RECLAIMING PUBLIC HEALTH AUTHORITY: Toward a Legal Framework that Centers the Public's Health, in the Courts and Beyond

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Abstract:
This paper summarizes key shifts in judicial decisions relating to public health pow- ers during the pandemic and the implications of those decisions for public health practice. Then, it gives a preview and call for partnership in devel- oping a legal framework for authority that guides public health to better activities, processes, and accountability in service of the public's health.

Introduction

State and federal statutes give executive officials broad authority to respond to public health threats. These "public health powers" can be abused, but can also be critical to protecting the public's health, including during pandemics. Amidst backlash to COVID-19 public health orders, some courts and legislatures have limited these powers. Act for Public Health (A4PH) — a partnership of public health law organizations — tracks this activity.[1] Based on more than 1,200 recent judicial decisions,[2] we demonstrate shifts in how courts review public health orders. We also ask what laws should be in place to support a more just and effective public health system.

A Tradition of Deference

Traditionally, judicial review has played a critical role in ensuring that officials can safeguard the public's health without violating constitutional rights or oth- erwise misusing their powers. Although courts have taken varied approaches, they generally have deferred to public health authorities, both in construing the scope of public health powers and in reviewing their application. As Chief Justice Roberts explained in 2020:

> Our Constitution principally entrusts "[t]he safety and the health of the people" to the politi- cally accountable officials of the States "to guard and protect…" ... Where those broad limits are not exceeded, they should not

be subject to second-guessing by an "unelected federal judi- ciary," which lacks the background, competence, and expertise to assess public health and is not accountable to the people.[3]

At the beginning of the COVID-19 pandemic, most courts adhered to this tradition, rejecting most challenges to public health orders. This deference extended to claims brought under the Free Exercise clause of the First Amendment, challenging restrictions on religious gatherings. Courts generally rejected such challenges, citing both the Supreme Court's seminal 1905 decision in Jacobson v. Massachusetts, which upheld a smallpox vaccination mandate during an outbreak, and the 1990 decision in Employment Divi- sion v. Smith, which held that a regulation of general application does not violate the Free Exercise clause if it is rationally related to a legitimate governmental purpose.[4]

The Erosion of Deference: Free Exercise Challenges

After Justice Amy Comey Barrett replaced Justice Ruth Bader Ginsburg on the Supreme Court, its approach changed. In November 2020, in *Roman Catholic Diocese v. Cuomo (RCD)*,[5] the Court issued a *per curiam* opinion from its "shadow," or emergency, docket holding that a New York regulation of worship was subject to strict scrutiny, the highest form of judicial review, because the state, in the Court's view, regulated worship more strictly than some comparable secular activities. The Court also concluded that the order could not withstand strict scrutiny because it was not the least restrictive means to achieve a com- pelling state interest. In its analysis, the Court neither deferred to health officials nor considered scientific evidence.

After *RCD*, the Court granted several other petitions challenging health orders on religious liberty grounds. Most critically, in Tandon v. Newsom, the Court blocked a California law, which regulated the number of people who could meet in a private home, as applied to petitioners who sought to meet for Bible study.[6] The opinion emphasized that the state regulated some secular activities, such as shopping, less strictly. As in RCD, the Court didn't defer to health authorities or consider the scientific evidence. The Court's approach effectively granted religious worshippers the right to opt out of broadly applicable public health laws if the state granted at least one type of secular exemption that the Court deemed comparable.

The Major Questions Doctrine

Plaintiffs also challenged COVID-related public health measures as exceeding government officials' statutory authority. Previously, under the *Chevron* doctrine, lower federal courts were obligated to defer to officials' interpretation of the scope of their author- ity as long as the enabling statute did not clearly pro- hibit their interpretation.[7]

As the pandemic continued, federal courts took a markedly new approach. Most importantly, in *Alabama Association of Realtors v. Department of Health & Human Services* the Supreme Court blocked the CDC's eviction moratorium, stating that Congress must use "exceedingly clear language if it wishes to significantly alter the balance between federal and state power and the power of the Government over

private property."[8] Termed the "major questions" doctrine, this approach requires a very clear delegation of authority by Congress for executive officials to regulate on issues of great economic and political significance. Subsequently, the Court applied this approach to block an emergency temporary standard by the Occupational Safety and Health Administration that ordered large employers to require employees to either be vaccinated or submit to testing and masking.[9] Lower federal courts later relied on the doctrine to enjoin CDC's order requiring masking on public transportation and vac- cine mandates for federal employees and contractors.[10]

Most state courts continued to read state public health powers broadly.[11] However, supreme courts in Michigan, Pennsylvania, and Wisconsin held that health orders exceeded the delegated authority.[12] And since 2022, the Supreme Court has applied the major questions doctrine and its COVID-related precedent to other contexts, including environmental law.[13]

The Fallout

As we move into the post-COVID era, one major area of impact has been vaccine law. Although most states include religious exemptions in their childhood vac- cine laws,[14] before COVID-19, numerous courts had held that such exemptions were not required.[15] Since COVID-19, litigants have relied on *Tandon* to argue that by granting medical but not religious exemptions, states have violated the Free Exercise Clause. In 2023, a federal court in Mississippi accepted that argument and ordered the state to provide religious exemp- tions, and a federal judge in Maine rejected the state's motion to dismiss a challenge to Maine's vaccine law.[16] Conversely, the Second Circuit rejected a challenge to Connecticut's lack of a religious exemption to its child- hood vaccine law, finding that medical and religious exemptions were not comparable.[17]

More generally, the decline of judicial deference to public health powers evident during the pandemic is related to broader trends that imperil the government's ability to protect the public's health and safety.

For example, a federal district court has ruled that the provision of the Affordable Care Act that ensures access to preventive services without cost-sharing is unconstitutional, and the Fifth Circuit has ruled that the FDA acted unlawfully in expanding access to the abortion medication mifepristone.[18] The Supreme Court has also made it harder for governments to regulate firearms and is considering eliminating the Chevron doctrine.[19]

These shifts in judicial approaches to public health decision-making may affect how practitioners respond to health threats, possibly extending beyond pandemic and emergency response to influence day-to-day pub- lic health activities. Legislative activity in some states also mirrors these limitations imposed by the courts.[20]

Troublingly, research shows a relationship between poorer COVID-19 outcomes and the political environments fostering such public health limitations, such as higher mortality rates and stress on hospital inten- sive care unit capacity.[21] Such changes to public health authority — the legal underpinnings that facilitate and guide public health activities — have potentially profound implications for the health and wellbeing of all people, especially marginalized communities.

Toward a Legal Framework

Amid the many rollbacks, some jurisdictions have made changes to public health authority to better support a more just and effective public health system.[22] These examples showcase what is possible when pub- lic health agencies are empowered to take evidence-backed steps to protect and promote the health of all people in their communities. To move from specific examples to broader principles requires a bigger-picture visioning of a just public health system as a whole, and particularly of the laws underlying that system. In this visioning, it is helpful to dig deeper into the concepts public, health, and authority, to identify key underlying legal principles, processes, and goals.

How can laws ensure public health activities serve the public? Effective, broadly applicable interventions require sufficient legal authority, and to address struc- tural power imbalances, they must also be grounded in community partnerships. Public health interventions must also consider a full range of health impacts across the communities they are meant to serve, especially those underserved or marginalized by existing systems. How can laws ensure public health activities pro- mote health? Health for all people includes ensuring access to Foundational Public Health Services,[23] improving social determinants of health,[24] and reducing the drivers of health inequity[25] like discrimination, poverty, and obstacles to meaningful participation in governance.

Finally, how can laws ensure just and effective applications of public health authority? The exercise of public health authority should follow clear standards that rely on sound legal principles, sound science, and com- munity needs. Officials' actions should be transparent and accountable to the public they serve, and the law should spell out processes to measure outcomes and to track impacts, both intentional and unintentional. Recognizing historical harms caused by public health and the resulting mistrust, laws and governance struc- tures must also include appropriate guardrails.

Conclusion

Building on the findings from our litigation and leg- islative tracking and outreach activities, A4PH partners are working to re-imagine what public health authority can and should look like by focusing both on the development of the new legal framework and, relatedly, on the role of the judiciary. This includes working with partners from both within and outside public health. With respect to the courts specifically, it requires strategic thinking and a series of action- oriented next steps, such as submitting amicus briefs, developing brief banks, educating lawyers and judges about public health, and new outreach to private-sector partners.

Although the COVID emergency has waned, attacks on public health authority continue. They require a coordinated response that does not simply preserve or reinstate the status quo, but also asks how the law can contribute to creating a more sustainable, equitable, evidence-based public health system.

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