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Appendix G For the Public's Health: Revitalizing Law and Policy to Meet New Challenges

Report Summary

For the Public's Health: Revitalizing Law and Public Policy to Meet New Challenges, the second of three reports by the Committee on Public Health Strategies to Improve Health, builds on earlier Institute of Medicine efforts to describe the activities and role of the public health system. As defined in the 2003 report *The Future of the Public's Health in the 21st Century* (IOM, 2003), the system is multi-sectoral and comprises governmental public health agencies and various partners, including the community (individuals and organizations), the clinical care delivery system, employers and business, the mass media, and academia, or more broadly, the education sector. The committee's first report (IOM, 2011) redefines the system as simply "the health system." By using this term, the committee seeks to reinstate the proper and evidence-based understanding of health as not merely the result of clinical care, but the result of the sum of what we do as a society to create the conditions in which people can be healthy (IOM, 1988).

The committee's charge in preparing the current report was to "review how statutes and regulations prevent injury and disease, save lives, and optimize health outcomes" and to "systematically discuss legal and regulatory authority; note past efforts to develop model public health legislation; and describe the implications of the changing social and policy context for public health laws and regulations."

"Law is foundational to U.S. public health practice. Laws establish and delineate the missions of public health agencies, authorize and delimit public health functions, and appropriate essential funds," wrote Goodman and colleagues (2006, p. 29). The law is also one of the main "drivers" facilitating population health improvement. The committee believes now is a critical time to examine the role and usefulness of the law and public policy more broadly, both in and outside the health sector, in efforts to improve population health. This sense of urgency is due to recent and evolving developments in the following areas: the sciences of public health; the economy (i.e., the economic crisis and the great uncertainty and severe budget cuts faced by governmental public health agencies); the social and legislative arenas (e.g., the *Affordable Care Act*); the functioning of public health (e.g., fragmentation of government response to public health issues, lack of interstate and intersectoral coordination of policies and regulations); and the health of the population (e.g., data on the increasing prevalence of obesity and poor rankings in international comparisons of major health indicators).

In the report's second chapter, the committee examines the laws that codify the mission, structure, duties, and authorities of public health agencies. The chapter also examines the loci—federal, state, and local—of government action to manage different types of health risk, as well as the interaction among the levels of government. In the third chapter, the committee discusses statutes, regulations, and court litigation as tools specifically designed to improve the public's health. In the fourth chapter, the report explores non-health laws and policies that are enacted or promulgated in other sectors of government, but have potentially important impacts on the public's health. These include public policy in areas such as transportation, agriculture, and education. Numerous examples of policies adopted in various sectors of government have had unintended consequences for health. These include (1) agricultural subsidies that spurred the development of inexpensive sweeteners, which are a key component of nutrient-poor foods and beverages, and (2) a national education policy that has led to diminished and even nonexistent physical education in schools.[1] The chapter discusses the intersectoral nature of the influences on the public's health, and refers to structured ways to consider health outcomes in all policymaking—a "Health in All Policies" (HIAP) approach. This approach takes into account health-producing or health-harming activities in all parts of government, as well as those of private sector actors. In this chapter, the committee also continues its discussion of the broad determinants of health begun in its first report, but now in the context of legal and policy interventions, many located outside the health sector or involving multiple sectors. The chapter ends with a discussion of the evidence needed for "healthy" policymaking.

The report's key messages focus on three major areas. First, the committee finds that laws and public policies that pertain to population health warrant systematic review and revision, given the enormous transformations in the practice, context, science, and goals of public health agencies and changes in society as a whole. Second, the committee urges government agencies to familiarize themselves with the toolbox of public health legal and policy interventions at their disposal. Also, the report discusses evidence of the effectiveness of legal and policy tools, as well as efforts to advance the science needed to inform policymaking to improve the public's health. (The effectiveness of policy interventions is especially noteworthy against a backdrop of current and future economic exigencies and the high premium placed on efficiency and accountability.) Third, the committee encourages government and private sector stakeholders to explore and embrace HIAP for their synergistic potential. The consideration of health in a wide range of public- and private-sector policymaking will lead both to improvements in population health and to the achievement of priority objectives in other sectors, such as job creation and educational reform, and a more vibrant and productive society. The report offers 10 recommendations and a conclusion to address the challenges it identifies and enhance the use of law and public policy to improve population health.

RECOMMENDATIONS

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Public health statutes—the laws that define the authorities and roles of federal, state and local public health agencies—were enacted when major population health threats were due to hygiene factors (water, food, sanitation), communicable diseases, public safety issues, maternal and child health challenges, and occupational injury and illness. The contemporary burden of disease has shifted increasingly to chronic conditions and injuries as infectious disease declined, but the evolving physical, social, and built environments have contributed new challenges. In addition to the health hazards of another era, older public health laws currently "on the books" were informed by the scientific standards of the day and the statutory context and constitutional jurisprudence of their time, including conceptions of individual rights. Some laws were enacted in piecemeal fashion in reaction to contemporary epidemics, leading to layers of statutory accretion rather than holistic or comprehensive legislation (Gostin et al., 2008).

Two major efforts to review and update public health law took place around the turn of the 21st century. These were the *Turning Point Model State Public Health Act* (1997–2003) and the *Model State Emergency Health Powers Act* (MSEHPA) (2001–2002). The *Turning Point Model Public Health Act* was a broad (though not comprehensive) model law composed of nine articles and incorporating two other model acts—a revised version of the MSEHPA in the article pertaining to emergency powers, and the *Model State Public Health Privacy Act* (Gostin et al., 2001, 2002). Despite the development and dissemination of these model acts, their use for widespread updating or modernization of public health statutes has been limited. Most public health law in jurisdictions today remains grounded in late 19th and early 20th century experiences. The *Turning Point Model State Public Health Act* and the *Model State Emergency Health Powers Act* drew on actual high-quality laws already in place in various jurisdictions around the country, and could continue to serve as benchmarks (i.e., legal best practices) in the process of reviewing and updating enabling statutes. Efforts may be made to identify statutory benchmarks in additional areas not explicitly covered in the existing model acts, such as performance measurement and accreditation, and contemporary leading causes of disease and death.

Recommendation 1: The committee recommends that state and local governments, in collaboration with their public health agencies, review existing public health laws and modernize these as needed to assure that appropriate powers are in place to enable public health agencies to address contemporary challenges to population health.

The 10 Essential Public Health Services (10 EPHS) (see Box S-1) are widely accepted and often incorporated into public health practice and in current strategies to measure and improve public health performance. However, the 10 EPHS are generally not incorporated into public health agency that enables statutes as standard of practice in public health (Meier et al., 2009). Exceptions are largely found in states that have updated their statutes (Meier et al., 2009). The committee believes all communities deserve access to the public health protections and services embodied in the language of the 10 EPHS and codified in the referenced model acts.

BOX S-1

The 10 Essential Public Health Services. Monitor health status to identify and solve community health problems. Diagnose and investigate health problems and health hazards in the community.

Changes in agency structure and organization are necessary to enable all jurisdictions to provide access to the full array of public health services. The wide range of programs and interventions that are consistent with operating under the 10 Essential Public Health Services can be (and in some cases are being) delivered directly by the state health department, by each local health department, by public health system partners, or by various permutations thereof including through centralization, regionalization, or interjurisdictional compacts among different agencies.

Many local public health agencies are small and have limited capabilities. Proposals have been made to explore different ways to reorganize local public health structure toward greater effectiveness, including through organizational restructuring, such as consolidation of services among public health agencies (IOM, 2003). However, multiple formidable barriers exist to such actions including state constitutions and court rulings as well as statutory requirements of local and state governments (Baker and Koplan, 2002; IOM, 2003; Libbey and Miyahara, 2011). These legal impediments urgently need to be re-examined and revised to improve the effective use of existing public health resources and broaden the impact of needed investments.

Recommendation 2: The committee recommends that states enact legislation with appropriate funding to ensure that all public health agencies have the mandate and the capacity to effectively deliver the Ten Essential Public Health Services.

Public health accreditation has been discussed for decades in the U.S. public health community, and many public health agencies have engaged in a variety of certification, accreditation, and performance measurement activities at the national, regional, and local levels. However, public health is far behind its clinical care system counterparts in implementing accreditation standards as uniform measures of performance. Despite a rich literature on health care accreditation, the empirical evidence for accreditation correlations between accreditation and performance is uneven, with modest positive findings for certain outcomes (e.g., promoting change through the self-evaluation that occurs in preparation for accreditation).

Nevertheless, the field of accreditation is moving in the direction of better data collection and more research. The committee believes that national public health accreditation, which is evolving and is not yet a mature process, holds the potential of becoming a mechanism toward certifying that an agency's delivery of the core public health functions and 10 EPHS meets uniform standards, and at a future date, perhaps, can be positioned to certify that they are executed with excellence.

The public health accreditation movement shares elements with many activities in and outside the public sector. These include measurement and reporting of performance, transparency in operations, and accountability for process and outcome. These contemporary values are reflected in the *Government Performance and Results Act* of the 1990s and in the current administration's Open Government Initiative. Existing public health statutes often do not reflect current demands for accountability and its relationship to the structure, function, and authority of public health agencies. As discussed in the committee's first report, it is necessary to integrate accountability into the way public health agencies *and* their partners perform their functions.

For the reasons described—the widespread use of accreditation in health care, and the public and policymaker familiarity with the notion; the need for a higher level of accountability and transparency; and the potential usefulness of accreditation in improving quality and other outcomes—the committee finds that national accreditation holds promise as a conduit in aiding governmental public health agencies to demonstrate minimum structural and quality process capabilities.

Recommendation 3: The committee recommends that states revise their laws to require public health accreditation for state and local health departments through the Public Health Accreditation Board accreditation process.

Several states have their own accreditation processes in place. These should resemble or be as rigorous as those set by the Public Health Accreditation Board. All states should set goals to have these standards in place no later than 2020.

Legal Capacity

Appropriately trained legal counsel needs to be readily accessible for all policy discussions in public health agencies to facilitate clear understanding of the legal basis for public health initiatives or interventions. The increasing availability of legal technical assistance from several existing national academic or not-for-profit sources, while beneficial, cannot take the place of an official legal advisor who is recognized by, and part of the same team as the health officer and the jurisdiction's chief executive. The committee recognizes that many agencies are too small to have their own dedicated counsel, and that some type of resource-sharing arrangement, aside from broader restructuring such as consolidation or regionalization, would be needed.

Public health agency legal counsel requires training in public health and in public health law. Attorneys counseling public health agencies also must possess knowledge and experience in the following areas: laws that establish the public health agency and set forth its jurisdiction and authorities, programmatic aspects of the agency's work, and procedures and processes consistent with applicable laws and policies. Such training, knowledge, and experience can be obtained through adequate career ladders within a health department, through education or, ideally, through a combination of both. One of the prerequisites for strengthening public health law capacity in health departments is the availability of legal training in schools of public health (for example, for individuals wishing to pursue a JD/MPH, and for other public health students) and in schools of law for individuals interested in public policy, and especially its health dimensions.

Recommendation 4: The committee recommends that every public health agency in the country have adequate access to dedicated governmental legal counsel with public health expertise.

Federalism and Preemption

"Preemption occurs when a higher level of government restricts, or even eliminates, a lower level of government's ability to regulate an issue" (NPLAN and Public health Law Center, 2010, p. 1). Preemption can advance or impede the achievement of population health objectives. States and localities play a vital and historic role in safeguarding the public's health and safety. They can be "laboratories" of innovation, with greater flexibility than at the national level. Consequently, unless there are compelling reasons to the contrary, the federal government ought not preempt state and local authority in advancing the public's health. A provision of the *Affordable Care Act*, for example, preempts state and local authority to require menu labeling in restaurants and vending machines that diverges from (e.g., is stricter than) the federal standards outlined in the Act. Although federal oversight of food manufacturing and processing may be appropriate because of its close nexus to interstate commerce, restaurants are locally regulated relative to sanitary standards and are locally permitted establishments. Other federal statutes, like the *Health Insurance Portability and Accountability Act*, create a national protective floor, but allow the states to enact stricter standards. This kind of "floor preemption" is usually preferable, enabling states and localities to enact more protective public health regulations.

Preemption in the field of public health may also lead to non-enforcement of a preemptive federal standard. When a federal agency is given preemptive authority to regulate in an area where local public health agencies have a greater capacity and infrastructure to regulate, the result is likely to be that the public health measure will not be enforced. In such instances preemption, and certainly "ceiling" preemption, should be avoided or arrangements for local enforcement should be put in place.

When considering the appropriateness of preemption the impact on public health and enforceability must be assessed. As the federal government embarks on a regulatory review to determine whether federal regulations unnecessarily hamper business activity, the committee urges that this principle be upheld and efforts be made to avoid creating new or interpreting existing preemptive laws in ways that may have unintended and unhealthful consequences.

Recommendation 5: The committee recommends that when the federal government regulates state authority, and the states regulate local authority in the area of public health, their actions, wherever appropriate, should set minimum standards (floor preemption) allowing states and localities to further protect the health and safety of their inhabitants. Preemption should avoid language that hinders public health action.

Some recent legislation, such as the *Affordable Care Act*'s establishment of menu labeling requirements, extends particular public health protections nationally, but also vests the Food and Drug Administration with regulatory authority over facilities it has not previously regulated, such as food service establishments that have been in the purview of state or local public health agencies. In these types of settings, the federal agency is unable to adequately enforce these requirements. Furthermore, federal efforts would be duplicative of state or local enforcement. Statutes and regulations need to allow public health agencies to enforce standards as necessary to protect and promote the public's health. Collaborative efforts are needed to facilitate enforcement of federal standards by states or localities. However, mandating that states and localities assume this federal responsibility would not be helpful unless they have adequate funding to do so.

Recommendation 6: The committee recommends that federal agencies, in collaboration with states, facilitate state and local enforcement of federal public health and safety standards, including the ability to use state or local courts or administrative bodies where appropriate. Federal, state, and local agencies should combine their resources, especially in areas where regulatory authority is vested in one level of government, but enforcement capacity exists in another level.

Intersectoral Laws and Policies That Contribute to the Public's Health

Significant and compelling evidence indicates that policies enacted by government agencies beyond the health sector have substantial effects on the health of the population. A Health In All Policies approach requires policymakers, with the support of public health agencies, to adopt a collaborative and structured approach to consider the health effects of major public policies in all governmental sectors. This "all-of-government" approach offers the benefits of improving health while also achieving key objectives in other parts of government. Seen from the perspective of other sectors, HIAP approaches could enhance their ability to achieve their own objectives because improvements in population health can have wide-reaching effects on many aspects of society.

A multi-sector strategy that explicitly considers the impact of non-health sector action on U.S. health can create progress in that sector (e.g., transportation, agriculture) while simultaneously increasing the quality of life, longevity and economic productivity of the population.

Recommendation 7: The committee recommends that states and the federal government develop and employ a Health In All Policies (HIAP) approach to consider the health effects—both positive and negative—of major legislation, regulations, and other policies that could potentially have a meaningful impact on the public's health.

As acknowledged in the committee's report on measurement, there is no formal accountability process for private-sector entities that influence, for good or bad, the health outcomes for the community (IOM, 2011). This is significant because an estimated one-third of overall public health expenditures are incurred by nongovernmental public health partners, such as employers and schools (Mays et al., 2004). Although the committee proposed a measurement framework for accountability in its first report, it did not discuss in any detail the issues of governance and the types of organizational structures that may be useful in operationalizing the framework, especially outside governmental agencies.

As noted in the first report, private sector employers, community organizations, and other stakeholders in the multisectoral health system can contribute to health through their actions including through policy. These actions range from employee health and wellness initiatives to efforts to strengthen potentially health-enhancing features of communities. In its present discussion about law and policy, the committee uses the model of the National Prevention, Health Promotion, and Public Health Council and its associated public–private advisory group as a point of departure for envisioning how intersectoral action on population health could be planned and implemented across government agencies and between the public and private sectors.

Recommendation 8: The committee recommends that state and local governments

- **create health councils of relevant government agencies convened under the auspices of the chief executive;**
- **engage multiple stakeholders in a planning process; and**
- **develop an ongoing, cross-sector, community health improvement plan informed by a HIAP approach. Stakeholders will advise in plan development and in monitoring its implementation.**

Evidence to Inform Policy

The rationale for all population health interventions, including laws, must be based on the best evidence available while taking into consideration the strength of the available evidence, the level of uncertainty surrounding the evidence, and the risk of harm (economic or health-related) that arises from implementing or failing to implement. In some cases, the best available evidence may be limited. In those cases, new laws and judicial review of public health legal interventions will need to be built on sound theory and the opinion of content experts. Such limited evidence may be used to craft legal interventions when health threats and potential harms from inaction are large; when opportunity costs and unintended harms from action are within acceptable limits; and when the time or costs required for gathering more definitive evidence are substantial relative to the expected value of the additional evidence.

In some cases, assessments of health impact may not be necessary or useful, such as in the cases of modest-sized commercial developments in a community or policies that are largely unrelated to or expected to have negligible health impacts. In other cases, assessing the impact is imperative to determine a policy's likely extent of negative or positive effects on population health and to take action to avert damaging consequences. Such cases would include several major health-consequential federal laws that require periodic reauthorization (e.g., the transportation bill).

Accurate and complete assessment of the outcomes and benefits of public health laws is complicated by the fact that the effects of laws are frequently distributed across multiple segments within the population, and affect multiple health and social endpoints over long periods of time. Thus, outcome measures for public health laws need to consider not only measures of mortality and morbidity, but also important intermediate outcome measures.

Legal interventions merit study for their effectiveness and comparative effectiveness (both against other legal intervention and compared to other kinds of interventions). Furthermore, a system of surveillance could be developed and pilot-tested to track the progress of efforts to expand the geographic reach of effective policies and laws, and to identify unmet needs for policy development and advocacy strategies. Although the administrative and methodological task of such research is challenging, the committee asserts as a general principle the obligation of policymakers to study, to whatever degree possible, the potential ramifications of policies in any sector that could substantially affect the health of the public.

Recommendation 9: The committee recommends that state and federal governments evaluate the health effects and costs of major legislation, regulations, and policies that could have a meaningful impact on health. This evaluation should occur before and after enactment.

This recommendation applies to both public health and non-public health agencies, working in concert. Before or after enactment, a scientific assessment would be conducted whenever possible. Before enactment of such policies, the vested authority (e.g., the public health agency) would study the potential health impact and/or cost-effectiveness. After enactment, the authority would review the health outcomes and costs associated with implementation of the policy and would, where appropriate, offer recommendations to the chief executive and legislature on changes that would improve outcomes.

Such evaluation and assessment could be conducted by the responsible agency, such as through *National Environmental Policy Act* (NEPA) requirements, or by the public health agency. Several models exist for requiring and conducting assessments of health policy impact, including government commissioning of assessments (e.g., actuarial analyses) of the impact of all health policies, and the requirements of NEPA. A knowledge base exists for crafting an accepted framework for evaluating the evidence of public policies, but an interdisciplinary team of experts is needed to build on the existing literature, review methodological challenges, and arrive at a consensus on preferred criteria.

Recommendation 10: The committee recommends that HHS convene relevant experts to enhance practical methodologies for assessing the strength of evidence regarding the health effects of public policies as well as to provide guidance on evidentiary standards to inform a rational process for translating evidence into policy.

Such guidance would include (1) methods for assessing the certainty of effectiveness (benefits and harms), and if a law or policy is effective, the magnitude of effect, for suitable populations; (2) methods for assessing the effectiveness of interventions (policies and programs) when used alone or in combination (i.e., their incremental and or synergistic benefits); and (3) priorities for and consideration of the contextual issues when determining whether (and where) to implement policies. The contextual issues to be considered include importance of the problem (severity, frequency, burden of disease, cost), feasibility (affordability, acceptability), availability of alternatives, demand, fairness (equity), preferences and values, cost-effectiveness, potential to advance other societal objectives, potential for harms, legal and ethical considerations, and administrative options.

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Footnotes

Go to:

1 For a discussion of the effect of the No Child Left Behind policy on physical education in schools, see http://sports.espn.go.com/espn/otl/news/story?id=4015831.

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