
- Finally, what about putting an age restriction on buying harmful products?

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Starting with the first question: Can the government quarantine South Koreans suspected of being exposed to MERS?

The answer is: No. The government must have a valid justification for distinguishing between members of certain protected categories, such as race or national origin, and such a law must pass the strict scrutiny test. Since *anyone* traveling to or living in South Korea during the MERS outbreak could just as likely have contracted MERS (regardless of their race or national origin), the quarantine cannot unjustifiably single out South Korean citizens.

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

The answer is: Yes. Zoning codes can restrict the number of fast food chains in certain parts of the city. Remember, however, that the distinctions between different parts of the city cannot be based on the race, national origin, or ethnicity of a community. The restrictions on fast food restaurants should instead be based on other classifications such as geography or disproportionate rates of diet-related diseases.

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Finally, the answer to putting an age restriction on buying harmful products is also: Yes. Unlike distinctions based on race, 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.

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Here's a recap of what we talked about today. We started by looking first at the legal history, to understand the origins of and the foundation for the practice of public health law.

We then talked about how this history shaped the government's modern day public health authority, and what that authority looks like for federal, state, and local governments.

And finally, we discussed the limitations on that authority, which must always be balanced against the rights of affected individuals.

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Thank you for attending our training! Are there any questions?