CHAPTER FOURTEEN

Health Justice and the Future of Public Health Law

A community’s health is as much the result of institutional policies and practice as it is personal choice. Which communities have fresh, nutritious food? Where do governments allow dumping? Who is more often targeted by advertisers with unhealthy products? Which communities have state-of-the-art medical facilities? Which ones don’t?

All of these factors (or social determinants) are symptoms of the bias and privilege that shape virtually every aspect of our lives. It is no secret that across nearly every indicator of health status, poor people and people of color are more likely to be sick, injured, or die prematurely. . . . It will take organizing from the ground up; social change that transforms the current systems of neglect, bias, and privilege into systems—policies, practices, institutions—that truly support healthy communities for all. That’s health justice.

—The Praxis Project, 2014

Public health is typically regarded as a positivistic pursuit, and undoubtedly our understanding of the etiology and response to disease and injury is heavily influenced by scientific inquiry. Nonetheless, this book has been devoted to the core idea that law is essential for creating the conditions that enable people to lead healthier and safer lives. Law creates a mission for public health agencies, assigns their functions, and specifies the manner in which they may exercise their authority. In public health work, the law is a tool that is used to identify and respond to health threats, set and enforce health and safety standards, and influence norms for healthy behavior.
Social justice is at the heart of this work. Although protecting and promoting overall population health is vitally important, justice also demands action to reduce disparities in health. Gains in average life expectancy belie stagnant or worsening health outcomes for the poor and socially marginalized. A social justice approach to public health demands that society embed fairness into the environment in which people live and that it allocate services equitably, with particular attention to the needs of the most disadvantaged.

The essential job of public health agencies is to identify what makes people healthy and what makes them sick, and then take the steps necessary to ensure that the population encounters a maximum of the former and a minimum of the latter. At first glance, this task would seem to be uncontroversial, but protecting the public’s health and reducing health disparities create fundamental social and political disputes almost by definition. Public health is rooted in the biomedical and social sciences, but from the moment of asserting some collective responsibility for the population’s health, officials have to manage a complex political process and operate with finite resources. Public health agencies, in particular, confront well-financed political opposition and face inherent problems of legitimacy and trust. These are not barriers to good public health that somehow can be overcome by law. They are, rather, unavoidable conditions of public health, conditions with which agencies must find ways to cope.

Public health has always been politically controversial. And public health law—which concerns the extent of government authority to intervene to protect the public’s health—lives in the thick of this controversy. In recent decades, as public health science, practice, and law have expanded to tackle noncommunicable disease threats, injuries, the social determinants of health, and health disparities, the political controversy over public health has grown. This chapter offers brief concluding reflections on the public health field and its inescapable connection to politics and government in a constitutional democracy.

**HEALTH DISPARITIES**

Health and the social distribution of health function as a kind of social accountant. So intimate is the connection between our set of social arrangements and health that we can use the degree of health inequalities to tell us about social progress in meeting basic human needs.

Deep and enduring socioeconomic inequalities form the backdrop to any public health policy, and these disparities help explain why social justice is a core value of public health. Poverty, inferior educational opportunities, unhygienic and polluted environments, social disintegration, and other causes lead to systematic hardships in health and in nearly every other aspect of social, economic, and political life. Prevailing inequalities beget other inequalities, which is one major reason that those who are already disadvantaged suffer disproportionately from health hazards.

Over the last few decades, life expectancy has increased dramatically among people in the top half of the income distribution while remaining nearly flat among those in the bottom half, and even declining among women in many parts of the United States. Average life expectancy can vary by as much as twenty-five years between neighborhoods just a few miles apart. African-Americans are eight times more likely to be diagnosed with HIV, twice as likely to die within the first year of life, and 50 percent more likely to die prematurely of heart disease or stroke than their non-Hispanic white peers. Black children are about 1.6 times as likely to be diagnosed with asthma than their peers, and they are six to seven times as likely to die of resulting complications. Hispanic women are 1.6 times as likely as non-Hispanic white women, and people living in poverty are about twice as likely as those with higher incomes, to be diagnosed with diabetes.

Some of these disparities are caused by unequal access to health care. Explicit, implicit, and structural biases continue to shape the health care experiences of racial and ethnic minorities and other socially and economically disadvantaged people. People of color, people with disabilities, and people with limited means are less likely to have health insurance coverage and less likely to receive needed medical care even if they do have coverage. The quality of care that they receive tends to be lower, they are subject to higher rates of medical error, and their health outcomes suffer as a result. Recent efforts to make reduction of health disparities a priority for federal agencies, which include development of the National Partnership for Action to End Health Disparities, its National Stakeholder Strategy for Achieving Health Equity, and the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, focus largely on addressing disparities in access to and quality of health care.

But significant health disparities persist even in places where there is universal access to health care. Safe working conditions, safe housing
free from community violence and toxins like lead and radon, clean air and water, healthy food, and improved sanitation are more powerful drivers of health than access to health care. Many of the “causes of the causes” of poor health and premature death are linked to household income, formal education, race and ethnicity, and neighborhood. The population perspective of public health and the “health in all policies” approach to action on the social determinants of health are more responsive to social justice concerns than a narrow view focusing on health care access and quality.

**Social Justice as a Core Value of Public Health Law**

Public health must go “back to the future” and integrate power and agency into our models for promoting the public’s health. History sensitizes us to the interplay of the varied social, political, and economic forces that positioned public health at different moments in time, regardless of the areas of responsibility the field claimed. History demands that we understand not only the forces that shaped public health action in the past but also the current forces that will shape the potential and limits of what we can do as professionals committed both to science and to its application.


The ideal of social justice is a core value of public health and is foundational to our conception of public health law. We define social justice as
a communitarian approach to ensuring the essential conditions for human well-being, including redistribution of social and economic goods and recognition of all people as equal participants in social and political life. Like public health practice, social justice is, by its nature, politically charged.12

The Community Orientation
The choice of the term social justice reflects “the idea that all developments relating to justice occur in society” and “the related desire to restore the comprehensive, overarching concept of the term ‘social,’ which in recent times has been relegated to the status of an appendix of the economic sphere.”13 It is inherently communitarian in its “attention to what is often ignored in contemporary policy debates: the social side of human nature; the responsibilities that must be borne by citizens, individually and collectively, in a regime of rights; the fragile ecology of families and their supporting communities; the ripple effects and long-term consequences of present decisions.”14 Social justice firmly rejects the libertarian view of society as “an aggregation of individuals for whom the meaning of freedom is choice within the scarcity of each person’s ‘own’ resources.”15 In contrast, social justice views assurance of the essential conditions for human well-being as the legitimating purpose of government.

Civic Participation
Among the most basic and commonly understood meanings of justice is fairness or reasonableness, especially in the ways people are treated and decisions affecting them are made. Justice stresses fair disbursement of common advantages and the sharing of common burdens. But it also goes further by demanding equal respect for and recognition of all members of the community as full and equal participants in social interaction and political life.16 Experience has shown that community engagement at every stage of public interventions—from the initial assessment of health needs to the ultimate evaluation of an intervention’s impact—promotes effective public health practice.17

The dual goals of redistribution (which emphasizes material outcomes) and recognition (which emphasizes process, participation, respect, and identity) threaten to pull public health in opposing directions. But they can and should function as complementary strains of the
social justice approach, allowing for advocacy strategies that combine a “cultural politics of identity” with a “social politics of equality,” promoting just distribution of economic and social goods rooted in participatory parity. Social justice requires action to preserve human dignity for all, particularly for those who suffer from systemic disadvantage.

Social justice and health disparities in three recent movements

Reproductive Justice analyzes how the ability of any woman to determine her own reproductive destiny is linked directly to the conditions in her community—and these conditions are not just a matter of individual choice and access. . . . Moving beyond a demand for privacy and respect for individual decision making to include the social supports necessary for our individual decisions to be optimally realized, this framework also includes obligations from our government for protecting women’s human rights.


Three recent social movements—environmental justice, reproductive justice, and food justice—have adopted health disparities as a central focus. Each has emerged as a critique from within a progressive project. The environmental justice movement originated as a civil rights–based critique of the process and outcomes of environmental protection. The reproductive justice movement began as a critique by women of color within the prochoice movement. And the food justice movement emerged in response to concerns about elitism in the alternative food movement, which seeks to reform industrial food production. In each case, the response has involved particular attention to the wide-ranging impacts of income inequality and white privilege, with eventual expansion to address other issues of bias and structural advantage such as ableism, privileged gender expression, heteronormativity, and nativism.

Environmental Justice

Galvanized by controversy over the location of waste and industrial sites in predominantly black communities, the environmental justice movement emerged in the 1980s as a response to environmental racism. Its focus is more expansive than that of the environmental protection movement. Posing crucial questions about “how individual events reflect broader historical and societal inequities,” the move-
ment emphasizes just distribution of environmental risks and benefits and recognition of socially marginalized groups in related decision-making processes. Together, the sustainability and environmental justice movements “guard against the risk of ‘tunnel vision’: one-dimensional environmental policymaking that fixates on a single goal . . . without considering or addressing broader implications.”

The relationship between environmentalism and environmental justice is not entirely harmonious. “Since at least the early 1990s, activists from the environmental justice movement consistently have criticized what they consider the ‘mainstream’ environmental movement’s racism, classism, and limited activist agenda.” In their efforts to probe the influence of elitism on mainstream environmentalism, environmental justice advocates raise difficult questions about the appropriate role for lawyers and other experts in defining the movement’s priorities and strategies. They have also grappled at length with the tension between the distributive and participatory commitments of social justice. Especially in cases where Native American tribal governments have opted to allow environmentally hazardous operations within their jurisdictions, legal scholars have struggled to conceptualize and implement the environmental justice movement’s commitment to procedural justice and self-determination for socially disadvantaged communities.

The environmental justice framework has had significant influence at the federal level. A 1994 executive order from President Bill Clinton directed all federal agencies, not merely the EPA, to incorporate the achievement of environmental justice into their missions by “identifying and addressing . . . disproportionately high and adverse human health or environmental effects of [their] programs, policies, and activities on minority populations and low income populations.”

The articulation of environmental justice in terms of disproportionate “human health or environmental effects” would arguably encompass all health disparities. Indeed, the Interagency Working Group created by Clinton’s executive order and reconvened by the Obama Administration in 2010 has, at times, interpreted the “environmental” part of environmental justice quite broadly to encompass “greater access to health care, clean air and water, healthy and affordable food, community capacity building through grants and technical assistance, and training to educate the health workforce about environmentally associated health conditions.”

DHHS strategies developed pursuant to Executive Order 12898 frequently reference the agency’s broader efforts to increase access to
health care, healthy food, and healthy living conditions, but with an emphasis on how those efforts are particularly relevant to the narrower environmental justice project of “reducing the health disparities that may result from disproportionate exposures to environmental hazards in minority and low income populations and Indian Tribes.” For example, DHHS officials emphasize national objectives in traditional environmental protection areas like air and water quality and hazardous waste disposal. EPA officials recognize that “addressing environmental health disparities through the lens of EPA is touching the tip of the iceberg[,] populations that experience health disparities related to other social determinants of health, such as access to health care and access to healthy foods, tend to be the same populations that live in communities overburdened with environmental pollution.” The fact that the environmental justice work of federal agencies is broad-based and cross-cutting is fortuitous for the future of public health law.

Reproductive Justice

The reproductive justice movement represents a transformation of the prochoice agenda into a much broader effort to protect and promote “the right to have children, not have children, and to parent the children we have in safe and healthy environments.” Loretta Ross, a key figure in the reproductive justice movement, traces its roots to the 1994 International Conference on Population and Development in Cairo, which “was explicitly given a broader mandate on development issues than previous population conferences, reflecting the growing awareness that population, poverty, patterns of production and consumption and the environment are so closely interconnected that none of them can be considered in isolation.” The program of action that arose out of the Cairo meeting recognized reproductive health as a human right and recognized gender equality, women’s empowerment, and equal access to education for girls as priorities for sustainable development.

Access to health care—not merely as a matter of ensuring women’s right to choose contraception or abortion, but as a matter of providing access to a wide range of affordable, culturally appropriate health services for women and families—is a priority issue for the reproductive justice movement. Additionally, reproductive justice advocates’ emphasis on “safe and healthy environments” for raising children encompasses access to clean air and water and safe and healthy food as well as health care, housing, education, employment, and other essential needs.
Food Justice

The food justice movement arose out of the confluence of environmental justice and the alternative food movement.41 The influential food writer Michael Pollan has said that the alternative food movement is “unified as yet by little more than the recognition that industrial food production is in need of reform because its social/environmental/public health/animal welfare/gastronomic costs are too high.”42 Critics soon noted, however, that “with its focus on farmers’ markets and a do-it-yourself avoidance of processed food . . . many of the [alternative] food movement’s goals . . . seem aimed at those with disposable income and disposable time.”43 In contrast, the food justice movement “focuses on the barriers that low income or otherwise marginalized groups face in realizing the goals of the broader food movement, such as access to fresh, unprocessed food.”44

Noting that “communities of color have long faced disproportionate rates of cancer, diabetes, and illnesses associated with lack of access to nutritious food and other forms of environmental racism,” many food-justice advocates put health disparities front and center, describing the movement as arising from “a deepening community health crisis.”45 Similarly, Just Food (a nonprofit organization devoted to “building a just and sustainable food system” for New York City) defines food justice in terms of “communities exercising their right to grow, sell, and eat healthy food.”46 The group goes on to define healthy food in a way that extends beyond a narrow conception of physical human health: “Healthy food is fresh, nutritious, affordable, culturally appropriate, and grown locally with care for the well-being of the land, workers, and animals.” The group also emphasizes the benefits of “people practicing food justice” in terms of “a strong local food system, self-reliant communities, and a healthy environment.” On the other hand, food justice advocates “almost never speak in terms of obesity, though some commentators see that as one underlying motivator. They speak instead about rights, equality, community empowerment, cultural appropriateness, and, of course, justice.”47

An Emerging Movement: Health Justice

The question of health-care reform in America, including politically acceptable and fair health-care rationing, is ideologically leveraged. If we find, after all the fuss, that politically we can’t do much to make the distribution of medical care more just, in spite of the apparent present opportunities to do so, then a pessimistic conclusion may be irresistible: we may abandon hope for any more widespread or general democratic concern for social justice. But if we do now make
substantial and recognizable political progress in this one urgent mat-
ter, we may learn more, from the experience, about what justice itself
is like, and we might find it to our taste, so that we can steadily, bit
by bit, incrementally, fight the same battle in other areas. . . . Health
might not be more important than anything else—but the fight for
justice in health might well be.
— Ronald Dworkin, “Justice in the Distribution of Health
Care,” 1993

Political philosophers and ethicists have begun a productive discussion
of the multifaceted relationship between health and social justice, which
ranges far beyond individual patient rights and allocation of health care
resources to focus on collective needs and problem solving with respect
to the social determinants of health.48 At the same time, a growing
number of nonprofit organizations are pursuing ambitious and wide-
ranging aims within an emerging health justice framework. For exam-
ple, the Praxis Project, a nonprofit company that supports community
organizers, situates its work with environmental and food justice groups
and those committed to health care access under the label of health
justice. Praxis defines health justice broadly, with an emphasis on the
social determinants of health, fighting cultural bias, and promoting
health at the community level.

The health justice framework unites the science and politics of public
health. It cuts across long-standing divisions in public policy, integrating
health care and population health priorities to meet the needs of the public
and reduce health disparities. It emphasizes social, economic, cultural, and
political inequalities not to despair over them, but rather to attack them
with the power and agency that emerge when science, law, and politics are
recognized as inextricably intertwined. Health justice demands an exami-
nation of the influence of social bias and structural advantage on interven-
tions aimed at reducing health disparities, particularly measures that
adopt an individualistic, victim-blaming approach. Interventions to reduce
health disparities should maximize community engagement and empow-
ernent. Scientific expertise, community knowledge, and shared values can
and must be united as advocates and experts face the many political, legal,
and cultural challenges that stand in the way of health justice.

THE CHALLENGES: PUBLIC HEALTH,
POLITICS, AND MONEY

From my perspective, as a White House official watching the
budgetary process, and subsequently as head first of a health care
financing agency and then of a public health agency, I was continu
ally amazed to watch as billions of dollars were allocated to financing medical care with little discussion, whereas endless arguments ensued over a few millions for community prevention programs. The sums that were the basis for prolonged, and often futile, budget fights in public health were treated as rounding errors in the Medicare budget.


While few dispute the basic goal of reducing health disparities, lawmakers, judges, scholars, and the general public are deeply divided over the most appropriate means for doing so. Sharp disagreement over our increasingly collective approach to health care financing is spilling over into a national conversation about personal versus public responsibility for health, in which political ideology and cultural biases threaten to overwhelm scientific inquiry and commitments to social justice.49

The ability of public health authorities to attract support is essential to their success, for, as its daily practice reminds us, public health operates in a world of choices in the allocation of limited resources. The great sanitarian Herman Biggs famously remarked that “public health is purchasable,” but because there will always be limits on how much we are willing to buy, public health will always turn on allocational decisions.50 Under these conditions, apathy toward the needs of the least advantaged threatens to widen existing health disparities. Thus the field of public health is as inherently political (i.e., concerned with the distribution of resources in society and addressing the social determinants of health disparities) as it is technological (concerned with the deployment of scientific knowledge).

One might assume that attracting public and financial support would not be difficult given the undoubted communal benefits of health. But the condition of public health is one of paradox. Although most people support a high level of public health, fewer are eager to pay for it. Public health officials have enormous legal power, yet they often cannot exercise it for political, cultural, or practical reasons. The public cares passionately about health threats, but that passion is often not proportional to the magnitude of the risk. The measures that will provide the most societal benefit often provide little or no discernible benefit to any one person, and vice versa. Although there is a virtually bottomless purse for the medical treatment of illness, it appears there is little in the budget to prevent it or, more generally, to ensure the conditions in which people can be healthy.

Even within the relatively modest budgets devoted to public health, there remain hard choices. Public health officials are inevitably faced
with the need to divide a small pie among many worthy competitors for resources. Injuries, HIV, emerging infectious diseases, bioterrorism, chronic diseases, child and maternal health, and many other priorities are, in some sense, in competition for prevention resources. Difficult decisions must be made about the most effective allocation of funds. Thus, rationing—a controversial notion in medicine—is, in public health, a "moral imperative . . . in the face of scarce resources."51

Additionally, public health officials increasingly face opposition from well-financed and politically powerful interests. Criticism of modern public health law is to some extent inevitable: as Roger Magnusson observes, “The use of law as a policy tool to respond comprehensively to environmental exposures, unhealthy lifestyles, and accidental injuries threatens to impinge on the interests of a wide variety of industries, and to significantly expand sites for state intervention."52 By extending the reach of public health law beyond the traditional domain of infectious disease to the social and economic influences of infectious and noncommunicable disease and injuries, social epidemiologists have inquired into causal connections between ill health and such powerful institutions as tobacco companies, industrial polluters, firearm manufacturers, industrial agriculture, beverage companies, and fast food chains.

LEGITIMACY AND TRUST AT RISK

In democratic social orders, the formation of science policy is an ethical and political process. . . . Policy formation . . . include[s] contestable judgments, the search for credibility and legitimation, the marshalling and critique of evidence, and often rhetorical appeals to the public good.


Social justice demands more than fair distributions of benefits and burdens. Failure to engage community groups with diverse needs and interests harms the whole community by eroding public trust and undermining social cohesion. Public health agencies rely heavily on voluntary cooperation by those at risk of harm and the support of the population at large. Consequently, they must appear credible in the advice they render and trustworthy in their practices. Despite its importance, agencies face considerable challenges in maintaining public confidence both because they are organs of government and because, by necessity, they are engaged in a highly political process.

Public health agencies are fixtures of public administration, part of the structure of government since the earliest times of the Republic. As such,
they face the daunting task of ensuring the conditions required for people to be healthy while bearing the burden of antigovernment sentiment: generalized mistrust, doubts about efficiency and efficacy, and fear of oppression. If the public perceives health officials simply as the tool of an overreaching government captured by special interests, their ability to engage collaboratively with communities and earn their support is compromised. Likewise, public health measures are subject to general legal limitations on government activity and to prevailing attitudes about the sorts of things government ought to do. This dynamic can be seen in multiple public health activities characterized as interference by the “nanny state”—e.g., laws mandating the use of seat belts and motorcycle helmets, fluoridation of public water supplies, smoking bans in public places, and healthy eating initiatives. Many disputes in public health turn less on its goal, which everyone professes to support, and more on the proper scope of government intervention to achieve it.

Health officials and experts must maintain scientific rigor while engaging effectively in the political process, and these aims sometimes appear to conflict. To maintain legitimacy and public trust, public health authorities rely on expert scientific knowledge. Scientific decisions are thought to be more objective and systematic and less captive to political ideology. Health officials know that this expertise gives them the authority and the ability to convince. Yet to be effective, health officials must also be willing to embrace and excel in the political process. Many fear that this political involvement risks weakening the impression of professional neutrality and expertise from which health officials draw their public credibility.

Are the science and politics of public health in conflict? Can the public’s trust be ensured only if health agencies and experts remain within the cramped confines of the “basic six” public health functions—collecting vital statistics; controlling communicable disease; sanitation; laboratory services; maternal, infant, and child health services; and health education? If so, then public health must resign itself to ineffectiveness and irrelevance.

While health officials fret over the effect of politicization on the authority derived from their scientific expertise, that authority is already waning among those who distrust mainstream science. Critics across the political spectrum call the validity of scientific evidence into question. Counterintuitively, distrust of science with regard to some issues—especially vaccination, fluoridation, and genetic engineering of foods and medicines—is highest among those who have higher household incomes and more formal education.
Frustrated by the lack of individual control over such hazards as air, water, and soil pollution, many people become irrationally concerned with ensuring the “naturalness” of the products they can control. The fetishization of “natural” foods, household products, and medical therapies and rejection of seemingly “unnatural” interventions like water fluoridation, vaccination, antimicrobial drugs, and sunscreen is linked to justifiable fears about toxic exposures but reflects irrational thinking about priorities and scientific evidence.

The public’s trust in scientific expertise is undermined by perceived conflicts of interest. Antivaccination crusaders accuse provaccination experts of being shills for the pharmaceutical industry and ignore volumes of scientific evidence on the grounds that it is all biased. Similar accusations are made against proponents of sunscreen use, water fluoridation, and the potential for genetic engineering to generate solutions to pressing health problems. As Michael Specter has observed, “Denialism couldn’t exist without the common belief that scientists are linked, often with the government, in an intricate web of lies. When evidence becomes too powerful to challenge, collusion provides a perfect explanation.” Health justice demands recognition of public values and concerns, even—perhaps especially—when they conflict with orthodox expertise.

Health justice also requires recognition, participatory engagement, and voice for historically underrepresented groups. This insistence on participatory parity may generate tension over the appropriate role for lawyers, scientists, and other formally educated experts, as it has in the environmental and reproductive justice movements. In some cases, law and policy interventions to serve the interests of the poor and disenfranchised may conflict with the autonomy of those groups to choose other approaches that might be disfavored by experts. Striking the balance between the substantive and procedural commitments of social justice is challenging, but it is crucial to successful public health strategies.

Efforts to ensure access to health care and healthy living conditions must be firmly rooted in community engagement and participatory parity. The processes of “public participation and deliberation in political decisions and social choice [are] a constitutive part of public policy.” They “are crucial to the formation of values and priorities, and we cannot, in general, take preferences as given independently of public discussion.”

Many of the most effective public health measures are pioneered at the local level. Although local government is typically associated with
greater democratic accountability and civic engagement, in the case of many recent healthy eating and tobacco control measures, there has been a deliberate attempt to eschew political accountability in favor of decisions by insulated experts. Mayor Michael Bloomberg explicitly framed New York City’s pioneering public health law interventions as efforts to reduce health disparities. These measures threaten the interests of politically powerful industries, and for that reason it is perhaps entirely understandable that Bloomberg pursued them through the New York City Board of Health, which is far more insulated from political pressure than the directly elected city council. On the other hand, public health, local government, and administrative law scholars have been critical of the antidemocratic nature of Bloomberg’s strategy. For example, Wendy Parmet has recently suggested that popular backlash against Bloomberg-style interventions might be better understood as resistance to expert opinion in favor of the democratic process, rather than opposition to paternalism.

Pursuing substantive reforms believed to be in the interests of the poor without recognizing affected community members as full participants in a collaborative problem-solving process may remedy distributive injustices, but it perpetuates and exacerbates failures of respect and recognition. Bloomberg’s public health legacy raises important and difficult questions about how best to reconcile the substantive and procedural aims of social justice.

THE PROBLEM OF FRAMING

People must take responsibility for their own lives. They must recognize that the pose of helplessness is not just detrimental to their individual dignity, it also saps them and their communities of the spirit of enterprise that makes a healthy and vibrant society. The real epidemics threatening Britain today are not smoking or obesity; they are passivity, the culture of victimhood and stifling government paternalism.

— The Times (London), 2004

Under the Affordable Care Act, the health care system is shifting away from “actuarial fairness” (whereby each individual pays according to the likelihood that he or she will require services) toward a “mutual aid” approach (all individuals pay rates determined at the community level, contributing toward a common pool of resources to provide care for those who need it). This shift toward a more collective approach to health care financing has generated increased public interest in the
root causes of poor health. When health care costs affect society as a whole, we share a common interest in prevention.

There is major disagreement, however, over whether the root causes of poor health are a matter of collective responsibility or personal responsibility. On the one hand, social epidemiology suggests that social, economic, and environmental factors are the true “causes of the causes” of death, disease, and disability, demanding collective action to regulate commercial activities that are harmful to the public’s health and ensure social support for basic human needs. On the other hand, measures that put the onus on individuals to change their behaviors, without necessarily making it more feasible for them to do so, are far more politically palatable. Many of the most important drivers of death and disability—cancer, heart disease, injuries, diabetes, and stroke attributable to tobacco use, alcohol and drug abuse, unhealthy eating, and physical inactivity—are constructed as matters of individual choice and personal responsibility. In the popular imagination, these behaviors are divorced from their social bases.

Our collective inability to overcome the stubborn persistence of health inequalities reflects deep ambivalence about efforts to reduce disparities. The cultural and political resonance of arguments against the “nanny state” and in favor of personal responsibility is readily apparent. These arguments are fueling political opposition to law and policy interventions (such as soda taxes); legal challenges aimed at striking down newly enacted public health laws (such as tobacco and portion-control regulations); the failure of public health litigation (such as lawsuits against the firearms and fast food industries); and efforts to roll back long-standing public health interventions (such as water fluoridation).

The attribution of ill health to personal responsibility is intimately connected to deep-seated cultural biases. Viewing the other person’s poor health as the consequence of internal, controllable causes—rather than sheer chance—is comforting. Attribution of illness to individual failings “serves a symbolic, or value expressive function . . . , reinforcing a world view consistent with a belief in a just world, self determination, the Protestant work ethic, self-contained individualism, and the notion that people get what they deserve.” People like to think of themselves and others as autonomous agents making fully informed, independent judgments. Blaming other people for their own problems makes it easier to make sense of the world, justifying complacency in the face of overwhelming human needs.
Health justice demands collective responsibility for health rather than individualistic, behavior-based interventions. “Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victims. These behavioral explanations for public problems tend to protect the larger society and powerful interests from the burdens of collective action, and instead encourage attempts to change the ‘faulty’ behavior of victims.”68 Personal responsibility interventions to discourage unhealthy behaviors through individually targeted incentives and penalties are counter to the communitarian commitment of social justice. The health justice framework demands more rigorous attention to these issues. Scholars and lawyers have an obligation to probe proposed interventions ostensibly aimed at reducing health disparities for evidence of social and structural biases. Even well-intentioned public health officials may sometimes neglect the disadvantaged and propose interventions that exacerbate underlying inequalities.

Moving forward in the face of the backlash against the “nanny state” and apathy toward the plight of the socially disadvantaged will require a reframing of public health action in controversial areas. Public health has a proud tradition of promoting equity and justice. It should not surrender the moral high ground to industry groups casting themselves as defenders of individual liberty. What is needed is a salient, culturally resonant vision of communities coming together to create healthier living conditions.69 Government is not an external force: it is how “we the people” achieve collectively what we cannot achieve individually. Some interventions may ultimately prove to be unwise from a policy standpoint, but to kill innovative local government experiments in their infancy, to block the will of the people expressed through the democratic process based on a counter-majoritarian protection of commercial interests, would be a tragic loss for the health of the republic.

We are undoubtedly making gains, especially on access to health care. Many of the interventions being proposed and deployed in the name of reducing health disparities are encouraging from a social justice standpoint. But as the public health ethicist Dan Beauchamp has cautioned, “As long as these actions are seen as merely minor exceptions to the rule of individual responsibility, the goals of public health will remain beyond our reach.”70 The health justice framework offers a powerful critique of the ways in which dominant norms about fairness, emphasizing “just deserts,” shore up a narrow vision of health that is
dominated by the health care industry, an impoverished vision of community as the aggregation of quasi-contractual relationships between autonomous and atomized individuals and their exogenous social environment, and a lopsided vision of reform as driven by privileged experts who fail to engage meaningfully with the communities they purport to serve.

THE FUTURE OF PUBLIC HEALTH LAW

Either the social epidemiologists’ contention that socioeconomic disparities are a primary factor in causing good public health is accurate, or it is not . . . [I]f socioeconomic disparities are truly productive of public health, policies consistent with the narrow model [of old public health], which by definition do nothing to ameliorate social conditions, will do little to actually improve health in the aggregate. . . . If public health practice is not intended to facilitate the public’s health, it is unclear what use such a practice has and why public monies should be forthcoming to support it.


In this book, we have sought to provide a fuller understanding of the varied roles of law in advancing the public’s health. The field of public health is purposive and interventionist. It does not settle for existing conditions of health but actively seeks effective techniques for identifying and reducing health threats. Law is a very important, and increasingly recognized, tool in furthering the public’s health. Public health law should not be seen as an arcane, indecipherable set of technical rules buried deep within state health codes. Rather, it should be seen broadly as the authority and responsibility of government to assure the conditions for the population’s health. As such, public health law has transcending importance in how we think about government, politics, and policy.

Critics of public health efforts to address noncommunicable diseases and the social determinants of health begin from the proposition that, regardless of the validity of social epidemiology as a scientific matter, it does not necessarily follow that state authority to intervene “under the banner of public health” should be expansive. They stress the need “to more clearly differentiate between public health analysis and public health authority,” arguing that “public health law is much more limited than public health science.”

In a subtle but fundamental way, the division between science and law championed by these critics would also disconnect public health
from the social justice mission that has been integral to its disciplinary identity for centuries. We agree that scientific inquiry to describe the causes and patterns of health conditions at a population level should aim for neutrality. But eliminating threats to public health involves multiple activities that are far from being exclusively within the domain of either law or science. The demarcations among science, practice, policy, and law are inherently blurry. It is not possible for the science of public health to exist in a vacuum. The questions it seeks to answer (and the answers it eventually provides) are informed by practice, policy, and law. The identification of causal pathways is intimately tied to developing and evaluating potential interventions within them. The practice of public health is useless unless it is informed by science and guided by policy. And public health policy easily blends into the law, which is its expression.

Law is a vitally important determinant of population health. The interplay among law, social norms, cultural beliefs, health behaviors, and healthy living conditions is complex. To limit the scope of public health law to the control of proximal determinants of infectious diseases, to cut off the law and policy of public health from the advances of health science and practice, would be utterly unjustifiable in the face of so much preventable death, disability, and disparity. The push to limit public health law's scope is deeply counter-majoritarian and undemocratic, threatening to disable communities from undertaking measures to improve their own wellbeing.

We reject the critics' contention that public health science should (or even could) be cut off from its social justice mission, but we do believe their fundamental concern is a valid one. Designating a concern as a public health threat has important legal consequences. To the extent that the public interest is invoked as a liberty-limiting principle, it should be thoughtfully defined and theorized. While government has responsibility to assure the conditions for health, at times, public health has overreached, failing to consider the full range of concerns and interests of the public it seeks to protect.

Communities may rightly weigh ends and values other than health differently than public health experts would. In this regard public health advocates could take a page from the environmentalists' book. As Douglas Kysar puts it: “Environmental law must form part of the social glue that binds a political community together in pursuit of long-term and uncertain goals. To serve that function, in turn, laws must have continuity with the concepts, values, and discourses expressed by real
people.” Public health law, likewise, should strive to reflect community engagement.

This objective leads to one of the most complicated problems in the field, which is how to balance the collective good achieved by public health regulation with the resulting infringements of individual rights and freedoms. The difficult trade-offs between collective goods and individual rights form a major part of the study of public health law. Civil liberties, including free speech, have intrinsic value for libertarians and progressives alike—and they play an important role in promoting public health.

Public health, like the law itself, is highly political, influenced by strong social, cultural, and economic forces. As these forces shift over the years, as different political ideologies and economic conditions take hold, the field of public health will change and adapt, as it has always done. It will continue to provide intellectually enticing and socially important terrain for scholars and practitioners to explore.

John Ruskin, a nineteenth-century British scholar whose work ranged from art history, literary criticism, and mythology to the pervasive health hazards of the industrial economy, captured better than most the essential message of this book: “I desire, in closing the series of introductory papers, to have this one great fact clearly stated. There is no wealth but life. Life, including all its powers of love, of joy, and of admiration. That country is the richest which nourishes the greatest number of noble and happy human beings; that man is richest, who, having perfected the functions of his own life to the utmost, has also the widest helpful influence, both personal, and by means of his possessions, over the lives of others.”