

A Theory and Definition of Public Health Law

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[Public health law] should not be confused with medical jurisprudence, which is concerned only in the legal aspects of the application of medical and surgical knowledge to individuals. . . . [P]ublic health is not a branch of medicine, but a science in itself, to which, however, preventive medicine is an important contributor. Public health law is that branch of jurisprudence which treats of the application of common and statutory law to the principles of hygiene and sanitary science.

James A. Tobey (1926)

The literature, both academic and judicial, on the intersection of law and health is pervasive. The subject of law and health is widely taught (in schools of law, medicine, public health, and health administration), practiced (by “health lawyers”), and analyzed (by scholars in the related fields of health law, bioethics, and health policy).¹ The fields that characterize these branches of study are called health law, health care law, law and medicine, forensic medicine, and public health law. Do these names imply different disciplines, each with a coherent theory, structure, and method that sets it apart? Notably absent from the extant literature is a theory of the discipline of public health law, an exploration of its doctrinal boundaries, and an assessment of its analytical methodology.²

Public health law shares conceptual terrain with the field of law and medicine, or health care law, but remains a distinct discipline. My claim is not that public health law is contained within a tidy doctrinal package; its boundaries are blurred and overlap other paths of study within law and health. Nor is public health law easy to define and characterize; the field is as complex and confused as public health itself. Rather, I posit,

public health law is susceptible to theoretical and practical differentiation from other disciplines at the nexus of law and health.

Public health law can be defined, its boundaries circumscribed, and its analytical methods detailed in ways that distinguish it as a discrete discipline—just as the disciplines of medicine and public health can be demarcated.³ With this book I hope to provide a fuller understanding of the varied roles of law in advancing the public's health. The core idea I propose is that law can be an essential tool for creating conditions to enable people to lead healthier and safer lives.

In this opening chapter, I offer a theory and definition of public health law, an examination of its core values, an assessment of state statutes in establishing the legal foundations of public health agencies, a categorization of the various models through which law acts as a tool to advance the public's health, and, finally, a description of the current debate over the legitimate scope of public health. These are the questions I will pursue: What is public health law and what are its doctrinal boundaries? Why should population health be a salient public value? What are the legal foundations of governmental public health? How can law be effective in reducing illness and premature death? And what are the political conflicts faced by public health in the early twenty-first century?

PUBLIC HEALTH LAW: A DEFINITION AND CORE VALUES

My definition of public health law follows, and the remainder of this chapter offers a justification as well as an expansion of the ideas presented:

Public health law is the study of the legal powers and duties of the state, in collaboration with its partners (e.g., health care, business, the community, the media, and academe), to ensure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population), and of the limitations on the power of the state to constrain for the common good the autonomy, privacy, liberty, proprietary, and other legally protected interests of individuals. The prime objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.

Several themes emerge from this definition: (1) government power and duty, (2) coercion and limits on state power, (3) government's partners

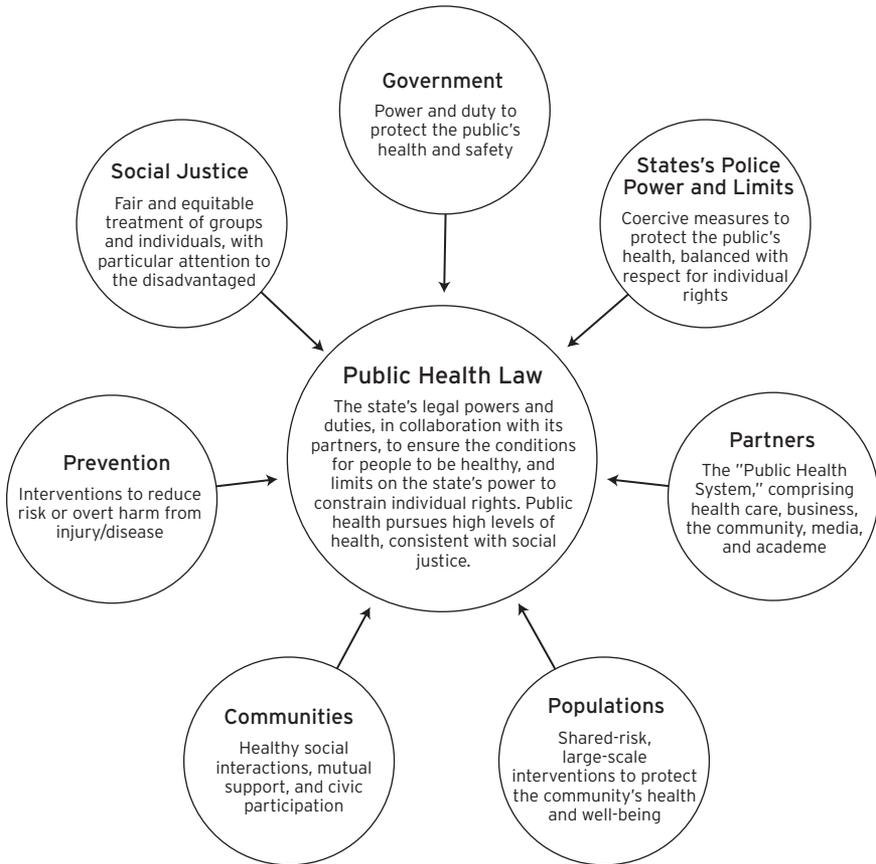


Figure 2. Public health law: A definition and core values.

in the “public health system,” (4) the population focus, (5) communities and civic participation, (6) the prevention orientation, and (7) social justice (see figure 2).

Government Power and Duty: Health as a Salient Value

Why does government have the power and duty to safeguard the public’s health? To understand the state’s obligations, it will be helpful first to explore the meaning of the concepts of “public health” and the “common good.” I will then offer a theory as to why health should be a salient value of government.

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THE “PUBLIC’S” HEALTH

The word *public* in public health has two overlapping meanings—one that refers to the entity that takes primary responsibility for the public’s health, and another that indicates who has a legitimate expectation of receiving the benefits.

The government has primary responsibility for the public’s health. The government is the public entity that acts on behalf of the people and gains its legitimacy through a political process. A characteristic form of “public” or state action occurs when a democratically elected government exercises powers or duties to protect or promote the population’s health.

The population as a whole has a legitimate expectation of benefiting from public health services. The population elects the government and holds the state accountable for a meaningful level of health protection. Public health should possess broad appeal to the electorate because it is a universal aspiration. What best serves the population, of course, may not always be in the interests of all its members, making public health highly political. What constitutes “enough” health? What kinds of services are necessary? How will services be paid for and distributed? These remain political questions. Democratic governments will never devote unlimited resources to public health. Core public health functions compete for scarce resources with other demands for services, and resources are allocated through a prescribed political process. In this sense, Dan Beauchamp is instructive in suggesting that a healthy republic is not achieved solely through a strong sense of communal welfare, but is also the result of a vigorous and expanded democratic discussion about the population’s health.⁴

“THE COMMON” AND “THE GOOD”

If individual interests are to give way to communal interests in healthy populations, it is important to understand the value of “the common” and “the good.” The field of public health would profit from a vibrant conception of “the common” that sees the public interest as more than the aggregation of individual interests. A nonaggregative understanding of public goods recognizes that everyone benefits from living in a society that regulates the risks shared by all.⁵ Laws designed to promote the common good may sometimes constrain individual actions (smoking in public places, riding a motorcycle without a helmet, etc.). As members of society, we have common goals that go beyond our narrow interests. Individuals have a stake in healthy and secure communities where they

can live in peace and well-being. An unhealthy or insecure community may produce harms common to all, such as increased crime and violence, impaired social relationships, and a less productive workforce. Consequently, people may have to forgo some self-interest in exchange for the protection and satisfaction gained from sustaining healthier and safer communities.

We also need to better understand the concept of “the good.” In medicine, the meaning of “the good” is defined purely in terms of the individual’s wants and needs. It is the patient, not the physician or family, who decides the appropriate course of action. In public health, the meaning of “the good” is far less clear. Who decides which value is more important—freedom or health? One strategy for public health decision making would be to allow people to decide for themselves, but this would thwart many public health initiatives. For example, if individuals could decide whether to acquiesce to a vaccination or permit reporting of personal information to the health department, it would result in a “tragedy of the commons.”⁶

The public health community takes it as an act of faith that health must be society’s overarching value. Yet politicians do not always see it that way, expressing preferences, say, for highways, energy, and the military. The lack of political commitment to population health can be seen in relatively low public health expenditures.⁷ Public health professionals often distrust and shun politicians rather than engage them in dialogue about the importance of population health. What is needed is a clear vision of and rationale for healthy populations as a political priority.

Why should health, as opposed to other communal goods, be a salient value? Two interrelated theories support the role of health as a primary value: (1) *a theory of human functioning*—health is a foundation for personal well-being and the exercise of social and political rights; and (2) *a theory of democracy*—governments are formed primarily to achieve health, safety, and welfare for the population.

HEALTH IS FOUNDATIONAL: A THEORY OF HUMAN FUNCTIONING

Health is foundationally important because of its intrinsic value and singular contribution to human functioning. Health has a special meaning and importance to individuals and the community as a whole.⁸ Every person understands, at least intuitively, why health is vital to well-being. Health is necessary for much of the joy, creativity, and productivity that a person derives from life. Individuals with physical and mental health

recreate, socialize, work, and engage in family and social activities that bring meaning and happiness to their lives. Certainly, persons with ill health or disability can lead deeply fulfilling lives, but personal health does facilitate many of life's joys and accomplishments. Every person strives for the best physical and mental health achievable, even in the face of existing disease, injury, or disability. The public's health is so instinctively essential that human rights norms embrace health as a basic right.⁹

Perhaps it is not as obvious, however, that health is also essential for the functioning of populations. Without minimum levels of health, people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art, and provide for the common security. A safe and healthy population builds strong roots for a country's governmental structures, social organizations, cultural endowment, economic prosperity, and national defense. Population health becomes a transcendent value because a certain level of human functioning is a prerequisite for activities that are critical to the public's welfare—social, political, and economic.

Health has an intrinsic and instrumental value for individuals, communities, and nations. People aspire to achieve health because of its importance to a satisfying life, communities promote the health of their neighbors for the mutual benefits of social interactions, and nations build health care and public health infrastructures to cultivate a decent and prosperous civilization.

GOVERNMENT'S OBLIGATION
TO PROMOTE HEALTH: A THEORY OF DEMOCRACY

Why does government have an enduring obligation to protect and promote the public's health? Theories of democracy help to explain the government's role in matters of population health. People form governments for their common defense, security, and welfare—goods that can be achieved only through collective action. The first thing that public officials owe to their constituents is protection against natural and man-made hazards. Michael Walzer explains that public health is a classic case of a general communal provision because public funds are expended to benefit all or most of the population without any specific distribution to individuals.¹⁰

A political community stresses a shared bond among members; organized society safeguards the common goods of health, welfare, and security, while members subordinate themselves to the welfare of the com-

munity as a whole.¹¹ Public health can be achieved only through collective action, not through individual endeavors. Acting alone, individuals cannot ensure even minimum levels of health. Any person of means can procure many of the necessities of life—food, housing, clothing, and even medical care. Yet no single individual or group of individuals can ensure his or her health. Meaningful protection and assurance of the population's health require communal effort. The community as a whole has a stake in environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. These collective goods, and many more, are essential conditions for health. Yet these benefits can be secured only through organized action on behalf of the people.

The Power to Coerce and Limits on State Power

[It is well to cite] the oft quoted aphorism of the Earl of Derby that “sanitary instruction is even more important than sanitary legislation.” Sanitarians work toward the ideal that all people will in time know what healthful living is, and that they will in time reach that moral plane when they will practice what they know. While hopeful for the millennium we must work. Law is still necessary. People still incline to acts which are not for their neighbors' good. In our complicated civilization, many restrictions must be placed on individual conduct in order that we may live happily and healthfully one with another.

Charles V. Chapin (1926)

I have suggested that public health law is concerned with governmental responsibilities to the community and the well-being of the population. These ideas encompass what can be regarded as “public” and what constitutes “health” within a political community. Although it may not be obvious, I also suggest that the use of coercion must be part of an informed understanding of public health law, and that state power also must be subject to limits.

Government can do many things to safeguard the public's health and safety that do not require the exercise of compulsory powers, and the state's first recourse should be voluntary measures. Yet government alone is authorized to require conformance with publicly established standards

of conduct. Governments are formed not only to attend to the general needs of their constituents, but to insist, through force of law if necessary, that individuals and businesses act in ways that do not place others at unreasonable risk of harm. To defend the common welfare, governments assert their collective power to tax, inspect, regulate, and coerce. Of course, different ideas exist about what compulsory measures are necessary to safeguard the public's health. Reconciling divergent opinions about the desirability of coercion in a given situation (should government resort to force, what kind, and under what circumstances?) is an issue for political resolution. In the next chapter, I propose standards for evaluating public health regulation to help guide policymakers.

THE POWER TO COMPEL INDIVIDUALS
AND BUSINESSES FOR THE COMMON GOOD

Protecting and preserving community health is not possible without constraining a wide range of private activities that pose unacceptable risks. Private actors can profit by engaging in practices that damage the rest of society:¹² individuals derive satisfaction from intimate relationships despite the risks of sexually transmitted infections, industry has incentives to produce goods without consideration of workers' safety or pollution of surrounding areas, and manufacturers find it economical to offer products without regard to high standards of hygiene and safety. In each instance, individuals or organizations act rationally for their own interests, but their actions may adversely affect communal health and safety. Absent governmental authority and willingness to coerce, such threats to the public's health and safety could not easily be reduced.

Although regulation in the name of public health is theoretically intended to safeguard the health and safety of whole populations, it often benefits those most at risk of injury and disease. Everyone gains value from public health regulations, such as food and water standards, but some regulations protect the most vulnerable. For instance, eliminating a toxic waste site, enforcing a building code in a crowded tenement, or closing an unhygienic restaurant holds particular significance for those at immediate risk. Frequently, those at increased risk are particularly vulnerable due to their race, gender, or socioeconomic status.¹³

Perhaps because engaging in risk behavior may promote personal or economic interests, individuals and businesses frequently oppose government regulation. Resistance is sometimes based on philosophical grounds of autonomy, choice, or freedom from government interference. Citizens, and the groups that represent them, claim that regulating self-regarding

behaviors, such as the use of seat belts or motorcycle helmets, is not the business of government. Sometimes these arguments extend to activities that harm others, such as unsafe workplace conditions, fuel-inefficient vehicles, or unhygienic restaurants.

Industry often asserts that economic principles militate against state interference. Entrepreneurs tend to accept as a matter of faith that governmental health and safety standards retard economic development and should be avoided. In political arenas, they contest these standards in the name of economic liberty, holding out government taxation and regulation as burdensome and inefficient.

Public health has historically constrained the rights of individuals and businesses so as to protect community interests in health.¹⁴ Whether through the use of reporting requirements affecting privacy, mandatory testing or screening affecting autonomy, environmental standards affecting property, industrial regulation affecting economic freedom, or isolation and quarantine affecting liberty, public health has not shied from controlling individuals and businesses for the aggregate good.

LIMITATIONS ON STATE POWER

Public health powers can legitimately be used to restrict human freedoms and rights to achieve a collective good, but they must be exercised consistently with constitutional and statutory constraints on state action. The inherent prerogative of the state to protect the public's health, safety, and welfare (known as the police powers) is limited by individual rights to autonomy, privacy, liberty, property, and other legally protected interests (see chapter 4). Achieving a just balance between constitutionally protected rights and the powers and duties of the state to defend and advance the public's health poses an enduring problem for public health law.

Any theory of public health law presents a paradox. Government, on the one hand, is compelled by its role as the elected representative of the community to act affirmatively to promote the health of the people. To many, this role requires vigorous measures to control obvious health risks. On the other hand, government cannot unduly assault individuals' rights in the name of the communal good. Health regulation that overreaches, in that it achieves a minimal health benefit with disproportionate human burdens, conflicts with ethical considerations and is not tolerated in a society based on the rule of law. Consequently, scholars and practitioners often perceive a tension between the community's claim to reduce obvious health risks and individuals' claim to be free from government

interference. This perceived conflict might be agonizing in some cases and absent in others. Thus, public health law must always pose the questions: does a coercive intervention truly reduce aggregate health risks, and what, if any, less intrusive interventions might reduce those risks as well or better? Respect for the rights of individuals and fairness toward groups of all races, religions, and cultures remain at the heart of public health law.

It has become fashionable to claim that no real conflict exists between the protection of individual rights and the promotion of population health.¹⁵ According to this view, safeguarding rights is always (or virtually always) consistent with preserving communal health. Indeed, according to this perspective, individual rights and public health are synergistic—the defense of one enhances the value of the other. This rhetorical position serves a purpose but is simplistic. It suggests that a decision to avert a discrete health risk through coercion actually may result in an aggregate increase in injury or disease in the population. The exercise of compulsory powers of isolation or quarantine, for example, may prevent individuals from transmitting a communicable infection, but the social decision to coerce affects group behavior and, ultimately, the population's health. By provoking distrust of or alienation from medical and public health authorities, coercion may shift behaviors to avoidance of testing, counseling, or treatment.

Public health decision making involves complex trade-offs. Will coercive measures to avert a known individual risk be the correct course of action (e.g., isolating a person with tuberculosis who refuses to take the full course of medication), even if doing so may produce a greater aggregate risk? The social calculus is hardly scientific or precise regarding whether compulsion will alter behavior and, if so, in what direction.

Distinct tensions exist in public health law between voluntarism and coercion, civil liberties and public health, and discrete (or individual) health threats and aggregate health outcomes. These competing interests, and the substantive standards and procedural safeguards that circumscribe the lawful exercise of state powers, form the corpus of public health law.

The Public Health System: Partners for Population Health

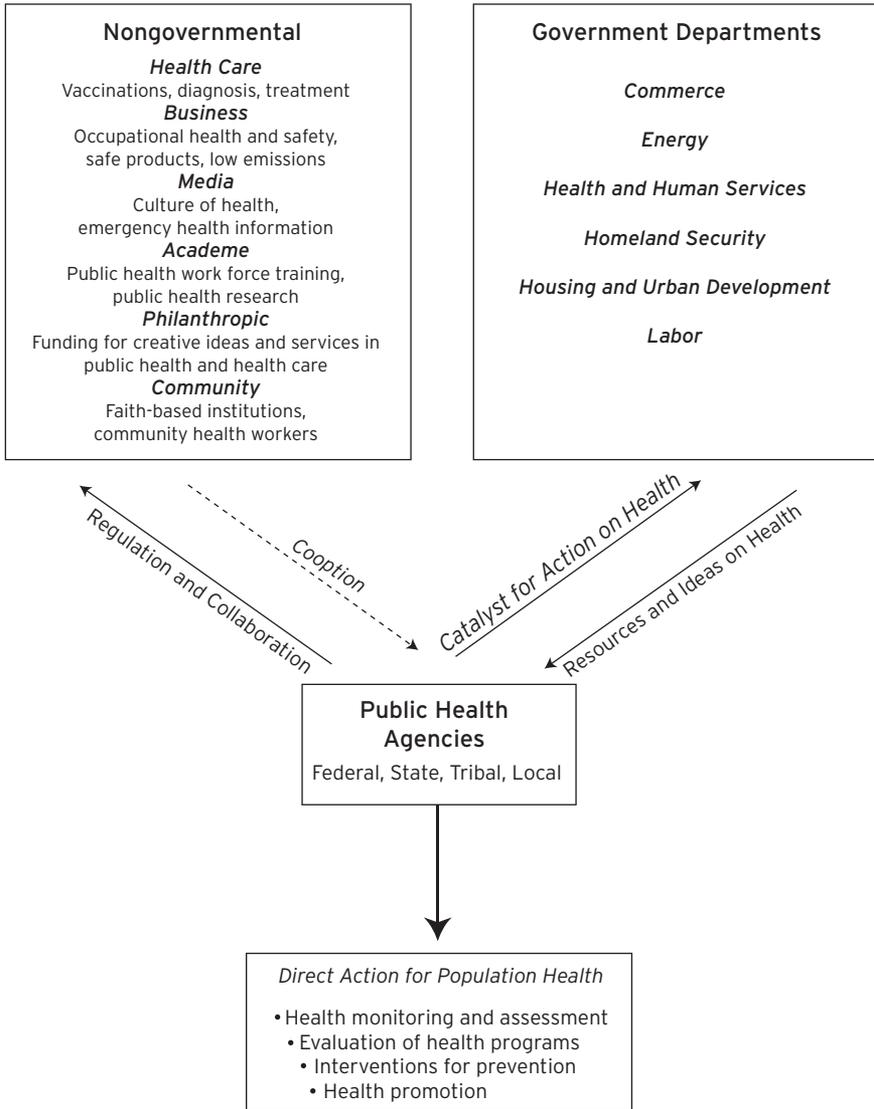
Although the power and duty to safeguard the public's health historically has been assigned to government through the work of national, state, tribal, and local health agencies, no single agency can ensure the conditions for the public's health. The Institute of Medicine (IOM) views public

health agencies as focal institutions at the center of a multisectoral “public health system.”¹⁶ Public health agencies can act as a catalyst for action by other government departments (e.g., housing, labor, transportation, and environment). Public health agencies also stimulate, coordinate, and often regulate nongovernmental actors. At the same time, these actors may co-opt agency officials into advocating for their private interests—an idea referred to in the literature as “regulatory capture.”¹⁷ The public health system includes many nongovernmental actors, but the IOM focuses on five: health care institutions, the community, businesses, the media, and academe (see figure 3). Although not discussed by the IOM, philanthropic organizations (e.g., Gates Foundation, Rockefeller Foundation, and Kaiser Family Foundation) have far-reaching effects on health policy, service delivery, and research.

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Health care institutions. Health care is important because personal health is a value in itself and one of the conditions necessary for individual and population health. Public health and health care interact in multiple important ways.¹⁸ Health care institutions collect information and report it to public health agencies, vaccinate populations, diagnose and treat patients with infectious diseases that endanger the public, and provide a range of services to improve community health (e.g., child and maternal health, family planning, and emergency services). However, health care is not fully available to many people. About 15.3 percent of the U.S. population (nearly 45 million people) lacks health insurance, with minorities and the poor disproportionately burdened.¹⁹ Also, health plans do not cover many services for prevention, mental health, substance abuse, and dental health. Health care providers can play an important role in improving health through patient care and investment in promoting the health of the communities they serve.²⁰

Community. The term *community* is often imprecise, but includes local entities such as churches, civic organizations, and health advocacy groups, which can contribute to their neighbors’ health. Community involvement can effectively promote healthy activities.²¹ Community organizations are well positioned to assess needs and inventory resources, formulate collaborative responses, and evaluate outcomes for community health improvements. They can promote healthy lifestyles and facilitate social networks. Communities can also advocate for more government services and help to care for their own members (family, friends, and neighbors).



Note: This figure represents the “public health system,” consisting of public health agencies and their governmental and nongovernmental partners. Public health agencies take primary responsibility for ensuring the conditions for the public’s health. They regulate or collaborate with health care, business, the media, and academe. Sometimes the private sector “co-opts” governmental agencies to act in the interests of private actors. Public health agencies provide a catalyst for other government departments to act on population health. These departments in turn provide resources and ideas to further population health.

Figure 3. The public health system.

Businesses. Businesses play a major role in the health of their employees and the local population through their impact on natural and built environments, workplace conditions, and relationships with communities. They affect worker health (e.g., workplace safety and exposures), economic conditions (e.g., income and quality of life), the natural environment (e.g., emission of toxins or pollutants), and the physical environment (e.g., green spaces). Many businesses also offer health insurance for their workers, demonstrating the close ties between public health, health care, and the private sector.²² Research demonstrates the cost-effectiveness of prevention and health promotion efforts for an employer's workforce and the value of corporate action in promoting broader community health.²³

The Media. The news and entertainment media shape public opinion and influence decision making, with potentially critical effects on population health. The media (including television, cinema, and newspapers) help shape popular culture relating to tobacco, food, alcoholic beverages, sex, and illicit drugs. They disseminate information about healthy behaviors and play a particularly crucial role in times of public health emergency. Yet public health activities often attract little media coverage, perhaps because journalists and public health officials do not understand each other's perspectives and methods. Furthermore, the print and broadcast media tend to be much less attentive to diseases that disproportionately burden Blacks relative to Whites.²⁴ Ongoing dialogue and educational opportunities could improve media coverage of public health and increase airtime for public health messages.

Academe. Academe provides degrees and continuing education to the public health workforce. Academic institutions also foster research into many of the most pressing public health problems, such as obesity, smoking, and HIV/AIDS. However, modifications are needed in curricular and financial incentives to link curricular content and teaching methods more closely to the practice needs of the public health workforce. New investments and academic reorganization can promote community-based prevention research that evaluates the effects of interventions on population health.²⁵

Government agencies, therefore, are not only charged with the task of direct action to safeguard the population's health; they also engage with the public and private sectors in partnerships for health. The relationships between public health agencies and their partners are complex,

involving a dynamic that ranges from regulation to volunteerism, and from cooperation to cooption. Still, a multisectoral public health system is necessary to ensure favorable conditions for the population's health.

The Population Focus

Measures to improve public health, relating as they do to such obvious and mundane matters as housing, smoking, and food, may lack the glamour of high-technology medicine, but what they lack in excitement they gain in their potential impact on health, precisely because they deal with the major causes of common disease and disabilities.

Geoffrey Rose (1992)

The crux of public health, as I have sought to demonstrate, is a public or governmental entity that harbors the power and responsibility to assure community well-being. Public health is organized to provide an aggregate benefit to the mental and physical health of all the people in a given community. Classic definitions of public health emphasize this population-based perspective: "Public health' means the prevailingly healthful or sanitary condition of the general body of people or the community in mass, and the absence of any general or widespread disease or cause of mortality. It is the wholesome sanitary condition of the community at large."²⁶

Perhaps the single most important feature of public health is that it strives to improve the functioning and longevity of populations. The field's purpose is to monitor and evaluate health status, as well as to devise strategies and interventions designed to ease the burden of injury, disease, and disability and, more generally, to promote the public's health and safety. Public health interventions reduce mortality and morbidity, thus saving lives and preventing disease on a population level.

Public health differs from medicine, which has the individual patient as its primary focus. The physician diagnoses disease and offers medical treatment to ease symptoms and, where possible, to cure disease. The British epidemiologist Geoffrey Rose compares the scientific methods and objectives of medicine with those of public health. "Why did this patient get this disease at this time?" is a prevailing question in medicine, and it underscores a physician's central concern for sick individuals.²⁷ Public health, on the other hand, seeks to understand the conditions and causes

of ill health (and good health) in the populace as a whole. It seeks to assure a favorable environment in which people can maintain their health. Public health cares about individuals, of course, because of their inherent worth and because a population is healthy only if its constituents (individuals) are relatively free from injury and disease. Indeed, many public health agencies offer medical care for the poor, particularly for conditions that have “spillover” effects for the wider community, such as treatment for sexually transmitted infections (STIs), tuberculosis (TB), and HIV/AIDS. Still, public health’s abiding interest is in the well-being and security of populations, not individual patients.

The focus on populations rather than individual patients is grounded not only in theory but in the methods of scientific inquiry and the services offered by public health. The analytical methods and objectives of the primary sciences of public health—epidemiology and biostatistics—are directed toward understanding risk, injury, and disease within populations. Epidemiology, literally translated from Greek, is “the study (*logos*) of what is among (*epi*) the people (*demos*).”²⁸ Roger Detels notes that “all epidemiologists will agree that epidemiology concerns itself with populations rather than individuals, thereby separating itself from the rest of medicine and constituting the basic science of public health.”²⁹ Epidemiology examines the frequency and distribution of diseases in the population.³⁰ The population strategy “is the attempt to control the determinants of incidents, to lower the mean level of risk factors, [and] to shift the whole distribution of exposure in a favourable direction.”³¹ The advantage of a population strategy is that it seeks to reduce underlying causes that make diseases common in populations, creating the potential for reduction in morbidity and premature mortality at the broadest population level.

Communities and Civic Participation

Public health is interested in communities and how they function to protect and promote (or, as is too often the case, endanger) the health of their members. A community has a life in common that stems from such things as a shared history, language, and values. The term *community* can apply to small groups, such as self-help groups, which share a common goal, or to very large groups that, despite the diversity of their members, have common political institutions, symbols, and memories.³²

Public health officials want to understand what health risks exist among varying populations and, of equal importance, why differences

in health risks exist, who engages in risk behavior (e.g., smoking, a high-fat diet, or unsafe sex), and who suffers from high rates of disease (e.g., cancer, heart disease, or diabetes). Public health professionals often observe differences in risk behavior and disease based on race, sex, or socioeconomic status.³³ Understanding the mechanisms and pathways of risk is vital to developing efficacious interventions to improve health within communities.

Beyond understanding the variance of risk within groups, public health encourages individual connectedness to the community. Individuals who feel they belong to a community are more likely to strive for health and security for all members. Viewing health risks as common to the group, rather than specific to individuals, helps foster a sense of collective responsibility for the mutual well-being of *all* individuals. Finding solutions to common problems can forge more cohesive and meaningful community associations.

Finally, many forward thinkers urge greater community involvement in public health decision making so that policy formation becomes a genuinely civic endeavor. Under this view, citizens strive to safeguard their communities through civic participation, open forums, and capacity-building to solve local problems. Public involvement should result in stronger support for health policies and encourage citizens to take a more active role in protecting themselves and the health of their neighbors.³⁴ Public health authorities, for example, might practice more deliberative forms of democracy, involving closer consultation with consumers and the voluntary organizations that represent them (e.g., town meetings and consumer membership on government advisory committees). This kind of deliberative democracy in public health is increasingly evident in government-community partnerships at the federal, state, and local levels (e.g., AIDS action and breast cancer awareness).

The Prevention Orientation

It has been shown that external agents have as great an influence on the frequency of sickness as on its fatality; the obvious corollary is that man has as much power to prevent as to cure disease. . . . Yet, medical men, the guardians of public health, never have their attention called to the prevention of sickness; it forms no part of their education. . . . The public do not seek the shield of medical art . . . till the arrows of death already rankle

in the veins. . . . Public health may be promoted by placing the medical institutions of the country on a liberal scientific basis; by medical societies co-operating to collect statistical observations; and by medical writers renouncing the notion that a science can be founded upon the limited experience of an individual.

William Farr (1837)

We are moved by sensational images of heroes who leap into action as calamity unfolds before them. But the long, pedestrian slog of prevention is thankless. That is because prevention is nameless and abstract, while a hero's actions are grounded in an easy-to-understand narrative.

Nassim Nicholas Taleb (2005)

The field of public health is often understood to emphasize prevention of injury and disease as opposed to their amelioration or cure. Public health historians tell a classic story of the power of prevention. In September 1854, John Snow wrote, "The most terrible outbreak of cholera which ever occurred in this Kingdom, is probably that which took place in Broad Street, Golden Square [Soho, London], and the adjoining streets, a few weeks ago." Snow, a celebrated epidemiologist, linked the cholera outbreak to a single source of polluted water—the Broad Street pump. He convinced the Board of Guardians of St. James Parish, in whose parish the pump fell, to remove the pump handle as an experiment. Within a week, the outbreak was all but over, with the death toll standing at 616 Sohoites.³⁵

Public health prevention may be defined as interventions designed to avert the occurrence of injury or disease. Many of public health's most potent activities are oriented toward prevention: vaccination against infectious diseases, health education to reduce risk behavior, fluoridation to avert dental caries, and seat belts or motorcycle helmets to avoid injuries. Medicine, by contrast, is often focused on the amelioration or cure of injuries or diseases after they have occurred. Physicians usually see patients following an adverse health event, and they target their interventions to reducing the health impact.

Prevention and amelioration, of course, are not mutually exclusive. Medicine is also concerned with prevention, as physicians often counsel patients to avoid risk behaviors such as smoking, consuming high-fat

—Sohoites.
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Photo 2. Cholera: The Broad Street pump. In this cartoon, a boy thinks the Water Board man is turning on cholera. In response to the mid nineteenth-century outbreaks of cholera in Soho, London, John Snow engaged in shoe-leather epidemiology to find the source of the outbreak. He traced the epidemic to a single water pump on Broad Street. Courtesy of The Image Works.

foods, engaging in unprotected sex, or drinking alcoholic beverages to excess. Similarly, public health is concerned with amelioration, as health departments frequently offer health care for the poor. The goals of medicine and public health are especially intertwined in the field of infectious diseases, where medical treatment can reduce contagiousness. The individual benefits from treatment, and society benefits from overall reduced exposure to disease.

A foundational article by Michael McGinnis and William Foege examines the leading causes of death in the United States, revealing different types of thinking in medicine and public health.³⁶ Medical explanations of death point to discrete pathophysiological conditions, such as

cancer, heart disease, cerebrovascular disease, and pulmonary disease.³⁷ Public health explanations, by contrast, examine the root causes of disease. From this perspective, the leading causes of death are environmental, social, and behavioral factors, such as smoking, alcohol and drug use, diet and activity patterns, sexual behavior, toxic agents, firearms, and motor vehicles. McGinnis and Foege observe that the vast preponderance of government expenditures are devoted to medical treatment of diseases ultimately recorded on death certificates as the nation's leading killers. Only a small fraction of funding is directed to control the root determinants of death and disability. The central message, of course, is that prevention is often more cost-effective than amelioration, and that much of the burden of disease, disability, and premature death can be reduced through prevention.

Social Justice

The challenge to public health . . . is to overcome inequitable allocation of benefits, the tragedy that would befall us if we made the promise of [science] only for those who could afford it and not for all society. Social evolution . . . will be what we want it to be, and now is the time to make our case. . . . [Public health sciences] offer unbelievable opportunities and unbelievable inequities.

William Foege (2005)

Social justice is viewed as so central to the mission of public health that it has been described as the field's core value: "The historic dream of public health . . . is a dream of social justice."³⁸ Among the most basic and commonly understood meanings of justice is fair, equitable, and appropriate treatment in light of what is due or owed to individuals and groups.³⁹

Social justice captures the twin moral impulses that animate public health: to advance human well-being by improving health and to do so particularly by focusing on the needs of the most disadvantaged.⁴⁰ This account of justice has the aim of bringing about the human good of health for all members of the population. An integral part of that aim is the task of identifying and ameliorating patterns of systematic disadvantage that profoundly and pervasively undermine the prospects for well-being of oppressed and subordinated groups—people whose prospects for good health are so limited that their life choices are not even remotely like those

of others.⁴¹ These two aspects of justice—health improvement for the population and fair treatment of the disadvantaged—create a richer understanding of public health. Seen through the lens of social justice, the central mission of the public health system is to engage in systematic action to ensure the conditions for improved health for all members of the population, and to redress persistent patterns of systematic disadvantage.

A core insight of social justice is that there are multiple causal pathways to numerous dimensions of disadvantage. The causal pathways to disadvantage include poverty, substandard housing, poor education, unhygienic and polluted environments, and social disintegration. These, and many other causal agents, lead to systematic disadvantage not only in health but also in nearly every aspect of social, economic, and political life. Inequalities of one kind beget other inequalities, and existing inequalities compound, sustain, and reproduce a multitude of deprivations in well-being. Taken in their totality, multiple disadvantages add up to markedly unequal life prospects.

This account of social justice focuses on the totality of social institutions, practices, and policies that both independently and in combination deeply and persistently affect human well-being. It is interventionist, not passive or market-driven, vigorously addressing the determinants of health throughout the lifespan. It recognizes that there are multiple causes of ill and good health, that policies and practices affecting health also affect other valued dimensions of life, and that health is intimately connected to many of the important goods in life. The critical questions at the intersection of public health and justice are what people in society are most vulnerable and at greatest risk, how best to reduce the risk or ameliorate the harm, and how to fairly allocate services and benefits.

Social justice stresses the fair disbursement of common advantages and the sharing of common burdens. Known as distributive justice, this form of justice requires that government act to limit the extent to which the burden of disease falls unfairly upon the least advantaged and to ensure that the burden of the interventions themselves is distributed equitably. Distributive justice also requires fair allocation of public health benefits. This principle might apply, for example, to the fair distribution of vaccines or antiviral medications during a public health emergency, such as a pandemic influenza epidemic.⁴²

Social justice demands more than fair distribution of resources. Health hazards threaten the entire population, but the poor and disabled are at heightened risk. For example, during the Gulf Coast hurricanes in 2005, state and federal agencies failed to act expeditiously and with equal concern

for all citizens, including the poor and less powerful.⁴³ Neglecting the needs of the vulnerable predictably harms the whole community by eroding public trust and undermining social cohesion. It signals to those affected and to everyone else that the basic human needs of some matter less than those of others, and it thereby fails to show the respect due to all members of the community. Social justice thus not only encompasses a core commitment to fair distribution of resources, but it also calls for policies of action that are consistent with the preservation of human dignity and showing of equal respect for the interests of all members of the community.

These are the quintessential values of public health law—government power and duty, coercion and limits on state power, government’s partners in the “public health system,” the population focus, communities and civic participation, the prevention orientation, and social justice. To achieve the goals of population health under the rule of law requires sound legal foundations. As the following discussion explains, state statutes establish the infrastructure for public health agencies, ranging from their mission, functions, and powers to their organization and funding.

PUBLIC HEALTH STATUTES: LEGAL FOUNDATIONS OF PUBLIC HEALTH AGENCIES

The field of public health is typically regarded as a positivistic pursuit, and undoubtedly our understanding of the etiology and response to disease is heavily influenced by scientific inquiry. Less well understood is the role of law in public health practice. Law defines the jurisdiction of public health officials and specifies the manner in which they may exercise their authority. State public health statutes create public health agencies, designate their mission and core functions, appropriate their funds, grant their power, and limit their actions to protect a sphere of freedom. They establish boards of health, authorize the collection of health information, and enable monitoring and regulation of dangerous activities. The most important social debates about public health take place in legal forums—legislatures, courts, and administrative agencies—and in the law’s language of rights, duties, and justice. It is no exaggeration to say that “the field of public health . . . could not long exist in the manner in which we know it today except for its sound legal basis.”⁴⁴

In its influential report, *The Future of Public Health*, the IOM agreed that law is essential to population health, but cast serious doubt on the soundness of public health’s legal basis. Concluding generally that “this

BOX 1

THE NEED FOR PUBLIC HEALTH LAW REFORM

Scholars have identified deficiencies in many public health law statutes, justifying a political process of modernization.

Problem of Antiquity

The most striking characteristic of state public health law—and the one that underlies many of its defects—is its overall antiquity. Certainly, some statutes are relatively recent in origin. However, much of public health law was framed in the late nineteenth and early to mid-twentieth centuries and contains elements that are forty to one hundred years old. Old public health statutes are often outmoded in ways that directly reduce their effectiveness and conformity with modern standards. These laws often do not reflect contemporary scientific understandings of injury and disease or legal norms for protection of individual rights. Society faces different types of risks today and employs different methods of assessment and intervention. When many of these statutes were written, public health (e.g., epidemiology and biostatistics) and behavioral sciences (e.g., client-centered counseling) were in their infancy. Modern prevention and treatment methods did not exist.

Problem of Multiple Layers of Law

Related to the problem of antiquity is the problem of multiple layers of law. The law in most states consists of successive layers of statutes and amendments, constructed in some cases over one hundred years or more in response to existing or perceived health threats. This is particularly troublesome in the area of infectious disease, which forms a substantial part of state health codes. The disparate legal structures of state public health laws can significantly undermine their effectiveness. Because communicable disease laws have been enacted piecemeal in response to specific epidemics, they tell the story of the history of disease control (e.g., smallpox, yellow fever, cholera, tuberculosis, venereal diseases, polio, HIV/AIDS, West Nile virus, and SARS). Laws enacted in such an ad hoc fashion are often inconsistent, redundant, and ambiguous.

Problems of Inconsistency

Public health laws remain fragmented not only within states but also among them. Health codes within the states and territories have evolved independently, leading to profound variation in the structure, substance, and procedures for detecting, controlling, and preventing injury and disease. In fact, statutes and regulations among U.S. jurisdictions vary so significantly in definitions, methods, age, and scope that they defy orderly categorization.¹ There is good reason for wanting greater uniformity among the states in matters of public health: health threats are rarely confined to single jurisdictions, but pose risks regionally, nationally, or even globally (e.g., air or water pollution, disposal of toxic waste, and the spread of infectious diseases, either naturally or through bioterrorist events). One need only take note of the contemporary outbreaks of West Nile virus, SARS, avian influenza, or Marburg to understand the trans-jurisdictional effects of health threats.

¹ Lawrence O. Gostin, Scott Burris, and Zita Lazzarini, "The Law and the Public's Health: A Study of Infectious Disease Law in the United States," *Columbia Law Review*, 99 (1999): 59-128.

nation has lost sight of its public health goals and has allowed the system of public health activities to fall into disarray,”⁴⁵ the IOM put some of the blame on an obsolete and inadequate body of enabling laws and regulations. “Public health law . . . is often outdated and internally inconsistent. This leads to inefficiency and a lack of coordination and may even pose a danger in a crisis.”⁴⁶ The IOM recommended reform based on the “pioneering work” of the “Turning Point” Model Public Health Act, available on the *Reader Web* site.⁴⁷ Problems of antiquity, inconsistency, redundancy, and ambiguity render many statutes ineffective, or even counterproductive, in advancing the population’s health (see box 1). These problems exist not only in the United States but in many other countries.⁴⁸

POWER, DUTY, RESTRAINT

The “Turning Point” Model Public Health Act adopts the reform principles characterized in the title of this book: power, duty, and restraint. As the following discussion shows, a modern statute should define the mission and functions of public health agencies, afford a full range of powers, and impose limits on those powers to safeguard personal liberties (see further box 36).⁴⁹

Define the Mission and Functions. Broad and well-considered statements of mission and functions are important for organizational, political, and legal reasons (see figures 4 and 5). From an organizational perspective, they establish the purposes or goals of public health agencies, thereby informing and influencing the government’s activities. From a political perspective, statements of mission and functions provide a measure of the kinds of activities that are politically sanctioned. When a public health agency is acting under a broad mission and set of core functions, that agency can better justify its decisions to legislators, the governor, and the public. From a legal perspective, courts pay deference to statements of legislative intent and may permit a broad range of activities consistent with the statutory language. Thus, even if the aspirational qualities of mission statements do not produce the desired results, they can help support agency action.

Provide a Full Range of Powers. Although voluntary cooperation is vital to public health officials, they need a full range of powers to ensure compliance with health and safety standards. At present, officials in many states have a sterile choice of either exercising draconian authority, such as deprivation of liberty, or refraining from coercion entirely. The temptation is either to abstain from exercising statutory power completely or to reach for measures that are too restrictive of individual liberty to be

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Figure 4. The mission of public health. *Source*: “Turning Point” Model State Public Health Act, September 2003, section II-101, p. 18.

acceptable in a liberal democracy. As a result, authorities may make wrong choices in two opposite directions: failing to react in the face of a real health threat or overreacting by exercising powers that are more intrusive than necessary. Public health officials need a more flexible set of tools, ranging from incentives and minimally coercive interventions to personally restrictive measures.

Impose limits on powers. Public health statutes should carefully balance power exercised for the common good with limits on power to protect personal freedom. Restraint on power has both substantive and procedural aspects. Substantively, state statutes should articulate clear criteria for the exercise of public health powers based on objective risk as-

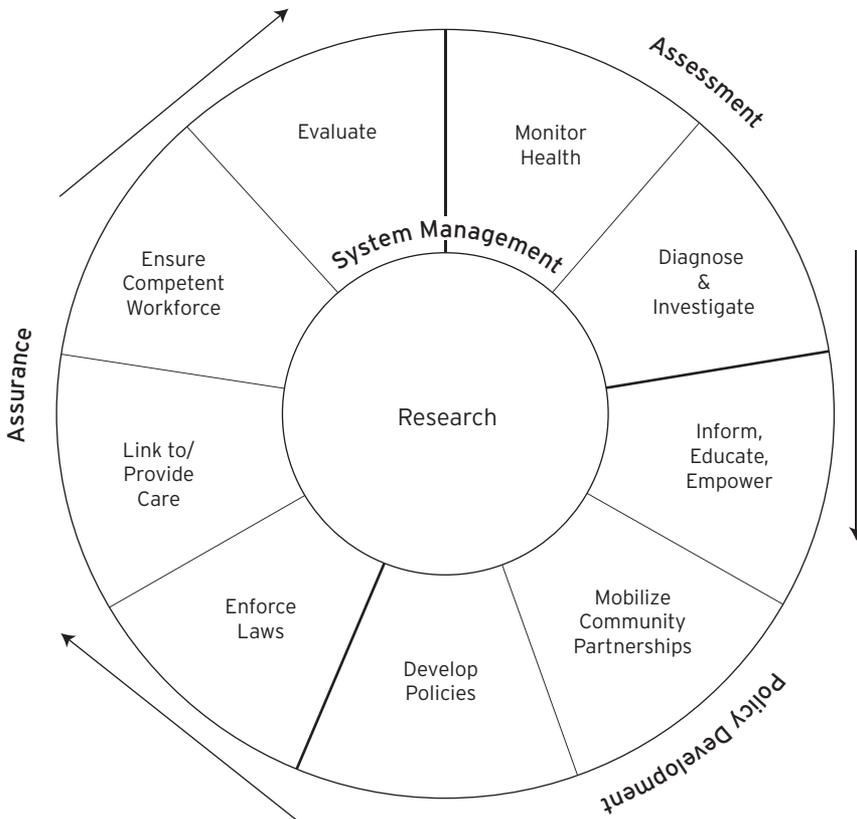


Figure 5. The core functions of public health. *Source:* Public Health Functions Steering Committee, July 1995.

assessments. Although public officials may prefer unfettered discretion, sound standards for action facilitate consistent and informed judgments. Procedurally, public health statutes should require fair processes whenever there is deprivation of a personal, proprietary, or other legally protected interest. Procedural due process, for example, usually should apply to actions that deprive a person of liberty (e.g., isolation or quarantine) or property (e.g., an inspection, license, or nuisance abatement).

THE LAWMAKING PROCESS:

BUILDING CONSTITUENCIES AND FORMING PARTNERSHIPS

The methods and goals of public health are often misunderstood and undervalued within government and society. The fact that public health

polices the commons and champions population-based risk reduction through behavior change (e.g., smoking cessation, designated drivers, exercise, and diet modification) deprives it of specific beneficiaries who are motivated to form political constituencies. The prevalence of an individualistic market ideology makes it difficult to even speak of public health in the vocabulary of contemporary politics.⁵⁰ Public health needs opportunities to draw attention to its resource requirements and its achievements so that it can develop constituencies for programs.

The lawmaking process provides such an opportunity. A bill is the first step toward a coalition. It is an occasion for contact with interest groups and affected communities, some of whom may be motivated to act in support of the bill. Contacts and collaborative efforts also help to establish long-term ties and identify important sources of support for other programs. Moreover, the process of negotiating for support can be a useful and concrete way for health agencies to incorporate the views of those who receive public health services or are subject to regulation.

Legal reform also has the potential to enhance health agencies' relationships with the legislature. Positive lawmaking offers a different sort of contact with legislators than tends to occur in the appropriations process. Public health law reform may offer an occasion to deal with a far greater range of legislators outside the context of contentious budget discussions. The drafting, negotiating, and hearing processes provide a variety of forums for educating lawmakers and their staffs about public health needs and methods and to provide health planners with better information about legislative views and priorities.

Law reform, of course, cannot guarantee better public health. However, by crafting a consistent and uniform approach, carefully delineating the mission and functions of public health agencies, designating a range of flexible powers, and specifying the criteria and procedures for using those powers, the law can become a catalyst, rather than an impediment, to reinvigorating the public health system.

LAW AS A TOOL FOR THE PUBLIC'S HEALTH: MODELS OF LEGAL INTERVENTION

The definition I have proposed and defended does not depict the field of public health law narrowly as a complex set of technical rules buried within state health codes. Rather, public health law should be seen broadly as the authority for and responsibility of organized society to

ensure the conditions for the population's health. The law can be empowering, providing innovative solutions to the most implacable health problems. Of the ten great public health achievements in the twentieth century, most were realized, at least in part, through law reform or litigation: vaccinations, safer workplaces, safer and healthier foods, motor vehicle safety, control of infectious diseases, tobacco control, fluoridation of drinking water, family planning, healthier mothers and babies, and the decline in deaths from coronary heart disease and stroke (see figure 6). Consider what role the law might play in addressing the major public health challenges of the twenty-first century, depicted in table 1.

The study of public health law requires, therefore, a detailed understanding of the various legal tools available to prevent injury and disease and to promote the health of the populace.⁵¹ In this section, I offer a taxonomy of the legal tools available to government and private citizens to advance the public's health: taxation and spending, alteration of the informational environment, alteration of the built environment, alteration of the socioeconomic environment, direct regulation, indirect regulation through the tort system, and deregulation (see figure 7). Although in each case the law can be a powerful agent for change, the interventions raise critical social, ethical, or constitutional concerns that warrant careful study. I frame these problems quite simply here but develop the ideas more systematically in the ensuing chapters. What is clear is that public health law is not a scientifically neutral field, but is inextricably bound to politics and society.

Model 1: The Power to Tax and Spend

The power to tax and spend is found in Article I of the U.S. Constitution, providing government with an important regulatory technique.⁵² The power to spend supports a broad array of public health services, ranging from education to research. Although funding is far too limited, government spends to establish and maintain a public health infrastructure consisting of a well-trained workforce, electronic information and communications systems, rapid disease surveillance, laboratory capacity, and response capability. In addition to direct funding, government can also set health-related conditions for the receipt of public funds. For example, government can grant funds for highway construction or other public works projects on the condition that the recipients meet designated safety requirements.⁵³

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Celebrating a Century of Success

Ten Great Public Health Achievements — United States, 1900-1999



A score of reports has been published in CDC's *Morbidity and Mortality Weekly Report* (MMWR) regarding the 10 great public health achievements highlighted in this exhibit. For more information, point your web browser to <http://www2.cdc.gov/mmwr>.



CDC

Note: This illustration by the Centers for Disease Control and Prevention listing the ten great public health achievements of the twentieth century suggests a wide range of modern public health functions.

Figure 6. Ten great public health achievements. *Source:* Centers for Disease Control and Prevention.

TABLE 1. Current and future public health challenges

To position the nation for the century ahead, we believe that the medical, scientific, and public health communities must do the following:

1. Institute a rational health care system
 2. Eliminate health disparities among racial and ethnic groups
 3. Focus on children's emotional and intellectual development
 4. Achieve a longer "healthspan" for the rapidly growing aging population
 5. Integrate physical activity and healthy eating into daily lives
 6. Clean up and protect the environment
 7. Prepare to respond to emerging infectious diseases
 8. Recognize and address the contributions of mental health to overall health and well-being
 9. Reduce the toll of violence in society
 10. Use new scientific knowledge and technological advances wisely
-

SOURCE: Jeffrey P. Koplan and David W. Fleming, "Current and Future Public Health Challenges," *JAMA*, 284 (October 4, 2000): 1696-98.

The power to tax provides inducements to engage in beneficial behavior and disincentives to engage in risk activities. Tax relief can be offered for health-producing activities such as medical services, child care, and charitable contributions. At the same time, tax burdens can be placed on the sale of hazardous products, such as cigarettes, alcoholic beverages, and firearms. Of course, taxation can also create perverse incentives, such as tax relief for the purchase of unsafe and fuel-inefficient sport utility vehicles.⁵⁴

Market incentives through the power to tax and spend are more likely than command-and-control regulation to win political acceptance—for example, inducements to avert or clean up dangerous environmental hazards are more acceptable than a compulsory measure. Still, spending and taxing powers are not entirely benign. Taxing and spending can be coercive precisely because the government wields such significant economic power. Economic conservatives, for example, are antagonistic toward proposals to tax high-calorie foods, viewing such proposals as paternalistic and meddlesome. On the other hand, liberals view some taxation as inequitable if rich people benefit while the poor are disadvantaged (e.g., tax breaks for capital gains or offshore tax shelters). Some tax policies serve the rich, the politically connected, or those with special interests (e.g., tax preferences for energy companies or tobacco farmers). Other taxes penalize the poor because they are highly regressive. For example, almost all public health advocates support cigarette taxes, but the individuals who

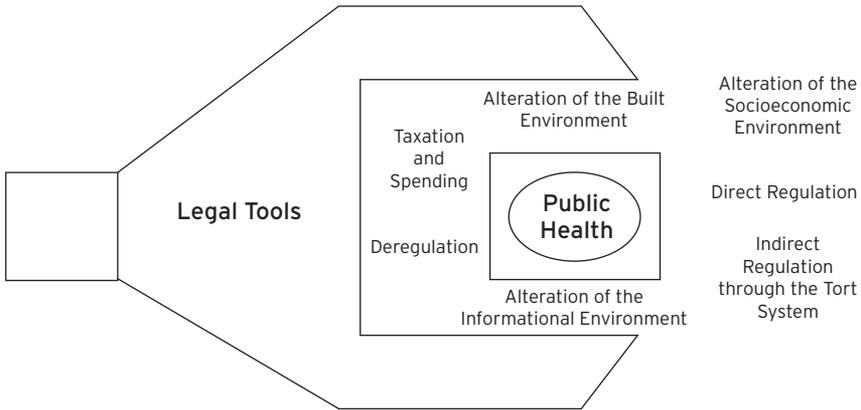


Figure 7. Law as a tool for the public's health: Seven models of legal intervention.

shoulder the principal financial burden are disproportionately indigent and are often members of minority groups⁵⁵ (see further chapter 12).

Model 2: The Power to Alter the Informational Environment

The public is bombarded with information that influences life's choices, and this undoubtedly affects health and behavior. The government has several tools at its disposal to alter the informational environment, thereby encouraging people to make more healthful choices about diet, exercise, cigarette smoking, and other behaviors: (1) government, as a health educator, can use communication campaigns as a major public health strategy; (2) government can require businesses to label their products to include instructions for safe use, disclosure of contents or ingredients, and health warnings; and (3) government can limit harmful or misleading information in private marketing by regulating advertising for potentially harmful products, such as cigarettes, firearms, and even dietary supplements.

To many public health advocates, there is nothing inherently wrong with or controversial in ensuring consumers receive full and truthful information. Yet health communication campaigns on topics such as sex, abortion, smoking, or high-fat diets are sometimes highly contested; businesses strongly protest compelled disclosure of certain health risks (e.g., the adverse effects of pharmaceuticals), and the Supreme Court has strongly protected advertising as a First Amendment right.⁵⁶ Conse-



Figure before call to keep in section, okay? SRS/ICS

Photo 3. Public Health Service syphilis poster. The cover of a 1940s Public Health Service publication emphasizing the role of state and local governments in planning and conducting campaigns for the diagnosis and treatment of persons with syphilis. This poster illustrates a range of interventions to control syphilis.

quently, there are powerful economic and constitutional interests at stake in any intervention designed to alter the informational environment (see further chapter 9).

Model 3: The Power to Alter the Built Environment

The design of the built or physical environment can hold great potential for addressing the major health threats facing the global community. Public health has a long history of altering the built environment to reduce injury (e.g., workplace safety, traffic calming, and fire codes), infectious diseases (e.g., sanitation, zoning, and housing codes), and environmentally associated harms (e.g., lead paint and toxic emissions). The epidemiological transition from infectious to chronic diseases raises new challenges in the design of neighborhoods to facilitate physical and mental well-being. Although research is limited, we know environments can be designed to promote livable cities and facilitate health-affirming behavior. For example, urban design can be used to encourage more active lifestyles (walking, biking, and playing), improve nutrition (by making healthful foods more accessible and high-calorie foods more avoidable), decrease the use of harmful products (cigarettes and alcoholic beverages), reduce violence (domestic abuse, street crime, and firearm use), and increase social interactions (helping neighbors and building social capital).⁵⁷

Critics offer a stinging assessment of public health efforts to alter the built environment: “The anti-sprawl campaign is about telling [people] how they should live and work, about sacrificing individuals’ values to the values of their politically powerful betters. It is coercive, moralistic, nostalgic, [and lacks honesty].”⁵⁸ The public health response: “[The] national landscape is largely devoid of places worth caring about. Soulless subdivisions, residential ‘communities’ utterly lacking in communal life . . . and mile upon mile of clogged collector roads, the only fabric tying our disassociated lives together.”⁵⁹ Serious disagreement and acrimony apparently exist about the extent to which government should pursue environmental changes in the name of public health. Many of the sharpest disputes focus on modifications to the built environment to reduce obesity, a subject I return to in chapter 13 (see also box 12).

Model 4: The Power to Alter the Socioeconomic Environment

There is a social gradient in health that runs from the top to the bottom of society and affects all of us. A

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way to understand this link between status and health is to think of three fundamental human needs: health, autonomy and opportunity for full social participation. All the usual suspects affect health—material conditions, smoking, diet, physical activity and the like—but autonomy and participation are two other crucial influences on health; and the lower the social status, the less autonomy and the less social participation.

Michael Marmot (2005)

A strong and consistent finding of epidemiological research is that socioeconomic status (SES) is correlated with morbidity, mortality, and functioning.⁶⁰ SES is a complex phenomenon based on income, education, and occupation. As the epigraph indicates, theorists posit that material disadvantage, diminished control over life's circumstances, and lack of social acceptance all contribute to poor health outcomes.⁶¹ The relationship between SES and health often is referred to as a “gradient” because of the graded and continuous nature of the association; health differences are observed well into the middle ranges of SES.⁶² These empirical findings have persisted across time and cultures and remain viable today.⁶³

Some researchers go further, concluding that the overall level of economic inequality in a society correlates with (and adversely affects) population health.⁶⁴ That is, societies with wide disparities between rich and poor tend to have worse health status than societies with smaller disparities, after controlling for per capita income. These researchers hypothesize that societies with higher degrees of inequality provide less social support and cohesion, making life more stressful and pathogenic. Drawing upon this line of argument, some ethicists contend that “social justice is good for our health.”⁶⁵

There is some persuasive anecdotal evidence for this societal inequality theory. The United States ranks twenty-ninth in the world in life expectancy—behind countries with half the income and half the health care expenditures per capita.⁶⁶ Among countries with available data, all but four of the twenty-eight preceding the United States have more equal income distributions.⁶⁷ The authors of a recent meta-analysis, however, cast doubt on the theory that more equal societies are necessarily healthier, while acknowledging that raising the incomes of the least advantaged will improve their health and thereby increase society-wide health:

Overall, there seems to be little support for the idea that income inequality is a major, generalizable determinant of population health differences within or between rich countries. Income inequality may, however, directly influence some health outcomes, such as homicide . . . in the United States, but even that is somewhat mixed. Despite little support for a direct effect of income inequality on health per se, reducing income inequality by raising the incomes of the most disadvantaged will improve their health, help reduce health inequalities, and generally improve population health.⁶⁸

Opponents of redistributive policies challenge this last claim, arguing that such policies punish personal accomplishment, thereby discouraging economic growth. Pointing to the correlation between population-wide health and national per capita income, they say redistribution *reduces* population-wide health over the long run by suppressing the growth of per capita income.⁶⁹ Redistribution of private wealth, they contend, is a political matter, outside the appropriate scope of the public health enterprise.⁷⁰

The political divide on the role of socioeconomic status in population health may be impossible to bridge. Public health advocates believe a reduction in health disparities is a social imperative, while economic conservatives believe a free-market economy is indispensable to a vibrant and prosperous society. Some commentators go so far as to distinguish between the “old” public health, focused mainly on infectious disease control, and the “new” public health, aimed more broadly at the social and economic determinants of health.⁷¹

Model 5: Direct Regulation of Persons, Professionals, and Businesses

Government has the power to directly regulate individuals, professionals, and businesses. In a well-regulated society, public health authorities set clear, enforceable rules to protect the health and safety of workers, consumers, and the population at large. Regulation of individual behavior reduces injuries and deaths (e.g., use of seat belts and motorcycle helmets).⁷² Licenses and permits enable government to monitor and control the standards and practices of professionals and institutions (e.g., doctors, hospitals, and nursing homes). Finally, inspection and regulation of businesses helps to ensure humane conditions at work, reduce toxic emissions, and improve consumer product safety.

Despite its undoubted value, public health regulation is highly contested terrain. Civil libertarians favor personal freedoms, including autonomy, privacy, and liberty. The fault lines between public health and

civil liberties were exposed during the debates about the Model State Emergency Health Powers Act following September 11 and the subsequent anthrax attacks (see box 36). Should government act boldly in a public health emergency to quell health threats or should it give precedence to personal rights and liberties?⁷³ Similar tensions are evident in the area of commercial regulation.⁷⁴ Influential economic theories (e.g., laissez-faire) favor open competition and the undeterred entrepreneur. Theorists advocate redressing market failures, such as monopolistic and other anticompetitive practices, rather than restraining free trade. They support relatively unfettered private enterprise and free-market solutions to social problems. Many citizens see a changing role for government from one that actively orders society for the good of the people (what the English call the “nanny state”)⁷⁵ to one that leaves individuals to make their own personal and economic choices. (For additional discussion of direct regulation of businesses and individuals, see chapters 5, 10, 11, and 12).

Model 6: Indirect Regulation through the Tort System

Attorneys general, public health authorities, and private citizens possess a powerful means of indirect regulation through the tort system. Civil litigation can redress many different kinds of public health harms: environmental damage (e.g., air pollution or groundwater contamination), exposure to toxic substances (e.g., pesticides, radiation, or chemicals), hazardous products (e.g., tobacco or firearms), and defective consumer products (e.g., children’s toys, recreational equipment, or household goods). Recently, public health advocates, drawing lessons from successful tobacco strategies, have brought tort actions against firearms manufacturers⁷⁶ and fast food restaurants.⁷⁷

While tort law can be an effective method of advancing the public’s health, like any form of regulation, it is not an unmitigated good. The tort system imposes economic and personal burdens on individuals and businesses. Litigation, for example, increases the cost of doing business, thus driving up the price of consumer products. It is important to note that tort actions can deter not only socially harmful activities (e.g., unsafe automobile designs) but also socially beneficial ones (e.g., innovation in vaccine development). It is perhaps for this reason that federal and state legislators have sharply limited tort liability in such controversial areas as consumer protection class actions,⁷⁸ medical malpractice lawsuits,⁷⁹ and firearm⁸⁰ and obesity litigation.⁸¹ Thus, although tort litiga-

tion remains a prime strategy for the public health community, it is actively resisted in some political circles (see chapter 6).

Model 7: Deregulation: Laws as a Barrier to Health

Sometimes laws are harmful to the public's health and stand as an obstacle to effective action. In such cases, the best remedy is deregulation. Politicians may urge superficially popular policies that have unintended health consequences. Consider laws that penalize needle exchange programs and pharmacy sales of sterile syringes; that close bathhouses, making it more difficult to reach gay men with condoms and safe sex literature; or that criminalize sex for persons living with HIV/AIDS, thereby potentially driving the epidemic underground.⁸²

Deregulation can be controversial because it often involves direct conflict between public health and other social values, such as crime prevention or morality. Drug laws, the closure of bathhouses, and HIV-specific criminal penalties represent society's disapproval of disfavored behaviors. Deregulation becomes a symbol of weakness that is often politically unpopular. Public health advocates may believe passionately in harm-reduction strategies, but the political community may want to use the law to demonstrate social disapproval of certain activities, such as illicit drug use or unprotected sex.⁸³

The government, then, has many legal "levers" designed to prevent injury and disease and promote the public's health. Legal interventions can be highly effective and need to be part of the public health officer's arsenal. However, legal interventions can also be controversial, raising important ethical, social, constitutional, and political issues. These conflicts are complex, important, and fascinating for students and scholars of public health law. Much of the remainder of this book examines these difficult problems in more detail.

THE LEGITIMATE SCOPE
OF PUBLIC HEALTH AND THE LAW

Public health is purchasable. Within natural limitations, every community can determine its own death rate.

Hermann Biggs (1894)

In this chapter, I have offered a definition of public health law, suggesting that it has several core values: government responsibility for health,

state power and restraint, partnerships in the public health system, a population focus, community and civic participation, a prevention orientation, and social justice. I have shown how public health law provides both the foundation for public health agencies and the broader legal tools to advance the population's health. The law creates the mission, functions, funding, and powers of public health agencies, and supplies an array of interventions to ensure conditions in which people can be healthy.

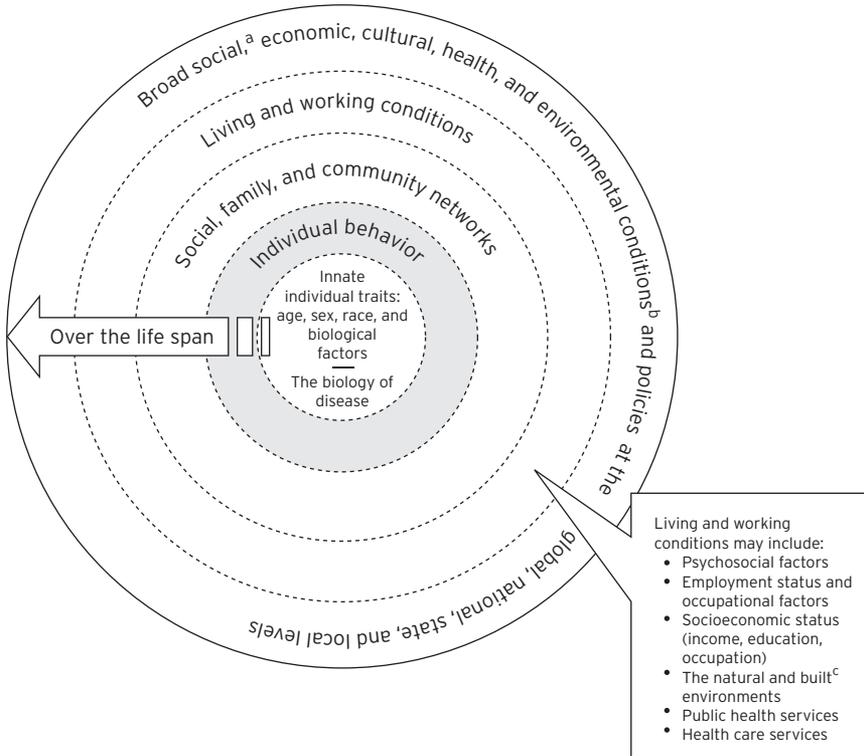
Most public health law and regulation has deep historical roots and strong public support.⁸⁴ However, activities at the cutting edge of population health often spark deep social and political dissent. Much of this controversy is about the legitimate scope, or “reach,” of public health. The controversy may be informed, in large part, by ideas of individualism, freedom, self-discipline, and personal responsibility that have been foundational in our society.⁸⁵ There is a disjunction between the kinds of problems and solutions that are needed on a population level and the way the layperson conceptualizes these problems and their solutions. The lay public conceptualizes health as largely an individual matter rather than a societal issue.

It is not surprising, then, that some prefer a narrow focus on the proximal risk factors for injury and disease.⁸⁶ The role of public health agencies, according to this perspective, is to identify risks or harms and intervene to prevent or reduce them. This has been the traditional role of public health: exercising discrete powers such as surveillance (e.g., screening and reporting), injury prevention (e.g., safe consumer products), and infectious disease control (e.g., vaccination, partner notification, and quarantine).

Others prefer a broad focus on the underlying social, economic, and ecological causes of injury and disease. Those favoring this position see public health as an all-embracing enterprise united by the common value of societal well-being.⁸⁷ They claim that the jurisdiction of public health reaches “social ills rooted in distal social structures.”⁸⁸ Ultimately, the field is interested in the equitable distribution of social and economic resources, because social status, race, and wealth are important influences on the health of populations. Similarly, the field is interested in “social capital” because social networks of family and friends, as well as associations with religious and civic organizations, are important factors in public health.⁸⁹ (See figure 8 for a depiction of the broad determinants of health).

For better or worse, the dispute is highly political, with conservative scholars urging limited state action and progressive scholars urging far-reaching policies. The debate is contentious precisely because both sides

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Note: The dotted lines between levels of the model denote interaction effects among the various levels of health determinants.

^a Social conditions include but are not limited to: economic inequality, urbanization, mobility, cultural values, attitudes, and policies related to discrimination and intolerance on the basis of race, gender, and other differences.

^b Other conditions at the national level might include major sociopolitical shifts, such as recession, war, and governmental collapse.

^c The built environment includes transportation, water and sanitation, housing, and other dimensions of urban planning.

Figure 8. A guide to thinking about the determinants of population health.

Source: Reprinted from Institute of Medicine, *The Future of the Public's Health in the Twenty-first Century* (2000), p. 52.

have strong positions. A growing body of evidence demonstrates the value of city planning, building social capital, reducing disparities, and changing aspects of popular culture.⁹⁰ Public health agencies must act on the basis of data, and those data are informing officials about the importance of the deep underlying causes of injury and disease.⁹¹

Yet this all-embracing domain of public health can be troublesome, particularly in a political culture that prizes individual choice and re-

sponsibility. Almost everything human beings undertake impacts the public's health, but this does not necessarily justify an overly expansive reach. Public health agencies lack the expertise and resources to tackle problems relating, for example, to culture, housing, and discrimination. This leads inexorably to the problem of garnering political and public support for the public health enterprise. By espousing controversial issues of economic redistribution and social restructuring, the field risks losing its legitimacy. Public health gains credibility from its adherence to science, and if it strays too far into political advocacy, it may lose the appearance of objectivity.

In the end, the field of public health is caught in a dilemma. If it conceives of itself too narrowly, public health will be accused of lacking vision. It will fail to see the root causes of ill health and will fail to utilize the broad range of social, economic, scientific, and behavioral tools necessary to achieve a healthier population. If, however, public health conceives of itself too expansively, it will be accused of overreaching and invading a sphere reserved for politics, not science. The field will lose its ability to explain its mission and functions in comprehensible terms and, consequently, to sell public health in the marketplace of politics and priorities.

The politics of public health are daunting. American culture openly tolerates the expression and enjoyment of wealth and privilege, and it is inclined to treat people's disparate life circumstances as a matter of personal responsibility. Meanwhile, voters have become skeptical of government's ability to ameliorate the harshest consequences of economic and social disadvantage. Polarizing debates about faith and race have supplanted discussions of economic fairness in political campaigns and the public sphere more generally. Political liberalism has been complicit in these trends. Over the past forty years, emphasis has shifted from social obligation and economic fairness to individual freedom, self-reliance, and personal responsibility, thus relocating health from the public sphere to the private realm.⁹²

These are the challenges of public health law: Does it act modestly or boldly? Does it choose scientific neutrality or political engagement? Does it leave people alone or change them for their own good? Does it intervene for the common welfare or respect civil liberties? Does it aggressively tax and regulate or nurture free enterprise? The field of public health law presents complex trade-offs and poses enticing intellectual challenges that are both theoretical and essential to the body politic.

[FIGURE]
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Photo 4
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Photo 4. Containment of infectious disease around military training camps. During the First World War, the U.S. Public Health Service cooperated with local health departments to contain infectious diseases, which were assumed to be the principal threats to public health in the areas around the military training camps. Sanitation and public health regulation were health officers' principal weapons against these diseases.