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REVIEW ESSAY

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INTRODUCTION

Life in a world without public health laws would surely be shorter and nastier, even if not more brutish. Public health laws serve to protect us against serious injuries and the spread of ravaging diseases. Although we live in a pluralistic society characterized by many competing conceptions of the good, ill health and untimely death are circumstances we all share an interest in avoiding. It thus seems natural—at least absent a commitment to anarchism—that we should view the promotion of the public's health as a legitimate and important function of the state.[1] At the same time, because public health laws often achieve their aims through the regulation of individual and business activity, the unfettered use of state power to advance the public's health would raise the specter of unwarranted infringements of liberty and property interests. Thus, while we have good reason to promote public health laws, we must be equally concerned with carefully delimiting their boundaries.

Lawrence O. Gostin's seminal treatise, *Public Health Law*, offers a sustained inquiry into the nature and legitimate scope of the state's power

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1. Even libertarians, who adhere to a minimalist view of the state, can endorse some public health measures. Robert Nozick's libertarian view, for example, would presumably allow the isolation and quarantining of persons to control infectious diseases, since he holds that we may use "force in defense against another party who is a threat, even though he is innocent and deserves no retribution." ROBERT NOZICK, ANARCHY, STATE, UTOPIA 34 (1974).

to promote public health. Gostin formulates a definition of public health law that both identifies the distinctive features of the discipline and sets the agenda for his theoretical discussion:

> 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.[2]

The central theoretical issues this definition reflects are those of (a) the state's authority and responsibility to advance the population's health, and (b) the potential conflicts that arise between promoting public health and protecting private rights. Gostin engages these issues at the descriptive and the normative level. He both describes how existing law specifies the state's power to promote public health and sketches a moral vision of the state's responsibility to use the law for public health objectives. Likewise, he both describes the conflicts between public health regulation and private rights in several areas of public health practice and develops an account of the conditions under which it is permissible to sacrifice civil liberties to safeguard the population's health.

Gostin's exposition of the doctrinal terrain of public health law is remarkable in its breadth and detail. Gostin explores public health law doctrine through an erudite and accessible sweep across the landscapes of constitutional law, administrative law, statutory law, and tort law. This contribution alone is enough to recommend the book to a wide audience. But Gostin's more significant contributions are his articulation of a conceptual framework for public health law and his prescriptions for the field. Gostin's theory of public health law represents a milestone in the literature, and will no doubt serve as the foundation for future scholarship in the area.

In this essay I want to describe the lineaments of Gostin's theory of public health law and offer some critical reflections. While I believe that Gostin's definition of public health law properly identifies the central issues for the field, I will argue that his theory is not extensive enough to fully address these issues. I will maintain that his account (a) does not allow us to attach appropriate weight to the value of individual liberty and

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2. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 4 (2000).

(b) neglects fundamental questions about the scope of the state's responsibility that emerge from a consideration of the social and economic determinants of health. I will turn to these issues after a brief overview of his theory of public health law.

I. GOSTIN'S THEORY OF PUBLIC HEALTH LAW

The core theoretical claim Gostin makes in his book is that "public health law should be seen broadly as the authority and responsibility of the government to assure the conditions for the population's health."[3] Gostin illuminates this claim through a delineation of "five essential characteristics of public health law."[4]

The first essential feature of public health law is that the government has a "special responsibility" to ensure the public's health.[5] Although the judiciary has consistently denied that the government has positive duties to provide services or protection to persons,[6] Gostin derives a governmental duty to promote public health from considerations of political philosophy and constitutional design. The political arguments are that (a) membership in a political community entails obligations on the part of members to provide for the basic security and welfare of the community; (b) securing public health requires a coordinated effort on behalf of the community; and (c) health is required for populations to fully participate in the social, economic, and political life of the community. The constitutional consideration is that the Constitution grants the power to tax, spend, and regulate to the government, but not to the private sector. Since these powers are critical to securing public health, the government must play the primary role in promoting public health.

Second, public health law "focuses on the health of populations."[7] The population perspective of public health distinguishes the enterprise of

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3. *Id.* at 21, 327.

4. *Id.* at 4.

5. *Id.*

6. Deshaney v. Winnebago County Dept. of Social Services, 489 U.S. 189, 195 (1989). "[The Due Process Clause] forbids the State itself to deprive individuals of life, liberty, or property without 'due process of law,' but its language cannot fairly be extended to impose an affirmative obligation on the State to ensure that those interests do not come to harm through other means." *Id.*

7. GOSTIN, *supra* note 2, at 11.

public health from that of medicine. While medicine is principally concerned with the health of the individual, public health aims to "provide an aggregate benefit to the mental and physical health of all the people in a given community."[8]

Third, 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)."[9] This feature of public health law distinguishes public health law from health care law. Public health law is concerned with the state's role in advancing the health of the community, whereas health care law is concerned with the "microrelationships between health care providers and patients."[10]

The final two characteristics of public health law describe the mechanisms by which public health authorities seek to assure the health of the population. One means is through the provision of population-based services.[11] These services include, among other things, monitoring the health status of the community, investigating and diagnosing health problems, educating the population about health, and implementing health and safety regulations. The other means–and final "essential characteristic" of public health law–is coercion.[12] Public health authorities sometimes must coerce individuals (e.g., through quarantine and mandatory treatment) and businesses (e.g., through environmental and industrial regulation) to protect the community.

The use of coercion to promote the population's health is the most controversial aspect of public health law. This is because coercive public health practices can conflict with interests in liberty, bodily integrity, privacy, and property. While coercion is sometimes necessary to protect the population from health threats, any interference with interests like liberty and property requires a rigorous justification.

Gostin seeks to provide an approach to public health regulation that will assist courts and policymakers in deciding "when the public good to be achieved is worth the infringement of individual rights."[13] He argues that public health authorities should bear the burden of justifying public

8. *Id.* at 12.
9. *Id.* at 14.
10. *Id.* at 15.
11. *See id.* at 16-18.
12. *See id.* at 19-21.
13. *Id.* at 85.

health regulations, and that there are five elements public health authorities must establish to meet this burden. Public health authorities must demonstrate that (1) the regulation is necessary to avert a significant risk of harm; (2) the intervention will be effective; (3) the economic costs of the regulation are reasonable in light of the likely benefits; (4) the regulation is the least restrictive alternative for preventing the health problem; and (5) the regulation fairly distributes benefits and burdens, offering services to all those in need and imposing burdens only on those who present a serious health risk.[14]

Gostin's account of the essential characteristics of public health law and the conditions for justified public health regulation comprise his basic theory of public health law. Gostin draws "three concepts of public health and liberty" from his account that he believes should inform public health statutes.[15] The three concepts are duty, power, and restraint. The government has an affirmative *duty* to assure the population's health. In order to fulfill this duty, public health authorities must have adequate *power* to prevent disease and injury and promote health. Finally, public health laws should place appropriate *restraints* on the use of regulatory power, permitting the sacrifice of private rights only where public health authorities meet the justificatory burden specified above. On Gostin's view, laws governed by these concepts can serve as morally and politically well-calibrated tools for advancing the public's health.

Gostin's analysis helpfully charts some of the significant moral, political, and legal issues health policymakers must address. However, his theoretical map elides other important regions of moral thought and establishes boundaries for public health law that are detrimental to the cause he advocates. There are two fundamental problems with Gostin's account that I will address. One problem is his commitment to the population perspective, which precludes his giving due consideration to the value of individual liberty. The other problem is that his account of public health law is too narrow because it fails to pay sufficient attention to the profound impact social and economic conditions have on health. Let us consider each of these issues in turn.

II. POPULATIONS AND PERSONS

To see the way in which the population perspective of public health

14. *See id.* at 93-107.

15. *See id.* at 315-16.

loses sight of the value of individual liberty, it will be helpful to begin with John Stuart Mill's classic statement of the conditions under which it is permissible to interfere with a person's liberty:

> [T]he sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise or even right.[16]

Mill here formulates a thesis that is often referred to as the "harm principle," according to which the only ground that supports a policy limiting an individual's liberty is that the policy would be effective in preventing (or eliminating or minimizing) harm to persons other than the actor. This is not to say that prevention of harm to others is a sufficient condition for such a policy. For example, the policy might not be acceptable if there were other means of avoiding the harm to others that were equally effective but less intrusive. Nonetheless, prevention of harm is at least always a good reason for a policy that limits liberty.

What Mill rejects in this passage are paternalism and moralism. Paternalism is the thesis that it is a good reason in support of a restriction on individual liberty that it is necessary to prevent harm or produce a benefit to the agent herself. Moralism is the thesis that a state may legitimately prohibit conduct where the conduct is immoral, regardless of whether it causes harm to the agent or others. Mill's view is that competent adults have an absolute right to engage in conduct that is essentially self-regarding: "Over himself, over his own body and mind, the individual is sovereign."[17] According to Mill, persons must be free to define their own conception of the good and act on it where doing so poses no serious risk of harm to others. Any government regulation of such conduct constitutes an unwarranted and oppressive use of state power.

Now, the public health approach Gostin articulates is neither paternalistic nor moralistic in the sense just described. The goal of public

16. JOHN STUART MILL, ON LIBERTY 68 (Penguin Books 1985) (1859).

17. *Id.* at 69.

health is not to promote the welfare of the individual; nor is the objective to prevent conduct thought to be immoral. Instead, the aim of public health practices is to promote the collective good by securing the health of the population. The population perspective focuses on communal welfare, not on individual well-being or conduct. Dan Beauchamp describes this concern with the welfare of the community as "public health paternalism," and he notes how it is distinct from the individualistic account of paternalism: "Practices are communal in nature, and concerned with the well-being of the community as a whole and not just the well-being of any particular person. Policy, and here public health paternalism, operates at the level of practices and not at the level of individual behavior."[18]

Beauchamp affirms public health paternalism and cautions against embracing Mill's individualism in the context of public health: "By ignoring the communitarian language of public health, we risk shrinking its claims. We also risk undermining the sense in which health and safety are a signal commitment of the common life."[19] Gostin echoes Beauchamp's remarks: "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. . . ."[20] On this communitarian view, we can never properly regard individuals as "sovereigns" where they engage in practices that impact the collective welfare. From this perspective, it is always a good reason (even if not a determinative reason) in support of a restriction on individual liberty that the restriction is necessary to avert a significant risk to the health of the population.

The population approach to public health regulation does not recognize a moral distinction between self-regarding and other-regarding health risks because both kinds of risk can substantially affect the population's health. For example, even if we suppose that the choice to wear seat belts or motorcycle helmets is for each individual essentially a self-regarding choice, the aggregate effect of persons choosing not to wear seat belts and motorcycle helmets is thousands of preventable deaths and injuries in the population. From the population perspective, there is *prima facie* as

18. Dan Beauchamp, *Community: The Neglected Tradition of Public Health*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH 66 (Dan Beauchamp & Bonnie Steinbock eds., 1999).

19. *Id.* at 65.

20. GOSTIN, *supra* note 2, at 7.

much reason to implement liberty-limiting regulations here as there is in the case of acts that affect the health of persons other than the actor.

The problem with this approach lies in one of its communitarian premises. We can represent the argument under consideration as follows:

(1)Individuals in society are members of a collective.

(2) As members of a collective, individuals have a responsibility to help ensure the good of the collective.

(3)Public health is a collective good.

(4) Therefore, persons must be prepared to sacrifice their private interests to secure public health.

Premise (1) is uncontroversial enough. However, premises (2) and (3) are open to serious challenge. As to the claim that individuals have a responsibility to help ensure the good of the collective, some would counter that the only obligation we have as citizens of a political community is to refrain from violating the rights of other citizens.[21] But even if we accept that we have robust positive duties to secure the collective good, there is reason to question whether promoting health in the population is necessarily tantamount to promoting the collective good.

To see the problem here, consider an activity (like riding a motorcycle without a helmet) that poses a health risk only to the individuals who pursue the activity. Suppose that (a) the activity is highly valued by the individuals engaged in it for the pleasures or way of life it offers; (b) there is a one in a thousand lifetime chance of death or serious injury from pursuing the activity; (c) those who pursue the activity recognize the risks but judge that the benefits outweigh the risks; and (d) prohibiting the activity would prevent substantial numbers of deaths and injuries in the population. Now, assuming a person attaches a high enough value to the activity, it would not be irrational for the person to take a one in a thousand chance of death or injury. While we might not share this individual's valuation of the pursuit, we could acknowledge that the action is reasonable given her conception of her good. The population approach nevertheless allows us to consider interfering with individuals like her because of the cumulative effect of their choices on the population's health. But if, as in this instance, the population that stands to suffer adverse health consequences just consists of those individuals who reasonably judge that the health risks are worth assuming, then promoting the population's health will not advance the collective good.

21. *See, e.g.*, Nozick, *supra* note 1.

We cannot abstract the good of the policy from a consideration of the good of the persons the policy is meant to protect. In those cases in which individuals can best realize their ends by assuming a health risk, preventing that risk will not maximize aggregate well-being.

The population perspective is myopic because it excludes the particular values and interests of individuals from its field of vision. It fails to recognize that the collective good is derivative of the good of the individuals who form the collective. A liberty-limiting measure that promotes the population's health will sometimes not advance the collective good precisely because it interferes with the good of the individuals who comprise the relevant population. The population perspective blurs the moral distinction between self-regarding and other-regarding acts because it falsely assumes that all acts that pose a risk to the population's health constitute a threat to the collective good. Acts that pose health risks exclusively to the actor do pose a threat to the population's health. But if the action reflects the actor's conception of the good, we cannot presume that the good of the collective will suffer. The presumption should perhaps rather be that interfering with competent adults who pose health risks to themselves but not to others would be detrimental to the collective. The population approach cannot even entertain adopting such a presumption because this approach is underwritten by the communitarian idea that public health is intrinsically a collective good. Thus, if we are to give due consideration to individual liberty, we must banish the communitarian premise from the province of public health law. We need to temper the population perspective so that it is sensitive to the plurality of values of the individuals who form the collective.

III. THE BOUNDARIES OF PUBLIC HEALTH LAW

Gostin states that his book is "devoted to the core idea that law is essential for creating the conditions for people to lead healthier lives."[22] Because "[t]he mission of public health law is broad, encompassing systematic efforts to promote physical and mental health and to prevent disease, injury, and disability,"[23] Gostin holds that we should embrace an expansive view of public health law: "Public health law should not be seen as an arcane, indecipherable set of technical rules buried deep within state

22. GOSTIN, *supra* note 2, at 309.

23. *Id.* at 16.

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."[24]

According to Gostin, the role of the law in assuring the population's health is to grant sufficient authority and power to public health agencies to perform their essential functions and services. The main functions of public health agencies are to "prevent epidemics, protect against environmental hazards, promote healthy behaviors, respond to disasters and assist communities in recovery, and assure the quality and accessibility of health services."[25] Public health authorities perform their functions by providing a wide range of services:

> 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.[26]

Given the manifold functions and services of public health agencies, it is evident that Gostin issues a broad and ambitious mandate for public health law when he declares that the law "ought to be as effective as possible in helping agencies to create the conditions necessary for the health of the populace."[27] Nonetheless, there is reason for thinking that Gostin too narrowly circumscribes the boundaries of public health law. The problem is that the functions and services public health agencies perform do not address all of the conditions that impact the public's health. There are social and economic determinants of health that fall well outside the reach of public health authorities. Once we acknowledge these determinants, it will be clear that we must consider significantly redrawing the boundaries of pubic health law.

It has long been understood that socioeconomic status (*viz.*, status as defined by income, education and occupation) has an impact on health. Early studies examining the health effects of socioeconomic status compared the health of persons at the lowest rungs of the socioeconomic

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24. *Id.* at 327.
25. *Id.* at 16-17.
26. *Id.* at 17.
27. *Id.* at 310.

ladder with the health of those above the poverty level.[28] The studies revealed great disparities between the health statuses of impoverished and well-off (or at least better-off) persons. This comparison appeared to suggest that it was the adverse effects of poverty that accounted for the impact of socioeconomic status on health. Poor nutrition, crowded and unsanitary living conditions, inadequate medical care, and the like were thought to explain the disparities between the health of the poor and the health of the well-off. If this explanation were correct, we could eliminate serious health disparities by eliminating poverty or its effects.

There are, however, more recent studies that suggest that poverty alone cannot explain the effects of socioeconomic status on health. These studies show that the association of socioeconomic status and health occurs at every point in the socioeconomic hierarchy. It is not only the case that impoverished persons have poorer health than those who have more wealth; it is also true that those at the highest level of the socioeconomic gradient have better health than those who are just below them. Michael Marmot's Whitehall study provides strong support for this claim.[29] The Whitehall study of mortality covered 17,350 British civil servants over a period of ten years. The British Civil Service operates with ranked grades of employment, which—going from the lowest to highest grade—include unskilled workers, clerical workers, professionals and executives, and top administrators. The study showed that the relative risk of mortality over ten years increased at each point at which employment grade decreased. Other studies have similarly found a graded relationship between years of education and mortality, with an increasing ratio of observed to expected deaths as levels of education decreased.[30]

There is also growing evidence that the distribution of income is an important factor in explaining the health of a society. There are numerous studies suggesting that an individual's health is affected by the level of inequality in society as a whole, and not just by her own level of income.[31]

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28. For a review of these studies, see Aaron Antonovsky, *Social Class, Life Expectancy and Overall Mortality*, 45 MILBANK MEMORIAL Q. 31 (1967).

29. *See* M.G. Marmot et al., *Inequalities in Death: Specific Explanations of a General Pattern*, 337 LANCET 1003 (1984).

30. *See, e.g.*, DIFFERENTIAL MORTALITY IN THE UNITED STATES: A STUDY IN SOCIOECONOMIC EPIDEMIOLOGY (E.M. Kitagawa & P.M. Hauser eds., 1973).

31. *See, e.g.*, 1 THE SOCIETY AND POPULATION HEALTH READER (Ichiro Kawachi et al., eds., 2000).

Absolute deprivation does not adequately account for disparities in health outcomes. The level of relative deprivation within a society also impacts health. This idea is known as the "relative income hypothesis."[32] The relative income hypothesis states that income inequality is strongly related to life expectancy and population mortality across nations. While it is true that wealthier countries generally have higher average life expectancy, these countries also vary in life expectancy according to differences in income distribution. Wealthy countries that have more equal income distributions, like Sweden and Japan, have a lower per capita gross domestic product but higher life expectancies than the United States. Poorer countries with high life expectancy, such as Costa Rica, also generally have a more equitable distribution of income.[33]

When we compare states within the United States, a similar pattern emerges. While wealthier states generally have lower mortality rates, inequality accounts for roughly twenty-five percent of the state variation in age-adjusted mortality rates.[34] A recent study also found a relationship between inequality and mortality across metropolitan areas in the United States.[35] The study showed that death rates in cities with great income inequality far exceed the death rates in cities with low income inequality.

It is also important to note that there are marked racial variations in health status. Blacks have higher death rates than whites for all the leading causes of death in the United States except suicide.[36] While race is strongly correlated with socioeconomic status, it has often been found that blacks have higher levels of ill health than whites even when education and income levels are held constant.[37] Such evidence suggests that racism plays a key role in racial inequalities in health.[38]

The significance of all of these studies is their implication that "assuring

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32. *Id.* at xvi.

33. *See* RICHARD G. WILKINSON, UNHEALTHY SOCIETIES: THE AFFLICTIONS OF INEQUALITY (1996).

34. *See* Bruce P. Kennedy et al., *Income Distribution and Mortality,* 312 BRITISH MED. J. 1004 (1996).

35. *See* J.W. Lynch et al., *Income Inequality and Mortality in Metropolitan Areas of the United States,* 88 AM. J. PUB. HEALTH 1074 (1998).

36. *See* David R. Williams, *Racial Variations in Adult Health-Status: Patterns, Paradoxes, and Prospects, in* AMERICA BECOMING: RACIAL TRENDS AND THEIR CONSEQUENCES 371 (Neil Smelser et al. eds., 2000).

37. *See id.* at 388.

38. *See id.* at 388-401.

the conditions for the population's health" requires doing much more than effectively performing traditional public health functions and services. Those devoted to the mission of promoting the public's health must be prepared to wage a battle against, *inter alia*, income inequality, unequal educational opportunities, and racism. As Jonathan Mann notes: "[A]s public health seeks to 'ensure the conditions in which people can be healthy,' and as those conditions are societal, to be engaged in public health necessarily involves a commitment to societal transformation."[39] Sol Levine likewise suggests that we must revise our conception of health policy in light of the impact socioeconomic factors have on health: "Health policy should not be separated from social and economic policy. Indeed, health leaders might find themselves becoming involved in issues ordinarily viewed as distant from health concerns – such as tax policy, ways to fight inflation, and the kind of remedies we use for unemployment."[40]

If we take seriously Gostin's idea that law is a vital tool for assuring the conditions of the population's health, then we must allow for the possibility that all laws affecting such things as income distribution, education opportunities, and race relations fall within the ambit of public health law. Given that Gostin believes the state has an "inherent responsibility to advance the population's health and well-being,"[41] his vision of public health law as an instrument for empowering public health authorities to effectively perform their functions and services is too narrow for the cause he champions. The commitment to assuring the population's health requires a view of public health law that also encompasses structural features of social and economic relations.

Of course, it is a matter of controversy what the legitimate reach of the law is in advancing social and economic equality. While radical schemes to redistribute wealth and power might do much to promote health, there are competing views about the extent to which justice demands or permits such measures. Once we acknowledge the socioeconomic determinants of health, specifying the state's "authority and responsibility" to secure public health requires that we engage fundamental and vexing questions

39. Jonathan Mann, *Medicine and Public Health, Ethics and Human Rights*, in NEW ETHICS FOR THE PUBLIC'S HEALTH 93 (Dan Beauchamp & Bonnie Steinbock eds., 1999).

40. Sol Levine, *If Our Government Really Cared About Health*, 29 SOC. POL'Y 6 (1994).

41. GOSTIN, *supra* note 2 at xviii.

of political philosophy. In the end, it is the hand of justice that draws the boundaries of public health law. The final stage in the evolution of public health law theory is to locate those points where law and justice converge.