

10 | State and Local Public Health Authority

Learning Objectives

- Define *police power* and explain the scope of state authority to regulate for public health.
- Understand the source of local public health authority and the difference between “Dillon’s Rule” and “home rule” jurisdictions.
- Explain why regulated entities and public health advocates may have different preferences regarding what level of government engages in regulation.

Introduction

We next turn to the authority of state and local governments to engage in public health regulation. Unlike Congress, state governments are not limited to a set of enumerated powers. Instead, they have *plenary power*, or broad authority to regulate, except as limited by the US Constitution, federal law, or the state’s own constitution. The scope of local government authority, by contrast, depends on the specifics of the state’s law, which establishes the system of county and municipal government.

Under federalism, there is “competition” for authority. Lawmakers at each level—federal, state, and local—can be expected, all else being equal, to carve out more power for themselves. Advocates for a cause generally want power to be concentrated at the level where they are most likely to win: when your side has the support of the federal government, states’ rights seems like a bad idea, and vice versa. Cities like New York City and states like California are hubs of policy innovation where public health advocates champion states’ rights, while regulated industries often invest heavily in advocacy for blanket federal rules.

Aside from political considerations, there are enduring trade-offs in political economy between centralization and *subsidiarity*, the principle that decisions should be made at the most local level possible. The venerable idea that local and state governments, in their social and political variety, can serve as “laboratories of democracy” is countered by the principle that the affairs of regional and national markets should be governed by uniform rules. While the previous chapter explored federal public health authority, this chapter examines state public health authority and how it is apportioned to local governments and state administrative agencies.

State Public Health Powers

The 10th Amendment to the US Constitution provides that “[t]he powers not delegated to the United States by the Constitution, nor prohibited to it by the States, are reserved to the States respectively, or to the people.” Among the historic powers that states possessed prior to the ratification of the Constitution, and which the 10th Amendment thereafter reserved to the states, was the “police power.” In this context, the police power refers to states’ far-reaching authority to regulate for the health, safety, and welfare of their residents.

The Supreme Court explained the outlines of the police power in the landmark public health law case, *Jacobson v. Massachusetts* (1905). In that case, Rev. Henning Jacobson challenged a law requiring members of the public to be vaccinated against smallpox—during a smallpox outbreak—or else pay a fine. The Court described the broad scope of the state’s police power as applied to public health:

The authority of the state to enact this statute [arises from] what is commonly called the police power. . . . Although this court has refrained from any attempt to define the limits of that power, yet it has distinctly recognized the authority of a state to enact . . . “health laws of every description.” . . . According to settled principles, the police power of a state must be held to embrace, at least, such reasonable regulations established directly by legislative enactment as will protect the public health and the public safety. . . . The mode or manner in which those results are to be accomplished is within the discretion of the state, subject, of course, so far as Federal power is concerned, only to the condition that no rule prescribed by

a state, nor any regulation adopted by a local governmental agency acting under the sanction of state legislation, shall contravene the Constitution of the United States, nor infringe any right granted or secured by that instrument.

Under *Jacobson*, police power authority is not unlimited; states cannot “infringe any right granted or secured by” the Constitution. Nonetheless, police power authority is exceedingly broad. For example, there is no real question that states possess the authority to require individuals to obtain insurance coverage (an “individual mandate”), as Massachusetts did when enacting the 2006 health care reform law that served as a model for the Affordable Care Act. Unlike Congress, whose power to impose this requirement was sorely tested in *NFIB v. Sibelius* (see Chapter 9), states have no need to point to an enumerated power—they can instead rely on their broad police power. When the Massachusetts individual mandate was challenged, the state Superior Court quickly dismissed the suit, writing:

The field for the legitimate exercise of the police power is coextensive with the changing needs of society. . . . The Legislature could have found that the Act bears a real and substantial relation to the health, safety, good order, comfort, and general welfare of the community because, by virtue of its mandate, more of those who fall ill will have insurance coverage and the burden of paying for such coverage will be more equitably distributed. As a rational basis of fact can reasonably be conceived to sustain it, the Act is a proper exercise of police power (*Fountas v. Com’r of the Massachusetts Dept. of Revenue*, 2009).

Judicial review of the exercise of the police power is typically deferential: so long as a state can identify a “real and substantial relation” between its law and improving public health, its law can be sustained under its police power. This means that the evidentiary bar is extremely low. As noted in *Fountas*, “legislation [based on the police power] may be struck down only if no rational basis of fact can reasonably be conceived to sustain it.” While state authority to enact health laws is broad, we will see in later chapters that the exercise of that authority may also be challenged on federal constitutional grounds, such as the First Amendment, which entail more stringent review by the courts.

Local Public Health Powers

Local governments are, legally, administrative subdivisions of the state. In the Supreme Court's words, they are "convenient entities" established to manage affairs and preserve order at the local level (*Hunter v. City of Pittsburgh*, 1907). Since these entities derive their powers from the state, the state can decide how much of its broad police power it will share.

States vary considerably in how much authority they give to local governments, and the balance of power between state and local governments has shifted over time. In the late 19th century, *Dillon's Rule*, named for Judge John Forrest Dillon (author of an influential treatise on municipal law), became the general default rule. Under Dillon's Rule, a locality possesses only those powers expressly granted to it by the state, and the scope of those powers is to be construed narrowly. In other words, municipalities can only regulate in areas where the state has explicitly authorized them to do so, and if there is any question as to whether or not a municipality has authority to act, the presumption is that it does not. This approach, which sharply limited local government power, reflected Judge Dillon's "strong belief in private property rights . . . and skepticism of government in general" (Spitzer, 2015).

In the Progressive Era of the early 20th century, reformers took aim at Dillon's Rule. The "home rule movement" sought to "undo Dillon's Rule by giving localities broad lawmaking authority and to provide local governments freedom from state interference in areas of local concern" (Briffault, 1990). These reformers argued that cities needed the flexibility to address their own challenges, particularly as the importance of cities grew due to industrialization and urbanization. Local governments resented the frequent interference of state lawmakers, many of whom were from more rural areas and did not seem to understand or care about the needs of cities.

Over time, more states moved to adopt some form of home rule, often through amendments to state constitutions. Under its broadest form, localities in home rule states are authorized to exercise the full range of police power granted to the state, so long as their actions are not in conflict with state law. This full form of home rule provides a default rule that is the opposite of Dillon's: unless the state explicitly provides otherwise, municipalities possess the full range of police power, and their actions are presumed to be valid in the absence of a direct conflict with state law. Other states allow local governments to adopt "home rule charters"—often

by popular vote—that specify the scope of the locality’s powers. This is home rule in the sense that voters are able to define the scope of their own government’s powers, but the local powers may not be as broad as in a full home rule jurisdiction.

The historic debate between proponents of Dillon’s Rule and home rule carries on today in various forms. Should the default rule keep power at the state level, unless there is a deliberate decision to delegate it to local governments? Or should cities by default have broad authority to address public health issues and other local challenges? Public health advocates tend to support home rule, because local governments tend to be less subject to pressure from well-funded lobbying campaigns than state governments and correspondingly more open to taking on public health issues that may challenge entrenched interests. As Gorovitz, Mosher, and Pertschuk (1998) write:

Most industries cannot afford to place lobbyists in every community, contribute to numerous local campaigns, nor even keep abreast of every proposed piece of local regulation which may concern them. Local representatives also tend to be responsive to individual citizens and community organizations more directly than state or federal legislators, because local lawmakers must live and work among their constituents. Conversely, trade associations and other industry representatives are seen as outsiders rather than as *bona fide* constituents.

By contrast, trade association and other industry groups often have more influence at the state level, where they can pool their resources to employ lobbyists and make strategic campaign contributions.

For similar reasons, industry groups—as well as organizations ideologically committed to limited government, as Judge Dillon was in his day—may push to limit local control. In the past few decades, there have been a number of industry-funded efforts to limit the scope of home rule. For example, California’s broad home rule authority was limited by Proposition 26, approved by voters in 2010, requiring a two-thirds vote before a local government can impose a fee on businesses. Tobacco, alcohol, and fossil fuel companies all poured money into the campaign for this proposition (Rogers, 2010). Similarly, various conservative groups have successfully advocated for laws that limit the authority of local governments to impose taxes or increase municipal spending (Deller & Stallman, 2006). Such measures directly limit cities’ ability to impose fees or taxes on businesses that harm public health. They also squeeze cities’ budgets, decreasing their

ability to support public health initiatives (particularly those that might invite costly lawsuits).

State Preemption

Chapter 8 discussed Congress’s power to displace state laws through the preemption doctrine. States have a parallel ability to preempt local action, although it is not rooted in the Constitution. Rather, because local governments are subdivisions of the state and derive their powers from the state, the state retains the power to limit the scope of local authority, including by preempting local laws. The specifics of preemption law vary from state to state.

Ohio, for example, recognizes only *conflict* preemption. Under the state’s strong home rule doctrine, it is not enough for the legislature to declare its intent to preempt local law; to find preemption, a court must determine that there is a real conflict between state and local law (in other words, that it is impossible to comply with both). In 2011, the city council of Cleveland, Ohio, enacted a “trans-fat ban,” sharply limiting local restaurants’ use of trans-fats in cooking. Shortly thereafter, the Ohio General Assembly (the state legislature) enacted a law prohibiting local governments from regulating trans-fat content in food, in an attempt to preempt laws like Cleveland’s. Cleveland sued the state, and the state law was ultimately invalidated because, as the court wrote, it “[did] not set forth [affirmative] regulations but simply purport[ed] to limit municipal legislative power ” (*Cleveland v. State*, 2013). Because the state had not itself regulated trans-fats in a way that conflicted with the city’s rule, there was no preemption.

Other states, however, do not place the same emphasis on home rule and allow the state legislature to preempt local laws more easily. Texas law blocks a wide range of potential local gun control ordinances by simply stating that “a municipality may not adopt regulations relating to . . . the transfer, private ownership, keeping, transportation, licensing, or registration of firearms, air guns, knives, ammunition, or firearm or air gun supplies.” (“Regulation of Firearms, Knives, and Explosives,” 2017).

Like efforts to limit home rule, preemptive state laws—such as the Ohio law at issue in Cleveland’s trans-fat litigation—are often pushed by industries or interest groups that seek to avoid local regulation. These groups often hold more sway at the state level, and so they prefer that decisions be made there. Industry arguments for these laws are often framed in

terms of promoting “uniformity,” “fairness,” or “economic growth.” These are legitimate considerations in the abstract. In practice, however, these laws “abrogate . . . local authority to adopt innovative solutions to public health problems, eliminate the flexibility to respond to the needs of diverse communities, [and] undermine grassroots public health movements” (Pertschuk, Pomeranz, Aoki, Larkin, & Paloma, 2013).

In the 1980s, when local governments started to prohibit smoking in bars, restaurants, and other workplaces, the tobacco industry responded by pushing state legislatures to preempt local ordinances—and several such preemptive state laws are still in effect. The National Rifle Association later pressed for state laws to preempt local gun control provisions and succeeded in almost every state. More recently, at the urging of industry-backed groups, state legislatures are going beyond preempting local laws and are “threatening to withhold resources from communities that defy them and to hold their elected officials legally and financially liable” (Badger, 2017). A recent Florida law provides that officials who enact or enforce preempted gun control laws can be held personally liable in court (“Fl. Stat. Ann.,” 2017), and an Arizona law provides that a city that passes a preempted law can lose *all* of its state funding (“Ariz. Rev. Stat. Ann.,” 2016).

State Administrative Authority and Delegation

As at the federal level, when state or local legislative bodies pass a law, they usually delegate the authority for its implementation to an administrative agency. Most states, for example, have their own environmental protection agencies that are tasked with carrying out environmental laws at the state level. Like federal agencies, state and local regulatory bodies derive their authority to act from the legislatures that created them. These authorities are limited by the applicable governing statutes and the extent of the delegation in each instance, but delegations of power relating to public health tend to be quite broad. For example, Wisconsin state law provides that the state Department of Health Service (the public health agency) has “general supervision throughout the state of the health of citizens” and possesses the “power to execute what is reasonable and necessary for the prevention and suppression of disease” (“Fl. Stat. Ann. 790.33,” 2017) Likewise, many states have their own analogues to the federal Administrative Procedure Act, setting out the process that must be followed before an agency can issue an administrative rule.

Conclusion

This chapter completes our introduction of the sources of public health authority at the federal, state, and local level. As we have seen, the federal government is one of enumerated powers, while state governments have broad police power. The scope of local authority has been a point of tension between local and state governments for well over a century, and that debate continues today—with significant implications for public health.

Further Reading

- Gostin, L. O. (2005). *Jacobson v Massachusetts* at 100 Years: Police Power and Civil Liberties in Tension. *American Journal of Public Health*, 95, 576–581.
- Pomeranz, J. L., & Pertschuk, M. (2017). State Preemption: A Significant and Quiet Threat to Public Health in the United States. *American Journal of Public Health*, 107, 900–902.
- Su, R. (2017). Have Cities Abandoned Home Rule? *Fordham Urban Law Journal*, 44, 181–216.