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Introduction to Public Health Law

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Abstract and Keywords

This chapter provides an overview of public health law. In contrast to healthcare law, public health law seeks to protect health at a broad population, as opposed to an individual patient, level. The field of public health emphasizes prevention and health promotion, as opposed to the treatment of disease. The chapter looks at three critical areas of public health law: communicable disease control, the control of noncommunicable diseases, and efforts to address the social determinants of health. While the United States and Europe face broadly similar questions, the answers given often differ. In part, this is because the European Union is for the most part a supranational organization, while the United States is a more integrated, albeit federal, nation state. In addition, important distinctions between the legal traditions and the value given to individual liberty versus the public good provide a focus of the comparison between the US and European approaches to public health.

Keywords: public health law, public health, health promotion, communicable disease control, noncommunicable diseases, United States, Europe, European Union, individual liberty, public good

PUBLIC health laws are among the most ancient health laws. Long before states had complex healthcare financing systems or regulated pharmaceuticals and medical technologies, they enacted laws designed to stem fearsome epidemics and protect their populations from the more common diseases that plagued the pre-modern era.¹ Over the past 150 years, as medical knowledge has increased and healthcare systems have grown in terms of cost and complexity, public health law has often been overshadowed by other areas of health law. That may now be changing. In the face of emerging infectious diseases, such as SARS, Ebola, and COVID-19, and a growing appreciation of the critical role that social, environmental, and economic forces play in shaping public health, policymakers and scholars have begun to pay increasing attention to the theoretical foundations of, ethical justifications for, and scope of public health laws.

In the three paired chapters that follow, we focus on three critical areas of public health law: communicable disease control, the control of noncommunicable diseases (NCDs), and efforts to address the social determinants of health. In each set of paired chapters,

we follow a common structure and consider the US perspective on the one side and the European perspective on the other. The analyses that emerge from these chapters, which were written before COVID-19 overtook much of the globe, reveal that legal systems on either side of the Atlantic face broadly similar questions. These include: What is the appropriate scope of public health law? How should responsibility be divided between centralized and more localized authorities? What circumstances justify the limitation of individual liberty to protect public health? How should governments regulate in the face of scientific uncertainty? And, what protections should be in place to prevent public health laws from targeting vulnerable individuals and populations?

(p. 70) Yet while the questions raised on either side of the Atlantic are common, the answers given often differ. In part, this is because the European Union is for the most part a supranational organization, while the United States is a more integrated, albeit federal, nation state. In addition, important distinctions between the legal traditions and the value given to individual liberty versus the public good provide a focus of our comparison between the US and the European approaches to public health.

The following discussion offers a brief introduction to the key issues and themes presented in the paired chapters. We begin by shedding some light on the broad definition of public health law. We also explicate what we are referring to when we discuss “Europe” in the chapters that follow. We then provide a short preview of some of the key themes in each paired set of chapters.

1 What Is Public Health Law?

There is no authoritative definition of public health law. In a recent report for the World Health Organization (WHO), Roger Magnusson explains that “the concept of public health, as understood in this report, is not restricted to laws that regulate the provision of health care services, but includes the legal powers that are necessary for the State to discharge its obligation to realize the right to health for all members of the population.”² Taking a somewhat different tack, Richard Goodman and colleagues from the US Centers for Disease Control and Prevention (CDC) define public health laws as including “any laws that have important consequences for the health of a defined population.”³ Both of these definitions accept that public health laws are laws that affect health and are not limited to those that regulate the care, financing, or organization of clinical health services. Instead, public health laws encompass a wide array of laws that impact the health of populations, including traditional infectious disease control laws, such as quarantine or vaccination laws; environmental laws; and laws that regulate food safety, to give just a few examples. The focus on impact also holds true for Micah Berman, who writes, “[p]ublic health law is the study of the legal powers and duties of the state to identify, prevent, and ameliorate risks to the health of populations, as well as the study of legal structures that have a significant impact on the health of populations.”⁴

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In their influential treatise, US scholars Lawrence O. Gostin and Lindsay F. Wiley accept the idea that public health laws relate to the health of populations and not just the provision of clinical care. They also observe that public health law recognizes other (p. 71) important interests, including individual liberty and social justice.⁵ Likewise, in Europe, Tamara Hervey and Jean McHale adopt a broad definition in which public health is seen as “an almost impossibly wide concept,” which encompasses environmental law (e.g., air and water quality), welfare law (e.g., social security, social care, and education), consumer protection, and many more.⁶ This breadth is reflected in the “Health in All Policies” recommended by the US CDC or “mainstreaming” obligation requiring the EU to ensure a high level of public health protection in the development and implementation of all its policies.⁷

In the three chapters that follow, we embrace these broad and implicitly normative definitions. The discussions recognize that public health law, in contrast to healthcare law, seeks to protect health at a broad population, as opposed to an individual patient, level. They also acknowledge that the field of public health emphasizes prevention and health promotion, as opposed to the treatment of disease. However, as the definition by Goodman and colleagues implies with its reference to laws that have important *consequences* for health, the impact of public health laws is not always positive: they may fail to have the impact that lawmakers seek, or they may be misguided, even deleterious, to population health.

In addition, as Gostin and Wiley suggest, we accept that the field of public health *law*, to which we hope these chapters are a contribution, is broader than a study of public health laws themselves. Instead, the field and the discussions that follow, seek to understand not only public health laws, but also the larger questions of how states can assure the conditions by which people can be healthy while respecting other critical human rights and values within their constitutional structures and adhering to the rule of law. As we shall see, both the United States and Europe grapple with these tensions, even as they often adopt different answers.

Before turning to the overview of the three chapters that follow, it may be worth clarifying—particularly for readers who are not familiar with European governance—what we mean by “Europe.” We have, so far, used the term loosely to distinguish Europe from the United States, which together constitute the focus of this book. However, the term “Europe” is somewhat misleading in that, depending on how it is used, it can refer to different realities. For our purposes, three different organizations should be noted. First, the WHO regional office for Europe (WHO EURO) operates in 53 countries, covering a population of around 900 million people. As one of six WHO regional offices around the world, WHO EURO has published a series of regional action plans, technical guidance, and recommendations, and it supports the development, implementation, monitoring, and evaluation of effective public health policies, including public health (p. 72) laws, in its 53 member countries (which include Russia and the other former members of the USSR as well as Israel and Turkey). Second, the Council of Europe (CoE) is the leading human rights organization on the continent. It sits in Strasbourg and comprises 47 Member States that

have all signed up to the European Convention on Human Rights (ECHR)⁸ whose implementation in CoE Member States is overseen by the European Court of Human Rights (ECtHR). Several other CoE instruments are relevant to the development of public health laws and policies in the Member States, not least the European Social Charter.⁹ Third, the EU now comprises 27 Member States,¹⁰ covering a total population of around 450 million people. EU law, characterized by deeper economic and political integration, is interpreted by the Court of Justice of the EU (CJEU) that sits in Luxembourg. All EU Member States are CoE members; they are therefore bound by the ECHR as well as the Charter of Fundamental Rights of the EU (CFREU)¹¹.

2 Communicable and Other Infectious Diseases

A “communicable disease” is an infectious disease that “is transmitted from person to person by direct contact with an infected individual or by indirect means such as exposure to a vector, animal, fomite, product or environment, or exchange of fluid, which is contaminated with the contagious agent.”¹² As the definition suggests, not all infectious diseases are communicable; for example, infection from toxins of the tetanus bacterium is not. Public health measures can be critical in protecting against both communicable and noncommunicable infectious diseases.

Long before science understood the role that microorganisms play in causing illness, states enacted a variety of laws that were designed to protect a population from outbreaks of infectious disease. As Gostin, Burris, and Lazzarini note, contemporary infectious disease laws bear the influence of changing understandings of the etiology of infection as well as innovations in medicine and pharmacology.¹³ In both Europe and the United States, ancient laws relating to isolation and quarantine co-exist with more modern laws that relate to surveillance or the regulation of new pharmaceutical innovations.

(p. 73) Both the United States and Europe confront some similar challenges. A key one is the distribution of *authority* (the term used in the United States) or *competency* (the term employed in the European Union) over infectious disease control. Should it be more centralized or remain rather decentralized? Another important question relates to how officials should respond to scientific uncertainty, which often exists at the outset of a new epidemic. A third, overarching question, is the relationship between individual autonomy and disease control. Historically, officials have often responded to epidemics by limiting the rights of individuals to travel or even to determine their own medical care. Reasonableness of public action, or the “principle of proportionality,” which has been shaped by the CJEU, is the key to keeping the right balance in this regard. Traditionally, human rights are classified as positive (right to benefits) or negative rights (a right to non-interference).¹⁴ However, against the background of the broad notion of “public health,” limiting rights (in the sense of negative rights) might often not be enough, especially to prevent infectious diseases. Moreover, vulnerable populations have often borne the brunt of infectious disease control measures, such as quarantine. How to prevent these dangers while protecting public health in an increasingly integrated world that faces new risks of

emerging infectious diseases remains a paramount question for both the United States and Europe.

Gostin, Burris, and Lazzarini have described three different models of conceptualizing the role of the individual in the context of infectious diseases and, therefore, how government should shape its public health regulations.¹⁵ First, the “microbial model,” which sees disease as a “product of microbial infection,” where it is the task of “public health” “to identify the pathogen and to eliminate or contain it.”¹⁶ Second, the “behavioral model,” which focuses on human (risky) behavior, closely monitoring “the activities that give rise to morbidity and premature mortality,” as well as addressing the question of behavior that moves the germ “from person to person or that makes people susceptible to becoming ill when they encounter a pathogen.”¹⁷ Third, the “ecological model,” which emphasizes the role of socioeconomic factors in the spread of communicable disease.¹⁸ Taking the lens of these three models, Wendy E. Parmet analyzes the United States, and Markus Frischhut presents the EU situation and describes selectively to what extent these models can also be identified in the European Union.

3 Noncommunicable Diseases: Tobacco and Other Unhealthy Commodities

The four main groups of NCDs—cancers, cardiovascular diseases, chronic respiratory diseases, and diabetes—have become the most common cause of death and disability (p. 74) worldwide, accounting for 71% of all deaths and more than three out of four years lived with a disability.¹⁹ The human and economic cost of NCDs is immense: they affect the health of individuals, significantly increase the cost to national health services, and entail broader societal costs such as lost productivity and absenteeism related to ill-health while increasing health inequities.²⁰ However, many NCDs are eminently preventable by addressing proximal risk factors, including tobacco use and unhealthy diets.

Determining whether, and if so, how to regulate the tobacco and other industries that manufacture, distribute, and promote harmful commodities requires a careful engagement with difficult, culturally sensitive questions which the paired chapters on NCDs attempt to address. A critical initial question is the extent to which individuals should take responsibility for their own health and what role, if any, governments should have in limiting the demand and supply for these commodities. As the paired chapters highlight, there is a marked difference between the approaches taken in the United States and in Europe on this question. US public authorities have been notoriously more reluctant to interfere with free market mechanisms than EU authorities, including with respect to tobacco control. This reluctance has been compounded by the US Supreme Court’s sweeping interpretation of the First Amendment to the US Constitution, which protects the right to free speech, including advertising and other forms of commercial expression. Parmet’s discussion of NCDs in the United States engages with the tensions between individual autonomy and public health this stance raises.

By contrast, the European Union and its Member States have been, overall, less ideologically opposed to regulating the markets for tobacco products and other potentially harmful commodities—though one notes different stances from one Member State to another. Rather, the key questions that the European Union has faced relate to the nature of the intervention required and the sharing of competences between the Union and its Member States to adopt an effective regulatory framework to protect European citizens from NCDs associated with tobacco, alcohol, and unhealthy diet consumption. In her chapter, Amandine Garde reviews how the European Union and its Member States have shared powers to address the harm resulting from tobacco, alcohol, and unhealthy diets, looking both at the intensity and the nature of their intervention.

The two sections of this paired chapter have a similar structure that is intended to facilitate comparisons between the US and EU approaches to the prevention of NCDs. Nevertheless, Parmet and Garde focus on the most topical issues in the United States and Europe, respectively. This explains why the US chapter focuses primarily on tobacco, unhealthy diets, firearms, and opioids, while the EU chapter focuses on (p. 75) tobacco, alcohol, and unhealthy diets without referring to opioids and firearms, which have not gained much prominence at the EU level.

4 Social Determinants of Health

The WHO defines the social determinants of health as “the conditions in which people are born, grow, live, work and age.”²¹ These conditions are important contributors to health inequalities. “Socioeconomic health inequalities,” as opposed to inequalities due to biological variations or individual choice, are generally considered to be unnecessary and avoidable.²² However, whether public health law should or can alter these conditions and, if so, how remains highly contested, especially in the United States.

In her chapter on the social determinants in the United States, Parmet explains the different pathways through which law can influence the social determinants of health and argues that law should itself be viewed as a critical social determinant. She then reviews some deep-seated characteristics of US law, including the heavy influence of individualism and the prioritization of negative over positive rights,²³ which may help to explain the underinvestment in the United States, as compared to Europe, in social welfare programs. The US section of the chapter concludes with a discussion of several initiatives and proposals in the United States to address social determinants, including “Health in All Policies,” which seek to promote cross-sectoral collaboration, and recognition of the health impact of non-health policies. However, such policies, as well as several others discussed in the section, do not engage with broader societal concerns like wealth and inequality. To address these issues, consideration must be given to other laws, including minimum wage laws, labor laws, and the federal tax code, that are not ordinarily thought of as “public health laws.” Whether such fundamental drivers of health should be understood as falling within the purview of public health law or, instead, should be addressed as questions of social justice remains deeply contentious.

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Brigit Toebes, in her chapter on the social determinants of health in Europe, observes that, at the EU level and within European states, dedicated policies and strategies have been adopted to reduce socioeconomic health inequalities. However, the efforts remain fragmented and there is a lack of evidence as to whether these measures have worked. She also observes that academic research on the role of law in relation to the social determinants of health in Europe is scant compared to what has been done in the United States. In Europe more than in the United States, human rights standards have been linked to the social determinants of health. Toebes argues that human rights law (p. 76) provides a compelling moral and legal framework for assessing matters of social justice, including socioeconomic health inequalities. Human rights law can serve as an overarching framework protecting the rights and interests of those affected by health inequalities and poor social conditions. Taking a human rights approach then also requires looking at the right to health in an interaction with other human rights, including rights to housing and social security, as well as labor rights. This chapter makes it clear that in Europe, and much more than in the United States, social rights are a driver for addressing socioeconomic health inequalities.

Notes:

⁽¹⁾ An “epidemic” refers to a contagious, infectious, or viral illness that spreads to many people in a specific region, whereas a “pandemic” surpasses this region.

⁽²⁾ Roger Magnusson, *Advancing the Right to Health: The Vital Role of Law*, 27 (2017), <https://www.who.int/healthsystems/topics/health-law/chapter2.pdf?ua=1>.

⁽³⁾ Richard Goodman et al., “Law and Public Health at CDC,” 55 *Morb Mort Wk Rep Sup.* 02 23–33 (Dec. 22, 2006), <https://www.cdc.gov/mmwr/preview/mmwrhtml/su5502a11.htm>.

⁽⁴⁾ Micah L Berman, “Defining the Field of Public Health Law” (2013) 15(2) *DePaul J Health Care L* 45 80.

⁽⁵⁾ Lawrence O Gostin and Lindsay A Wiley, *Public Health Law: Power, Duty, Restraint* 4 (3d ed. 2016).

⁽⁶⁾ Hervey TK and McHale JV, *European Union Health Law: Themes and Implications* (Cambridge University Press 2015) 27.

⁽⁷⁾ Articles 9 and 168(1) of the Treaty on the Functioning of the EU and Article 35 of the Charter of Fundamental Rights of the EU ([2016] OJ C202); Office of the Associate Director for Policy and Strategy, Centers for Disease Control and Prevention, *Health in All Policies*, <https://www.cdc.gov/policy/hiap/index.html> (9 June 2016).

⁽⁸⁾ Convention for the Protection of Human Rights and Fundamental Freedoms (European Convention on Human Rights, as amended) (signed 4 November 1950, entered into force 3 September 1953) CETS 5.

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⁽⁹⁾ European Social Charter (Revised) (adopted 3 May 1996, entered into force 1 July 1999) CETS 163.

⁽¹⁰⁾ [2020] OJ L29 and C 34.

⁽¹¹⁾ [2016] OJ C202/389.

⁽¹²⁾ European Parliament and Council Decision 1082/2013/EU of 22 October 2013 on Serious Cross-Border Threats to Health and Repealing Decision 2119/98/EC [2013] OJ L293/1, as corrected by [2015] OJ L231/16, art 3 lit b.

⁽¹³⁾ Lawrence O Gostin, Scott Burris, and Zita Lazzarini, "The Law and the Public's Health: A Study of Infectious Disease Law in the United States" (1999) 99(1) Colum L Rev 59.

⁽¹⁴⁾ Tom L Beauchamp and RR Faden, "The Right to Health and the Right to Health Care" (1979) 4(2) J Med Philosophy 118 120.

⁽¹⁵⁾ Gostin, Burris, and Lazzarini (n 13) 69–77.

⁽¹⁶⁾ *Id.*, 70.

⁽¹⁷⁾ *Id.*, 71–72.

⁽¹⁸⁾ *Id.*, 74.

⁽¹⁹⁾ UN General Assembly Resolution 73/2 of 10 October 2018 (A/73/L.2) adopting the Political declaration of the third high-level meeting of the General Assembly on the prevention and control of NCDs, following the high-level meeting held on 27 September 2018 to undertake a comprehensive review of the prevention and control of NCDs.

⁽²⁰⁾ In 2011, the Harvard School of Public Health and the World Economic Forum estimated that, on top of the social and psychological burdens of chronic disease, the cumulative loss to the global economy could reach \$47 trillion by 2030 if things remained as they were: *The Global Economic Burden of Non-communicable Diseases* (Geneva: World Economic Forum, September 2011).

⁽²¹⁾ World Health Organization, Social Determinants of Health, https://www.who.int/social_determinants/sdh_definition/en.

⁽²²⁾ WHO, Social Determinants of Health. Available at http://www.who.int/social_determinants/sdh_definition/en/. Accessed January 2019. *See also* WHO, 10 Facts on Health Inequities and Their Causes, https://www.who.int/features/factfiles/health_inequities/en/. Accessed 17 January 2019.

⁽²³⁾ *See* Beauchamp and Faden (n 14).

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