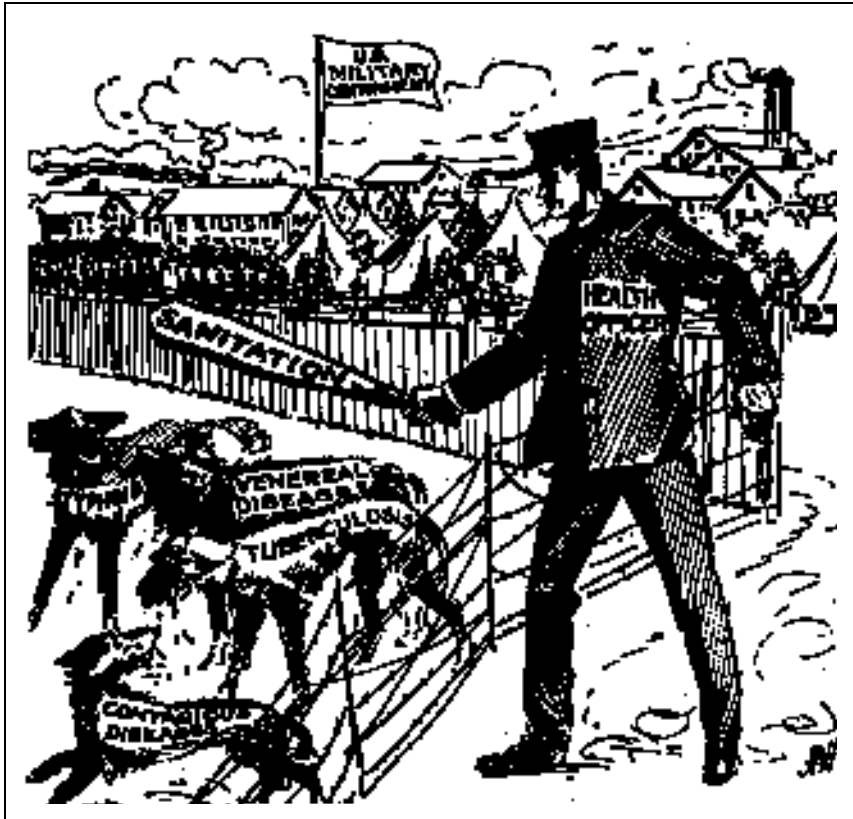


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PART ONE

Conceptual Foundations of Public Health Law



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.

I A Theory and Definition of Public Health Law

[Public health law] should not be confused with medical jurisprudence, which is concerned only in 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). Organized groups of teachers, scholars, and practitioners in law and health are active and visible, including the American Society of Law, Medicine & Ethics; the American Health Lawyers Association; and the American College of Legal Medicine.

The fields that characterize these branches of study are variously 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.

Public health law shares conceptual terrain with the field of law and medicine, or health care law, but is 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 in law and health. Nor is public health law easy to define and operationalize; the field is as complex and confused as public health itself. Rather, I posit that 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 I hope to provide a fuller understanding of the varied roles of law in advancing the public's health. The core idea that I propose is that law can be an essential tool for creating the conditions that enable people to lead healthier and safer lives.

In this chapter, I construct a definition of public health law, borrowing from ideas in constitutional law, theories of democracy and community, and public health history and practice. My definition of public health law follows, and the remainder of this chapter offers a justification for each component of the definition.

Public health law is the study of the legal powers and duties of the state to assure the conditions for people to be healthy (e.g., 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 protection or promotion of community health.

Through this definition, I suggest five essential characteristics of public health law (see Figure 2):

Government: Public health activities are a special responsibility of the government.

Populations: Public health focuses on the health of populations.

Relationships: Public health addresses the relationship between the state and the population (or between the state and individuals who place themselves or the community at risk).

Services: Public health deals with the provision of population-based services grounded on the scientific methodologies of public health (e.g., biostatistics and epidemiology).

Coercion: Public health authorities possess the power to coerce individuals and businesses for the protection of the community, rather than relying on a near universal ethic of voluntarism.



Figure 2. Public health law: a definition and essential characteristics.

GOVERNMENT POWER AND DUTY IN PUBLIC HEALTH: WHAT IS "PUBLIC" IN PUBLIC HEALTH LAW

A systematic understanding of public health law requires a careful examination of what is "public." A public entity 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. What follows is a systematic justification of government's special responsibility in matters of public health. I base my argument on the primacy of government in the constitutional design, the obligations of government in a democracy, and governmental health regulation in history and practice. I do not mean to suggest, however, that government is exclusively engaged in the work of public health. The private and charitable sectors have played, and continue to play, a vital role in improving the health of the populace.¹

the role of government in the constitutional design

The Constitution, it is widely assumed, is conceived in negative terms to restrain government from invading a sphere of individual liberty and property interests. According to this settled view, the Constitution does not oblige the government to act for the common good. I will return to the idea of a negative constitution in the next chapter. For the present, it is important to understand that the constitutional design shows that the government is empowered to, and actually does, defend the common welfare.

The Preamble to the Constitution reveals the influence of republican ideals of government as the wellspring of communal life and mutual security:² “We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution. . . .”

The common defense and the general welfare could not have been conceived as relating solely to physical security, for perhaps the principal threat to civil society during the generation in which the Constitution was ratified (the “framing era”) was epidemic disease and other forms of ill health. After examining public and private roles during the framing era, Wendy Parmet concludes, “Despite the disagreement and uncertainty over the actual meaning of ‘the common good,’ it seems likely that the preservation of public health . . . was one meaning that all would share. Tradition and practice pointed to it. Theorists such as Montesquieu supported it. So did popular political discourse.”³

The constitutional design reveals a plain intent to vest power in government, at every level, to protect community health and safety. In its very first sentence, the Constitution provides sole legislative, or policy-making, authority to the Congress,⁴ and the first enumerated legislative power is expressly to provide for the “common Defence” and “general Welfare” of the United States.⁵ The legislative role is to enact laws necessary to safeguard the population from harms, including harms relating to health and safety risks. The executive branch, pursuant to its constitutional obligation to “take Care that the Laws be faithfully executed,” enforces and amplifies legislative health and safety standards.⁶ Executive agencies have developed special expertise in matters of health and have long promulgated regulations to safeguard public health and safety.⁷ The judicial role is to construe the law and to ensure that legislative and

executive actions are congruent with the Constitution.⁸ Since the earliest times, the courts have authorized compulsion—notably through common law nuisance abatement—to protect the public health.⁹

From a constitutional perspective, only government—whether federal, state, or local—can collect taxes and expend public resources, and only government can require members of the community to submit to inspection and regulation. The Constitution grants no residual power to the private sector to tax, spend, or regulate—all necessary for the preservation of the public's health. To the extent that the private sector uses public funds or demands compliance with health and safety standards, it does so principally through delegated governmental authority. The private sector's role in public health is simply not found in the constitutional design.

the responsibilities of government in democracies

Why is it that a political, or governmental, entity possesses principal, if not sole, responsibility to protect and promote public health? Theories of democracy and political communities help to explain the primacy of government in matters of public health. Michael Walzer has articulated an essential truth about the nature and purposes of political communities: "Membership is important because of what the members of a political community owe to one another . . . and the first thing they owe is the communal provision of security and welfare."¹⁰ Public health, according to Walzer, is the "easy" 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. To contrast public health with medicine, the former is most often a general communal provision, while the latter is most often particular.¹¹

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.¹² Public health can be achieved only through collective action, not through individual endeavor. Acting alone, individuals cannot assure even minimum levels of health. Individuals may procure personal medical services and many of the necessities of living; any person of means can purchase a home, clothing, food, and the services of a physician or hospital. Yet no single individual, or group of individuals, can assure 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 goods can be secured only through organized action on behalf of the population.

Moreover, the population, or electorate, legitimizes systematic community activity for the public health. Public health activities in a democracy cannot be organized, funded, or implemented without the assent of the people. It is government that possesses the sole authority to empower, regulate, or carry out activities designed to protect or promote the general health, safety, and welfare of the population. It is the public that bands together to achieve social goods that could not be secured absent collective action. And it is the public, or electorate, that legitimizes or authorizes government to act for the common welfare. Walzer argues that every set of political officials is at least putatively committed to securing health for the population, and every set of members of a political community is committed to bear the necessary burdens (and does so). “The first commitment has to do with the duties of office; the second, with the duties of membership.”¹³ Consequently, the communal efforts of the body politic to protect and promote the population’s health represent a central theoretical tenet of what we call public health law.

Political philosophers, such as Norm Daniels and Dan Brock, show that health takes on a special meaning and importance in political communities.¹⁴ Public health is indispensable not only to individuals, but to the community as a whole. The benefits of health to each individual are indisputable. Health is necessary for much of the joy, creativity, and productivity that a person derives from life. Perhaps not as obvious, however, health is also essential for political communities. Without minimum levels of health, populations cannot fully engage in the social interactions of a community, participate in the political process, generate wealth and assure economic prosperity, and provide for common defense and security. Public health, then, becomes a transcendent value because a fundamental level of human functioning is a prerequisite for engaging in activities that are critical to communities—social, political, and economic.

I do not mean to suggest that the political commitment to public health must be absolute. What constitutes “enough” public health? How much? What kinds of services? How will they be paid for and distributed? These remain political questions.¹⁵ Democratic government 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.¹⁶

governmental health regulation in history and practice

Constitutional law and democratic theory support the basic power or obligation of organized society (principally through government) to protect and preserve the health of populations. But in a very real sense, governmental health activities form part of the fabric and experience of public health in America. Throughout the history of public health, the line between public and private action has never been hard and fast. Moreover, private, charitable, and religious influences have been manifest.¹⁷ Still, from the colonial and framing periods to the Progressive Era and the New Deal—and continuing to modern times—government in all its various forms has assumed responsibility for public health.

The early history of public health in America has been widely chronicled and need not be reiterated here.¹⁸ Public health regulation had become a common feature by the colonial and federalist periods.¹⁹ Health regulation, which reaches at least as far back as the seventeenth century, included conditions of travel at sea; isolation and quarantine; inoculation with smallpox pus; sanitary controls on dead fish, animals, and garbage; and quality controls on bread, meat, and drinking water (see chapters 7, 8, and 9).²⁰ From the earliest times of the republic, public bodies acted in cases of necessity and were prepared to subordinate the freedoms of individuals for the sake of the common welfare.²¹

During the early nineteenth century, the sanitary movement emerged in response to epidemic diseases (e.g., cholera, smallpox, yellow fever, and tuberculosis).²² Local sanitary surveys, notably the Shattuck report in Massachusetts,²³ assessed the health effects of decaying waste, foul air, and an immoral lifestyle.²⁴ During this period, local government began to expand sanitary regulation to improve sewage, drinking water, and garbage disposal.²⁵ As the Institute of Medicine observed, "Sanitation changed the way society thought about health. Illness came to be seen as an indicator of poor social and environmental conditions, as well as poor moral and spiritual conditions. . . . Sanitation also changed the way society thought about public responsibility for citizen's health. Protecting health became a social responsibility."²⁶

The Progressive Era of the early twentieth century is often regarded as a high-water mark of local government regulation, principally regarding sanitary controls introduced by city and, later, state boards of health.²⁷ This was a complex period during which public health activities were influenced by many factors. Remarkable successes of bacteriology inspired by the pioneering work of Koch and Pasteur foreshadowed the discoveries of Dubos, Fleming, and Waksman. W.T. Sedgwick, a familiar name in sanitary and bacteriologic research in Massachusetts, remarked, “[B]efore 1880 we knew nothing; after 1890 we knew it all.”²⁸ Public health began to embrace medicine and science, so the identification and treatment of persons with infectious disease took on a new importance. Legislatures enacted disease reporting requirements, while public health agencies traced sexual contacts and established clinics for treating tuberculosis. It was clear even then, however, that efforts to identify and treat persons with infectious disease were insufficient. Sanitary and hygienic conditions aggravated by industrialization and immigration were regarded as potent causes of ill health.²⁹ The health risks associated with urban growth were thought to demand a collective, governmental response in the form of expanded sewer systems, creative drain designs, improved garbage collection, and other hygienic measures.³⁰ “Public health once again became a task of promoting a healthy society.”³¹ During the Progressive Era, this goal was pursued through scientific analysis of disease and epidemics, medical treatment of individuals, education, and advancements in social conditions.

Although the American Public Health Association (APHA) was formed in 1879 and the United States Public Health Service emerged from the Marine Hospital Service in 1912,³² most public health initiatives of the early twentieth century concentrated on local activity.³³ Many observers saw the New Deal in Franklin Delano Roosevelt’s administration (and, to a lesser extent, the Great Society in Lyndon Johnson’s administration) as an important juncture in developing an active federal role in public health.³⁴ During this period, the federal government asserted regulatory jurisdiction over adulterated or otherwise harmful food, drugs, and cosmetics;³⁵ established national standards for drinking water;³⁶ enacted a venereal disease control program in response to a reemergent sexually transmitted infection epidemic;³⁷ and formed a federal grant-in-aid program requiring the states to establish and maintain public health services and training for public health professionals.³⁸ Also during this period, the National Hygienic Laboratory moved to Bethesda, Maryland, and was renamed the

National Institutes of Health. Meanwhile, the states expanded their capacity to engage in classic public health activities, including the collection of vital statistics, communicable disease reporting, venereal disease investigation, milk pasteurization, and institution of school hygiene standards.³⁹

Public health activities, both federal and state, are omnipresent in the late twentieth century. Government assesses population health status, investigates health threats, sets policies and standards, regulates the private sector, funds research, finances and delivers personal health services, and performs other health-related functions. Federal regulation now reaches broad aspects of public health, such as air and water quality, food and drug safety, tobacco advertising, pesticide production and sales, consumer product protection, and occupational health and safety. States exercise jurisdiction in virtually all areas of public health—ranging from surveillance, disease reporting, and control of injury and disease to regulating sanitation and hygienic conditions in schools, child care facilities, and restaurants.

This brief historical overview is not intended to provide a systematic account of American public health practice. Rather, it demonstrates the ubiquity of health regulation and underscores the historic governmental authority in public health. From the founding of the republic to the present day, government has assumed a significant level of responsibility for community well-being. Earlier this century, Tobey noted this central role of government within the discipline of public health law: “The protection and promotion of the public health has long been recognized as the responsibility of the sovereign power. Government is, in fact, organized for the express purpose, among others, of conserving the public health and cannot divest itself of this important duty.”⁴⁰

THE POPULATION-BASED PERSPECTIVE OF PUBLIC HEALTH

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, however, also focuses on persons or groups that stake a claim to health protection or promotion. Most scholars who have compared public health with medicine have noted that, generally, public health focuses on the health of populations, while medicine focuses on the health of individuals.⁴¹ Elizabeth Fee observes that medicine

and public health have contradictory interests. “Public health is oriented toward the analysis of the determinants of health and disease on a population basis, while medicine is oriented toward individual patients.”⁴²

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: “As one of the objects of the police power of the state, the ‘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. The wholesome sanitary condition of the community at large.”⁴³ Consequently, while the art or science of medicine seeks to identify and ameliorate ill health in the individual patient, public health seeks to improve the health of the population.

Admittedly, it is not easy to separate individual and population-based health interventions. A direct relationship exists between the health of each individual and the health of the community at large. After all, the well-being of the whole may be accomplished by little more than assuring the health of each individual. This is not to suggest, however, that the public health system is, or should be, solely responsible for population-level approaches and the health care system responsible for individual-level approaches. Sometimes the dividing line between health care and public health is exceedingly difficult to draw. The medical treatment of an infectious disease, for example, benefits both the individual and the wider population. The boundaries between medicine and public health become obfuscated in such cases, and it is not unusual to see both the health care and public health systems accept responsibility for patient care, health education, and follow-up for infectious diseases.

Despite the lack of clarity, strong arguments exist—based on theory and practice—that the quintessential feature of public health is its concentration on communal well-being, and that this feature separates public health from medicine. The organized community activity known as public health is conceptually designed to benefit the collective population. If political communities form for the communal provision of security and welfare, it is the community—not individuals—that stakes a claim to disease prevention and health promotion. Public health services are those shared by all members of the community, organized and supported by, and for the benefit of, the people as a whole.

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 the Greek, is the study (*logos*) of what is among (*epi*) the people (*demos*). Roger Detels notes that “[a]ll 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.”⁴⁴ Epidemiology examines the frequencies and distributions of disease in the population.⁴⁵ 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.”⁴⁶ The advantage of a population strategy is that it seeks to reduce underlying causes that make diseases common in populations.

In his authoritative article “Sick Individuals and Sick Populations,” 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.⁴⁷ Other accounts of the medical profession emphasize its reductionist tendencies, even while recognizing its cyclical interest in broader issues, such as the ecological and social meanings of disease. “It follows from disease theory,” writes Eric Cassell, “that the purpose of the clinician is to discover in the sick patient that unique phenomenon with its unique cause that is the disease (and thus the source of the sickness), and to base diagnostic and therapeutic actions accordingly.”⁴⁸

The concentration on aggregate health effects in populations helps construct a thoughtful definition of public health that I incorporate into my broader definition of public health law. Definitions of public health vary widely, ranging from the utopian conception of the World Health Organization of an ideal state of physical and mental health⁴⁹ to a more concrete listing of public health practices.⁵⁰ The Institute of Medicine has proposed one of the most influential contemporary definitions of public health:⁵¹

Public health is what we, as a society, do collectively to assure the conditions for people to be healthy. This requires that continuing and emerging threats to the health of the public be successfully countered. These threats include immediate crises, such as the AIDS epidemic; enduring problems, such as injuries and chronic illness; and growing challenges, such as the aging of our population and the toxic by-products of a modern economy, transmitted through air, water, soil, or food. These and many other problems raise in common the need to protect the nation’s health through effective, organized, and sustained efforts led by the public sector.

This definition can be appreciated by examining its constituent parts. The emphasis on cooperative and mutually shared responsibility (“we, as a society”) reinforces that people form political communities precisely because the collective entity can best protect and promote the population’s health. What do communities do to preserve health? Notably, communal responsibilities are intended to “assure the conditions for people to be healthy.” These conditions of health include a variety of behavioral, economic, and environmental interventions to reduce the burden of injury and disease in populations. Finally, the definition emphasizes the “public sector” responsibility to engage in “effective, organized, and sustained efforts” to safeguard communal health.

The foundational article by Michael McGinnis and William Foege examines the leading causes of death in the United States, revealing different forms of thinking in medicine and public health. Medical explanations of death point to discrete pathophysiological conditions, such as cancer, heart disease, cerebrovascular disease, and pulmonary disease. Public health explanations, on the other hand, 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 is devoted to medical treatment of diseases ultimately recorded on death certificates as the nation’s leading killers. Only a small fraction is directed to control the root determinants of death and disability.⁵²

THE RELATIONSHIP BETWEEN THE PEOPLE AND THE STATE

Public health law studies the relationship between the state and the community at large (or between the state and individuals who place themselves or the community at risk) rather than the relationship between health care providers and patients. Public health is interested in organized community efforts to improve the health of populations. Accordingly, public health law observes collective action—principally by government through federal, state, and local health agencies—and its effects on various populations.

Public health law similarly examines the benefits and burdens placed by government on legally protected interests. As government acts to

promote or protect public health, it may enhance or diminish individual interests in autonomy, liberty, privacy, or property. The powers and obligations of government itself, as well as the limitations on state action, capture the attention of students of public health. Thus, public health law considers how government acts, or fails to act, to address the major health problems facing large populations (e.g., tobacco use, drug or alcohol dependency, communicable diseases, injuries, violence, and occupational or environmental risks). And when government acts, or fails to act, public health law studies the effects on personal and organizational interests (e.g., restraints on commercial speech, free association, liberty, and control of property).

In contrast, health care law has an abiding and material interest in the microrelationships between health care providers and patients. The duties of physicians and the “rights” claims of individual patients in the course of the therapeutic relationship are central to the discipline of health care law. Consequently, issues regarding informed consent and confidentiality shape the discourse of health care law. The doctor has certain obligations to the patient to provide information concerning treatment alternatives and to respect confidences divulged during the therapeutic exchange. Similarly, malpractice law involves the study of duties of care owed by physicians to patients and, more recently, the duties—if any—owed by systems of care to patients.⁵³

Health care law, moreover, studies the organization, financing, and provision of personal medical services. It focuses on the relationships among health care providers (e.g., managed care organizations and integrated delivery systems), third-party payers (e.g., state or employer-sponsored health care benefits and private insurers), and regulators (e.g., government oversight of access, quality, and costs of personal medical services). Scholars in the field of health care law scrutinize each of the major components of a well-functioning system in providing personal medical services. Who has *access* to the health care system? Is the system *fair* for various economic, racial, and social groups? Does the system provide adequate *choice* of physicians and providers? Are the services provided of high *quality*? Is the health care system *cost-effective*? Thus, the field of health care law is concerned with relationships between physicians and patients and with indicators of access, equity, choice, quality, and cost of personal medical services.

Seldom do students of health care law focus on the questions that dominate thinking in public health: What is the health status of the

population, and what broad societal measures can reduce the overall level of injury and disease?

THE MISSION, FUNCTIONS, AND SERVICES OF THE PUBLIC HEALTH SYSTEM

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

Hermann Biggs (1894)

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)

If government has the primary responsibility to assure the conditions of health for populations, then what public health activities best assure health, and what organizational arrangements are necessary to provide these services? The answers to these questions inform not only traditional methods for population-based health improvement but, more important, the critical differences between medical and public health services.

The literature is replete with attempts to identify the mission of public health, classify “core” functions, and set national and international⁵⁴ standards for “essential” services.⁵⁵ The mission of public health is broad, encompassing systematic efforts to promote physical and mental health and to prevent disease, injury, and disability.⁵⁶ The core functions of public health agencies are to prevent epidemics, protect against environmental hazards, promote healthy behaviors, respond to disasters and assist com-

munities in recovery, and assure the quality and accessibility of health services.⁵⁷

The “essential services” of public health are to monitor community health status; diagnose and investigate health problems; inform and educate people about health; mobilize community partnerships; develop and enforce health and safety protection; link people to needed personal health services; assure a competent health workforce; foster health-enhancing public policies; evaluate the quality and effectiveness of services; and research for new insights and innovations.⁵⁸

Public health professionals have devised a set of “leading health indicators” to help measure the health of communities. Modeled on economic indicators, these criteria evaluate whether communities are becoming healthier or sicker. The leading health indicators measure the most important attributes of health in populations: physical activity, overweight and obesity, tobacco use, substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to health care.⁵⁹

This description of the mission, functions, services, and leading indicators shows the breadth of public health activities. Public health addresses the root causes of disease and disability; agencies identify these causes and intervene at various levels. Notably, public health subsumes personal medical services as one of many conditions necessary to preserve the population’s health. Contrary to popular belief, the public sector assumes considerable responsibility for health care. Taking into consideration public insurance programs, such as Medicare and Medicaid, and foregone revenue as a result of tax exclusion of employee health benefits, the public sector accounts for roughly 58 percent of total health care spending.⁶⁰ Additionally, the public health system traditionally provides direct medical services for pregnant women, persons with contagious diseases (e.g., TB, STDs, and HIV/AIDS), and other discrete populations.

The dividing line between medicine and public health is not always clear. Both fields are concerned with prevention. Clinical prevention services, such as immunizations, mammograms, Pap smears, PPD skin tests and chest X-rays, HIV antibody tests, and colorectal screening, are central to the mission of both the health care and public health systems. So, too, are both systems concerned with counseling and health education to change individual behavior.

Despite the absence of a clear boundary, major differences exist between the services performed in the health care and public health systems. At its core, health care is devoted to personal medical diagnosis, clinical preven-

tion, and treatment, while public health is devoted to strategies to identify health risks and improve behavioral, environmental, social, and economic conditions that affect the health of wider populations. The dividing line is not neat, but the methodologies, practices, and services in these respective disciplines are distinct.

THE ROLE OF COERCION AND INDIVIDUAL RIGHTS IN PUBLIC HEALTH LAW

I have suggested that public health law is concerned with governmental responsibilities to the community; the well-being of the population; the relationship between the state and the community at large; and a broad range of services designed to identify, prevent, and ameliorate health threats within society. These ideas encompass what can be regarded as “public” and what constitutes “health” within a political community. Although it may not be obvious, I am also suggesting that the use of coercion must be part of an informed understanding of public health law.

Government can do many things to promote public health and safety that do not require the exercise of compulsory powers. 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, political communities 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 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 an issue for political resolution. I propose standards for evaluating public health regulation in chapter 4.

Protecting and preserving community health is not possible without the constraint of a wide range of private activities. Private actors—whether individuals, groups, or corporate entities—have incentives to engage in behaviors that are personally profitable or pleasurable but may threaten other individuals or groups.⁶¹ Individuals with sexually transmitted infections derive satisfaction from intimate relationships; industry finds it profitable to produce goods without considering

broader social or environmental costs; and manufacturers find it economical to offer products without the highest available safety or hygiene standards. In each instance, individuals or organizations act rationally for their own interests, but their actions may adversely affect communal health and safety. Absent a governmental authority, and willingness, to coerce, these threats to public 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 regulation protects the most vulnerable. For instance, the elimination of a toxic waste site, a building code in a crowded tenement, and the closure of an unhygienic restaurant hold particular significance for those at immediate risk.

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 or freedom from government interference. Citizens, and the groups that represent them, claim that self-regarding behaviors, such as the use of seatbelts or motorcycle helmets, are not the business of government. Sometimes these arguments are extended to behavior that threatens others, such as sex or needle sharing by persons with blood-borne infections.

Industry often asserts that economic principles militate against government control. Entrepreneurs tend to accept as a matter of faith that governmental health and safety standards often 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 inefficient.

Debates such as these should take place within a democratic society. My intention is not to say whether, in any particular case, government control is desirable. Governments of all description have historically used force to benefit communal health; compulsion is sometimes necessary to avert obvious social risks. The study of the coercive powers of the state is a staple of what we call public health law. Charles V. Chapin, a pioneering city health officer from the Progressive Era, reached one of the core understandings of public health law—that the state, in the exercise of its police powers, sets boundaries on the behavior of individuals that poses risks to the public:⁶²

[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.

Public health, then, historically has constrained the rights of individuals and organizations to protect community interests in health.⁶³ Whether through the use of reporting requirements that affect privacy, mandatory testing or screening that affects autonomy, environmental standards that affect property, industrial regulation that affects economic freedom, or isolation and quarantine that affect liberty, public health has not shied from controlling individuals and organizations for the aggregate good.

Assuredly, public health is empowered to restrict human freedoms and rights to achieve a collective good, but it must do so consistent with constitutional constraints on state action. The inherent prerogative of the state to protect and promote the public health, safety, and welfare (known as the police powers) is limited by individual rights to liberty, autonomy, property, and other constitutionally protected interests (see chapter 3). Achieving a just balance between the powers and duties of the state to defend and advance the public health and constitutionally protected rights 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 invade 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, is not tolerated in a society based on the rule of law. Consequently, scholars and practitioners often perceive an irreconcilable conflict between the claim of the community to reduce obvious health risks and the claim of individuals to be free from government interference. This perceived conflict may 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?

It has become fashionable to claim that no real conflict exists between the protection of individual rights and the promotion of public health.⁶⁴ According to this view, safeguarding rights is always (or virtually always) consistent with preserving communal health.⁶⁵ Indeed, according to this perspective, individual rights and public health are synergistic—the defense of one enhances the value of the other, and vice versa. This rhetorical position serves a purpose but is simplistic. It suggests that a decision to avert a discrete health risk actually may result in an aggregate increase in injury or disease in the population as a whole. The exercise of compulsory powers (e.g., isolation or quarantine) may prevent individuals from, say, transmitting a communicable infection. But the social decision to coerce affects group behavior and, ultimately, the population's health. By provoking distrust in, or alienation toward, 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 calculation is hardly scientific or precise regarding whether compulsion will alter behavior and, if so, in what direction.⁶⁶

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

CONCLUSION

The definition of public health law 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 and responsibility of government to assure the conditions for the population's health. The study of the field requires a detailed understanding of the various legal tools

available to prevent injury and disease and to promote the health of the populace.

Several important characteristics of the field help to separate public health law from other disciplines at the intersection of law and health. First, even though the private and voluntary sectors make important contributions, the *government* retains a special responsibility for ensuring the health of the people. Second, government carries out its public health duties to benefit *populations*. Third, public health law scholars study the *relationships* between the state and the public (or between the state and individuals who place themselves or the community at risk). Fourth, public health authorities deliver *services* to the public based on the sciences of public health. Finally, public health authorities possess the power to *coerce* individuals and businesses for the protection of the community. These characteristics—government, populations, relationships, services, and coercion—form the basis of public health law, a field that poses enticing intellectual challenges, both theoretical and essential to the body politic.