

PART ONE

Conceptual Foundations of Public Health Law

A Theory and Definition of Public Health Law

[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. . . . Public 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, *Public Health Law: A Manual of Law for Sanitarians*, 1926

The intersection of law and health has generated a rich body of academic literature, statutes, and judicial opinions. Health law is widely taught (in schools of law, medicine, public health, business, and health administration), practiced, and analyzed by scholars.¹ Public health law shares conceptual terrain with the fields of health care law, bioethics, and health policy but remains a distinct discipline, with a growing body of literature, statutes, and judicial decisions of its own.² Our claim is not that public health law is contained within a tidy doctrinal package; its boundaries are blurred and overlap other paths of study in 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, we 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. With this book we hope to provide a fuller understanding of the varied roles of law in advancing the public's health. The core idea we propose is that law is an essential tool for creating conditions to enable people to lead healthier and safer lives.

In this opening chapter, we offer a theory and definition of public health law, an examination of its core values, an introduction to evolving models of public health problem solving, a categorization of legal tools to advance the public's health, and an assessment of the legitimate scope of public health. We consider the following questions: What is public health law and what are its doctrinal boundaries? Why is health a salient value? What are the legal foundations of government intervention to promote public health? How can law be effective in reducing illness, injury, 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

Here we present our definition of public health law; the remainder of this chapter offers a justification and elaboration of the ideas it encompasses.

Public health law is the study of the legal powers and duties of the state to assure the conditions for people to be healthy (to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the common good. 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) the population perspective, (4) the prevention orientation, and (5) the social justice commitment (see figure 1.1).

GOVERNMENT POWER AND DUTY: HEALTH AS A SALIENT VALUE

Anyone concerned about health, and about whether, when, how, and why it gives rise to meaningful responsibilities, needs to address the question *what makes health public?*

—John Coggan, *What Makes Health Public?*, 2012



FIGURE 1.1. Public health law: a definition and core values.

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*.

The "Public's" Health

The word *public* in *public health* has two overlapping meanings: one that explains the entity that takes primary responsibility for the public's

health, and another that explains 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.³

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. But what best serves the population may not always be in the interests of all its members, making public health highly political. What constitutes "good enough" health? What kinds of services are necessary? How will services be paid for and distributed? These remain political questions. 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 (such as smoking in public places or riding a motorcycle without a helmet). Members of society have common goals that go beyond narrow personal 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 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, allowing individuals to decide whether to acquiesce to a vaccination or permit reporting of personal information to the health department would result in a “tragedy of the commons”: that is, what is good for the individual may be harmful for the community at large.⁶

Public health advocates take it as an article of faith that health must be society’s overarching value. Yet politicians do not always see it that way, expressing preferences for funding, say, highways, energy, or 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, whereby health is seen as a foundation for personal well-being and the exercise of social and political rights; and (2) a theory of democracy, whereby the primary role of government is seen as achieving health, safety, and welfare for the population.

Health as Foundational

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

person derives from life. Physical and mental health allow individuals to recreate, socialize, work, and engage in family and social activities that bring meaning and happiness to their lives. Certainly persons with poor health or disabilities can lead deeply fulfilling lives, but personal health facilitates many joys and accomplishments. Every person desires 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 not as obvious, however, is 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, or provide for the common security. A safe and healthy population provides the basis for a country's government structures, social organizations, cultural endowment, economic prosperity, and national defense. Population health is 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, then, 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 members for the mutual benefits of social interactions, and nations build health care and public health infrastructure to cultivate a decent and prosperous civilization.

Government's Obligation to Promote Health

Over the course of the past two centuries, studies and interventions influenced by the population perspective have taught the world much and paved the way for collective actions that have saved millions of lives. More often than not, these interventions have relied on law.

—Wendy E. Parmet, *Populations, Public Health, and the Law*,
2009

Why does government have an enduring obligation to protect and promote the public's health? The answer lies in theories of democracy. 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 human 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 community as a whole. Public health can be achieved only through collective action—often expressed in law—rather than through individual endeavors. Any person of means can procure many of the necessities of life, such as food, housing, clothing, and medical care. Yet no single individual can assure his or her health and safety. Meaningful protection and assurance of the population’s health require communal effort. The community as a whole has a stake in hygiene and sanitation, clean air and water, uncontaminated food, safe roads and products, and control of infectious disease. These collective goods, and many more, are essential conditions for health, and these benefits can be secured only through organized action on behalf of the people.

THE POWER TO COERCE AND LIMITS ON STATE POWER

We have suggested that public health law is concerned with government 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, we also suggest that the use of coercion must be part of an informed understanding of public health law, and that the state’s 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 also 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 interests about the desirability of coercion in a given situation—should government resort to force, what kind, and under what circumstances?—is a matter for political resolution. In chapter 2, we

propose standards for evaluating public health regulation to help guide policy makers.

*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: 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 health and safety.¹¹ In each instance, individuals or organizations act rationally with respect to 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 averted.

Although the aim of public health regulation is to safeguard the health and safety of the public as a whole, it often has disproportionate benefits for those most at risk of injury and disease. For instance, reducing air pollution, removing lead paint from rental housing units, and eliminating trans fats in the food supply have particular significance for vulnerable populations. Those at increased risk may be particularly vulnerable because of their socioeconomic status, neighborhood, race, ethnicity, age, sexual orientation, gender, or disability.¹²

Perhaps because engaging in risky behavior may promote personal or economic interests, individuals and businesses often oppose government regulation. Resistance is sometimes based on philosophical grounds of choice or freedom from government interference. Citizens, and the groups that represent them, claim that regulating self-regarding behaviors, such as the use of motorcycle helmets or consumption of sugary drinks, is not the business of government. Sometimes these arguments are raised against regulation of activities or situations 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 government health and safety standards retard economic development and should be avoided. In political arenas, they contest these standards in the

name of economic liberty, characterizing government taxation and regulation as burdensome and inefficient. Overall, they trust the market to adjust to consumer preferences, including those related to health and safety.

Public health has historically constrained the rights of individuals and businesses to protect community interests.¹³ Whether through the use of reporting requirements affecting privacy, mandatory testing or screening affecting autonomy, environmental standards affecting private property, industrial regulation affecting economic freedom, or isolation and quarantine affecting liberty, public health has not shied away 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 guided by science and exercised in conformity with constitutional and statutory constraints on state action. The state's inherent prerogative to protect the public's health, safety, and welfare is known as the police power. Legally protected interests (e.g., autonomy, privacy, liberty, and property), however, place limits on the police power. Achieving a just balance between the powers and duties of the state to defend and advance the public's health and legally protected personal interests poses an enduring problem for public health law.

Any theory of public health law presents a paradox. On the one hand, government is compelled by its role as the elected representative of the community to act affirmatively to promote the health of the people. Many consider that this role requires vigorous measures to control obvious health risks. On the other hand, government cannot unduly limit individuals' rights in the name of the common good. Health regulation that overreaches, in that it achieves a minimal health benefit with disproportionate burdens, is not tolerated in a society based on the rule of law. Consequently, a tension exists 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 of whether a coercive intervention truly reduces 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.

Public health and individual rights are not always in conflict: in some cases they are synergistic. A decision to avert a health risk through coercion 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 by fostering distrust and alienation, coercion may cause other individuals to avoid testing, counseling, or treatment, ultimately increasing the spread of disease. The decision to coerce affects group behavior and, ultimately, the population's health.

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. The substantive standards and procedural safeguards that balance these competing interests form the corpus of public health law.

THE POPULATION PERSPECTIVE

Public health's assertion of both the empirical and ethical relationship between the health of individuals and the wellbeing of their communities helps underpin the . . . population perspective.

—Wendy E. Parmet, *Populations, Public Health, and the Law*, 2009

At the heart of public health, as we have sought to demonstrate, is a public or government entity that harbors the power and responsibility to assure community well-being. Perhaps the single most important feature of public health is that it strives to improve the functioning and longevity of populations. Classic definitions of public health emphasize this population-based perspective: “‘Public health’ means the prevailing 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.”¹⁴

Public health differs from medicine, which treats the individual patient as its primary focus. The physician diagnoses disease and offers medical treatment to ease symptoms, prevent complications, and, where possible, to cure disease. British epidemiologist Geoffrey Rose compares the scientific methods and objectives of medicine with those of public health. Medicine asks, “Why did this patient get this disease at this time?,” underscoring a physician's central concern for sick individuals.¹⁵ 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 ensure a favorable environment in which people can maintain their health.

Public health cares about individuals too, 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 sexually transmitted infections (STIs), tuberculosis (TB), and HIV/AIDS. Still, public health's quintessential interest is in the well-being and security of populations, not individual patients.

The focus on populations rather than individuals is grounded not only in theory but also 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, a term derived from Greek, is “the study (*logos*) of what is among (*epi*) the people (*demos*).”¹⁶ 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.”¹⁷ Epidemiology encompasses scientific study of the distribution and determinants of health (and related states and events) in populations and the application of resulting knowledge to the control of injury and disease.¹⁸ It adopts a population strategy “to control the determinants of incidence, to lower the mean level of risk factors, [and] to shift the whole distribution of exposure in a favourable direction.”¹⁹ The advantage of a population strategy is that it addresses the underlying causes that make diseases or injuries common in populations, creating the potential for reductions in morbidity and premature mortality at the broadest population level.

THE PREVENTION ORIENTATION

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, “Scaring Us Senseless,” 2005

The field of public health is often understood to emphasize the prevention of injury and disease as opposed to their amelioration or cure, which are the province of medicine. Public health historians tell a classic

MISTAKING CAUSE FOR EFFECT.

Boy. "I SAY, TOMMY, I'M BLOW'D IF THERE ISN'T A MAN A TURNING ON THE CHOLERA."

PHOTO 1.2. "Mistaking Cause for Effect," *Punch*, 17 (1849). In this cartoon, a boy thinks a water board official turning on a water pipe is "turning on the cholera." That year, John Snow publicized his theory that cholera was spread "through the medium of polluted water," especially in poor neighborhoods. During the 1854 cholera epidemic in the Soho district of London, Snow traced the outbreak to a single contaminated water pump on Broad Street.

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, where the pump was located, to remove the pump handle. Within a week, the outbreak was all but over, with the death toll standing at 616 Soho residents.²⁰

A foundational article by Michael McGinnis and William Foege, examining the leading causes of death in the United States, reveals the distinct analytical orientations of medicine and public health.²¹ Medical explanations of death point to discrete pathophysiological conditions

such as cancer, heart disease, cerebrovascular disease, pulmonary disease, poisoning, or physical trauma.²² Public health explanations, on the other hand, examine the root causes of these conditions. 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 is devoted to medical treatment of diseases ultimately recorded as the nation's leading killers on death certificates. Only a small fraction of funding is directed at addressing the root causes of death and disability. Their central message, of course, is that prevention is often more cost-effective than treatment, and that much of the burden of disease, disability, and premature death can be reduced through prevention.

Prevention activities fall into four stages: community (also referred to as *preprimary*, or *primordial*), primary, secondary, and tertiary (see figure 1.2). These stages mark a continuum in which public health and medicine, prevention and amelioration are intertwined. Public health experts often think of this continuum in terms of “upstream” and “downstream” interventions, echoing a parable in which the residents of a riverside village become so overwhelmed by rescuing people who are drowning that they do not have time to travel upstream to discover why so many people are falling in.

Many of public health's most potent activities are oriented toward community prevention (e.g., sanitation and waste removal systems to reduce exposure to infectious agents, commercial regulation to reduce exposure to environmental toxins, water fluoridation to avert dental caries, occupational and consumer product safety regulations to reduce exposure to hazards, and safety-net programs to ensure adequate nutrition for pregnant women, infants, and schoolchildren) and primary prevention (e.g., vaccination against infectious diseases, health education to reduce risk behavior, and the use of seat belts or motorcycle helmets to avoid injuries). Medicine, by contrast, is often focused on tertiary prevention and on treatment of disease or trauma after it has occurred (e.g., by prescribing drugs to control blood pressure or cholesterol, surgically removing an arterial blockage to prevent heart attack, administering antimicrobial drugs to cure infection, and repairing injuries suffered in a motor vehicle crash).

The prevention orientation, the population focus, and the social-ecological model of public health (discussed below) are equally important in demarcating the permeable boundary between public health and