The Unique Authority of State and Local Health Departments to Address Obesity

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The United States has 51 state health departments and thousands of local health agencies. Their size, structure, and authority differ, but they all possess unique abilities to address obesity. Because they are responsible for public health, they can take various steps themselves and can coordinate efforts with other agencies to further health in all policy domains.

I describe the value of health agencies' rule-making authority and clarify this process through 2 case studies involving menu-labeling regulations. I detail rule-making procedures and examine the legal and practical limitations on agency activity.

Health departments have many options to effect change in the incidence of obesity but need the support of other government entities and officials. (*Am J Public Health.* 2011; 101:1192–1197. doi:10.2105/AJPH.2010.300023)

STATES AND LOCALES ARE often innovators in creating and implementing public health policy. They can respond to local concerns and consider issues and costs that directly affect their specific interests.[1] The public health and financial toll of obesity is a burden in every state.[2–4] Annual obesity-attributable medical expenditures range from $87 million to $7.7 billion per state, with approximately half of those expenditures financed by Medicare and Medicaid.[5] If the government assumes responsibility for addressing this public health issue, action at multiple levels and across disciplines is required. In certain venues officials have a limited view of what state health agencies can do to address obesity[6]; however, more than 90% of these agencies report that they are responsible for obesity prevention.[7]

The United States has 51 state health departments (including the District of Columbia's) and approximately 2800 local health agencies.[7,8] The majority of states also have local health agencies. Depending on the state's structure, local agencies' authority may flow through the state health department or be granted independently.[7] Their size, structure, and authority differ, but all were created by a legislative grant and share the common goal of promoting and protecting health within their communities. Health departments traditionally work in concert with other agencies and nongovernmental organizations. Approximately half of the state health agencies have a significant source of authority that allows them to enact rules and regulations to further their public health missions,[7] and 73% of local health departments report using this authority to adopt public health regulations.[8] This rule-making authority stems from laws passed to advance public health in specific ways.

I explore the actions that are available to health departments through their authority over public health and their ability to coordinate across agencies to bring health concerns into other policy domains. I assess the value of agency rule-making authority, the legal and practical constraints on departments' ability to use this authority, and the legal procedure of rulemaking through 2 case studies of successful menu-labeling regulations developed and carried out by a state and a local health department. Although health departments have the ability to effect change in the incidence of obesity, they need motivated leaders and the support of other government entities or officials to successfully address this public health problem.

AGENCY ACTION TO ADDRESS OBESITY

The increased incidence of obesity in the United States is attributable to many factors; however, the modern food environment is considered a primary driver.[9] The transition has been influenced by federal farm subsidies, economic disparities and access issues, lax school food standards, increased industry involvement in government, and constant exposure to food marketing, among other triggers.[10–16] Although no single government entity can control every aspect of the problem, state and local health departments can work independently and in concert with other agencies and nongovernmental entities to effectuate change within their communities.

Because no single solution has been shown to reduce the incidence of obesity by itself, several options should be explored. The Institute of Medicine released a report that drew on the best evidence available to suggest local government actions that might reduce childhood obesity.[17] Many of the suggested strategies are directed at correcting disparities in community food environments where the lack of access to affordable healthy food has been shown to contribute to obesity rates for the entire community.[18] The legal authority granted to health departments varies by state, but in general their available options include offering incentives for restaurants and food stores to carry and promote healthier options, mandating strong nutrition standards for food and beverages in government-run and -maintained facilities and programs, increasing participation in government nutrition assistance programs,

and allowing farmers' markets to accept government benefits.[17,19]

Cross-Agency Cooperation

State health departments report collaborating with other state agencies, such as (in order of regularity) emergency response, transportation, parks and recreation, tribal, housing, and land-use agencies.[7] Other agencies involved in public health include departments of education, city planning, and agriculture. By coordinating cross-agency conversations and policymaking, health departments can insert health concerns into a vast range of policymaking activities within their jurisdictions. This approach, called health in all policies, brings health issues from the traditional health sectors into other government entities, thereby positively influencing transportation, housing, environment, education, and fiscal policies.[20] Underlying this concept is the recognition that public health is determined by living conditions and other social and economic factors outside the health sector and is thus best influenced by policies and activities across all levels of government.[21]

Inserting health concerns into other policy areas requires partnerships and alliance building.[21] Although other sectors of government may not primarily focus on health, they similarly need partners and cooperation to get their initiatives considered and implemented. In addition to fostering cooperation, health departments can educate policymakers on the cost savings and social gains that stem from promoting prevention and health policy across sectors.[22] Quantifying the cost of obesity to state budgets[23] and the inequities suffered by underserved communities could help persuade other government entities and officials to agree to initiatives to reduce these burdens.

Many Institute of Medicine recommendations would be well suited for such cross-agency work: creating incentive programs to attract supermarkets to underserved areas, enacting zoning or land-use regulations to enable healthy food providers to locate in underserved neighborhoods and to prevent vendors of unhealthy food from locating near schools and playgrounds, adopting building codes that require clean and accessible water fountains, and enacting planning guidelines for the creation, maintenance, and security of sidewalks, parks, and playgrounds.[17,24] Additional local options would regulate the retail environment by restricting unhealthy food in checkout aisles, for example, or setting default nutritional standards for restaurant food that comes with toys or other incentives.[25]

Health departments can also educate the private sector and insurance companies about the potential cost savings, increased productivity, and reduced absenteeism that reward promotion of wellness and prevention.[22,26] Local health departments can collaborate with employers to develop and implement wellness plans to advance obesity prevention and control measures.[27]

Health Department Rulemaking

The concept of lawmaking in the United States has traditionally been defined by the legislative process, the progress of a proposed bill to an enacted law. Agencies' ability to create regulation, with the full force and effect of legislation, may be overlooked. Health agencies with regulatory authority were granted this authority through legislation defining its scope. In the past, most health agencies used their varying authorities over food to address acute issues of sanitation and safety. Modern health departments have broadened their view of their role in ensuring food safety and protecting health to consider the long-term consequences of deficiencies in the food supply including access issues, obesity, and malnutrition. Health departments with regulatory authority can use rulemaking to address long-term public health issues such as obesity.

Approximately half of the public health departments in the country can promulgate regulations; however, only approximately 17% report enacting regulations as a primary activity.[7] Significantly, 73% of local health departments report using this authority to adopt public health regulations.[8] In the past, public health departments used rulemaking to regulate a wide range of issues, including sanitation,[28] smoking restrictions,[29] school vaccinations,[30] breathalyzer machine calibration,[31] and menu labeling.[32] In locations where rule-making authority does not exist to address long-term health concerns, agency officials can publicly call for increased authority over such issues,[33] and grassroots movements can urge their legislators to grant it.[34]

Agency rulemaking has certain advantages over the legislative process. Although the legislative process is effective, it often takes years for a bill to become law. Enacting regulation is relatively quick and does not require multiple levels of action (e.g., committees, floor votes) in the 2 separate chambers of a state legislature. Regulatory action is grounded in the expertise of the agency. Agency officials can consider competing interests but can act to further the general purpose of the agency: protecting and advancing public health. Legislation is frequently the result of compromise by many competing interests. Finally, if an agency acts within its authority, judicial deference to the agency's action can be quite strong, so if such action is challenged in court, the judiciary frequently gives the agency the benefit of the doubt on certain issues.

Limitations on Regulatory Action

An agency's ability to undertake regulatory action may face legal and practical limitations. The practical limitations are largely political and financial and can function as a barrier to regulation.

An agency cannot usurp the legislature's legislative function. The federal and all state constitutions provide that legislative powers are vested in the Congress[35] and state legislatures,[36] respectively. A health department, therefore, can only act as an administrative body in its own province: it cannot enact a regulation that requires not public health expertise but rather the balancing

of purely economic or social concerns.[37]

Agencies may be delegated a broad range of powers, but they cannot exceed their legislative mandate. In 1996, for example, the Food and Drug Administration attempted to establish its authority to regulate tobacco products by defining nicotine as a drug and cigarettes and smokeless tobacco products as drug delivery devices, within the meaning of the Food, Drug, and Cosmetics Act.[38] The Supreme Court found, however, that Congress had not granted the agency authority over tobacco, so the proposed regulations were promulgated outside of its legislated authority and thus were rendered void.[39] Notably, Congress recently passed the Family Smoking Prevention and Tobacco Control Act, granting the Food and Drug Administration authority to regulate tobacco.[40] Although details of the act have been challenged by the tobacco industry in court, the agency is now vested with the regulatory authority it previously lacked.[41]

If an agency's position conflicts with the political position of elected officials in a jurisdiction, those officials can obstruct agency activity. More than half of the state health agencies report directly to the governor,[7] and most of the others report to a health official appointed by the governor.[7,42] Boards of health face generalized pressure to conform to the views of the governor, who also has the power to replace their members. For example, in Massachusetts, then-governor Mitt Romney replaced members of the state's Public Health Council with business-oriented representatives when the original members disagreed with his position on certain issues.[43] Governor Deval Patrick later replaced Romney's appointees to encourage public health research and policy in alignment with his administration's objectives.[44]

The legislature's power over public health agencies also extends to granting and withdrawing regulatory authority, approving agency budgets, and passing public health laws and fees.[7] The legislature can thus decrease an agency's budget if the agency's actions thwart the legislature's political will, and this threat alone can function to inhibit agency action at odds with elected officials' positions.

The legislature can also withdraw the agency's rule-making authority over a particular issue. For instance, the Metropolitan Board of Health of Nashville and Davidson County, Tennessee, passed a menu-labeling regulation in 2009.[45,46] Although the ordinance was very popular locally, its passage conflicted with the position of state legislators. Legislators therefore passed a law forbidding nonelected government bodies (i.e., boards of health) to enact regulations "pertaining to the provision of food nutritional information or otherwise regulate menus at food service establishments."[47] This legislation withdrew the authority of the state's health departments from enacting menu-labeling laws and simultaneously preempted all agency regulation in this area. The governor vetoed this law, but the legislature overrode the governor's veto in February 2010, effectively voiding the local ordinance.[48]

The federal and state legislatures can preempt, or preclude, state or local agencies' action on an issue before activity even begins or as part of another law. For example, in 2008, Georgia's legislature passed a law, signed by the governor, that enjoined all local boards of health and political subdivisions from issuing any law requiring food service establishments to provide nutrition information about their products.[49] This law means that no community in the entire state of Georgia can pass a menu-labeling ordinance. Similarly, when California passed a menu-labeling law, the legislature preempted all local action on the matter.[50] This voided previously enacted ordinances in San Francisco and Santa Clara.[51,52]

MENU-LABELING REGULATION CASE STUDIES

Despite the obstacles, success stories exist. Many state and local public health departments have the power to enact regulations to implement policy options. When elected officials support such measures, rulemaking becomes an effective mechanism to address public health. Two case studies of menu-labeling efforts provide insight into the law and procedure of rulemaking, although not all jurisdictions have similar authority. Since passage of the federal menu-labeling law in March 2010, states and locales are generally preempted from enacting nutrient disclosure requirements that are not identical to the federal mandate.[53] As a result, the state of menu labeling is in flux nationwide. However, health agencies may be able to devise the next generation of public health regulations to address obesity. Each health department needs to research its own legislative grant and think creatively about ways to use its authority in the context of the obesity epidemic.

Proposals in New York City and Massachusetts

New York City's Department of Health and Mental Hygiene (DOHMH) was the first local agency and the Massachusetts Department of Public Health was the first state agency to pass a menu-labeling ordinance. New York City's charter distributes power and establishes the duties and authorities of officers, departments, and agencies. Under the charter, the DOHMH could pursue menu labeling under its dual authority over chronic diseases[54] and the food supply.[55] The charter grants the agency rule-making authority[56] and the power to amend the New York City Health Code for public health purposes.[57] Similarly, the General Laws of Massachusetts grant the Massachusetts Department of Public Health the authority to promulgate regulations to prevent and control disease to protect public health[58] and to amend the state Sanitary Code[59] to address public health in food service establishments.[60]

In accordance with their respective authorities, the agencies used their expertise to develop a response to obesity. New York City health officials undertook considerable research into the obesity epidemic in the city, the

efficacy of nutrition labeling, residents' consumption rates outside the home, and consumer confusion over the caloric content of restaurant foods. It also considered polling data that supported a menu-labeling measure.[61] This research provided a strong basis for the city and other jurisdictions to enact menu-labeling laws. The Massachusetts Department of Public Health cited the New York City regulation in its summary of findings to support its own regulation.[62]

Once an agency determines the basis for a proposed regulation and drafts the regulatory language, it must publish a notice of its intent to amend the relevant code to allow for public comments. Public hearings are generally required to be held at least 30 days after the date of notice, but this can vary among jurisdictions. Agencies traditionally accept written comments, and the hearing allows time for oral testimony. New York City's DOHMH published its notice in the city record on September 29, 2006, and held its public hearing on October 30, 2006. The department received more than 2200 written and oral comments, including testimony from 45 persons at the hearing.[61] On December 15, 2006, the Board of Health adopted the menu-labeling law, §81.50 to the New York City Health Code. The regulation was to become effective in July 2007.

On January 21, 2009, the Massachusetts Department of Public Health filed a copy of its notice to amend the code with the secretary of state, who published it in the state register.[63] Hearings were held on February 24 and 25, 2009,[64] and 10 people testified.[65] The department also received 139 written comments and met with representatives from the food industry.[65] On May 13, 2009, the Public Health Council approved the amendment, and the menu-labeling law was to become effective on November 1, 2010.

The ability of a department of health to make rules despite barriers inherent to the process often reflects the presence and goals of motivated leaders. In New York City, the former commissioner of the DOHMH and the mayor are strong public health advocates, as are the health commissioner and governor of Massachusetts.

Lessons Learned

Because an agency must act within its legislative mandate, it needs to determine whether it has the authority to establish rules in this context and work creatively to address obesity under its legislative grant. If legal questions arise, the department may ask its internal legal advisers or the attorney general to answer questions about its authority or duties,[66] ambiguities of the law,[67] and other legal issues that bear on its proposed action.[68] The agency may also seek answers when the law is clear but the outcome may be unpopular, to protect those who must put a new law into practice.

Although the difficult determinations were made prior to drafting the proposed ordinances, the timelines in New York City and Massachusetts highlight the procedural speed of rulemaking once it begins. After the notices of intent to amend the codes were published, rulemaking was under way and was efficiently completed.

Both agencies considered many comments from competing interests. In fact, Massachusetts officials responded to industry's concerns that it would be financially difficult to comply with the regulation in the original time allotted (6 months)—and their own need to effectively enforce the ordinance—by implementing a longer phase-in period (a year and a half) for the law to become effective.[69,70] This compromise highlights the value and success of the notice and comment phase of rulemaking.

Litigation can result from agency action. In New York City, the original menu-labeling law was scheduled to become effective in July 2007, but the New York State Restaurant Association sued the DOHMH to prevent enforcement of the ordinance.[71,72] New York City was the first to implement a menu-labeling regulation, and thus it had to be prepared to defend its action if challenged. Not all innovative public health regulations result in litigation; in fact, at the same time that the DOHMH passed the menu-labeling law, it also passed the nation's first trans fat ban, which went into effect without incident. However, new and innovative public health regulations can render an agency susceptible to industry lawsuits.[73]

The judicial branch serves as a necessary check on agency action to ensure that entities' and individuals' rights are not infringed by regulation. Absent legal defects, agency rulemaking receives deferential judicial review. Thus, regulations will not be struck down unless they are procedurally defective, arbitrary, or capricious in substance or manifestly contrary to the statute delegating authority to the agency.[74] This deference to agencies' interpretation of their own authority gives health departments some leeway in enacting regulations that advance public health.

CONCLUSIONS

Health departments are vested with important and valuable authority to address long-term public health issues, including obesity. By partnering with nonprofit and private organizations and other government agencies, health departments can encourage consideration of health issues across disciplines and bring health into a vast array of policymaking initiatives. Health departments with rule-making authority can use this power to address obesity-related health concerns. Research into the authorizing language for all public health departments would clarify the diverse nature of health agencies' authority and encourage those with broader authority to move beyond traditionally established activities to mitigate the obesity problem.

Practical limitations to public health departments' ability to address obesity include political and budgetary constraints, which can challenge even highly motivated health officials. Governments that want to reduce obesity incidence must remove these barriers to enable health departments to use their unique authority. Public health education, advocacy, and grassroots movements can

highlight the need for government action to address obesity and encourage elected officials to support their health agencies and grant them broader regulatory authority where it is needed. ■

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