


## PUBLIC HEALTH STATUTES AND REGULATIONS Fact Sheet

# Strengthening Public Health Authority to Contain and Prevent Communicable Disease

In its pervasive scope, its high rate of asymptomatic spread, and its economic impact, the COVID-19 pandemic has been unprecedented in the United States and the world. Yet in other respects, the U.S. public health system was designed, and has evolved, in response to a series of precedents with respect to outbreaks and epidemics of communicable diseases including tuberculosis, cholera, smallpox, polio, measles, chicken pox, hepatitis, HIV/AIDS, Ebola, and influenza. The practical tools and legal authority of federal, tribal, state, and local public health officials to contain the spread of infectious disease have developed through an ongoing process of balancing and aligning a number of important interests. Public health officials and practitioners who are able to explain and demonstrate the critical role of robust and effective public health legal authority in an emergency will maximize their ability to inform and influence the conversation about adjustments to public health authority during and after the COVID-19 pandemic, navigate any controversy that may arise in the future, and retain the support of their communities.

In many respects, public health authority rests on a strong foundation. Relatively recently, and partially in response to a [1988 recommendation by the Institute of Medicine](#), as well as the threat of terrorism (including bioterrorism) and naturally occurring infectious diseases at the dawn of the 21<sup>st</sup> century, many states engaged in [multi-state, multi-year initiatives](#) to update and modernize statutes and regulations that govern public health emergencies. These efforts included (1) a [Model State Emergency Health Powers Act](#) (MSEHPA), (2) the [Turning Point Public Health Statute Modernization Collaborative](#), which produced a [Model State Public Health Act](#), and (3) committees of the [Uniform Law Commission](#), including a committee which proposed a [Uniform Emergency Volunteer Health Practitioners Act](#) for consideration by state legislatures. Importantly, all three of these efforts involved collaboration, discussion, and debate among public health practitioners, lawyers, and policy-makers in a variety of jurisdictions. Other key stakeholders, including the business, faith, and healthcare communities, as well as educators, and nonprofit and community-based organizations, also participated to some extent.

A quick review of the [table of contents for MSEHPA](#) hints at some of the key flashpoints in controversies during the COVID-19 pandemic, such as testing, contact tracing, surveillance activities, isolation and quarantine, business and school closures, vaccination, nondiscrimination, coordination and collaboration across



jurisdictions and sectors, emergency declarations, access to PPE, mutual aid, data privacy, workforce development, and enforcement. Before the nation has even fully emerged from one of the worst threats to public health in over a century, the amount of [legislation proposed to categorically limit and re-allocate public health authority](#) (i.e., from the executive branch to the legislative branch or from the local to state level), often with no standards to guide legislative bodies is nothing short of astonishing. These laws have clearly been tested by their first application of community mitigation measures at such a large scale. A [set of principles](#) to guide legal reform has been proposed by legal scholar Lindsay Wiley, and may provide a useful reference point for consideration in discussions. The need for legal analysis and legislation that seeks to engage with and improve upon this legal framework, rather than simply change the governmental decision-makers or strip public health authority altogether, is urgent.


Together with its partners in emergency preparedness, management, and response, as public health legal authority developed, the public health field began to develop the infrastructure to enhance the relevant knowledge, skills, and expertise among its workforce. These include opportunities to develop knowledge, practical skills, and relationships with key partners through the [Hospital Preparedness Program](#). [Legal preparedness](#) has been a primary area of focus, including through [online training in emergency public health law](#), as supported by the CDC's public health law program, as well as by the [National Incident Management System](#), and the [Emergency Management Institute](#). Many in public health have embraced [voluntary accreditation](#) in order to elevate the standard of practice, including attending to the ongoing need to update and implement relevant laws and policies. Legislative efforts to restructure public health systems at the local and regional level in order to [share services](#) and make the most of scarce resources have been ongoing, as with the recent [Blueprint for Public Health Excellence](#) and [State Action for Public Health Excellence](#) in [Massachusetts](#).

The public health field has a [demonstrated capacity for self-reflection and reinvention](#), as evidenced by the recent Public Health 3.0 initiative. As the nation emerges from the COVID-19 pandemic, public health leaders and practitioners must engage in honest and searching self-reflection. [After action reports](#) are an established tool for reflection and recommendations for corrective action and improvement that should be put to use, with the need to communicate effectively with both expert and lay audiences firmly in mind.

Legislative and financial efforts to strengthen public health infrastructure and workforce are critical to meet the everyday challenges of protecting public health, address and remove the systemic factors that contribute to inequitable health outcomes, and prepare for and overcome large-scale challenges such as new infectious diseases and climate change. With the concerted effort of leaders and practitioners in the public health field, such reforms may come to the fore in the years ahead, particularly if some of the more sweeping and reactive laws enacted have the foreseeable effect of rendering response to public health emergencies substantially less effective in the affected jurisdictions. The remainder of this fact sheet describes some initial steps in the direction of strengthening public health authority.

## **Strengthening Public Health: A Legislative Overview**

As states assess their responses to the COVID-19 pandemic and consider reforms, it is important that they take action to clarify and strengthen public health emergency powers. Any changes should follow a clear set of principles, allowing for a nuanced response that is evidence-based, ensures accountability, and protects individual rights. Current attempts by state legislatures to enact blanket curbs on public health emergency power fail to recognize that future pandemics will pose different risks that require flexibility to act in accordance with the threat. During the 2020 and 2021 legislative sessions, some governors successfully vetoed bills that




would have weakened their emergency powers (see for example [Louisiana](#) and [Michigan](#)), while some state legislatures have seen failed attempts to get such legislation passed (see [Washington](#)). While many state legislatures were successful in advancing bills limiting and re-allocating public health authority, others successfully passed measures to improve collective decision-making, strengthen local public health authority, and increase transparency.

There are few outright examples of bills that would solely strengthen emergency powers, which is perhaps a reflection of the lack of coordinated efforts in this arena parallel to the [efforts to limit emergency power](#) through template legislation provided to conservative lawmakers. Many bills contain provisions that strengthen some aspect of the public health emergency response, while weakening some others. Florida's Senate Bill 2006 (SB2006), recently signed into law, is an example of this. SB2006 severely limits local public health emergency powers, gives the legislature expanded authority, and places restrictions on businesses regarding vaccine requirements. However, it also makes public health emergencies subject to the State Emergency Management Act, formalizing a finding in [Abramson v. DeSantis](#) that a pandemic is a "natural emergency" for the purposes of the Act, and potentially allowing for better preparation and coordination across state agencies for future emergencies. It also requires the Department of Health to submit an emergency management plan, requires an inventory of state-owned personal protective equipment, and requires medical examiners to certify deaths and to assist the State Health Officer in identifying and reporting deaths if requested, among other things.

One major trend for the better among state legislatures is establishing commissions or other advisory bodies to make recommendations regarding public health emergency response efforts. In New Jersey, the [Local and County Health Department Infectious Disease Preparedness Study Commission](#) was established early in the pandemic to assess the roles and responsibilities of local and county health departments, communication and coordination with the state health department, and to make recommendations on improving the response to future outbreaks. In Alabama, the [Pandemic Response and Preparedness Commission](#) was established to study the state's response to COVID-19, assess the state's response against efforts in other states, and to make recommendations that will assist in a more effective response to future pandemics. New Mexico took a generalized approach and requested the state department of health to convene a [public health task force](#) to study and make recommendations regarding the public health infrastructure, workforce, and laws that protect public health. Finally, there is also a federal bill ([H.R. 1306](#)) that would establish the *Commission on the Coronavirus Pandemic in the United States*. Notably, none of these commissions explicitly includes community members as appointees although [community participation is critical](#) to a successful pandemic response.

A second positive trend among state legislatures is taking measures to strengthen local public health emergency authority. In line with the previous trend, Washington ([House Bill 1152](#)) established a public health advisory board to the department of health that includes community representatives, and also in the same bill changed the composition of local boards of health to require members who are not elected officials and who are in a defined list that includes public health and health care practitioners, people with an MPH or equivalent, community health workers, Tribal representatives, and consumers of public health. In Oklahoma, [Senate Bill 736](#) (enacted) allows for the creation of health districts composed of two or more county boards of health operating under a contractual agreement to share resources with the intent of maximizing public health services and outcomes. The Massachusetts legislature is considering a bill ([H.3717](#)) that would allow some mayors, city managers, and selectmen to impose limitations on businesses during a declared emergency.

A third positive trend is bills related to increasing transparency and accountability. The most common requirement is for some form of written explanation or justification for actions taken. Examples include Florida (noted above), requiring the governor to state specific reasons for school and business closures, and Oregon ([House Bill 2243](#)), requiring written, fact-based, public explanations for declarations and extensions of states of



emergency, including geographic scope. Both New York ([Assembly Bill 4907](#)) and Hawaii ([House Bill 103](#)) are considering bills that would, among other things, require an explanation and written justification for the suspension of any laws. In addition to written explanations, legislatures have also considered or enacted bills to require public hearings or public comment. Colorado [House Bill 1426](#) requires the governor to provide comprehensive information to the legislature and respond to questions about a current disaster emergency. A New Jersey bill ([A5543](#)) would require the governor to hold public hearings throughout the state when there is a declared public health emergency. It remains to be seen in implementation if these attempts at increasing transparency will just create more bureaucracy and harmful delay or if they will serve to bolster public confidence in governmental agencies and actors.


## **Federal Financial Resources to Strengthen State and Local Response to Public Health Emergencies: The American Rescue Plan Act**

In addition to certain state-based initiatives to empower public health emergency (PHE) preparedness and response efforts, the federal government has provided additional emergency response support and aid to states and localities via [the American Rescue Plan Act](#) (ARP or the Act). Signed into law by President Joe Biden on [March 11, 2021](#), the [\\$1.9 trillion package](#) contains billions in disaster relief via the Federal Emergency Management Agency (FEMA) to support responses to the COVID-19 emergency, as well as funding to ensure preparedness in future emergencies. Included in this relief is [\\$100 million to FEMA for emergency management performance grants \(EMPGs\)](#), which provide funds to help state, local, Tribal, and territorial governments' emergency management agencies be prepared in implementing the National Preparedness System and improve the ability to, among other objectives, mitigate loss of life in future disasters. [FEMA's Preparedness Grants Manual](#) provides additional information on the EMPG program.

The Act also allocates [approximately \\$350 billion](#) to enable states, localities, territories, and Tribal governments to respond directly to the COVID-19 PHE. Appropriate uses for these funds include providing economic assistance to individuals or organizations, providing premium pay for essential workers, replacing lost public-sector revenue, or making necessary infrastructure investments. Roughly [\\$195.3 billion is allocated to states](#), while the rest of the sum is split between localities, Tribal governments, and territories. More details on this funding are available in the [Treasury Department's interim final rule](#). Additionally, the ARP [helps states to guard against population health insurance losses in future emergencies](#) by providing additional incentives for states that have not yet expanded their Medicaid populations under the Patient Protection and Affordable Care Act (ACA) to do so. The Act would temporarily increase a newly-expanding state's (i.e., states that did not expand Medicaid under the ACA, but which agree to expand under the ARP) federal matching rate (FMAP) [by 5% for the traditional, non-expansion Medicaid population](#), and would extend a 90% FMAP for the expansion population, for two years following the date of expansion. This offer would more than offset expansion costs, resulting in a net fiscal benefit to states of [approximately \\$9.6 billion](#).

The Act also provides [\\$7.4 billion to hire and train public health workers](#) to respond to the COVID-19 pandemic. Approximately \$4.4 billion funds the expansion by states and localities of public health departments with additional staff, while \$3 billion will be allocated toward a grant program to "expand, train, and modernize the public health workforce for the future." These grants will specifically prioritize recruiting individuals from communities they will then serve, as well as those with underrepresented backgrounds in public health occupations.

The ARP contains many more allocations than those described above. The National Association of Counties has [developed a tool](#) to illustrate the funding made available via the ARP, and the specific funds for which



counties may be eligible. The National League of Cities has similarly [created a tool](#) for municipalities. Ultimately, the funding made available in the ARP may strengthen state, local, tribal, and territorial public health agency preparedness and response in future emergencies in many different ways.

## **Increasing the Effectiveness of Public Health Authority, Infrastructure, and Workforce for Future Public Health Emergencies**


As the nation continues to emerge from the COVID-19 pandemic and associated economic and social disruptions, efforts to strengthen our collective response to public health emergencies, as well as to communicate the value and role of public health in day to day life, are imperative. For truly effective responses at every level of government, policy-makers should consider procedural, substantive, and financial measures to strengthen public health authority, infrastructure, and workforce.

Several overarching observations may be made from this perspective. First, strategic communication is essential, in order to convey the need for, rationale underlying, and value of public health authority and interventions, in order to retain community support. Second, systemic inequality places members of communities of color, low-income communities, and members of other marginalized and vulnerable populations at greater risk of infection, severe illness, and death. These systems must be changed to root out these unequal outcomes. Third, legal reforms comparable in intent, scale, and process of deliberative consultation to efforts following September 11, 2001 are called for in order to meet the moment.

[Initial analyses](#) have revealed both strengths and areas for improvement in the response to the COVID-19 pandemic. Interim hearings for legislative health and human services committees may provide another forum to hear expert testimony, solicit community feedback, and engage in discussions to inform future legislative sessions. As noted above, [after action reports](#) may serve as powerful vehicles for reflection and evaluation, as well as informing the public and making the affirmative case for continuing to strengthen the public health system's effectiveness in preventing and responding to public health emergencies in order to protect, promote, and improve community health.

The public health community and its allies must [defend against](#) legislative and judicial efforts that would hamstring response to public health emergencies in the future, but it cannot stop there. Excellent overviews of the types of sustained investments in public health infrastructure and workforce that are required have been developed by the [Trust for America's Health](#) and [National Network of Public Health Institutes](#). The needed investments include public health lab capacity; IT infrastructure modernization; broadband infrastructure and affordability; data privacy, security, and sharing; flexible contact tracing workforce; surveillance; training and capacity-building in cross-sector collaboration and community-based decision-making; equitable enforcement of public health orders; legal research and analysis, and policy surveillance; and strategic communications. In light of the potential for increases in scope and severity of vector-borne, water-borne, and food-borne illnesses, it is critical to include environmental health workers in these investments. [The Environmental Health Workforce Act](#) recently introduced in Congress offers one approach. Similarly, at a time when the pandemic is generating heightened interest in careers in public health, governmental action to increase access to advanced study for all, such as the [Public Health Workforce Loan Repayment Act](#), may warrant consideration.

The COVID-19 pandemic additionally demonstrated that to prepare for future pandemics, we must expand our focus beyond physical health, and invest in mental health promotion, including the mental and behavioral health workforce as well as the infrastructure to promote mental health in schools, prevent adverse childhood experiences and suicide, promote positive childhood experiences, and boost coping skills to promote resilience



following trauma. We must invest in green space and care for the natural environment, as climate change and loss of wildlife habitat exacerbate the threat of infectious disease while access to nature promotes well-being.

Public health authority will and must continue to evolve, in order to maintain existing strengths, carry out core functions, and respond to a wide range of public health emergencies quickly and effectively, all while striking a balance between government power, individual rights, and community mitigation measures that will garner broad acceptance in communities. The efforts described in this fact sheet represent important early next steps in this evolution prompted by COVID-19.

## **SUPPORTERS**



Robert Wood Johnson Foundation

**Support for the Network provided by the Robert Wood Johnson Foundation. The views expressed in this document do not necessarily reflect the views of the Foundation.**

**This document was developed by Jill Krueger, Region Director for the Network for Public Health Law—Northern Region, Dawn Hunter, Deputy Director for the Southeastern Region, and Jennifer Piatt, Senior Attorney for the Western Region. The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.**

**June 2021**