Conceptualizing the Field After September 11th: Forward to a Symposium on Public Health Law

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FOREWORD

Conceptualizing the Field After September 11th: Foreword to a Symposium on Public Health Law*

BY LAWRENCE O. GOSTIN, J.D., LL.D (Hon.)**

Disease has long been the deadliest enemy of mankind. Infectious diseases make no distinctions among people and recognize no borders. We have fought the causes and consequences of disease throughout history and must continue to do so with every available means. All civilized nations reject as intolerable the use of disease and biological weapons as instruments of war and terror.

President George W. Bush
November 1, 2001

* This Foreword is derived from the following sources: LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW AND ETHICS: A READER (2002); LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2000); Lawrence O. Gostin et al., The Law and the Public’s Health: A Study of Infectious Disease Law in the United States, 99 COLUM. L. REV. 59 (1999); Lawrence O. Gostin et al., The Law and the Public’s Health: The Foundations, in LAW IN PUBLIC HEALTH PRACTICE (Richard A. Goodman et al. eds., forthcoming 2002).

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Safeguarding the public's health, safety, and security took on new meaning and urgency after the attacks on the World Trade Center in New York and the Pentagon in Washington, D.C. on September 11, 2001. On October 4, 2001, a Florida man named Robert Stevens was diagnosed with inhalational anthrax. The intentional dispersal of anthrax through the U.S. postal system in New York, Washington, Pennsylvania and other locations resulted in at least five deaths, hundreds treated, and thousands tested. The prospects of new, larger, and more sophisticated attacks have created a sense of deep vulnerability. The need to rapidly detect and react to bioterrorism, as well as naturally occurring infectious diseases, has never been greater.

In the aftermath of September 11th, the President and the Congress acted to strengthen the public health infrastructure. The Center for Law and the Public's Health drafted the Model State Emergency Health Powers Act at the request of the Centers for Disease Control and Prevention and in collaboration with members of national organizations representing governors, legislators, attorneys general, and health commissioners.

2 Shortly before the emergence of anthrax in the U.S. Postal system, Alan P. Zelicoff correctly foretold the impact of just one or two cases of anthrax, saying: The chance of a large [bioweapons] attack that affects tens of thousands or hundreds of thousands is very small. . . . But is that what the terrorist cares about? Inducing enough disease to produce panic or disrupt life is probably enough. I would posit that one or two cases of pulmonary anthrax in downtown Washington or New York would achieve that goal. David Brown, Biological, Chemical Threat is Term Tricky, Complex, WASH. POST, Sept. 30, 2001, at A12 (alteration in original). Indeed, after a rash of anthrax-laced letters in late 2001, though few contracted anthrax and fewer still died from the disease, the high profile cases provoked anxiety throughout the country.

3 See, e.g., Larry M. Bush et al., Index Case of Fatal Inhalational Anthrax Due to Bioterrorism in the United States, 345 NEW ENG. J. MED. 1607 (2001); John A. Jemigan et al., Bioterrorism-Related Inhalational Anthrax: The First 10 Cases Reported in the United States, 7 EMERGING INFECTIOUS DISEASES 933 (2001); see also Thomas V. Inglesby et al., Anthrax as a Biological Weapon: Medical and Public Health Management, 281 JAMA 1735 (1999); Morton N. Swartz, Recognition and Management of Anthrax—An Update, 345 NEW ENG. J. MED. 1621 (2001).

4 See, e.g., FY2003 Budget, supra note 1, at 15-23.

5 See infra notes 26-27 and accompanying text.

6 The Model State Emergency Health Powers Act ("Model Act") was drafted by the Center for Law and the Public's Health at Georgetown and Johns Hopkins Universities. The Model Act was drafted at the request of the Centers for Disease Control and Prevention in consultation with members of the National Governors
Many Americans have come to rethink the role of government and the importance of the public health and safety system. The anti-government, anti-regulatory, and anti-taxation tenor of our times has begun to dissipate. Recent events have made the electorate understand that individuals, acting alone, cannot safeguard their own health and safety, even with full access to the sophisticated technologies of modern science and medicine.

Certainly, with sufficient resources, people can meet many of their own needs for survival such as housing, clothing, food, and medical care. Each individual can also behave in ways that promote personal health and safety by eating healthy foods, exercising, using safety equipment (e.g., seatbelts and motorcycle helmets), or refraining from smoking, using illicit drugs or drinking alcoholic beverages excessively. However, there is still a great deal that individuals cannot do to secure their health and, therefore, they need to organize, build together, and share resources. Acting alone, people cannot achieve environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious diseases. Each of these collective goods, and many more, are achievable only by organized and sustained community activities. Individuals, therefore, have powerful interests in living in a society that places a high value on community health, safety, and security. With the current threat of bioterrorism, individuals are particularly dependent on the collective provision of public health services. Proper surveillance, testing, and other epidemiological investigations would likely mitigate the effects of a bioterrorist agent released into the population by identifying the point of release and containing the spread of infectious diseases.

In this Foreword, I present the foundations of public health law—its definition, objectives, and methods. Before turning to an exploration of the legal basis of public health, however, it will be helpful to think about the field of public health itself.

I. THE POPULATION BASIS FOR PUBLIC HEALTH

Definitions of public health vary widely, ranging from the utopian conception of the World Health Organization of an ideal state of "physical,
mental and social” health to a more concrete listing of public health practices. Charles-Edward Winslow, for example, defined public health as the science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease and... organizing these benefits in such a fashion as to enable every citizen to realize his birthright of health and longevity.

More recent definitions focus on “positive health,” emphasizing a person’s complete well-being. Definitions of positive health include at least four constructs: a healthy body, high-quality personal relationships, a sense of purpose in life, and self-regard and resilience.

The Institute of Medicine (“IOM”), in its seminal report on the Future of Public Health, proposed one of the most influential contemporary definitions: “Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.” The IOM’s definition can be appreciated by examining its constituent parts. The emphasis on cooperative and mutually shared obligation (“we, as a society”) reinforces that collective entities (e.g., governments and communities) take responsibility for healthy populations. The definition also makes clear that even the most organized and socially conscious society cannot guarantee complete physical and mental well-being. There will always be a certain amount of

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9 See Declaration of Alma-Ata, supra note 7. The WHO’s definition set forth in 1978 is an example of “positive health” in how it focuses on the complete well-being of a person.
12 See id. at 41-42.
13 See id. at 53-54.
injury and disease in the population that is beyond the reach of individuals or government. The role of public health, therefore, is to assure the conditions in which people can lead healthy lives. These conditions include a variety of educational, economic, social, and environmental factors that are necessary for good health.

Most definitions share the premise that the subject of public health is the health of populations—rather than the health of individuals—and that this goal is reached by a generally high level of health throughout society, rather than the best possible health for a few. Thus, the field of public health is concerned with health promotion and disease prevention throughout society. Consequently, public health is less interested in clinical interactions between health care professionals and patients, and more interested in devising broad strategies to prevent, or ameliorate, injury and disease.

Public health is concerned with the root causes of injury and disease. The field takes a broad view of the determinants of ill health, focusing on behavior, environment, and conditions in which people live (e.g., in the home, workplace, and community). As a result, public health values prevention and health promotion. The goal is to identify risk factors and reduce the burden of injury and disease in the community. Public health involves numerous disciplines (e.g., medicine, nursing, epidemiology, economics, and political science), settings (e.g., schools, workplaces, and institutions), and tools (e.g., surveillance, education, regulation, and litigation).

The overall objective of public health is to achieve the common goods of population health and safety (e.g., a clean environment, safe roads and products, uncontaminated food and water, and control of infectious diseases). Its activities are not intended to benefit any given individual, but the community as a whole (e.g., surveillance to monitor the health status of populations, laboratories to track strains of disease, and teams of epidemiologist to respond to outbreaks). As explained above, no private or non-

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14 See id. at 54.
15 See id. at 40.
16 See id. at 38-40.
17 See id.
20 See Rose, supra note 18, at 32.
profit entity could support these public functions.\textsuperscript{21} Moreover, there are few, if any, market-based financial incentives or disincentives that could achieve these communal benefits.\textsuperscript{22} In this sense, the results of public health activities are truly common goods that benefit all of us, whether we are wealthy or poor, insured or not, urban or rural, healthy or sick.

II. PUBLIC HEALTH'S INFRASTRUCTURE

The IOM's report on the \textit{Future of Public Health}\textsuperscript{23} and the pending report on \textit{Assuring the Health of the Public in the 21st Century}\textsuperscript{24} observe that the public health system has been chronically underfunded and is in disarray. State and local health agencies have inadequate and incomplete surveillance capacity, antiquated data systems, technologically inferior laboratories, and an under-trained, under-qualified workforce.\textsuperscript{25} After decades of neglect, the federal government is now recognizing the glaring deficiencies in the public health infrastructure. Congress appropriated funding for public health preparedness (e.g., early detection and response to potential bioterrorist attacks) even before the attacks on the World Trade Center and the Pentagon,\textsuperscript{26} and funding after September 11th has risen dramatically.\textsuperscript{27}

\begin{itemize}
\item \textsuperscript{21} \textit{See supra} notes 11-16 and accompanying text.
\item \textsuperscript{23} \textit{COMM. FOR THE STUDY OF THE FUTURE OF PUBLIC HEALTH, INST. OF MED., supra} note 11.
\item \textsuperscript{25} \textit{See CTRS. FOR DISEASE CONTROL & PREVENTION, DEP'T OF HEALTH & HUM. SERVS., PUBLIC HEALTH'S INFRASTRUCTURE: A STATUS REPORT} (2001) (prepared for the Appropriations Committee of the United States Senate).
\item \textsuperscript{26} S. 1765, 107th Cong. (2001); S. 2731, 106th Cong. (2000). The Bioterrorism Preparedness Act, sponsored by Senators William Frist of Tennessee and Edward Kennedy of Massachusetts, seeks, among other things, to upgrade federal capacities to respond to bioterrorism through expanding surveillance and response capacities and enlarging pharmaceutical stockpiles. In addition, the Act allows for grants in order to assist individual states with planning a response to potential bioterrorist attacks. The Act also allows for the accelerated production of the smallpox vaccine, and takes steps to ensure the authority of the FDA to safeguard the nation's food supply.
\item \textsuperscript{27} FY 2003 Budget, \textit{supra} note 1, at 18-19 (requesting $5.9 billion to enhance defenses against bioterrorism).
\end{itemize}
Before the recent infusion of federal funds, the government allocated only approximately one percent of all health dollars to traditional public health services; the rest of America's health resources went to personal medical care and high technology research and development. This funding mismatch is illustrated in congressional funding of federal health agencies. Nondiscretionary funding of federal agencies accounts for over ninety-five percent of the health budget; this funding goes exclusively to personal health care services such as Medicaid and Medicare. Congress allocates half of the remaining five percent to the National Institutes of Health, whose budget has been approximately doubling in each of the last several years. All the rest of the federal Public Health Services agencies share the remainder. This hardly represents a national commitment to assuring the health of the public. This grossly inadequate funding for public health agencies also leaves the country more vulnerable to a biological attack. Public health functions, such as the monitoring and reporting of disease patterns, which have fallen victim to the increasing privatization of American health care, are necessary for determining when and where a biological attack has occurred.

**FIGURE 1**

A Century of Public Health Accomplishment

- thirty years of increased longevity
- vaccinations
- healthier mothers and babies
- family planning
- safer and healthier foods
- fluoridation of drinking water
- control of infectious diseases
- decline in deaths from heart disease and stroke
- recognition of tobacco use as a health hazard
- motor vehicle safety
- safer workplaces

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31 For detailed descriptions of each of these achievements, see Ctrs. for Disease Control & Prevention, U.S. Dep't Health & Hum. Servs., *Achievements in Public*
The relatively dismal funding of public health services does not reflect the contribution made by public health to improving the health and safety of the population. The average life span has been dramatically extended from forty-five years at the turn of the century to nearly eighty years today. Of these thirty-five years of "extra" longevity, only five or so can be attributed to advances in clinical medicine. Public health can take much of the credit for the other thirty years, with improvements in sanitation, health education, the development of effective vaccines, and other advances.32

For a list of ten public health achievements during the past century, in addition to increased longevity, see Figure 1. Notice that for most of these achievements, the law has played a vital role—e.g., compulsory vaccinations, food and drug safety, regulation of the water supply, personal control

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See supra note 31.
measures for contagious diseases, tobacco regulation (taxation, labeling and advertising, and tort actions), and regulation of car design and seatbelt use. Overall, these achievements highlight public health’s protective role—the identification and minimization of risk, whether it emanates from behavior, the environment in which people live and work, and the population’s genetic legacy, or, as is often the case, some interplay among these factors.

III. FOUNDATIONS OF PUBLIC HEALTH LAW

Public health law plays a unique role in assuring the population’s health. To demonstrate its importance, it is helpful to define public health law and examine its mission, functions, and powers.

A. Defining Public Health Law

In Public Health Law: Power, Duty, Restraint, and a companion text, I define public health law as

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.

This definition suggests five essential characteristics of public health law, which correspond with the characteristics of public health itself described in the previous section:

- **Government:** Public health activities are the primary (but not exclusive) responsibility of government. Government creates policy

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and enacts laws and regulations designed to safeguard community health.

- **Populations:** Public health focuses on the health of populations. Certainly, public health authorities are concerned with access and quality in medical care, but their principal concern is to create the conditions in which communities can be healthy.

- **Relationships:** Public health contemplates 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.

The legal foundations of public health include public health laws (statutes principally at the state level that establish the mission, functions, powers, and structures of health agencies) and laws about the public's health (laws and regulations that offer a variety of tools to prevent injury and disease and promote the population's health).


Public health law is often perceived as an arcane set of rules buried deep within indecipherable statute books and regulatory codes. However, it does not have to be this way. The law can be transformed to become an essential tool for creating the conditions for people to be healthy. The IOM\textsuperscript{36} and the Department of Health and Human Services\textsuperscript{37} recommend reform of an obsolete and inadequate body of enabling laws and regulations. Currently, a consortium of states and national experts are drafting a model public health law\textsuperscript{38} and the Centers for Disease Control and Prevention has recommended that states adopt the Model Emergency Health Powers Act or its functional equivalent.\textsuperscript{39}

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\textsuperscript{36} COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, INST. OF MED., supra note 11.
\textsuperscript{37} 1 DEP'T HEALTH & HUM. SERVS., HEALTHY PEOPLE 2010 (2000).
\textsuperscript{38} www.hss.state.ak.us/dph/aphip/collaborative.htm.
\textsuperscript{39} See supra note 6 and accompanying text.
A model public health statute should reflect at least three principles—duty, power, and restraint. First, the law should impose duties on government to promote health and well-being within the population. Surprisingly, state statutes rarely impose affirmative obligations on public health agencies, and the Supreme Court finds no constitutional duty to safeguard the public. However, the creation of statutory duties to perform essential public health functions and to protect the community’s health and safety would be beneficial in several ways: (i) legislatures would have a standard by which health authority performance could be assessed; (ii) the electorate would have higher expectations for adequate services and health protection; and (iii) government would demonstrate its enduring commitment to a strong public health infrastructure. Agencies should also have the responsibility to work with the private (e.g., managed care and business) and voluntary (e.g., community-based) sectors to assure the public’s health.

Second, the law should afford public health authorities ample power to regulate individuals and businesses to achieve the communal benefits of health and security. This idea of regulatory power is counterintuitive to a civil libertarian, but natural and instinctive to a sanitarian. The power to regulate is the power to make people secure in the most important aspect of their lives—people’s health, safety, and well-being. Individuals cannot exercise civil or political rights, or enjoy a life full of contentment without a

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40 The Model State Emergency Health Powers Act assigns a number of duties to the public health authority of any given state. These duties include, but are not limited to, the collection of information reported by medical providers, coroners, pharmacists, veterinarians, and others in order to track any unusual disease clusters, and the investigation (including identifying and interviewing those thought to be exposed to an illness causing concern and the examination of facilities thought to endanger the public health) of any potential cause of a public health emergency. See MODEL STATE EMERGENCY HEALTH POWERS ACT, supra note 6, §§ 301-302.

41 See, e.g., DeShaney v. Winnebago County Dep’t of Soc. Servs., 489 U.S. 189, 194-97 (1989) (concluding that the Due Process Clause is a restraint on a state’s power, not a guarantee of specific protections).

42 See generally Rene Bowser & Lawrence O. Gostin, Managed Care and the Health of a Nation, 72 S. CAL. L. REV. 1209 (1999).

43 The Model State Emergency Health Powers Act bestows upon the public health authority a number of powers in order to govern during a public health emergency. These powers include, but are not limited to, the ability to declare a public health emergency, the ability to procure, condemn, or otherwise control certain facilities, the ability to procure and ration health care supplies, the ability to vaccinate, isolate, and quarantine individuals, and the ability to disclose necessary health information. MODEL STATE EMERGENCY HEALTH POWERS ACT, supra note 6, §§ 401, 501-502, 505, 603-604, 607.
certain measure of security. One important way of assuring the health of the community is by giving government adequate powers, and flexibility, to regulate. Individuals acting independently, without organized community activity, cannot assure many of the essential conditions of health. Sound and effective public health statutes, therefore, should afford agencies ample authority to set standards of health and safety and to assure compliance.

Third, the law should restrain government from overreaching in the name of public health. Public health authorities should respect, to the extent possible, individual autonomy, liberty, and privacy. They should act only on the basis of clear criteria where necessary to protect the community. Public health agencies should also provide procedural due process before exercising coercive powers. Fair and objective decision making is essential in a democracy.

Effective public health protection is technically and politically difficult. Law cannot solve all, or even most, of the challenges facing public health authorities. Yet, law can become an important part of the ongoing work of creating the conditions necessary for people to live healthier and safer lives. A public health law that contributes to health will, of course, be up-to-date in

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44 For each power the Model State Emergency Health Powers Act bestows upon the public health authority, certain restraints are enforced as well. For example, in order to constrain the powers that come with the declaration of a state of emergency, the state of emergency automatically expires after thirty days (if not renewed by the governor) so as to limit the duration with which the public health authority may act with the enhanced powers provided in the Act. Id. § 405(b). The State must compensate (in most cases) the owner of materials or facilities taken for its permanent or temporary use. Id. § 506. Vaccines must be administered by a qualified person and may not be administered to an individual if there is a reasonable likelihood the vaccine will cause that individual serious harm. Id. § 603(a)(2). Isolation and quarantine must be done by the least restrictive means possible. Id. § 604(b)(1). When individuals no longer pose a threat, they must be immediately released from isolation or quarantine. Id. § 604(b)(5). The premises on which individuals are isolated or quarantined must be maintained in a manner designed to minimize further infection. Id. § 604(b)(7). The cultural and religious beliefs of those under isolation or quarantine must be respected to the greatest extent possible. Id. § 604(b)(8). Finally, individuals may apply to the court for relief from isolation or quarantine. Id. § 604(c)(1).


the methods of assessment and intervention it authorizes. It will also conform
to modern standards of law and prevailing social norms. It should be designed
to enhance the reality and the public perception of the health department’s
rationality, fairness, and responsibility. It should help health agencies
overcome the defects of their limited jurisdiction over health threats facing
the population. Finally, a new law and the process of its enactment should
provide an opportunity for the health department to challenge the apathy
about public health that is all too common within the government and the
population at large.

At present, the law relating to public health is scattered across count-
less statutes and regulations at the state and local level. Problems of anti-
quity, inconsistency, redundancy, and ambiguity render these laws ineffective,
or even counterproductive, in advancing the population’s health. In
particular, health codes frequently are outdated, built up in layers over
different periods of time, and highly fragmented among the fifty states and
territories.

Problem of Antiquity. The most striking characteristic of state public
health law, and the one that underlies many of its defects, is its overall
antiquity. Certainly, some statutes are relatively recent in origin. However,

a great deal of public health law was framed in the late-nineteenth and early-to mid-twentieth centuries and contains elements that are forty to one hundred
years old. Old public health statutes are often outmoded in ways that directly
reduce their effectiveness and conformity with modern standards. These laws
often do not reflect contemporary scientific understandings of injury and
disease (e.g., surveillance, prevention, and response) or legal norms for
protection of individual rights. Rather, public health laws utilize scientific and
legal standards that prevailed at the time they were enacted. Society faces
different sorts of risks today and deploys different methods of assessment and
intervention. When many of these statutes were written, public health (e.g.,
epidemiology and biostatistics) and behavioral sciences (e.g., client-centered
counseling) were in their infancy. Modern prevention and treatment methods
did not exist.

47 See generally Lawrence O. Gostin et al., The Law and the Public’s Health:
A Study of Infectious Disease Law in the United States, 99 COLUM. L. REV. 59
(1999).

48 See, e.g., DEL. CODE ANN. tit. 29, § 7904 (1999); WASH. REV. CODE §§
43.70.520-.580 (1999).

49 See, e.g., N.J. STAT. ANN. § 26:4-2 (West 1996) (enacted in 1902 and last
amended in 1915); S.D. CODIFIED LAWS §§ 34-22-1 to -6 (Michie 1994) (enacted
At the same time, many public health laws pre-date the vast changes in constitutional (e.g., equal protection and due process) and statutory (e.g., disability discrimination) law that have transformed social and legal conceptions of individual rights. Failure to reform these laws may leave public health authorities vulnerable to legal challenge on grounds that they are unconstitutional or that they are preempted by modern federal statutes. Even if state public health law is not challenged in court, public health authorities may feel unsure about applying old legal remedies to new health problems within a very different social milieu.

**Problem of Multiple Layers of Law.** Related to the problem of antiquity is the problem of multiple layers of law. The law in most states consists of successive layers of statutes and amendments, built up in some cases over one hundred years or more in response to existing or perceived health threats. This is particularly troublesome in the area of infectious diseases which forms a substantial part of state health codes. Because communicable disease laws have been passed piecemeal in response to specific epidemics, they tell the story of the history of disease control in the United States (e.g., smallpox, cholera, TB, STDs, polio, and AIDS).

Through a process of accretion, the majority of states have come to have several classes of communicable disease law, each with different powers and protections of individual rights: those aimed at traditional STDs; those targeted at specific currently or historically pressing diseases, such as TB and HIV; and those applicable to “communicable” or “contagious” diseases, a residual class of conditions ranging from measles to malaria whose control does not usually seem to raise problematic political or social issues.

The disparate legal structure of state public health laws can significantly undermine their effectiveness. Laws enacted piecemeal over time are inconsistent, redundant, and ambiguous. Even the most astute lawyers in public health agencies or offices of the Attorney General have difficulty understanding these arcane laws and applying them to contemporary health threats.

**Problem of Inconsistency Among the States and Territories.** Public health laws remain fragmented not only within states but among them. Health codes within the fifty states and territories have evolved independently, leading to profound variation in the structure, substance, and procedures for detecting, controlling, and preventing injury and disease. In fact, statutes and regulations among American jurisdictions vary so significantly in definitions, methods, age, and scope that they defy orderly categorization. There is good reason for greater uniformity among the states in matters of public health. Health threats are rarely confined to single jurisdictions, but pose risks within whole regions.
or the nation as a whole (e.g., air or water pollution, disposal of toxic waste, and bioterrorism).  

Public health law, therefore, should be reformed so that it conforms with modern scientific and legal standards, is more consistent within and among states, and is more uniform in its approach to different health threats. A single set of standards and procedures would add needed clarity and coherence to legal regulation, and would reduce the opportunity for politically motivated disputes about how to classify newly emergent health threats.

C. Laws About Public Health: Regulation as a Tool to Safeguard Health and Safety

Public health laws not only establish the foundations for health services and practice, they also provide a set of tools for the prevention and control of injury and disease. There are at least five models for legal intervention designed to prevent injury and disease and promote the public’s health.  

While legal interventions can be effective, they often raise social, ethical, or constitutional concerns that warrant careful study.

Model 1 is the power to tax and spend. This power, found in federal and state constitutions, provides government with an important regulatory technique. The power to spend enables government to set conditions for the receipt of public funds. For example, the federal government grants highway funds to states on condition that they set the drinking age at twenty-one. The power to tax provides strong inducements to engage in beneficial behavior or refrain from risky behavior. For example, taxes on cigarettes significantly reduce smoking, particularly among young people.

The power to tax and spend may appear benign and uncontroversial, but it is often perceived as coercive or unfair. The conditions placed on spending

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50 In June 2001, a war game termed "Dark Winter" took place at Andrews Air Force base. Dark Winter aptly demonstrated the propensity of the smallpox virus to spread from one jurisdiction to another. In the exercise, a single case of smallpox was reported in Oklahoma City. During the course of the experiment, the government rapidly ran out of vaccines, and before the drill ended, the disease had spread to twenty-five states, killing millions of people. Sheryl Gay Stolberg, Some Experts Say U.S. is Vulnerable to a Germ Attack, N.Y. TIMES, Sept. 30, 2001, at 1A.

51 See infra notes 47-64 and accompanying text.


may appear coercive when the recipient has great need for the funding. If the
states, for example, obtain most, or all, of their health surveillance funds from
the federal government, states may feel obliged to accept the funding even if
the conditions seem unreasonable. The power to tax and spend may also be
regarded as unfair if the government distributes burdens or benefits inequita-
ably. As noted above, the government taxes tobacco products with the goal of
reducing smoking. Few people disagree that government should place
disincentives on highly dangerous behavior. However, tobacco taxes are
highly regressive, disproportionately burdening the poor. The disproportion-
ate burden arises because the tax takes a much larger percentage of the
income of poor people, and because cigarette smoking is more common
among lower socio-economic classes.\textsuperscript{54}

\textit{Model 2} is the power to alter the informational environment. Government
can add its voice to the marketplace of ideas through health promotion
activities such as health communication campaigns; provide relevant
consumer information through labeling requirements; and limit harmful or
misleading information through regulation of commercial advertising of
unsafe products (e.g., cigarettes and alcoholic beverages).\textsuperscript{55}

Most people find government's efforts to alter the informational
environment as unobjectionable. After all, the state has the responsibility to
inform the public about risk behaviors by providing health messages and
ensuring that corporate messages are not misleading or manipulative.
However, not everyone believes that public funds should be expended, or the
veneer of government legitimacy used, to prescribe particular social
orthodoxies. When the government associates an overweight person, for
example, with an unappealing, lazy personality, or a smoker with bad breath
or premature aging, it can cause social harm. Government regulation of
corporate speech is even more controversial, implicating First Amendment
values. The Supreme Court in the last five years has become highly protective
of commercial speech, claiming that truthful speech deserves rigorous
protection in the marketplace of ideas.\textsuperscript{56}

\textsuperscript{54} Some studies, however, have shown that because of this economic impact,
"low-income, adolescent, Hispanic, and non-Hispanic black smokers are more
likely to stop smoking in response to a price increase." \textit{Id.} at 987.
\textsuperscript{55} See Lawrence O. Gostin & Gail H. Javitt, \textit{Health Promotion and the First
Amendment: Government Control of the Informational Environment}, 79 \textit{MILBANK
Q.} 547 (2001).
\textsuperscript{56} See, e.g., Lorillard Tobacco Co. v. Reilly, 533 U.S. 525 (2001); 44 Liquormart,
Inc. v. Rhode Island, 517 U.S. 484 (1996). \textit{See also} Gostin & Javitt, \textit{supra}
note 55.
Model 3 is direct regulation of individuals (e.g., seatbelt and motorcycle helmet laws), professionals (e.g., licenses), or businesses (e.g., inspections and occupational safety standards). Public health authorities regulate pervasively to reduce health and safety risks to the population.  

Although risk regulation is commonplace in America, it is nonetheless controversial. Regulation is attacked from both sides of the political spectrum. The political left complains about regulation that curtails personal freedom such as autonomy (e.g., compulsory testing), bodily integrity (e.g., compulsory treatment), privacy (e.g., reporting and surveillance), and liberty (e.g., isolation or quarantine). At the same time, the political right complains about regulation that curtails economic freedom such as the right to contract (e.g., occupational health and safety regulations), pursue a livelihood (e.g., licenses), or conduct a business (e.g., inspections). Liberals seek a society that values civil rights and liberties, while conservatives seek a society that values free enterprise and control of private property.

Model 4 is indirect regulation through the tort system. Tort litigation can provide strong incentives for businesses to engage in less risky activities. Litigation has been used as a tool of public health to influence manufacturers of automobiles, cigarettes, and firearms. Litigation resulted in safer automobiles; reduced advertising and promotion of cigarettes to young people; and encouraged at least one manufacturer (Smith & Wesson) to develop safer firearms.

Tort litigation can be highly effective in achieving public health goals by deterring and punishing risk behavior. But litigation is attacked for being undemocratic, inefficient, and unfair. Some tort actions are perceived as undemocratic because they impose economic penalties without legislative sanction. If the legislature wanted to control firearm manufacturers, for example, it could levy a tax, strictly regulate, or even ban the product. Tort actions are also criticized for their inefficiency. If the goal of litigation, for example, were to compensate victims, resources could be directed to injured

60 See Parmet & Daynard, supra note 59, at 443.  
61 Id. at 446-48.}
parties through less expensive, no-fault systems. Litigation is inefficient because it diverts resources from victims to attorneys and the judicial system. Finally, the tort system is criticized for being unfair because it provides windfalls to certain plaintiffs and their attorneys, while providing little or no relief to others. Consider the large punitive awards for disease or injury caused by motor vehicles, vaccines, or tobacco. Some plaintiffs receive millions of dollars in damages while similarly situated individuals may receive nothing.

The final model is deregulation. Sometimes laws are harmful to public health and stand as an obstacle to effective action. For example, criminal laws proscribe the possession and distribution of sterile syringes and needles. These laws, therefore, make it more difficult for public health authorities to engage in HIV prevention activities.

Deregulation can overcome impediments to effective public health action, but it can have political and social costs. Often deregulation sends a message that the underlying behavior is socially sanctioned and ethically appropriate. The de-criminalization of needle possession, for example, is bitterly contested by those who feel it would encourage illicit drug use and send the message that it is a socially condoned activity.

The government, then, has many legal "levers" designed to prevent injury and disease and promote the public's health. Legal interventions can be highly effective and need to be part of the public health officer's arsenal. At the same time, legal interventions can be controversial, raising important ethical, social, constitutional, and political issues. These conflicts are complex, important, and fascinating for students of public health law.

IV. A SYMPOSIUM ON PUBLIC HEALTH LAW

This issue of the Kentucky Law Journal may be the first in a major law review on the subject of law and the health of the population. It should usher in an era of greater attention to scholarship and teaching of public health law. There has been burgeoning attention devoted to health care law in the United

62 Id. at 447.
States in the past decades. It is now time for the same sustained focus on government’s powers and duties to safeguard the health, safety, and security of the population. Nothing can be more important to a legal scholar than the role of law in assuring the health the population.