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A Theory and Definition of Public Health Law

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A THEORY AND DEFINITION OF PUBLIC HEALTH LAW

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I offer a brief excerpt from my book, *Public Health Law: Power, Duty, Restraint.*[1] My definition of public health law follows, and the remainder of this excerpt offers a justification as well as an expansion of the ideas presented:

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

Several themes emerge from this definition: (1) government power and duty, (2) coercion and limits on state power, (3) government's partners in the "public health system," (4) the population focus, (5) communities and civic participation, (6) the prevention orientation, and (7) social justice.

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1. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT (2d ed. forthcoming 2007).

I. GOVERNMENT POWER AND DUTY: HEALTH AS A SALIENT VALUE

The public health community takes it as an act of faith that health must be society's overarching value. Yet politicians do not always see it that way, expressing preferences, say, for highways, energy, and the military. The lack of political commitment to population health can be seen in relatively low public health expenditures.[2] Public health professionals often distrust and shun politicians rather than engage them in dialogue about the importance of population health. What is needed is a clear vision of, and rationale for, healthy populations as a political priority.

Why should health, as opposed to other communal goods, be a salient value? Health is foundationally important because of its intrinsic value and singular contribution to human functioning. Health has a special meaning and importance to individuals and the community as a whole.[3] Every person understands, at least intuitively, why health is vital to well-being. Health is necessary for much of the joy, creativity, and productivity that a person derives from life. Perhaps not as obvious, however, health is also essential for the functioning of populations. Without minimum levels of health, people cannot fully engage in social interactions, participate in the political process, exercise rights of citizenship, generate wealth, create art, and provide for the common security. A safe and healthy population builds strong roots for a country's governmental structures, social organizations, cultural endowment, economic prosperity, and national defense. Population health becomes a transcendent value because a certain level of human functioning is a prerequisite for activities that are critical to the public's welfare—social, political, and economic.

Why does government have an enduring obligation to protect and promote the public's health? Theories of democracy help to explain the government's role in matters of population health. People form governments for their common defense, security, and welfare—goods that can be achieved only through collective action. The first thing that public officials owe to their constituents is protection against natural and man-made hazards.[4] 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

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2. *See* JO IVEY BOUFFORD & PHILLIP R. LEE, HEALTH POLICIES FOR THE 21ST CENTURY: CHALLENGES AND RECOMMENDATIONS FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES 14-15 (2001) (arguing that increased federal action is needed to strengthen the public health infrastructure); KAY W. EILBERT ET AL., MEASURING EXPENDITURES FOR ESSENTIAL PUBLIC HEALTH SERVICES 17 (1996) (describing population based health expenditures and stating that population based health spending was approximately 1% of total health expenditures).

3. *See* NORMAN DANIELS, JUST HEALTH CARE 1 (Daniel I. Wikler ed., 1985) (acknowledging the distinction between "individual or micro" and "social or macro" levels of health care decision-making).

4. *See* MICHAEL WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY 3-63 (1983).

community as a whole.[5] Public health can be achieved only through collective action, not through individual endeavors. Acting alone, individuals cannot assure even minimum levels of health. Meaningful protection and assurance of the population's health require communal effort. The community as a whole has a stake in environmental protection, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. These collective goods, and many more, are essential conditions for health. Yet these benefits can be secured only through organized action on behalf of the people.

II. THE POWER TO COERCE AND LIMITS ON STATE POWER

I have suggested that public health law is concerned with governmental responsibilities to the community and the well-being of the population. Although it may not be obvious, I also suggest that the use of coercion must be part of an informed understanding of public health law, and that state power also must be subject to limits. Government can do many things to safeguard the public's health and safety that do not require the exercise of compulsory powers, and the state's first recourse should be voluntary measures. Yet government alone is authorized to require conformance with publicly established standards of conduct. Governments are formed not only to attend to the general needs of their constituents, but to insist, through force of law if necessary, that individuals and businesses act in ways that do not place others at unreasonable risk of harm. To defend the common welfare, governments assert their collective power to tax, inspect, regulate, and coerce. Of course, different ideas exist about what compulsory measures are necessary to safeguard the public's health. Reconciling divergent 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.

Protecting and preserving community health is not possible without constraining a wide range of private activities that pose unacceptable risks. Private actors can profit by engaging in practices that damage the rest of society,[6] individuals derive satisfaction from intimate relationships despite the risks of sexually transmitted infections, industry has incentives to produce goods without consideration of workers' safety or pollution of surrounding areas, and manufacturers find it economical to offer products without regard to high standards of hygiene and safety. In each instance, individuals or organizations act rationally for their own interests, but their actions may adversely affect communal health and safety. Absent governmental authority and willingness to coerce, such threats to the public's health and safety could not easily be reduced.

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5. *Id.* at 63, 81.

6. *See* JARED M. DIAMOND, COLLAPSE: HOW SOCIETIES CHOOSE TO FAIL OR SUCCEED 441-85 (2005).

Although regulation in the name of public health is theoretically intended to safeguard the health and safety of whole populations, it often benefits those most at risk of injury and disease. Everyone gains value from public health regulations, such as food and water standards, but some regulations protect the most vulnerable. For instance, eliminating a toxic waste site, enforcing a building code in a crowded tenement, or closing an unhygienic restaurant holds particular significance for those at immediate risk. Frequently, those at increased risk are particularly vulnerable due to their race, gender, or socioeconomic status.[7]

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

It has become fashionable to claim that no real conflict exists between the protection of individual rights and the promotion of population health.[8] According to this view, safeguarding rights is always (or virtually always) consistent with preserving communal health. Indeed, according to this perspective, individual rights and public health are synergistic—the defense of one enhances the value of the other, and vice versa. This rhetorical position serves a purpose, but is simplistic. It suggests that a decision to avert a discrete health risk through coercion actually may result in an aggregate increase in injury or disease in the population. The exercise of compulsory powers of isolation or quarantine, for example, may prevent individuals from transmitting a communicable infection. But the social decision to coerce affects group behavior and, ultimately, the population's health. By provoking distrust 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. Distinct tensions exist in public health law between voluntarism and coercion, civil liberties and public health, and discrete (or individual) health threats and aggregate health outcomes. These competing interests, and the substantive standards and procedural safeguards that circumscribe the lawful exercise of state powers, form the corpus of public health law.

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7. *See* JOHN LYNCH & GEORGE KAPLAN, *Socioeconomic Position, in* SOCIAL EPIDEMIOLOGY 13 (Lisa F. Berkman & Ichiro Kawachi eds., 2000); NANCY KRIEGER, *Discrimination and Health, in* SOCIAL EPIDEMIOLOGY, *supra*, at 49-55 tbls. 3-5.

8. *E.g.*, Jonathan M. Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RTS. 6, 15-17 (1994).

III. THE PUBLIC HEALTH SYSTEM: PARTNERS FOR POPULATION HEALTH

Although the power and duty to safeguard the public's health historically has been assigned to government through the work of national, state, tribal, and local health agencies, no single agency can assure conditions for the public's health. The Institute of Medicine (IOM) views public health agencies as focal institutions at the center of a multisectoral "public health system."[9] Public health agencies can act as a catalyst for action by other government departments (e.g., housing, labor, transportation, and environment). Public health agencies also stimulate, coordinate, and often regulate non-governmental actors. At the same time, these actors may co-opt agency officials into advocating for their private interests—an idea referred to in the literature as "regulatory capture."[10] The public health system includes many non-governmental actors, but the IOM focuses on five: health care institutions, the community, businesses, the media, and academe.

Health Care Institutions. Health care is important because personal health is a value in itself and one of the conditions necessary for individual and population health. Public health and health care interact in multiple, important ways.[11] Health care institutions collect information and report it to public health agencies, vaccinate populations, diagnose and treat patients with infectious diseases that endanger the public, and provide a range of services to improve community health (e.g., child and maternal health, family planning, and emergency services). However, health care is not fully available to many people. About fifteen percent of the United States population (nearly forty-five million people) lacks health insurance, with minorities and the poor disproportionately burdened.[12] Also, health plans do not cover many services for prevention, mental health, substance abuse, and dental health. Health care providers can play an important role in improving health through patient care and investments in promoting the health of the communities they serve.[13]

Community. The term "community" is often imprecise, but includes local entities such as churches, civic organizations, and health advocacy groups, which can contribute to their neighbors' health. Community involvement can effectively promote healthy activities.[14] Community organizations are well positioned to assess needs and inventory resources, formulate collaborative responses, and evaluate

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9. INST. OF MED., THE FUTURE OF THE PUBLIC'S HEALTH IN THE 21ST CENTURY 27 (2003).

10. "Regulatory capture" entails powerful interest groups improperly influencing regulatory decisions. *See, e.g.*, George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971).

11. LAWRENCE O. GOSTIN & PETER D. JACOBSON, LAW AND THE HEALTH SYSTEM 1-7 (2006).

12. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2004, at 16-21 (2005).

13. *See* Matthew K. Wynia, *Oversimplifications I: Physicians Don't Do Public Health*, 5 AM. J. BIOETHICS 4, 4 (2005).

14. *See* Marion Gibbon et al., *Evaluating Community Capacity*, 10 HEALTH & SOC. CARE COMMUNITY 485, 485 (2002).

outcomes for community health improvements. They can promote healthy lifestyles and facilitate social networks. Communities can also advocate for more government services and help care for their own members.

Businesses. Businesses play a major role in the health of their employees and the local population through their impacts on natural and built environments, workplace conditions, and relationships with communities. They affect worker health (e.g., workplace safety and exposures), economic conditions (e.g., income and quality of life), the natural environment (e.g., emission of toxins or pollutants), and the physical environment (e.g., green spaces). Many businesses also offer health insurance for their workers, demonstrating the close ties between public health, health care, and the private sector.[15] Research demonstrates the cost-effectiveness of prevention and health promotion efforts for an employer's workforce and the value of corporate action in promoting broader community health.[16]

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

Academe. Academe provides degrees and continuing education to the public health workforce. Academic institutions also foster research into many of the most pressing public health problems such as obesity, smoking, and HIV/AIDS. However, modifications are needed in curricular and financial incentives to link curricular content and teaching methods more closely to the practice needs of the public health workforce. New investments and academic reorganization can promote community-based prevention research that evaluates the effects of interventions on population health.[17]

Government agencies, therefore, are not only charged with the task of direct action to safeguard the population's health. They also engage with the public and

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15. Elsewhere, my colleague and I make the case for closer public-private partnerships and we propose economic incentives for managed care organizations to assume traditional public health functions. René Bowser & Lawrence O. Gostin, *Managed Care and the Health of a Nation*, 72 S. CAL. L. REV. 1209, 1279 (1999); *see also* Mark Wolfson et al., *Managed Care, Population Health, and Public Health*, *in* 15 RESEARCH IN THE SOCIOLOGY OF HEALTH CARE 229, 239 (Jennie Jacobs Kronenfeld ed., 1998).

16. Dean M. Hashimoto, *The Future Role of Managed Care and Capitation in Workers' Compensation*, 22 AM. J.L. & MED. 233, 255-57 (1996).

17. *See* INST. OF MED., WHO WILL KEEP THE PUBLIC HEALTHY? EDUCATING PUBLIC HEALTH PROFESSIONALS FOR THE 21ST CENTURY 15-16 (Kristine Gebbie et al. eds. 2003).

private sectors in partnerships for health. The relationships between public health agencies and their partners are complex, involving a dynamic that ranges from regulation to volunteerism, and from cooperation to co-option. Still, a multisectoral public health system is necessary to assure favorable conditions for the population's health.

IV. THE POPULATION FOCUS

The crux of public health, as I have sought to demonstrate, is a public or governmental entity that harbors the power and responsibility to assure community well-being. Public health is organized to provide an aggregate benefit to the mental and physical health of all the people in a given community. Classic definitions of public health emphasize this population-based perspective: "'Public health' means the prevailingly healthful or sanitary condition of the general body of people or the community in mass, and the absence of any general or widespread disease or cause of mortality. The wholesome sanitary condition of the community at large."[18]

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

Public health differs from medicine, which has the individual patient as its primary focus. The physician diagnoses disease and offers medical treatment to ease symptoms and, where possible, to cure disease. The British epidemiologist Geoffrey Rose compares the scientific methods and objectives of medicine with those of public health. "Why did this patient get this disease at this time?" is a prevailing question in medicine, and it underscores a physician's central concern for sick individuals.[19] Public health, on the other hand, seeks to understand the conditions and causes of ill health (and good health) in the populace as a whole. It seeks to assure a favorable environment in which people can maintain their health. Public health, of course, cares about individuals because of their inherent worth and because a population is healthy only if its constituents (individuals) are relatively free from injury and disease. Indeed, many public health agencies offer medical care for the poor, particularly for conditions that have "spill over" effects for the wider community, such as treatment for sexually transmitted infections (STIs),

18. BLACK'S LAW DICTIONARY 737 (8th ed. 2004). The Supreme Court determined in *Whitman v. American Trucking Ass'ns, Inc.*, 531 U.S. 457, 465-66 (2001), that the ordinary meaning of the term "public health" is "health of the community" or "health of the public."

19. Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 INT'L J. EPIDEMIOLOGY 32, 32 (1985).

tuberculosis (TB), and HIV/AIDS. Still, public health's abiding interest is in the well-being and security of populations, not individual patients.

The focus on populations rather than individual patients is grounded not only in theory, but in the methods of scientific inquiry and the services offered by public health. The analytical methods and objectives of the primary sciences of public health—epidemiology and biostatistics—are directed toward understanding risk, injury, and disease within populations. Epidemiology, literally translated from Greek, is "the study (*logos*) of what is among (*epi*) the people (*demos*)."[20] 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."[21] Epidemiology examines the frequencies and distributions of disease in the population.[22] The population strategy "is the attempt to control the determinants of incidence, to lower the mean level of risk factors, [and] to shift the whole distribution of exposure in a favourable direction."[23] The advantage of a population strategy is that it seeks to reduce underlying causes that make diseases common in populations, creating the potential for reductions in morbidity and premature mortality at the broadest population level.

V. COMMUNITIES AND CIVIC PARTICIPATION

Public health is interested in communities and how they function to protect and promote (or, as is too often the case, endanger) the health of their members. "A community has a life in common which stems from such things as a shared history, language, and values. The term *community* can apply to small groups such as self-help groups, which share a common goal," or to very large groups, which, despite the diversity of their members, have "common political institutions, symbols, and memories."[24]

Public health officials want to understand what health risks exist among varying populations, and, of equal importance, why differences in health risks exist, who engages in risk behavior (e.g., smoking, high fat diet, or unsafe sex), and who suffers from high rates of disease (e.g., cancer, heart disease, or diabetes). Public health professionals often observe differences in risk behavior and disease based on

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20. Roger Detels, *Epidemiology: The Foundation of Public Health, in* 2 OXFORD TEXTBOOK OF PUBLIC HEALTH 485, 485 (Roger Detels et al. eds., 4th ed. 2002).

21. *Id.*

22. JUDITH S. MAUSNER & SHIRA KRAMER, EPIDEMIOLOGY—AN INTRODUCTORY TEXT 1 (2d ed. 1985).

23. Rose, *supra* note 19, at 37.

24. NEW ETHICS FOR THE PUBLIC'S HEALTH 53 (Dan E. Beauchamp & Bonnie Steinbock eds., 1999); *see also* PUBLIC HEALTH ETHICS: THEORY, POLICY, AND PRACTICE (Ronald Bayer et al. eds., forthcoming Oct. 2006).

race, sex, or socioeconomic status.[25] Understanding the mechanisms and pathways of risk is vital to developing efficacious interventions to improve health within communities.

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

Finally, many forward-thinkers urge greater community involvement in public health decision-making so that policy formation becomes a genuinely civic endeavor. Under this view, citizens strive to safeguard their communities through civic participation, open forums, and capacity building to solve local problems. Public involvement should result in stronger support for health policies and encourage citizens to take a more active role in protecting themselves and the health of their neighbors.[26] Public health authorities, for example, might practice more deliberative forms of democracy, involving closer consultation with consumers and the voluntary organizations that represent them (e.g., town meetings and consumer membership on government advisory committees). This kind of deliberative democracy in public health is increasingly evident in government-community partnerships at the federal, state, and local levels (e.g., AIDS action and breast cancer awareness).

VI. THE PREVENTION ORIENTATION

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

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

25. *See* Michael Marmot, *Introduction*, *in* SOCIAL DETERMINANTS OF HEALTH 1, 2-3 (Michael Marmot & Richard G. Wilkinson eds., 2d ed. 2006).

26. Nancy Kari et al., *Health as a Civic Question*, CIVIC PRACTICES NETWORK (Nov. 28, 1994), http://www.cpn.org/topics/health/healthquestion.html.

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

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.[27] Medical explanations of death point to discrete pathophysiological conditions such as cancer, heart disease, cerebrovascular disease, and pulmonary disease.[28] 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 are devoted to medical treatment of diseases ultimately recorded as the nation's leading killers on death certificates. Only a small fraction of funding is directed to control the root determinants of death and disability. The central message, of course, is that prevention is often more cost-effective than amelioration, and that much of the burden of disease, disability, and premature death can be reduced through prevention.

VII. SOCIAL JUSTICE

Social justice is viewed as so central to the mission of public health that it has been described as the field's core value: "[t]he historic dream of public health . . . is a dream of social justice."[29] Among the most basic and commonly understood meanings of justice is fair, equitable, and appropriate treatment in light of what is due or owed to individuals and groups.[30]

Social justice captures the twin moral impulses that animate public health: to advance human well-being by improving health and to do so particularly by focusing on the needs of the most disadvantaged.[31] This account of justice has the aim of bringing about the human good of health for all members of the population.

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27. J. Michael McGinnis & William H. Foege, *Actual Causes of Death in the United States*, 270 JAMA 2207 (1993). The data in the McGinnis and Foege article were updated in Ali H. Mokdad et al., *Actual Causes of Death in the United States, 2000*, 291 JAMA 1238 (2004).

28. Ahmedin Jemal et al., *Trends in the Leading Causes of Death in the United States, 1970-2002*, 294 JAMA 1255, 1255 (2005) (describing age-standardized deaths from each of the six leading causes of death: heart disease, stroke, cancer, chronic obstructive pulmonary disease, accidents, and diabetes mellitus).

29. Dan E. Beauchamp, *Public Health as Social Justice*, *in* NEW ETHICS FOR THE PUBLIC'S HEALTH, *supra* note 24, at 101, 105.

30. *See* JOHN RAWLS, A THEORY OF JUSTICE (1971).

31. *See* Lawrence O. Gostin & Madison Powers, *What Does Justice Require for the Public's Health? Public Health Ethics and Policy Imperatives*, 25 HEALTH AFF. 1053, 1054 (2006).

An integral part of that aim is the task of identifying and ameliorating patterns of systematic disadvantage that profoundly and pervasively undermine prospects for well-being of oppressed and subordinated groups—people whose prospects for good health are so limited that their life choices are not even remotely like those of others.[32] These two aspects of justice—health improvement for the population and fair treatment of the disadvantaged—create a richer understanding of public health. Seen through the lens of social justice, the central mission of the public health system is to engage in systematic action to assure the conditions for improved health for all members of the population, and to redress persistent patterns of systematic disadvantage.

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

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

Social justice stresses the fair disbursement of common advantages and sharing of common burdens. Known as distributive justice, this form of justice requires that government act to limit the extent to which the burden of disease falls unfairly upon the least advantaged and to ensure that the burdens of interventions themselves are distributed equitably. Distributive justice also requires fair allocation of public health benefits. This principle might apply, for example, to the fair distribution of vaccines or antiviral medications during a public health emergency such as a pandemic influenza epidemic.[33]

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32. *See* MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY 72 (2006).

33. Lawrence O. Gostin, *Medical Countermeasures for Pandemic Influenza: Ethics and the Law*, 295 JAMA 554, 556 (2006); Lawrence O. Gostin, *Public Health Strategies for Pandemic Influenza: Ethics and the Law*, 295 JAMA 1700, 1703 (2006); Lawrence O. Gostin, *Public Health Preparedness*

Social justice demands more than fair distribution of resources. Health hazards threaten the entire population, but the poor and disabled are at heightened risk. For example, during the Gulf Coast hurricanes in 2005, state and federal agencies failed to act expeditiously and with equal concern for all citizens, including the poor and less powerful.[34] Neglect of the needs of the vulnerable predictably harms the whole community by eroding public trust and undermining social cohesion. It signals to those affected, and to everyone else, that the basic human needs of some matter less than those of others, and it thereby fails to show the respect due to all members of the community. Social justice thus encompasses not only a core commitment to a fair distribution of resources, but it also calls for policies of action that are consistent with the preservation of human dignity and the showing of equal respect for the interests of all members of the community.

These are the quintessential values of public health law—government power and duty, coercion and limits on state power, government's partners in the "public health system," the population focus, communities and civic participation, the prevention orientation, and social justice. To achieve the goals of population health under the rule of law requires sound legal foundations.

CONCLUSION: THE CHALLENGES FACED BY THE FIELD OF PUBLIC HEALTH

I have offered a definition of public health law, suggesting it has several core values: government responsibility for health, state power and restraint, partnerships in the public health system, population focus, community and civic participation, prevention orientation, and social justice. These are the challenges of public health law: Does it act modestly or boldly? Does it choose scientific neutrality or political engagement? Does it leave people alone or change them for their own good? Does it intervene for the common welfare or respect civil liberties? Does it aggressively tax and regulate or nurture free enterprise? The field of public health law presents complex tradeoffs and poses enticing intellectual challenges, both theoretical and essential, to the body politic.

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and Ethical Values in Pandemic Influenza, *in* THE THREAT OF PANDEMIC INFLUENZA: ARE WE READY? 357, 368 (Stacey L. Knobler et al. eds., 2005).

34. Jonathan D. Moreno, *In the Wake of Katrina: Has "Bioethics" Failed?*, 5 AM. J. BIOETHICS W18, W19 (2005).