Public Health (▮▮▮▮) ▮, ▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Preface

In 1988, one of my predecessors as Chief Medical Officer, Sir Donald Acheson, wrote that in England there is a 'lack of clarity about the role and responsibilities in this field [of public health law] which derives from the complexity of the legislation and from a misunderstanding about its interpretation. The Public Health Acts comprise a complex body of legislation stretching back for more than a century. It is difficult to gain a coherent view of what is intended.'

The state's framing and application of public health laws reflect the contemporary balance between the rights of the state, of society, and of individuals. And this balance changes, as does our knowledge of public health, disease, and how our environment affects our health. The Public Health Acts to which Sir Donald referred were framed in the 19th century and based upon 19th century mores and 19th century scientific knowledge.

Public health law is a fascinating and sometimes controversial field, highlighting as it does social and political tensions, and the perennial balancing act of protecting individual liberties whilst securing public well-being. It is, therefore, surprising that so few contemporary scholars have researched the potential for law as a tool for the protection and improvement of public health.

Richard Coker and Robyn Martin have, by bringing together public health and legal experts, addressed in this series of papers the complex problems that arise when government regulates to prevent injury and disease or to promote the public's health. In doing so they, along with their colleagues, cause us to reflect on the nature, scope and purpose of public health law as well as the evidence base that informs judgments.

In my 2002 strategy for infectious diseases in England, *Getting Ahead of the Curve*, I suggested that there was a need to review legislation on infectious diseases in England with a view to modernizing it. This review is currently ongoing. This valuable collection of papers and the commentaries that accompany them form a powerful resource from which I, my colleagues in the Department of Health, public health professionals, and lawyers with an interest in public health can draw inspiration. These papers highlight the fundamental role that the law plays in securing public health.

Chief Medical Officer for England
Sir Liam Donaldson
Department of Health, Room 107 Richmond House, 79 Whitehall, London SWIA 2NS, UK
E-mail address: liam.donaldson@dh.gsi.gov.uk

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.004

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Editorial

Introduction: The importance of law for public health policy and practice

Background

In 2005, the London School of Hygiene and Tropical Medicine in association with the Centre for Research in Primary and Community Care, and with the support of the Nuffield Trust, organized and hosted a series of lectures on Public Health Law. This initiative, which attracted considerable interest and attention from public health professionals, lawyers, legislators, and policy makers, addressed a number of contemporary public health themes. Each lecture was followed by audience discussion and later, at the Nuffield Trust, a smaller audience was invited to discuss issues raised in the lecture. A rapporteur with expertise in the lecture subject was invited at the Nuffield Trust discussion to reflect on the lecture, to lead the discussion, and to summarize the debate in a brief commentary. This publication contains the collection of this series of lectures and commentaries.

At the 2005 United Kingdom Health Protection Agency conference, Rod Griffiths, president of the Faculty of Public Health, identified two professional areas that demanded attention from the public health profession: leadership and public health law. Most law taught in the field of health is focused not upon population perspectives but on individualized medical law. Following high profile media interest in rare cases involving difficult medical decision-making (such as the separation of conjoined twins, voluntary euthanasia or the allocation of fertility treatment services) there is now a proliferation of centres for medical law, medical policy and medical ethics in the UK and elsewhere. We would contend that this focus has served to distort the importance of medical law to the detriment of public health law, with consequent implications for the funding and dissemination of public health law research, and has resulted in insufficient institutional capacity to respond to the needs of public health professionals and policy makers. This lecture series was an attempt to address this gap by highlighting a number of challenging and pressing contemporary areas of public health and law overlap, with the objectives of provoking constructive critical debate and of identifying areas that will benefit from further research and analysis.

If law is to be an effective tool for the public health, then it must be framed on an evidence base derived from public health law research. Public health laws, the principles upon which they are founded and the legal framework of public health practice need to be understood by a professional audience, including public health policy makers, legislators, public health practitioners and lawyers working in the field. The United Kingdom, as other states, needs to establish a body of scholarship on the role of law in public health. This lecture series explored the potential of law as a tool for the public health. Most of the contributors would not claim to have expertise in public health law as such. Rather they come from a wide range of areas of law and public health, and they were given the brief of exploring the extent to which their own area of expertise could be used for the benefit of the public health (in the case of the law contributors), or of exploring the extent to which law might contribute to policy, practice, and public health outcomes (in the case of the public health contributors).

As a preliminary introduction to the public health law lecture series, this first contribution examines the evolution of law's involvement in public health, in order to set the scene for the more focused examinations of the role of law in public health to follow.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.005

The development of public health law

The importance of law as a tool for the protection of the public health in England was recognized well before the practice of medicine engaged with systemic approaches to illness and disease.[1] From early times laws have been passed to provide powers necessary to counter health threats such as poor sanitation, the adulteration of food, the health consequences of child labour and the epidemic spread of disease. Indeed many laws pre-date modern scientific causal paradigms. These early laws were included in the powers of police to secure law and order, in recognition that it was the mandate of the state to protect its citizens from physical harm, including a duty to protect against health harms.

It was not until the late 18th century that medical officers began to play a part in government efforts to address in an organized endeavour the health concerns of urban living. After the influenza and typhoid epidemics in 1837 and 1838, it was a lawyer not a doctor, Edwin Chadwick, who was asked by the British government to carry out an enquiry into the causes of disease. His *Report on the Sanitary Conditions of the Labouring Population of Great Britain*, published in 1842, argued that disease was directly related to living conditions and that coordinated measures should be taken to protect health by means of disease prevention. In 1848 the term 'public health' was first used in legislation, when a Central Board of Health was established with powers to oversee street cleansing, rubbish collection, water supply and systems of sewerage.[2] Even then, legislation was regional in application. Powers were granted to local authorities, and only in areas with particularly high rates of mortality. The first national public health statute was the Public Health Act 1875,[3] in which the role of local authorities in health protection was preserved. It remains the case in England and Wales under the current Public Health Act 1984 that it is local authorities and not health authorities which have responsibility for the exercise of public health powers.

Britain played a leading role on the world stage in its recognition that law could provide powers and duties which would underpin strategies aimed at securing population health. Because of its importance in the development of processes of industrialization and its high concentrations of population, Britain faced occupational and environmental health threats before other nations, and so needed to find ways of controlling the adverse effects of its industries. Early English public health legislation became a model for legal regulation of public health harms in other states, and much of the world has a public health legal framework which owes its jurisprudence to these early British attempts to use law for the benefit of public health.

Scientific understanding was being transformed at the time of these first statutes. Knowledge around the role of microbes in disease causation was emerging and the importance of disease linked to waste, poor systems of drainage and refuse was recognized. The legal mechanism applied to control disease was the old common law device of the legal nuisance, such that disease sources were classified as statutory nuisances. Statutory classification of a disease source as a nuisance brought into play a range of legal duties and powers, enabling removal, control and licensing of threats to public health. As medical science developed to recognize new sources of disease, so responses to these new sources of disease were either incorporated into the main public health acts or made subject of separate, parallel legislation,[4] with the end result that public health law developed into a patchwork of incoherent regulation with no overarching statutory framework. This lack of coherence led inevitably to inconsistencies and gaps, and measures passed to contain one risk to health served at times to create other public health threats.[5]

The foundation of modern public health law in England and Wales,[6] and indeed through its colonial networks the foundation of public health legislation

[1]Laws were passed to regulate repair of sewers in 1225. 9 Hen III, c15 and 16.See Warren M. A *chronology of state medicine, public health, welfare and related services in Britain* 1066–1999. Faculty of Public Health Medicine: Royal College of Physicians; 2000, unpublished.

[2]Public Health Act 1948.

[3]Other legislation played an important role in supporting public health regulation without using the term 'public health', for example the Disease Prevention (Metropolis) Act 1883. See Martin R, Domestic regulation of public health: England and Wales. In: Martin R, Johnson L, editors. *Law and the public dimension of health*. London:Cavendish; 2001.

[4]For example in England the Public Health (Water) Act 1878, the Public Health (Regulation of Food) Act 1907, the Public Health (Tuberculosis) act 1921.

[5]The Alkali Acts 1863, 1874 and 1906 attempted to control air pollution by prompting industry to dispose of its alkali waste in liquid form into water supplies, resulting in water pollution. Regulation of refuse collection has resulted in dumping of offending products. See Bell S, McGillivray D. *Environmental law*. London: Blackstone; 2000.

[6]Scotland and Northern Ireland have separate public health legislation that is also based on early English law.

in much of the world,[7] can be seen in the Public Health Act 1936 where the mechanism of specified nuisances prejudicial to health continued to provide the philosophical basis for public health powers and duties. No definition of nuisance was given in the statute but case law linked the statutory nuisance to the meaning of nuisance at common law[8] with the result that the focus of the legislation was not on the protection of human health but rather on the prevention of environmental harms.[9]

In England and Wales much of the 1936 Act has now been subsumed into legislation protecting the environment.[10] What is left of the 1936 Act and parallel legislation now forms the basis of the Public Health (Control of Disease) Act 1984. This, in a piecemeal manner, acknowledges something of the complex interactions between environment, microbial agents, and people. Other more narrowly focused public health legislation operates in parallel with the Public Health Act 1984 to provide more detailed regulation of particular disease concerns.[11] Despite recognition that the approach to public health regulation embodied in the 1984 legislation reflects 19th century epidemiological understanding and medical science, little attempt has been made to amend the law — to make, in current parlance, the law fit for purpose. This may be explained in part by the belief prevalent in the western world since the mid-20th century that science, in the form of vaccines and antibiotics, would have the capacity to eradicate or control communicable disease and that law had become a redundant mechanism for disease control. The emergence of HIV in the 1980s, the re-emergence of tuberculosis globally, the threat of the SARS virus in 2003, and the current concerns around human pandemic influenza to name a few contemporary public health challenges, have made clear, however, that science and technology alone cannot contain threats posed by communicable diseases. There is need for an appropriate legal support framework for disease control measures. The same may be said to hold for non-communicable diseases. Epidemics of obesity and tobacco-related illnesses challenge medical science. Laws in the public health armamentarium can be powerful tools.

In other jurisdictions, SARS and the threat of human pandemic influenza have prompted a renewed interest in public health law as a tool in the control of both communicable and non-communicable disease. The work of Laurence Gostin and his colleagues at the Georgetown/Johns Hopkins Program on Law and Public Health has resulted in a body of public health law scholarship and draft model legislation in the United States. Consultation papers, embodying contemporary jurisprudence on human rights and public health ethics in the context of public health law, have been prepared in New Zealand and Western Australia. Public health legislation has been reformed or amended in a range of states, and many other jurisdictions are in the process of reconsidering their public health law in recognition that law remains an essential mechanism in disease control.

The recent revision of the International Health Regulations strengthens global surveillance and response capacity, a direct consequence of international anxiety over the SARS experience and in response to demands from the international community for a more potent international legal framework to respond to global health emergencies.

The potential of law as a mechanism to protect the public health

Public health practice is premised on the state's responsibility to fulfil its moral mandate to protect its citizens from foreseeable threats of harm. Powers and duties within the realm of public health law are framed in ways which address populations, or groups of the population, and govern the organized efforts of the state to provide services and interventions aimed at population health.[12] Thus public health takes a collective rather than individualistic approach to health, and its focus lies not only on the provision of health services to persons who are suffering from illness and disease but also, critically, on the prevention of risks of health to the population as a whole. Law is a

[7]See Bidmeade I, Reynolds C. *Public health in Australia*. Canberra: Commonwealth of Australia; 1997; Reynolds C. *Public health law and regulation*. Sydney: Federation Press; 2004, on the development of public health legislation on Australia. Even countries as culturally and geographically distant as Japan based their early public health legislation on the original English public health acts. See Tatara K. Philosophy of public health: lessons from its history in England. *J. Public Health Med* 2002; 24(1) 11–15.

[8]For a detailed discussion of nuisance in this context. See Martin R. Domestic regulation of public health: England and Wales. In: Martin R, Johnson L, editors. *Law and the public dimension of health*. London: Cavendish; 2001.

[9]Other statutes such as the Public Health Act 1961 expanded the 1936 Act to cover a wider range of legal nuisances, such as petrol tanks and roller skating rinks, as new environmental threats were recognised.

[10]In particular the Environmental Protection Act 1990.

[11]Such as the Food Standards Act 1999.

[12]See Gostin LO, *Public Health Law: power, duty and restraint*, Berkeley: University of California Press; 2000.

mechanism particularly appropriate to public health regulation because it too works as a collective response to threats of harm in that it addresses populations rather than individuals, and it imposes general obligations.[13]

Public health operates within an ethical framework of communitarianism and utilitarianism, presupposing both that there are circumstances in which the greater good of the community justifies the overriding of autonomy of the individual, and that the intervention which results in the greatest health benefits for the greatest number is the most appropriate. Much common (case) law and medical legislation has developed to protect patient autonomy and patient rights, with the result that interference with autonomy and rights without specific legislative authority would potentially be actionable. The fine balance between common good and individual rights protection has shifted. Application of public health measures such as compulsory medical examination, quarantine and isolation might amount to tortious or criminal battery and breach of human rights unless there exists public health legislation which provides specific powers, and such legislation must be so framed as to ensure protection of the human rights of the subject of the power. Hence even the most fundamental of public health tools requires an underpinning of law, and a starting point of public health law is public health legislation justifying interference with individual rights for the benefit of the public good, where such interference is necessary to protect the public health and where it is proportionate to the public health threat.

Law has however a wider role to play in the protection of public health. Law also serves to provide a public expression of cultural values and cultural norms. Laws designed to protect health and safety operate not only by providing powers, duties and penalties which operate directly, but also by making a statement of acceptability of behaviour. People wear seat belts not because they fear criminal prosecution but because the existence of laws requiring the wearing of seat belts sets a public standard of behaviour with which good citizens would wish to comply. Laws against pollution or smoking in public places and laws which regulate workplace safety are effective only in part because of enforcement provisions. They are effective also because they have created expectations of standards of health and safety, and have educated the public to believe that these health protecting behaviours are the minimum standards of protection which are acceptable in our society. Laws can change socio-cultural norms.

The absence of law also serves to send messages about acceptable behaviours. Where there is no law to regulate the provision of information about food content, or to prevent the advertising of junk food to children, there is an implication that there is nothing unacceptable about the inclusion of high fat levels in processed food or targeting children with crisps advertisements. Increasingly, in a society where individuals have little control over their living environment, the public expects the state to intervene to prevent known threats to health. The failure of the state to intervene suggests that the threat is minimal, imaginary, or unimportant. Lack of parliamentary attention to our public health laws over the past century cannot be said to have created a neutral legal environment in public health. It has, in fact, created a legal environment which is harmful to public health endeavour through its failure to clarify unacceptable sources of health harms.

Where law is out of touch with contemporary mores, and in particular which conflicts with contemporary understandings of the balance between individual right and public benefit, and where law fails to acknowledge advancements in scientific understanding of public health, then that law also undermines the work of the state to protect its citizens from harm by eroding respect for public officials charged with implementing law. Public health laws that are based on 19th century science and cultural values create a dissonance between public health professional practice, which is obliged to apply outdated public health law, and the outmoded societal beliefs on which that law is premised, such that there is potential for public resistance to measures which are intended for the public benefit.

Hence the content of the body of public law has a value which is greater than the sum of its parts. Individual laws create individual duties and powers, but the overall body of law which underpins the efforts of the state to protect the public health reflects the weight and importance which the government attributes to addressing threats to health, and reflects the standards which the state expects of its citizens in relation to their health behaviours. Without a comprehensive and coherent legal framework, public health endeavours are considerably weakened and the failure of states to reform old law has hampered efforts to combat both communicable and non-communicable diseases and protect public well-being.

[13]See Reynolds C. *Public health: law and regulation*. Sydney: The Federation Press; 2004.

Redressing the flaws in public health law

It is essential then that the public health law of a society be monitored to respond both to contemporary threats to health, and to contemporary cultural norms and values. The failure of states to update public health laws has done a major disservice to those bodies responsible for making public health policy, to public health professionals working at the coal face, and to the public health of populations. Absence of law where it is needed misleads the public as to the seriousness of threats to health, and fails to provide the tools needed to protect and improve the public's health. Outdated laws which lack a scientific evidence base and which ignore public health ethics and human rights potentially undermine the public's respect for and faith in public health practice.

In the United Kingdom, as in many other states, there has for many years been a paucity of research and teaching in public health law. This is in marked contrast to the attention which has been given to other areas of law, in particular medical law (the regulation of the relationship between health care provider and patient), and in comparison with scholarship around public health law in some jurisdictions such as the United States. Additionally, there have been few opportunities for truly multidisciplinary exchanges of ideas and knowledge about the role of law as a tool for the public health, among the legal, public health and other interested professions.

Efforts to create a community of public health law expertise, so that ideas and scholarship on public health law can be shared, have been rudimentary.[14] Research that has been undertaken on public health law in the United Kingdom and elsewhere has been disparate, uncoordinated and isolated. Outside the United States there is no network, association or other mechanism for collaboration or communication between persons working on the wide range of legal issues relevant to public health. In the United Kingdom there are no centres for public health law. The wide range of areas of regulation which are not, at first glance, primarily concerned with public health (such as housing, the environment, and domestic violence) clearly, on reflection, have implications for public health which should not be ignored. The same could be said with respect to public health law teaching and education. It may well be that, although there are few dedicated public health law academic programmes in universities,[15] individual seminars and sessions are run as part of other teaching programmes such as medical law, health ethics, public health or environmental law programmes. This invisibility of public health law research and teaching is a barrier to access to knowledge and expertise on public health law, knowledge and expertise which has the potential to play an important part both in developing an effective regulatory framework for the practice of public health, and in the attainment of public health goods.

High-level policy makers have become increasingly aware of the need for public health law reform. It has been acknowledged by the British government that the newly revised International Health Regulations will require us to consider our public health law with regard to IHR compliance. In the United Kingdom the Chief Medical Officer, the Law Commission and the Nuffield Trust have all argued for review of our public health legislation, but as yet little has been done to achieve a major rethinking of how law might be used to support contemporary public health goals. Elsewhere some governments have begun the process of consultation for public health law reform, but the low standing of public health on the political and economic agenda means that initial efforts have not yet been translated into drafted laws.

It is to be hoped that this series of lectures and commentaries serves both to demonstrate the importance of the discipline of public health law, and to stimulate investment in and commitment to the development of a strong base of public health law research and expertise. The papers included in this collection make a strong case for a complete rethinking of the ways in which law might be used for the public health. There is much to be done, but the coming together of persons from a range of disciplines at these lectures has created a starting point of interest and understanding of what law might achieve. We hope these papers will stimulate debate and help galvanise support for public health law reform.

We would like to express our gratitude to the Nuffield Trust for sponsoring this series of lectures. We would also like to thank the Nuffield Trust, the Royal Institute of Public Health and the journal

[14]Two international endeavours have begun to develop such networks. The Global Exchange on Population Health Law, which was initially funded by Milbank Foundation NY and Nuffield Trust UK, has met to kickstart international communication on public health law. The Domestic Profiles on Public health law project funded by Yongsei University, South Korea, has compiled information on state public health laws, and contributors to the project met in Seoul in 2005. Both projects have lost some momentum owing to lack of ongoing funding.

[15]With the exception of the many dedicated public health law programmes in the United States. Some dedicated public health law teaching takes place in parts of Australia, South Africa, India and Hong Kong, but only on a minor scale, and few professional public health qualifications include a compulsory law component.

Public Health for their support in the publication of this special edition of the journal.

Richard Coker
London School of Hygiene and Tropical Medicine, Department of Public Health and Policy Keppel Street, London, WC1E 7HT, UK
E-mail address: richard.coker@lshtm.ac.uk

Robyn Martin
Professor of Public Health Law, Centre for Research in Primary and Community Care, University of Hertfordshire, College Lane, Hatfield, Herts., AL10 9AB, UK; Visiting Professor of Public Health Law, Chinese University of Hong Kong, Shatin, New Territories, Hong Kong SAR

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Legal foundations of public health law and its role in meeting future challenges ☆

Lawrence Gostin

Center for Law and the Public's Health, Georgetown University Law Center, 600 New Jersey Ave NW, Washington DC 20001, USA

Introduction

With this article I hope to provide a fuller understanding of the varied roles of law in advancing the public's health. The core idea that I propose is that law can be an essential tool for creating the conditions that enable people to lead healthier and safer lives. These are the questions I pursue: What is public health law and what are its doctrinal boundaries? Why should population health be a salient public value? What are the legal foundations of governmental public health? How can law be effective in reducing illness and premature death? And what are the political conflicts faced by public health in the early 21st century?

Public Health Law: A Definition and Core Values

My definition of public health law follows, and the remainder of this article 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 (e.g., to identify, prevent, and ameliorate risks to health in the population) and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the 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) the population focus, (4) communities and civic participation, (5) the prevention orientation, and (6) social justice.

1. Government power and duty: health as a salient value

The word 'public' in public health has two overlapping meanings — one that explains the entity that takes primary responsibility for the public's health, and another that explains who has a legitimate expectation to receive the benefits. The government has primary responsibility for the public's health. The government is the public entity that acts on behalf of the people and gains its legitimacy through a political process. A characteristic form of 'public' or state action occurs when a

☆This article is adapted from Gostin LO. Law and ethics in population health. Aust & New Zealand J Pub Health; 2004; 28:7-12. An expanded version of this article is forthcoming in: Gostin LO. Public health law: power, duty, restraint 2nd ed. Berkeley and New York: University of California Press and Milbank Memorial Fund.

E-mail address: gostin@law.georgetown.edu.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.006

democratically elected government exercises powers or duties to protect or promote the population's health.

The population as a whole has a legitimate expectation to benefit from public health services. The population elects the government and holds the state accountable for a meaningful level of health protection. Public health should possess broad appeal to the electorate because it is truly a universal aspiration. What best serves the population, of course, may not always be in the interests of all its members. And it is for this reason that public health is in fact highly political. What constitutes 'enough' health? What kinds of services? How will services be paid for and distributed? These remain political questions. Democratic government will never devote unlimited resources to public health. Core public health functions compete for scarce resources with other demands for services, and resources are allocated through a prescribed political process.

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. Why should health be a salient public value, as opposed to other communal goods?

Health is foundationally important because of its intrinsic value and singular contribution to human functioning. Health takes on a special meaning and importance to individuals and the community as a whole.[1] 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. If individuals have physical and mental health they are better able to recreate, socialize, work, and engage in the activities of family and social life that bring meaning and happiness. Certainly, persons with ill-health or disability can lead deeply fulfilling lives, but personal health does facilitate many of life's joys and accomplishments. Every person strives for the best physical and mental health achievable, even in the face of existing disease, injury, or disability. The public's health is so instinctively essential that human rights norms embrace health as a basic right.[2]

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 — its governmental structures, social organizations, cultural endowment, economic prosperity, and national defense. Population health, then, becomes a transcendent value because a certain level of human functioning is a prerequisite for engaging in activities that are critical to the public's welfare — social, political, and economic. Health has an intrinsic and instrumental value for individuals, communities, and entire nations. People aspire to achieve health because of its importance to a satisfying life; communities promote the health of their neighbours for the mutual benefits of social interactions; and nations build health care and public health infrastructures to cultivate a decent and prosperous civilization.

A political community stresses a shared bond among members: organized society safeguards the common goods of health, welfare, and security, while members subordinate themselves to the welfare of the community as a whole. Public health can be achieved only through collective action, not through individual endeavour. Acting alone, individuals cannot assure even minimum levels of health. Any person of means can procure many of the necessities of life — e.g., food, housing, clothing, and even medical care. Yet no single individual, or group of individuals, can assure his or her 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.

2. The power to coerce and limits on state power

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. 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.

Assuredly, public health is empowered to restrict human freedoms and rights to achieve a collective good, but it must do so consistent 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.

3. The population focus

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. 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.[3] 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 favourable environment in which people can maintain their health.

4. 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 very large groups, which, despite the diversity of their members, have common political institutions, symbols, and memories.[4]

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 behaviour (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 behaviour and disease based on race, sex, or socio-economic status.[5] 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 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.

5. 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. Many of public health's most potent activities are oriented toward prevention: vaccination against infectious diseases; health education to reduce risk behaviour; fluoridation to avert dental caries; and seat belts or motor cycle 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.

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.[6] Medical explanations of death point to discrete pathophysiological conditions, such as cancer, heart disease, cerebrovascular disease, and pulmonary disease. 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 behavioural factors, such as smoking, alcohol and drug use, diet and activity patterns, sexual behaviour, toxic agents, firearms, and motor vehicles. McGinnis and Foege observe that the vast preponderance of government expenditures is devoted to medical treatment of diseases ultimately recorded on death certificates as the nation's leading killers. Only a small fraction is directed to control the root determinants of death and disability. Their central message, of course, is that prevention often is more cost-effective than amelioration, and that much of

the burden of disease, disability, and premature death can be reduced through prevention.

6. 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: 'The historic dream of public health ... is a dream of social justice.'[7] The idea of 'justice' is complex and multifaceted, but it remains at the heart of public health's mission. Justice is fair, equitable, and appropriate treatment in light of what is due or owed to individuals and groups. Justice does not require universally equal treatment, but does require that similarly situated people be treated equally. Justice, in other words, requires that equals are treated the same and unequals are treated differently.

Justice requires the fair and proper administration of laws, and has three important attributes of special relevance to public health law. Perhaps the most important aspect of justice is non-discrimination — treating people equitably based on their individual characteristics rather than membership in a socially distinct group such as race, ethnicity, sex, religion, or disability. It cautions against public health judgments based on prejudice, irrational fear, or stereotype such as singling out persons because of group characteristics irrespective of the risk presented. A modern example is the exclusion of persons living with HIV/AIDS from ordinary aspects of life such as education, employment, or housing despite the low risk.

A second important aspect of justice is natural justice — affording individuals procedural fairness when imposing a burden or withholding a benefit. The conduct of legal proceedings according to established rules and principles for the protection and enforcement of individual rights (due process) lies at the heart of natural justice. The elements of due process include notice, trial rights including a lawyer, and a fair hearing. Natural justice requires public health officials to afford individuals procedural safeguards in conjunction with the exercise of compulsory powers such as isolation or quarantine.

The final aspect of justice is distributive justice — fair disbursement of common advantages and sharing of common burdens (fair allocation of risks, burdens, and benefits). This form of justice requires that officials act to limit the extent to which the burden of disease falls unfairly upon the least advantaged and to ensure that the burden of interventions themselves are distributed equitably. Coercive public health powers, therefore, should not be targeted against vulnerable groups such as injection drug users, prostitutes, or gay men without good cause based on careful risk assessments. Distributive justice also requires the fair allocation of public health benefits such as vaccines and medical treatment. This principle might apply, for example, to the fair distribution of vaccines or antiviral medications during pandemic influenza.[8]

These are the quintessential values of public health law — government power and duty, coercion and limits on state power, the population focus, communities and civic participation, the prevention orientation, and social justice.

Law as a tool for the public's health: models of legal intervention

The study of the field of public health law, therefore, requires a detailed understanding of the various legal tools available to prevent injury and disease and to promote the health of the populace. In this section, I offer a taxonomy of the legal tools available to government and private citizens to advance the public's health. Although in each case the law can be a powerful agent for change, the interventions raise critical social, ethical, or constitutional concerns that warrant careful study. I frame these problems quite simply here, but develop the ideas more systematically in my book on public health law.[9] What is clear is that public health law is not a scientifically neutral field, but is inextricably bound to politics and society.

Model 1: the power to tax and spend

The power to spend supports a broad array of public health services ranging from education to research. Although funding is far too limited, governments spend to establish and maintain a public health infrastructure In addition to direct funding, government can also set health-related conditions for the receipt of public funds. For example, government can grant funds for highway construction or other public works projects on the condition that the recipients meet designated safety requirements.

The power to tax provides inducements to engage in beneficial behaviour and disincentives to engage in risk activities. Tax relief can be offered for health-producing activities such as medical services, childcare, and charitable contributions. At the same time, tax burdens can be placed on the sale of hazardous products such as cigarettes, alcoholic beverages, and firearms. Of course, taxation can create perverse incentives such as tax relief for the purchase of unsafe and fuel inefficient sport utility vehicles.

Market incentives through the power to tax and spend are more likely than command-and-control regulation to win political acceptance — for

example, inducements to avert or clean-up dangerous environmental hazards. Still, the spending and taxing powers are not entirely benign. Taxing and spending can be seen as coercive precisely because the government wields such significant economic power. Economic conservatives, for example, are antagonistic toward proposals to tax high-caloric foods, viewing it as paternalistic and meddlesome. On the other hand, liberals view some taxation as inequitable if rich people benefit, while the poor are disadvantaged (e.g., tax breaks for capital gains or off-shore tax shelters). Some taxing policies serve the rich, the politically connected, or those with special interests (e.g., tax preferences for energy companies or tobacco farmers). Other taxes penalize the poor because they are highly regressive — e.g., cigarette taxes which fall disproportionately on the indigent and minorities.

Model 2: the power to alter the informational environment

The public is bombarded with information that influences life's choices, and this undoubtedly affects health and behaviour. The government has several tools at its disposal to alter the informational environment, encouraging people to make more healthful choices about diet, exercise, cigarette smoking, and other behaviours: (1) government, as a health educator, can use communication campaigns as a major public health strategy; (2) government can require businesses to label their products; and (3) government can regulate advertising of potentially harmful products such as cigarettes and firearms.

To many public health advocates, there is nothing inherently wrong with or controversial in ensuring that consumers receive full and truthful information. Yet, health communication campaigns (e.g., sex, abortion, smoking, or high-fat diet) are sometimes highly contested; businesses strongly protest compelled disclosure of certain health risks (e.g., the adverse effects of pharmaceuticals); and some courts protect advertising as a form of free expression.[10] Consequently, there are powerful economic and constitutional interests at stake in any intervention designed to alter the informational environment.

Model 3: the power to alter the built environment

The design of the built or physical environment can hold great potential for addressing the major health threats facing the global community. Public health has a long history in altering the built environment to reduce injury (e.g., workplace safety, traffic calming, and fire codes), infectious diseases (e.g., sanitation, zoning, and housing codes), and environmentally associated harms (e.g., lead paint and toxic emissions). The epidemiological transition from infectious to chronic diseases raises new city planning challenges. Neighborhoods should be designed to: encourage active lifestyles (walking, biking, and playing); improve nutrition (increased consumption of fruits and vegetables, and avoidance of high-caloric foods); reduce violence (domestic abuse, street crime, and firearm use); and increase social interactions (helping neighbours and building social capital).[11]

Critics offer a stinging assessment of public health efforts to alter the built environment: 'The anti-sprawl campaign is about telling [people] how they should live and work, about sacrificing individuals' values to the values of their politically powerful betters. It is coercive, moralistic, nostalgic, [and lacks honesty].'[12] It is apparent that serious disagreement, and some acrimony, exists about the extent to which government should pursue environmental changes in the name of public health.

Model 4: the power to alter the socio-economic environment

A strong and consistent finding of epidemiological research is that socio-economic status (SES) is correlated with morbidity, mortality, and functioning.[13] SES is a complex phenomenon based on income, education, and occupation. These empirical findings have persisted across time and cultures and remain viable today.

Some researchers go further, concluding that the overall level of economic inequality in a society correlates with (and adversely affects) population health.[14] That is, societies with wide disparities between rich and poor tend to have worse health status than societies with smaller disparities, after controlling for per capita income. These researchers hypothesize that societies with higher degrees of inequality provide less social support and cohesion, making life more stressful and pathogenic. Drawing upon this line of argument, some ethicists contend, 'social justice is good for our health.'[15]

Opponents of redistributive policies challenge this claim, arguing that such policies punish personal accomplishment and thereby discourage economic growth. Redistribution of private wealth, they contend, is a political matter, outside the appropriate scope of the public health enterprise.[16] The political divide on the role of socio-economic status in population health may be so wide as to be impossible to bridge. Public health advocates believe that reduction in health disparities is a social imperative, while economic conservatives

believe a free market economy is indispensable to a vibrant and prosperous society.

Model 5: direct regulation of persons, professionals, and businesses

Government has the power to directly regulate individuals, professionals, and businesses. In a well-regulated society, public health authorities set clear, enforceable rules to protect the health and safety of workers, consumers, and the population at large. Regulation of individual behaviour reduces injuries and deaths (e.g., use of seatbelts and motorcycle helmets). Licenses and permits enable government to monitor and control the standards and practices of professionals and institutions (e.g., doctors, hospitals, and nursing homes). Finally, inspection and regulation of businesses helps to assure humane conditions of work, reduction in toxic emissions, and safer consumer products.

Despite its undoubted value, public health regulation is highly contested terrain. Civil libertarians favour personal freedoms including autonomy, privacy, and liberty. Influential economic theories (e.g., laissez-faire and, more recently, a market economy) favour open competition and the undeterred entrepreneur. Theorists advocate redressing market failures (e.g., monopolistic and other anticompetitive practices) rather than restraining free trade. They support relatively unfettered private enterprise and free-market solutions to social problems. Many citizens see a changing role for government from one that actively orders society for the good of the people (the so-called 'nanny state'), to one that leaves individuals alone to make their own personal and economic choices.

Model 6: indirect regulation through the tort system

In some countries public health authorities and private citizens possess a powerful means of indirect regulation through the tort system. Civil litigation can redress different kinds of public health harms: environmental damage (e.g., air pollution or groundwater contamination); exposure to toxic substances (e.g. pesticides, radiation, or chemicals); hazardous products (e.g., tobacco or firearms); and defective consumer products (e.g., children's toys, recreational equipment, or household goods). Recently, public health advocates in the United States, drawing lessons from successful tobacco strategies, have brought tort actions against firearm manufacturers[17] and fast food restaurants.[18]

While tort law can be an effective method of advancing the public's health, like any form of regulation, it is not an unmitigated good. The tort system imposes economic and personal burdens on individuals and businesses. Litigation, for example, increases the cost of doing business, thus driving up the price of consumer products. It is important to note that tort actions can deter not only socially harmful activities (e.g., unsafe automobile designs), but also socially beneficial ones (e.g., innovation in vaccine development). Thus, although tort litigation remains a prime strategy for the public health community, it is actively resisted in some political circles.

Model 7: deregulation: law as a barrier to health

Sometimes laws are harmful to the public's health and stand as an obstacle to effective action. In such cases, the best remedy is deregulation. Politicians may urge superficially popular policies that have unintended health consequences. Examples include laws that penalize pharmacy sales of sterile syringes and needle exchange programmes; laws that close bathhouses making it more difficult to reach gay men with condoms and safe sex literature; and laws that criminalize sex for persons living with HIV/AIDS, possibly driving the epidemic underground.[19]

Deregulation can be controversial because it often involves a direct conflict between public health and other social values such as crime prevention or morality. Drug laws, the closure of bathhouses, and HIV-specific criminal penalties represent society's disapproval of disfavoured behaviours. Deregulation becomes a symbol of weakness that is often politically unpopular. Public health advocates, therefore, may believe passionately in harm reduction strategies, but the political community may want to use the law to demonstrate social disapproval of certain activities such as illicit drug use or unprotected sex.

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

The Politics of Public Health

The politics of public health are daunting. Western culture openly tolerates the expression and enjoyment of wealth and privilege, and it is more

inclined to treat people's disparate life circumstances as a matter of personal responsibility. Meanwhile, voters have become more sceptical of government's ability to ameliorate the harshest consequences of economic and social disadvantage. Polarizing debates about faith and race have supplanted discussions of economic fairness in political campaigns and the public sphere more generally. Political liberalism has been complicit in these trends. Its shift in emphasis, over the past 40 years, from social obligation and economic fairness to individual freedom, self-reliance and personal responsibility has shifted understandings of health from the public to the private realm.

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.

References

1. Daniels N. *Just health care*. Boston: Cambridge University Press; 1985.
2. The Right to the Highest Attainable Standard of Health. General Comment 14, E/C.12/2000/4 July 4, 2000
3. Rose G. Sick Individuals and sick populations. *Int J Epidemiol* 1985;**14**:32–7.
4. Beauchamp D, Steinbock B. *New ethics in public health*. New York: Oxford University Press; 1999.
5. Marmot M, Wilkinson RG, editors. *Social determinants of health*. Oxford: Oxford University Press; 1999
6. McGinnis MJ, Foege WH. Actual causes of death in the United States. *JAMA* 1993;**270**:2207.The data in the McGinnis and Foege article were updated in: Mokdad AH et al. Actual Causes of Death in the United States, 2000, *JAMA* 2003; 291: 1238.
7. Beauchamp DE. Public health as social justice. In: Beauchamp DE, Steinbock B, editors. *New ethics for the public's health*. New York: Oxford University Press; 1999.
8. Gostin LO. Pandemic influenza: public health preparedness for the next global emergency. *J Law, Med Ethics* 2004;**32**:565–73.
9. Gostin LO. *Public health law: power, duty, restraint*. Berkeley and New York: University of California Press and Milbank Memorial Fund.
10. Liquormart, Inc. v. Rhode Island, 517 U.S. 484 (1996).
11. Perdue WC, Stone LA, Gostin LO. The built environment and its relationship to the public's health: the legal framework. *Amer J Public Health* 2003;**93**:1390–4.
12. Postrel V. The pleasantville solution: the war on 'Sprawl' promises 'Livability' but delivers repression, intolerance – and more traffic. *Reason* 1999;**30**:4–11.
13. Syme L. Social and economic disparities in health: thoughts about intervention. *Milbank Quarterly* 1998;**76**:493–505.
14. Wilkinson RG. *Unhealthy societies: the afflictions of inequality*. London: Routledge; 1996.
15. Daniels N, Kennedy B, Kawachi I. Justice is good for our health. *Boston Rev* 2000;**25**(1):6–15.
16. Eberstadt N, Satel S. *Health and the income inequality hypothesis: a doctrine in search of data*. Washington, DC: AEI Press; 2004, 11-14.
17. Chicago v. Beretta, 213 Ill.2d 351 (2004).
18. Pelman v. McDonald's, 237 F.Supp.2d 512 (2003).
19. Gostin LO. *The AIDS pandemic: complacency, injustice, and unfulfilled expectations*. Chapel Hill: University of North Carolina Press; 2004.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on "Legal foundations of public health law and its role in meeting future challenges"

John A. Harrington

University of Liverpool Law School, Liverpool, L69 7ZS, UK

Professor Gostin's rich paper challenges us to think creatively about the foundations and purposes of public health law in the early 21st century. It makes the case for public health as an instrumental and an intrinsic good, which promotes economic and political development, as well as human flourishing. It defines positive and negative functions for law in this project. Antiquated statutes and regulations need to be systematically adapted and augmented in response to new and returning epidemics. The requirements of due process define the limits of these powers. Human rights, to liberty and health respectively, provide a common legal matrix for assessing the burdens imposed on the citizenry and on affected groups. Social justice is the heart of public health.

Theoretical understandings of what 'law' is and where it is created can contribute to this refurbishment of public health practice. In particular it will be useful to augment a wholly state-centred model of law creation with the insights of legal pluralism. The latter school emerged in the English-speaking world through the experiences of colonial administrators in non-European territories. In that setting the aspiration to a uniform state law had to accommodate the diverse and overlapping legal orders of different ethnic and religious groups. (Rather like multilingualism, legal pluralism seems to be the normal state for the greater part of the world's population outside the developed countries.) In more recent decades legal pluralism has been 'brought home' by legal anthropologists. Groups within western societies not only promote the interests of their members, providing material and moral support, they also create and maintain the norms of group conduct. They are in an important sense law-creating entities located between the level of the state and that of the individual.

This insight parallels a common understanding of effective public health practice in the developed and developing world. As well as states and individuals, societal groups are significant actors in health promotion. Improvements in reproductive health, for example, are achievable only through the agency of formal and informal women's groups. Indeed public health campaigns not only depend on these collectivities, they can also be constitutive of a new group consciousness. The emergence of an open and confident gay presence in Europe and North America was significantly due to the need to act against the spread of HIV/ AIDS and attendant discrimination in the mid-1980s. But this group activity was also comprised of norm creation. Acceptable modes of sexual behaviour, for example, or a taboo on spitting or smoking, are often most effectively defined and enforced at a sub-state level. Public health activism necessarily entails a measure of legal pluralism.

What are the tasks of state law in this situation? First, group norm-creation presumes a degree of benevolent non-intervention by the state. To this extent it is consistent with the contemporary trend

E-mail address: john.harrington@liverpool.ac.uk.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.007

away from direct command of society by the agencies of government. The latter is founded not only on fashionable libertarianism, but also on the cognitive shortcomings of centralized control. Second, group norm-enforcement will not always conform to the basic human rights and due process standards protected a democratic society. State law will have an important role in guaranteeing procedural rights and in curbing the sometimes oppressive tendencies of group life. In sum this type of 'reflexive law' is an important addition to the repertoire of legal techniques available to public health practitioners and strategists.

The problems of public health law considered in the vigorous and stimulating discussion which followed Professor Gostin's paper were of two sorts. First, the stresses imposed upon law in a liberal and democratic society by the exigencies of population health. The political turn to radical individualism is reflected in the legal prominence of fundamental human rights, in particular those protecting personal and economic liberty. Whether and how laws enjoining the use of crash helmets or seatbelts, for example, can withstand higher-order scrutiny is a difficult question. It is ever more acutely posed as citizens grow in awareness of their legal and constitutional rights. In addition, what Professor Gostin refers to as the 'positivistic basis' of public health challenges the law to adapt. New and re-emerging disease threats, as well as therapeutic developments, need to be reflected in public health legislation.

Second, the limitations upon effective public health practice imposed by this evolving rights regime was noted by practitioners with experience in Britain and overseas. State agencies are charged in the first instance with protecting the public's health. But they are of course also subject to the general law. The development and implementation of public health measures (such as isolation and confinement) are now subject to an express balancing exercise conditioned by law. There has been a decisive shift from ethical to legal discourse in the framing of these conflicts. Given the added element of sanction, and the potential for external resolution of the issues (by judges) it is not surprising that practitioners feel under increased pressure. This is heightened by intense media scrutiny, itself fed by high-profile cases and legislative reforms.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Health policy and European law: Closing the gaps

Martin McKee[a,*], Elias Mossialos[b]

[a]*European Public Health, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK*
[b]*Health Policy, LSE Health and Social Care, London School of Economics and Political Science, London WC2A 2AE, UK*

Introduction

Health policy in the European Union has, at its centre, a fundamental contradiction. On the one hand, recent Treaties, which are the definitive statements on the scope of European law, state explicitly that health care is a responsibility for Member States. On the other hand, as health systems involve interactions with people, goods and services, all of whose freedom to move across borders is guaranteed by the same Treaty, it is increasingly apparent that many of their activities are subject to European law.[1] Moreover, there is now compelling evidence that health care makes an important contribution to overall population health.[2] The goals of the European Union are both economic and social and, since the Treaty of Maastricht, it has been required to 'contribute to the attainment of a high level of health protection'.[3] It is not possible to do this without ensuring that health systems are providing effective care to their populations.

Another issue is that the European Union has, as one of its fundamental principles, an imperative to promote the free movement of people.[4] The twin challenges of ensuring that health systems promote a high level of health and that they facilitate the mobility of Europe's citizens pose certain problems. Reflecting the societal preferences of their citizens, member states have chosen different ways to organize their health care systems. These choices reflect many factors.[5] The ways in which varying goals are achieved reflects differing views about the legitimacy of regulation, incentives, and other levers to bring about change.

Health care systems across states reflect national culture, institutional frameworks, and contemporary political choices, and there is no obvious reason to seek to harmonize systems. Because of this, the application of a uniform legal framework, as set out in the EU Treaties, will inevitably be problematic. But at the same time, health care cannot be ignored by European legislators. Many of the things upon which Europe depends, such as pharmaceuticals or technology, are internationally traded and health care workers also have free movement between states.

So there is a paradox. Health systems in Europe are diverse, yet they are also interdependent. In themselves, they are exempt from European law, yet almost everything they do, and those elements that are essential for them to function, are governed by it.

*Corresponding author. Tel.: +44 20 7580 8183.
E-mail address: martin.mckee@lshtm.ac.uk (M. McKee).

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.008

Health care in the European Union

Fundamentally, all member states have signed up to the European social model.[6] When asked whether governments had an obligation to provide health care for all, only 4% across all European countries took the view that the government need not provide for those on low incomes. Only in Belgium was this view held by more than 5% of respondents.[7] There is little appetite in Europe, across countries with quite different health systems, for radical reforms that risk undermining the welfare state.

In the mid-1990s, a series of developments placed social protection more centrally on the EU's political agenda. One factor was the perception that the EU was increasingly seen as a solely economic entity. The political focus was on the implementation of the single European market; countries were competing to attract investment, potentially driving down social protection. At the same time, changes in age structure, labour force participation, and gender roles were forcing a rethink of some existing systems of financing the welfare state. These factors led to a reassessment of the role of the EU in the field of social protection, with the European Commission, in 2000, proposing a concerted strategy to modernize social protection.[8] One of its four objectives was to ensure high quality and sustainability of health care and it stated that 'everyone should be in a position to benefit from systems to promote health care, to treat illness, and to provide care and rehabilitation for those who need it.'

It is possible to identify important cross-border aspects of health care, especially where they concern people who need health care in a country other than their own, and issues that arise in the procurement of the many elements, such as pharmaceuticals or even health professionals needed to provide health care. It is also possible to identify certain commonalities in European health systems. Should the European Union, therefore, explicitly include health care in a Treaty? Before addressing this notion, however, it may be useful to trace the development of the EU's treaties.

Health policies and the European treaties

The European Economic Community grew out of the European Coal and Steel Community. Although the reason for creating this organization was political, to avoid a repetition of the three wars between France and Germany that had taken place in the previous century, the explicit goals were essentially economic. Social concerns, much less health-related ones, were not on the agenda.

Consistent with the European social model, the European Economic Community sought, through the 1957 Treaty of Rome, to go beyond a narrow free trade area to 'promote throughout the Community a harmonious development of economic activities, a continuous and balanced expansion, an increase in stability, an accelerated raising of the standard of living and closer relations between the states belonging to it.'

It is reasonable to argue that 'An accelerated raising of the standard of living' implies the promotion of health. At the same time, a recognition was slowly growing that free trade involved medicines, health technology, health professionals, and even health insurance, yet there were only a few attempts to confront any of the issues that arose. A notable example was the 1975 Doctor's Directive,[9] setting out the basic educational standards that each country must apply if its nationals were to be recognized as meeting a European standard. Another was the creation of the E111 and E112 schemes, which allowed people to obtain care when abroad in the case of emergency or, in much more limited circumstances, to be sent abroad to receive treatment.[10] However, in general, between the 1960s and early 1980s there was very little interest in further integration in Europe of any kind so that this period was often referred to as one of 'eurosclerosis'.

The situation changed markedly in 1987 when the Single European Act was signed.[11] This identified 1992 as the year when a true Single European Market would exist with free movement of capital, goods, and labour. Yet while the member states now recognized that greater integration would have an effect on health and health care in the Community, it was only possible to address those health-related matters directly related to the creation of the single market. Public health was not yet regarded as a distinct policy area.

Recognition of the limitations resulted, in 1992, in the Treaty of European Union (known more widely as the Treaty of Maastricht) where the term 'subsidiarity' gained currency. Essentially, subsidiarity meant that the European Union could only act where what it sought to achieve could not be accomplished by the actions of individual member states and, when it did act, it could do no more than was absolutely necessary to achieve its aims. The subsidiarity argument would be used time after time to justify the failure to act in relation to health care.

The Maastricht Treaty was, however, a landmark for public health. For the first time ever, public health was explicitly mentioned. Article 3(o) empowered the Community to 'contribute to the attainment of a high level of health protection' for its citizens. Then, to achieve this objective, Article 129, which has subsequently been referred to as the 'public health Article', set out a basic framework whereby the Community would meet this obligation. Its scope was extremely limited, however. It could encourage 'cooperation between the Member States and, if necessary, lend support to their action.' Community action was restricted to 'the prevention of diseases, in particular the major health scourges'.

The vague wording of the Article left room for considerable later interpretation. There was, however, one crucial phrase in the Treaty Article that offered some promise. This was that 'health protection requirements shall form a constituent part of the Community's other policies'. In theory, this provided a real opportunity for public health considerations to be taken into account in the future development of all other Community policies. In reality, it was a missed opportunity.

The 1990s were years of rapid change in Europe and the 1999 Treaty of Amsterdam paved the way for an unprecedented expansion that would eventually occur in May 2004.[12] Amsterdam offered an opportunity to tackle the weaknesses in Article 129 of the Treaty of Maastricht. Article 152 of Amsterdam, did not, however, differ greatly from its predecessor.[13] As in Article 129 of Maastricht, actions were to be achieved by ill-defined 'incentive measures'. There was still no clear definition of public health and, in particular, no recognition of the importance of addressing the wider determinants of health. There was now a firm pledge to 'ensure a high level of human health protection in the definition and implementation of all Community policies and activities', yet there was no indication of how this would be done.

Capturing something of these frustrations the then Social Affairs Commissioner, Padraig Flynn remarked 'I must confess to a certain degree of disappointment on the text… Yes, the draft Treaty does confer new Community competencies in the field of public health. However… in my view, the new Treaty provisions do not provide the Commission with an adequate legal basis to address future concerns.'[14]

The European Court of Justice

The failure to incorporate health care in a Treaty has therefore created an effective legal vacuum, and into this vacuum has stepped the European Court of Justice. Along with the Commission, the Parliament and the Council, the Court was one of the original four institutions established under the Treaty of Rome. Its three main purposes can be summarized as follows: to judge in disputes brought by the Commission or the Member States against the Member States concerning questions about the legality of action and non-compliance; judicial review of the actions and the failure to act by the European institutions; and to act as a preliminary reference procedure, in other words as a system whereby national courts can refer questions on European law to the Court. It is the last of these that constitutes the majority of its work.

Until 1963 the Court had a limited role. This changed following a series of judgements then and in subsequent years when the Court decided that individuals had the right to invoke European Community law.[15] More importantly, it resulted in the principle of 'direct effect' applying to all primary Treaty articles, so that member states could not get away with failing to pass into national law what had already been agreed at European level.

The concept of direct effect had at first only been applied to narrow Treaty provisions, where an individual takes action against a state for its actions or its failure to act. This is termed vertical direct effect. Subsequently, the concept of horizontal direct effect has developed, whereby one individual or legal entity, such as a company, can take action against another. This was, however, complicated by the nature of European law. Here it is necessary to step back for a brief explanation. In legislating, the European institutions can enact regulations which are sufficiently specific and widely applicable to be immediately binding on all member states. However, more often, to take account of national specificities, they can issue directives, whereby each member state is required to develop its own legislation that achieves the objectives set out in the directive, taking account the specificities that apply to it. These might include different institutional frameworks or terminology. It is this process of transposing directives that so often gives rise to unintended consequences when member states have failed to subject the initial directive to adequate scrutiny.

It was clear that Regulations have both vertical and horizontal effect. However, it is difficult to argue that an individual can be held responsible for failure to comply with a directive that has not been transposed into national law. This was the view taken by the Court ruling in the 1986 Marshall case.[16] However, to compensate for the lack of

horizontal direct effect of Directives, the Court developed the doctrine of 'state liability' whereby the state can be held liable for infringements of Directives.[17] The doctrine of state responsibility that emerged led to an increase in compliance with Directives, and indeed, direct effect has resulted in a massive increase in the number of cases brought before national courts in the name of European law. The concept of direct effect thus makes European law more like national than international law, in that individuals can invoke it directly, whereas they can only invoke international law once it has been transposed into domestic law.

The other major principle established by the Court was the 'doctrine of supremacy'. In 1964 the Court ruled that, where there was a conflict, national law gave way to European law.[18] The combination of direct effect and supremacy has meant that the European Court has been able to play a major role where the member states and the European Institutions have failed to act.

Direct effect is important because it inevitably leads to a degree of legal integration amongst the Member States and, as a consequence, political and economic integration by virtue of the cumulative effects of specific rulings.[19–21] In these ways, the European Court of Justice has created the basis for a federal legal system.

Making European health policy

Member states have conceded the need for the European Union to play a role in public health, but only in somewhat limited, ill-defined circumstances, and where its scope for action is extremely limited. Moreover, even though the provision of health care is one means of enhancing the health of Europe's citizens, it is an area that is specifically reserved for the member states. Yet when health systems seek to do anything, such as purchase pharmaceuticals or medical equipment, or to recruit a health professional, their scope to act is determined largely by laws that have their origins in European legislation. At the same time, when the citizens of a member state travel outside their national frontiers, they are often entitled to receive health care should they need it. Yet, they can have no such guarantee about the quality of the health care they receive.

The process of creating a new European law is undertaken by the European Commission. It must then be agreed both by the Council of Ministers of the Member States and by the European Parliament. The problem arises when a measure is being taken that arises in a policy area other than health but which has consequences for health or health care. The examples are legion, and include the Transfer of Undertakings (Protection of Employment) directive, which limited the ability of hospitals in the UK to achieve savings by contracting out ancillary services,[22] or the Working Time Directive,[23] which limits the hours worked by, among others, junior doctors. Measures such as these would typically be initiated in the Commission's Internal Market Directorate, discussed by trade or employment ministers from the member states at their council meeting, and examined by the Parliament's committees on employment or the internal market. Those with an interest in health care would have little say.

In other situations, where the legal basis for action is less clear, it often falls to the European Court of Justice. An example is the issue of patient mobility. This was tested by two citizens of Luxembourg, who received health care outside their country. On returning to Luxembourg they presented their receipts to the Luxembourg Social Insurance Fund, which declined to reimburse them as they had not obtained authorisation in advance, at the time widely viewed as a legal requirement.

The Court took a different view, arguing that to refuse to reimburse them represented an unlawful impediment to freedom of movement of goods and services.[24] These rulings immediately created an entirely new mechanism for patients to obtain treatment abroad, in parallel to the existing E112 system, whereby patients could get approval to receive treatment where they would otherwise be subject to undue delay. However they only created this mechanism for those cases arising in similar situations. In other words, they applied to people in health systems where they paid at the time of obtaining services and were later reimbursed, and not where services were free at the point of use. They also applied only to ambulatory care, and not to hospital care. Obviously, this raised as many questions as it answered. Not surprisingly, these cases were soon followed by a number of others and the Court decided that these rights to care extended to those insured in systems were they received benefits in kind, in this case the Dutch system.[25] However, yet again, the Court answered one question but generated another. In these cases it ruled that the right to travel was subject to the treatment being accepted as usual within professional circles, although it qualified this by saying that this meant international clinical practice. Given the wide diversity in many aspects of clinical practice within Europe, it is interesting to speculate what this might be. As time progresses, more

and more cases with specific features are coming before the Court.[26,27]

It is now clear that people have a much greater entitlement to treatment outside their own country than many realize. This piecemeal accretion of legislation is not a sensible way to proceed. Is there an alternative?

We have argued that the position of health and, particularly, health care within European law, is anomalous. Member states have sought to restrict the scope of the European Union to take actions that will interfere with their health systems. Yet too often, the result has been the opposite, with laws being passed with profound implications that are only recognized when it is too late.

There are differing views on what should have been done about health services. Obviously there are the American health care companies who, in the face of a domestic slowdown in growth, are seeking new opportunities.[28] There are also some commentators who argue that there should simply be an exemption for health services, although given the problem of defining the boundaries of the health system, this seems unlikely to succeed. Others argue for the development of a specific directive that would deal with the specificities that arise, although it is not clear how this would fit with the current treaty that formally recognizes the responsibility of member states for their health systems. In other words, it is a bit of a mess. And it is a problem that could have profound implications, given the huge scope for market failure, with new entrants cream-skimming low-risk elements, leaving state sectors to pick up the pieces that no-one else wants.

Moving forward

So what is the alternative? The 2000 Lisbon European Council, that launched the drive for European competitiveness, also developed a new method of working called the 'Open method of co-ordination'.[29] The idea behind it was to find a way in which member states could make progress in areas that defied attempts at harmonization. It was designed to allow sharing of best practice to help member states develop their own policies in ways that would promote convergence towards EU goals. The process includes developing guidelines, establishing indicators and benchmarks of progress towards agreed aims, and monitoring and peer review, with implementation of changes by means of domestic rather than European legislation.

Radaelli has made a strong case for the Open Method of Coordination as a new system of governance, arguing that it allows for a new, more limited role for legal instruments, a new approach to problem solving, greater participation, explicit recognition of diversity and subsidiarity, new ways of generating usable knowledge, and enhanced potential for policy learning.[30] However, he also identifies a number of tensions. These include how to balance the quest to promote convergence while accepting diversity, and how to deal with any potential conflicts between enhanced competitiveness and social protection.

To conclude, there is a gap in the European approach to health policy, especially in relation to the delivery of health care. The Treaties state that it is a matter for member states, yet it is clear that many aspects are within the ambit of European law. The inability of the legislative bodies of the EU to deal with the issues that arise, or to deal with them in a way that takes account of the specificities of health systems, means that it has fallen to the European Court of Justice to make law as it goes along.[31–34] There is a need for an explicit treaty competence in relation to health systems, but one that respects the wide diversity that exists. Ideally, this would allow the member states to co-operate where necessary and to learn from each other, using the open method of coordination. The challenge is to make this work, to ensure that the citizens of Europe have access to health systems that support social solidarity and economic growth at the same time. It is not impossible but it does need some work.

References

1. Mossialos E, McKee M. *EU law and the social character of health care*. Brussels: Peter Lang; 2002.
2. Nolte E, McKee M. *Does health care save lives? Avoidable mortality revisited*. London: Nuffield Trust; 2004.
3. Commission of the European Communities. *Treaty on European Union*. Luxembourg: CEC; 1992.
4. King R. *Sunset lives. British Retirement Migration to the Mediterranean*. Oxford: Berg; 2000.
5. Figueras J, Saltman R, Sakallerides C, editors. *Critical challenges for health care reform*. Buckingham: Open University Press; 1998.
6. McKee M, Values, beliefs and implications. In: Marinker M, editor. *Health targets in Europe*. London: BMJ Books; 2002. pp. 181–205.
7. Mossialos E. *Citizens and health systems: main results from a Eurobarometer survey*. Luxembourg: European Commission; 1998.
8. European Commission. Communication from the European Commission: a concerted strategy in order to modernise social protection. COM (1999) 347 final of 14 July 1999.
9. Council of the European Communities. Council Directive 75/362/EEC of 16 June 1975 concerning the mutual recognition of diplomas, certificates and other evidence of formal qualifications in medicine, including measures to facilitate the effective exercise of the right of establishment and

freedom to provide services, OJ L 167, 30 June 1975. p 0001-13.
10. Council of the European Communities. Council Regulation (EEC) 2793/81 of 17 September 1981 amending Regulation (EEC) 1408/71 on the application of social security schemes to employed persons and their families moving within the Community and Regulation (EEC) 574/72 fixing the procedure for implementing Regulation (EEC) 1408/71, OJ L 275, 29 September 1981
11. Commission of the European Communities. *Single European Act*. Brussels: CEC; 1987.
12. McKee M, MacLehose L, Nolte E, editors. *Health policy and European Union enlargement*. Open University Press: Buckingham; 2004.
13. Mossialos E, McKee M. The Amsterdam treaty and the future of European health policy. *J Health Serv Res Policy* 1998;**3**:65–7.
14. Flynn P. Reactions to the Treaty of Amsterdam. *Eurohealth* 1997;**3**(2):2–3.
15. European Court of Justice, C-26/62, Judgement of 05/02/1963, Van Gend en Loos Nederlandse Administratie der Belastingen.
16. Marshall v. Southampton and South-West Hampshire Area Health Authority, (1986) ECR 723, (1986) 1 CMLR 688.
17. European Court of Justice, C-6/90, Judgement of 19/11/1991, Francovich and Bonifaci.
18. European Court of Justice, C-6/64, Judgement of 03/06/1964, Costa E.N.E.L.
19. European Court of Justice, C- 8/74, Judgement of 11/07/1974, Procureur du Roi Benoit & Dassonville.
20. European Court of Justice, C-120/78, Judgement of 20/02/1979, Rewe-Zentral AG Bundesmonopolverwaltung fhr Branntwein (Cassis de Dijon).
21. European Court of Justice, C-43/75, Judgement of 08/04/1976. Defrenne Sabena (Defrenne II).
22. Council Directive 98/50/EC of 29 June 1998 amending Directive 77/187/EEC on the approximation of the laws of the Member States relating to the safeguarding of employees' rights in the event of transfers of undertakings, businesses or parts of businesses. Official J **L 201**: 1998; 0088-92.
23. Council of the European Union. Council Directive 93/104/EC of 23 November 1993 concerning certain aspects of the organisation of working time. Official J **L 307**, 1993, 0018-24.
24. European Court of Justice, C-158/96, Judgement of 28/04/1998, Kohll Union des caisses de maladie and European Court of Justice, C-120/95, Judgement of 28/04/1998, Decker Caisse de maladie des employés privés.
25. European Court of Justice, C-157/99, Judgement of 12/07/2001, Smits and Peerbooms.
26. European Court of Justice, C-326/00, Judgment of 25/02/2003, IKA
27. European Court of Justice, C-145/03 Judgment of 12/04/2005 Keller
28. Boaden R, Dusheiko M, Gravelle H, Parker S, et al. *Evercare evaluation interim report: implications for supporting people with long-term conditions*. Manchester: National Primary Care Research and Development Centre; 2005.
29. Zeitlin J, Pochet P, editors. *The open method of co-ordination in action*. Brussels: Peter Lang; 2005.
30. Radaelli CM. *The open method of coordination. A new governance architecture for the European Union?*. Stockholm: Swedish Institute for European Policy Studies; 2003.
31. Kanavos PG, McKee M. Cross-border issues in the provision of health services: are we moving towards a European Health Policy? *J Health Serv Res Pol* 2000;**5**:231–6.
32. Mossialos E, McKee M. Is a European healthcare policy emerging? *Brit Med J* 2001;**323**:248.
33. COM 304; Commission Communication on 'Modernising social protection for the development of high-quality, sustainable and accessible health care and long-term care: support for national strategies using the 'open method of co-ordination'; 2004.
34. Scharpf F. Governing in Europe: *effective and democractic*? Oxford: Oxford University Press; 1999, p. 192.

Commentary on "Health policy and European law: Closing the gaps"

Govin Permanand

LSE Health and Social Care, London School of Economics and Political Science, Houghton Street, London WC2A 2AE, UK

In their comprehensive review article, McKee and Mossialos highlight that European Union health policy — at least in terms of the emergence of a coherent framework — is affected by what Fritz Scharpf terms the 'constitutional asymmetry' between EU policies to promote market efficiency and those to promote social protection.[1] That this is exacerbated by a dissonance between the Commis-

E-mail address: g.permanand@lse.ac.uk.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.009

sion's policy-initiating role in respect of single market free movement priorities, and the member states' right to set their own health(care) priorities, is also noted. Both of these are Treaty-based competencies, leading to a somewhat peculiar situation where national healthcare systems fall outside European law, yet elements relating to financing, delivery and provision are directly impacted upon. The result has been an ad hoc development of measures, and an on-going tension between economic and social priorities in respect of the provision of healthcare.

The European Court of Justice (ECJ) is thus increasingly called upon to smooth those areas where the tension becomes most acute, and it has set important precedents in areas such as patient mobility and the reimbursement of medical costs. Rather than simply interpreting law, however, given the institutional constraints identified, the Court is in fact setting policy; and doing so on the basis of what McKee and Mossialos have elsewhere referred to as 'atypical cases'[2] within the single market rules. What we in essence have, therefore, is an unelected — and hence unrepresentative — body deciding on social policy matters in relation to member states' health systems. As it is clear that the ECJ's health policy-defining (if not –creating) role is not ideal, the question which emerges, and which McKee and Mossialos highlight, is: 'So what is the alternative?' And here they tentatively consider the applicability of the 'open method of co-ordination' (OMC), as the Commission has recently issued a communication regarding the extension of OMC to healthcare systems.[3]

Heralded as an emergent form of EU governance, OMC is a bottom-up incremental approach towards achieving common European objectives based on benchmarking national progress. Oriented around soft law mechanisms and 'mutual learning', it seeks convergence in policy areas which are primarily the purview of the member states but otherwise of interest to the Community as a whole; it has thus been used for social protection issues including employment, social inclusion, and pension reform. McKee and Mossialos cautiously endorse the view that OMC can play a role in health, and they are right to be cautious.

At the risk of delivering a soundbite: 'what can be counted does not necessarily count, what counts cannot necessarily be counted'. With regard to European healthcare systems then, what are the elements or indicators that can be benchmarked in a meaningful or beneficial way? The difficulties in the comparability of national health data have long-been recognized, and this is likely to prove an even greater challenge following the recent expansion of the Community to 25 members; many of which are still developing comprehensive health data collection capacities. Moreover, who is best-placed to decide on the indicators? High-level European policy-makers who seek to maximize outcomes in such a manner as to serve their own constituents or national self-interest, or the technocrats who will be required to dispassionately (dare one say inflexibly or bureaucratically) sort out the details in raising the 'convergence bar'? A more fundamental issue given the constitutional asymmetry, is that before even contemplating OMC as a possible solution, it first needs to be asked what the underlying objective is going to be, i.e. what are we working towards?

Is it to protect member states' economic development by pursuing healthcare efficiency gains and cost-saving while maintaining the social provision model; or is it to use market forces to help member states relieve pressures on public finances through privatisation and deregulation policies? The former would of course be commendable, but hard to pursue; the latter much easier to implement, but essentially resulting in the costs being shifted to the consumer/patient. Elements of each need to addressed together, particularly given the diversity in member state economic and social outlook.

In order to take the debate forward, therefore, what is first needed is a clear and shared European agenda as to the desired future 'European health policy'. And as McKee and Mossialos conclude, the challenge is to develop a framework under which European citizens benefit from healthcare systems that concomitantly support 'solidarity and economic growth'. Indeed, as Scharpf himself has written elsewhere: "Market-correcting regulations can succeed only as parts of a complex configuration of rules and practices which must maintain and increase allocative efficiency and competitiveness at the same time as they are protecting the non-economic values of a society."[4] Here we can only hope that it is an agenda which is guided by the principles of the European social model.

References

1. Scharpf F. *The European social model: coping with the challenges of diversity. Max-Planck Institut für Gesellschaftsforschung Working Paper 02/08*. Köln: MPIfG; 2002.
2. Mossialos M, Mckee M. Is a European healthcare policy emerging? *Br Med J* 2001;**323**:248.
3. Commission of the European Communities. COM (2004) 304 of 21.04.2004 on 'Modernising social protection for the development of high-quality, sustainable and accessible health care and long-term care: support for national strategies using open method of co-ordination'. 2004.
4. Scharpf F. *Governing in Europe: effective and democratic?*. Oxford: Oxford University Press; 1999.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Communicable disease control and contemporary themes in public health law

Richard Coker*

London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

Introduction

On Sunday 8 May 2005, under the headline 'TB HUMAN TIMEBOMB INFECTS 12', the Mail on Sunday described the case of a 'convicted criminal with a highly contagious form of tuberculosis' whom the 'authorities are powerless to make … accept medical treatment'.[1] This, the article suggests, is 'a shocking indictment of Labour's failure to update Victorian quarantine laws'. Dr. Philip Monk, Consultant in Communicable Disease Control, was quoted: 'We cannot adequately protect people from infectious diseases … This case illustrates the failures of the current public health laws to perfection. There is an urgent need to review them.' The balance between civil liberties and public good is one issue at the heart of public health law, and infectious diseases throw into relief these balancing tensions.

The scope of public health law

But first, let us ask, what is public health law? Public health law per se is not considered a subject in its own right. Beyond the purview of communicable diseases, little legislation in the UK directly targets specific public health matters, but rather may more generally impact upon public health. In the first paper in the series on public health law, Gostin gave the following definition of public health law, drawn from his book subtitled 'power, duty, restraint':

> The legal powers and duties of the state to assure the conditions for people to be healthy and the limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for protection or promotion of community health.[2]

Whilst public health law addresses the role of government, the relationship between the people and the state, and the functions and services of the public health system, Gostin also suggests that public health law must also always pose the question, 'Does a coercive intervention truly reduce aggregate health risks, and what, if any, less intrusive interventions might reduce those risks as well or better?'[2]

This determination of aggregate health benefit and the link with coercive measures has attracted much attention in recent years.

Shifts in protection of human rights: the example of detention and tuberculosis

Involvement of the law has a long history in the control of infectious diseases.[3] In England and

*Tel.: +207 927 2926; fax: +207 612 7812.
E-mail address: richard.coker@lshtm.ac.uk.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.010

Wales the scope to remove individuals in need of care and attention exists under Section 47 of the National Assistance Act 1948, and criminal charges might theoretically be brought against an individual who poses a threat to a child under the Children and Young Persons Act 1933 and the Children Act 1989. In practice, however, the key piece of legislation for England and Wales is the Public Health (Control of Disease) Act 1984. Six conditions are specified in the Act (cholera, plague, relapsing fever, smallpox, typhus, and food poisoning). Under section 13 of this Act the Secretary of State has the power to extend the Act to other diseases and has done this under the Public Health (Infectious Diseases) Regulations 1988. These provisions add a further 24 diseases. But, *all* the powers set out in the 1984 Act apply only to the diseases named in the Act. As the 1989 Department of Health Review on Infectious Disease Control noted, 'this has led to the confusion'.[4]

For tuberculosis, for example, two sections of the Act, sections 37 and 38, apply to tuberculosis 'of the respiratory tract in an infectious state.' These two sections relate to the removal and detention of individuals with TB. These are, broadly, the same as the powers introduced for the removal and detention of uncooperative TB patients under the Public Health Act 1936 and indeed, to a large degree, in law enacted in the nineteenth century through the 1875 Act.[3] The current power to detain individuals with TB has legislative roots 130 years old.

The history of the Public Health Act 1984 illustrates how human rights' protections can be lost as well as gained over time. The 1875 Public Health Act authorized the state to remove and detain persons 'suffering from any dangerous infectious disorder … without proper lodging or accommodation' for 'as long as may be necessary' but specifically excluded individuals with TB, wording almost identical to that of the 1984 Act.

The reasons for the exclusion of those with TB from the powers of the Act were in large part due to the endemic nature of the disease, the fact that it crossed class barriers. Epidemics of acutely infectious diseases, in particular cholera, generated considerably greater immediate public and political anxiety, and the duration of TB might at that time stretch to years. There was a concern that stigmatization of those with disease, already a problem, might be aggravated.

Under the 1925 Public Health Act the removal and detention of individuals with TB was sanctioned. But several important safeguards were incorporated—safeguards it is worth reminding ourselves of because they no longer exist. Specifically, detainees were given 3 days warning that an order was to be issued giving them sufficient time to mount a defence of their actions; detention was of limited duration; there was an automatic built in codified process of review; applications for the order to be rescinded could be made six week after the issuance of an order; and orders for detention had to be made in person, not ex parte. So, specific human rights protections were introduced in contrast to those suffering from other 'dangerous infectious diseases'.[3]

In 1968, one might argue at the height of the liberal era, all the civil rights safeguards that were legislated for in 1925 were removed. Why was this? One could posit that, in the light of recent therapeutic advances, the rise in living standards, and the apparent conquest of infectious diseases, the 1960s was, as well as being a liberal era, also a period when public intolerance of disease grew.[3]

A basic premise, enshrined in all major human rights instruments, is that the public good takes precedence over individual rights. But the public good does not take precedence irrespective of circumstance. The incorporation of much of the European Convention on Human Rights into British Law through the Human Rights Act 1998 allows us to scrutinise the justness of the current legislation used to detain individuals with TB.

The intention of article 5 of the Convention is to protect citizens from arbitrary detention. Under this article, detention becomes unlawful if it ceases to serve the purpose of the original order, that is, the purpose of protecting the public from a risk of infection. Because the magnitude of the danger posed by any individual with TB is likely to change qualitatively over time (for example, moving from infectious to non-infectious) and the purpose of the original order was to modify the threat, the European Court holds that it is necessary for an independent 'court' to review the merits of continuing detention at periodic intervals.[5] In England this does not happen. Currently courts may impose fixed-term orders on the basis of a prediction of *future* dangerousness. Indeed, orders of 6 months, well in excess of the 2 week periods in the minds of the original framers of the Act, have been issued in recent years.[6] The release of detainees may therefore, in theory at least, occur many months after they have ceased to be infectious and an imminent public health threat.

Yet, the framing and application of the Public Health Act seems likely to falter when we critique it as an effective public health tool too—for there is no evidence base that shows that detention as a public health tool is effective in the control of TB.[7]

Over time the line that has been drawn between the power of the state and civil liberties has shifted not necessarily because of changes in the nature of the public health risk, or the evidential basis of the law, but because of changing perceptions of risk and the social context in which demands are heard.

Pre-emptive strikes: from assessment of threat to anticipation of behaviour

The issuance of lengthy detention periods has occurred because of contemporary concerns, including drug resistance. The development of drug-resistant TB is a modern scourge. Iatrogenic in nature, fears over economic, personal and political costs have been profound and global. Indeed, one could argue that the issuance of orders for detention that correspond not with periods of infectiousness but with periods of treatment testify to these concerns and inform the contemporary framing of public health legal responses.

This concern over controlling the development of drug resistance, and by its nature ensuring compliance with treatment, was at the heart of novel regulatory changes adopted in New York in the early 1990s.[8] The tension between the waning nature of the public health threat as individuals started and continued their treatment and the need to ensure compliance was a difficult one for public health officials to manage. They did this through creating a fundamental shift from depending on an assessment of *threat* posed to the public by a noncompliant individual to an assessment of treatment *compliance*. This represented a significant shift in the balance between civil liberties and state authority.

At the time, the threat of detention was viewed as an effective measure that 'encouraged' compliance. Detention orders could be issued without patients having 'failed' to comply with treatment or, indeed, having failed to comply with a public health order that demanded treatment.

The problem for those urging detention as an effective public health tool in controlling TB (and the development of MDRTB) has been that although non-compliant, non-infectious individuals potentially pose a serious threat—MDRTB—it is neither immediate, quantifiable, nor probably, on an individual basis, substantial. And importantly, the threat declines the longer any individual is on treatment. At some point surely a threshold is crossed where, if detention were based on the risk of becoming a threat to public health, that patient should be released before treatment is completed even if future compliance is expected to be poor.[8,9]

There are parallels with contemporary approaches in the UK to manage the mentally ill through assertive outreach predicated on assessments of future poor compliance with treatment. Parallels can also be seen in the detention of people with dangerous severe personality disorders.[9]

Criminalization and HIV transmission

Societal influences and responses to HIV have an ignominious history. Musto noted some of these complex influences early in the HIV epidemic when calls for quarantine were being loudly voiced in some quarters in the US: 'The fear of disease … arises not just from a reflection on the physiological effects of a pathogen, but from a consideration of the kind of person and habits which are thought to predispose one to the disease.'[10]

Ethicist Ron Bayer wrote in his early history of HIV regarding the rejection of calls for quarantine for HIV: 'It was … unthinkable that the courts, which had developed such exacting standards for the protection of criminal defendants and which had rejected the unfettered discretion of the state in cases involving the control of juvenile offenders and the commitment of mental patients, would do less in the case of those who might become targets of efforts at isolation and quarantine.'[11] Bayer had documented what he saw as a fundamental change in the 1980s in the public health legal response to infectious disease. He suggested that a change occurred in the conceptions of individual and public well-being, a change that contributed to a review of the ethical foundations of healthcare practice.

Our contemporary responses to HIV, therefore, should force us to ask the question: Were our early responses to AIDS and HIV merely an aberration, a departure from the traditional model of public health practice in which coercion is perceived as a necessary part of the state's public health armamentarium?

In responding to this question, I reflect here on the criminalization of HIV transmission, a measure that has recently resulted in the prosecution of a number of people in Britain.

Eighteen months ago Mohammed Dica, a 37 year old Somali man, was successfully prosecuted and sentenced to 8 years imprisonment for 'unlawfully and maliciously inflicting grievous bodily harm' because he transmitted HIV. In England, following Dica, three further people have been convicted. Those convicted were not prosecuted under the Public Health Act, but found guilty of *recklessly* inflicting grievous bodily harm under the Offences

Against the Person Act 1861, section 20. These cases suggest that if someone knows he is HIV positive (or has reason to believe he is, despite not knowing—as was the position in one case) and is aware of the risk of transmission then he is potentially guilty of 'recklessly inflicting grievous bodily harm'.

To many this was a surprising judgement because of an important 1888 court decision. A Mr Clarence knew he had gonorrhoea, but did not inform his wife. Following sexual intercourse she acquired gonorrhoea. Clarence too was convicted under section 20 of the OAPA. Clarence's conviction was, however, quashed on appeal with the appeal court taking the view that a person could not be said to 'inflict' grievous bodily harm unless they had attacked the victim in some way, for example by hitting them.

Many legal scholars thought, therefore, that a prosecution for passing on a sexually transmitted disease by consensual sexual intercourse would fail. Although the Court of Appeal, in May 2004, ordered a re-trial of Dica, because the trial judge had refused to allow consideration of whether the women had consented to the risk of infection, the case appears to represent a novel approach to control of HIV.

This novel approach raises a large number of questions including how a court might determine whether someone consented to the risk of HIV transmission, whether the law applies to all sexual acts or just some given differences in risk (for example vaginal, anal or oral sex), and likewise does it apply differently depending upon an individual's infectious state (for example, based on their viral load or clinical status). Is it a crime to have unprotected consensual sex if HIV transmission does not occur?

Criminal sanctions serve four principle functions.[12] First, to stop an offender from harming anyone else whilst they are incarcerated; second, to rehabilitate an offender so he would not harm others in future on release; third, retribution; and fourth, to deter others from behaving in a similar manner in the future. From a public health perspective, perhaps the most important issue is the fourth function—to deter others from behaving in a similar manner in the future and consequently to enhance the public health overall. Our understanding of this may have profound implications for how we frame coercive public health measures.

Whilst criminalization of HIV transmission through a consensual sex may result in removal of an individual from society (and the consequent removal of risk emanating from that individual), may alter that individual's future behaviour, and may offer society retribution, the broader public health benefits are less easy to determine. If concealment of HIV status is a crime, then a consequent reduction in uptake of HIV testing is likely to result in greater transmission of HIV. The criminalization of concealment discourages people from seeking to know their HIV status with potentially very serious public health consequences.[12]

An important tension exists here. How does the law balance these four principles? Which takes precedence? How is the individualized health protection role to be balanced against the possible perverse public health consequences of sanctions? The Home Office in their consultation exercise on this issue suggested that, 'the criminal law deals with behaviour that is wrong in intent and in deed.'[13] But it does not, apparently, deal coherently with public health imperatives.

Migrant populations and public health protection

Self-interest, knowledge and fear mould social, political and legal responses to infectious diseases when national security and welfare are threatened. Responses are modified by forces beyond the narrowly epidemiological.

Self-interest and notions of global engagement are important driving forces. The world shrunk on 11th September 2001. Bio-terrorist threats coupled with the threat of a flu epidemic and SARS highlighted the inadequacy of global surveillance and response capacity. The re-writing of the International Health Regulations, woefully outdated, gained urgency. The new IHRs signify an important re-formulation of laws governing international surveillance with a general, more generic, acknowledgement of the emergencies of international concern beyond the purely narrow disease-specific framing of old. Their purpose is to provide a legal framework that enhances surveillance and responses both to known public health threats and also to those as yet unknown, without the need to be constantly revising the regulations.

In 2003, SARS was a novel disease caused by an unknown agent that provoked considerable media attention, public anxiety, and political concern. Public health systems were challenged in a way they had not been previously. Transnational relations were also tested and the relations between nation states and international institutions, notably the WHO, were re-framed, at first informally, and subsequently formally.[14] National and international surveillance capacities were examined more

critically. The public health discourse and rhetoric over previous years regarding preparedness for agents of bio-terror and dangerous antigenic shifts in the influenza virus were no longer theoretical but being tested by reality.

When faced by a novel infectious disease, uncertainty over its transmission dynamics, and the political imperative to protect public health, policy makers reach for several tools in their armamentarium including some approaches that lack an evidence base. The nature and urgency of the public health challenge demands action and the consequences of ineffective implementation of measures are deemed too risky. Mandatory airport screening for fever was one such measure.[15] Implementation of airport screening was intended to address two issues. First, and most importantly, to allay public anxiety and assure the public that 'something was being done and all was under control.' Second, as a rational public health intervention, to detect early those with SARS and facilitate isolation so that transmission would be curtailed. Whilst the first purpose was served, it seems likely that the second purpose was not. The transmission dynamics and non-specific nature of the SARS illness mean that large numbers of people with fever unrelated to SARS may be hindered from flying or entering a country if the screening is at ports of entry or exit, and many people incubating the disease will go onto develop SARS only after disembarking.[16]

This example of screening for SARS highlights the responses, sometimes apparently irrational or lacking in substantial public health benefit yet still serving a wider, though sometimes unacknowledged, political purpose.

Other diseases, notably HIV and TB, provoke different policy responses including those that internationally fit a global engagement/moral leadership model but on the domestic front fit the narrow self-interest model. And these two models do not always sit comfortably together.

For example, the charging of overseas visitors for HIV treatment in the UK seems, on the face of it, incoherent with advocating the necessity of a global response to HIV including the wider provision of anti-retrovirals in Africa. Imposed interruptions of antiretroviral treatment seem a paradoxical response to what is a global public health catastrophe. Yet this is an example of policy that appears to take account of economic constraints but disregards public health imperatives.

Global health scourges play out in countries receiving immigrants and asylum seekers and the Immigration Act 1971 gives immigration officers the authority to refer migrants to medical inspectors for medical examination.

In order to improve the effectiveness of screening for TB the UK Home Office's Five Year Plan for Immigration and Asylum, published in February 2005, aims to strengthen pre-entry screening of migrants for TB. Three points are worth reflecting when regarding this re-focus of an existing policy and the greater use of mandatory screening at the pre-entry stage. First, most active tuberculosis disease appears to develop after immigration. Second, there is little evidence that migrants delay seeking care for tuberculosis once they develop symptoms. Third, and perhaps of greatest importance, the public health benefits seem to be less than some might have anticipated.[17]

This re-positioning of public health policy raises a number of questions. Is narrow-self-interest the driver behind this renewed interest in screening policies for TB or are other, more pressing and politically popular issues to the fore? How does the evidence base inform policy-making in practice? Clearly, whilst public health gains are important, so too are other considerations, and senior politicians must make judgements which in the end are political. But these judgements should be coherent such that domestic policy should, as much as is practicable, align with the policies that are being advocated on the international stage.

Conclusion

The framing and application of many of the laws and policies outlined above seem to stumble when the following enquiry is levelled: How effective is the intervention in public health terms? For in truth, to almost all the themes I have addressed, the answer is 'we don't know'. But more than this, we have hardly begun to ask the question. For some reason, the evidential base that should support laws as public health tools is almost entirely lacking. Laws have only infrequently been viewed as public health interventions and subjected to examination as would be other interventions. The issue of criminalization of HIV transmission, which addresses individualized questions of behaviour, wrong-doing and retribution, yet at the same time potentially harms population welfare, illustrates how even when some evidence does exist policy (made in this case by the courts) seems to disregard it.

Our current public health legal framework was legislated in the 19th century and predicated on 19th century medical, social and epidemiological understandings of public health. Perhaps, with the

UK government now committed to reviewing public health laws, we might be in a position to inform how such laws might be framed in order that they improve public health to the greatest degree, balance human rights and social needs most appropriately, and provide a rational and coherent basis for the public health control of infectious diseases in line with 21st century knowledge and social mores.

Conflict of interest

Since February 2005, Richard Coker has been seconded part-time from the London School of Hygiene and Tropical Medicine to the Department of Health as Senior Medical Officer in the General Health Protection Branch. This paper and the lecture it draws upon was drafted ahead of his secondment. The views presented should not be interpreted in any way as those of the Department of Health.

References

1. Ellis R. TB human timebomb. *Mail on Sunday* 2005. p. 1.
2. Gostin LO. *Public health law: power, duty, restraint*. Berkeley, Los Angeles, London: University of California Press; 2000.
3. Coker RJ. Civil liberties and public good: detention of tuberculous patients and the Public Health Act 1984. *Med Hist* 2001;**45**:341–58.
4. Department of Health. *Review of law on infectious disease control: consultation document*. London: Department of Health; 1989.
5. Coker RJ. The law, human rights, and the detention of individuals with tuberculosis in England and Wales. *J Pub Health* 2000;**22**:263–67.
6. Coker RJ. National survey of detention and TB. *Thorax* 2001;**56**(10):818.
7. Coker RJ. Public health impact of detention of individuals with tuberculosis: systematic literature review. *Public Health* 2003;**117**:281–87.
8. Coker RJ. *From chaos to coercion: detention and the control of tuberculosis*. New York: St. Martin's Press; 2000.
9. Szmukler G, Appelbaum P. Treatment pressures, coercion and compulsion. In: Thornicroft G, Szmukler G, editors. *Textbook of community psychiatry,*.Oxford: Oxford University Press; 2001.
10. Musto DF. Popular and public health responses to tuberculosis in America after 1870. In: Harden VA, Risse GB, editors. *AIDS and the Historian*. Washington, DC: U.S. Department of Health and Human Services; 1991.
11. Bayer R. *Private acts, social consequences: AIDS and the politics of public health*. New York City: The Free Press; 1989.
12. Elliott R, Maluwa M. *Criminal law, public health and HIV transmission: a policy options paper*. Geneva: UNAIDS; 2002.
13. *Violence: reforming the Offences Against the Person Act 1861*. London: Home Office; 1998.
14. Fidler DP. Germs, governance, and global public health in the wake of SARS. *J Clin Invest* 2004;**113**:799–804.
15. St. John RK, King A, de Jong D, Bodie-Collins M, Squires SG, Tam TWS. Border screening for SARS. *EID* 2005;**11**:6–10.
16. Pitman RJ, Cooper BS, Trotter CL, Gay NJ, Edmunds WJ. Entry screening for severe acute respiratory syndrome (SARS) or influenza: policy evaluation. *BMJ* 2005.
17. Coker R. *Migration, public health and compulsory screening for TB and HIV*. Asylum and Migration Working Paper 1. London: ippr; 2003.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on ''Communicable disease control and contemporary themes in public health law''

John D.H. Porter

International Health, London School of Hygiene and Tropical Medicine, Keppel Street, London WC1E 7HT, UK

At this point in the 21st century there are disturbing themes, approaches and trends emerging in the control of infectious diseases. In his paper, Dr Coker highlights some of these: the shifts in the protection of human rights, pre-emptive strikes on the prediction of threat, and criminalization of transmission of infectious disease. In addition, globalized responses to the control of 'new infections' like SARS may be important, but the responses themselves may create discrimination and injustice. The emotion that underlies all these responses is 'fear'; and fear within a state and among its people can lead to increased control and a loss of civil liberties. We are frightened of disease and infectious disease in particular, and our 'natural response' is to protect ourselves, our families and our countries from 'others', who may be 'outsiders', who may harbour and potentially transmit these infections. The problem with this approach is that it lacks wisdom and lacks a humanitarian core, both essential for a 'healthy society'.[1] But through legal frameworks that balance arguments and present relevant facts and information, the law can help to reintroduce these concepts through reminding each of us, and society more broadly, of the issues and the dangers of the loss of civil liberties. A healthy society is one in which people are free to move around and to express themselves, but it is also a society in which people understand their duties to their society through their connection at all levels from the local community, to the district and region and finally to central government bodies. The law finds expression at all these levels.

Within public health ('providing the conditions in which people can be healthy'), infectious disease control is a useful lens for extracting information on the overall 'health' of the state and its people. Is this a state that wants to control individuals for the 'common good' or is this a state that does everything in its power not to use coercive measures to prevent individuals from leading the sort of lives that they wish for themselves and their families?[2] How a state treats its most vulnerable groups (like patients with TB or HIV for example) provides an insight into the overall philosophy of how the state works—is it utilitarian for example, or is it about virtues, or God and duties?[3,4]

Public health law in the UK needs to be updated to reflect public health in the 21st Century. Through this process there is the opportunity to help guide and instruct broader themes and ideas within UK society in general. As Coker states in his paper, the disturbing themes that are appearing like 'coercion' and a loss of civil liberties need to be counterbalanced and this can be done through appropriate updating of the public health laws. Perhaps more importantly, we also need to reflect on philosophy underlying public health law, and ask whether case law and a focus on the transgressor, is

E-mail address: john.porter@lshtm.ac.uk.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.011

the most appropriate approach for the legal process.

As mentioned by Coker, in the 1980s Ron Bayer documented a change in the public health legal response to infectious disease. He wrote, 'with the recognition of AIDS and HIV in the early 1980s, a change occurred in the conceptions of individual and public health well-being, a change that contributed to a review of the ethical foundations of healthcare practice'.[5,6] Perhaps, as part of the process of updating public health law, a review of the ethical foundations of UK public health law is also needed.

References

1. Porter JDH, Ogden JA, Pronyk PM. Infectious disease policy: towards the production of health. *Health Policy Planning* 1999;**14**(4):322–8.
2. Gostin L. 2000. *Public health law: power, duty and restraint*. University of California Press and the Millbank Memorial Fund.
3. Rawls J. *A theory of justice*. Oxford: Clarendon Press; 1972.
4. Themes from Catholic Social Teaching. http://www.osjspm.org/cst/themes.htm
5. Coker RJ. Silent travellers — communicable disease control and public health law.
6. Bayer R. *Private acts, social consequences: AIDS and the Politics of Public Health*. The Free Press; 1989.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Food, the law and public health: Three models of the relationship

Tim Lang

Centre for Food Policy, City University, Northampton Square, London EC1V 0HB, UK

The role of law in the governance of the relationship between food and public health is being altered by the changed structures and dynamics of modern food systems. A series of crises in food and health in the 1980s and 1990s shook up public health law throughout the world, providing a much needed modernization push, mostly over food safety.[1] Nevertheless, such is the pace and scale of change in the food supply chain — a near permanent state of change — that public health is being stretched by a new set of dynamics in which perfectly legal actions by food marketers (product-developers, technologists and the food businesses pursuing market share) have a sometimes unwitting impact on public health. The food system's modern dynamics — overproduction, brand-led marketing, highly processed value-added foods, and more— have contributed to the emergence of the current profile of diet-related ill-health, dominated by non-communicable diseases (NCDs).[2,3]

The role of law within these dynamics is problematic. There is a significant modern literature analysing the dynamics between the state and corporate systems,[4,5] echoed by a neo-liberal policy concern about excessive regulatory burden,[6] but the theoretical location of food, law and public health has not perhaps received its due attention. There is a rich seam to mine. Whereas in the 19th century, there was a long struggle to persuade the state to regulate adulterated food, today there is a struggle to contain not just over-supply of foods unhelpful for health but also poor quality foods and a pattern of eating which is slow, not quick, in contributing to premature mortality and morbidity. The role of the law as protection is thus stretched and reshaped. Can it prevent the NCDs which now dominate world health,[3] or is this a matter of choice? Until the early 2000s, much public health and diet debate focused on food safety, but the obesity pandemic has brought to a policy fore strong evidence of the burden of NCDs.

Conceptions of the relationship

This paper reviews different conceptions of how the relationship between food, health and the law can be conceived. Three models of the role of food law are discernible. In the first, a 'traditional' model posits that it is the state which sets laws and regulations that frame what the supply chain can and cannot do (Fig. 1a). The second model posits a duality in food governance (Fig. 1b), in which state and corporations compete for regulatory influence. This model has been promoted by studies highlighting the influence of food corporations at national and international levels. They shape not just food supply but culture (through marketing, advertising etc).[7–9] The third or 'triangular dynamic' model notes that despite this undoubted corporate power over what people eat (and how,

E-mail address: t.lang@city.ac.uk.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.013

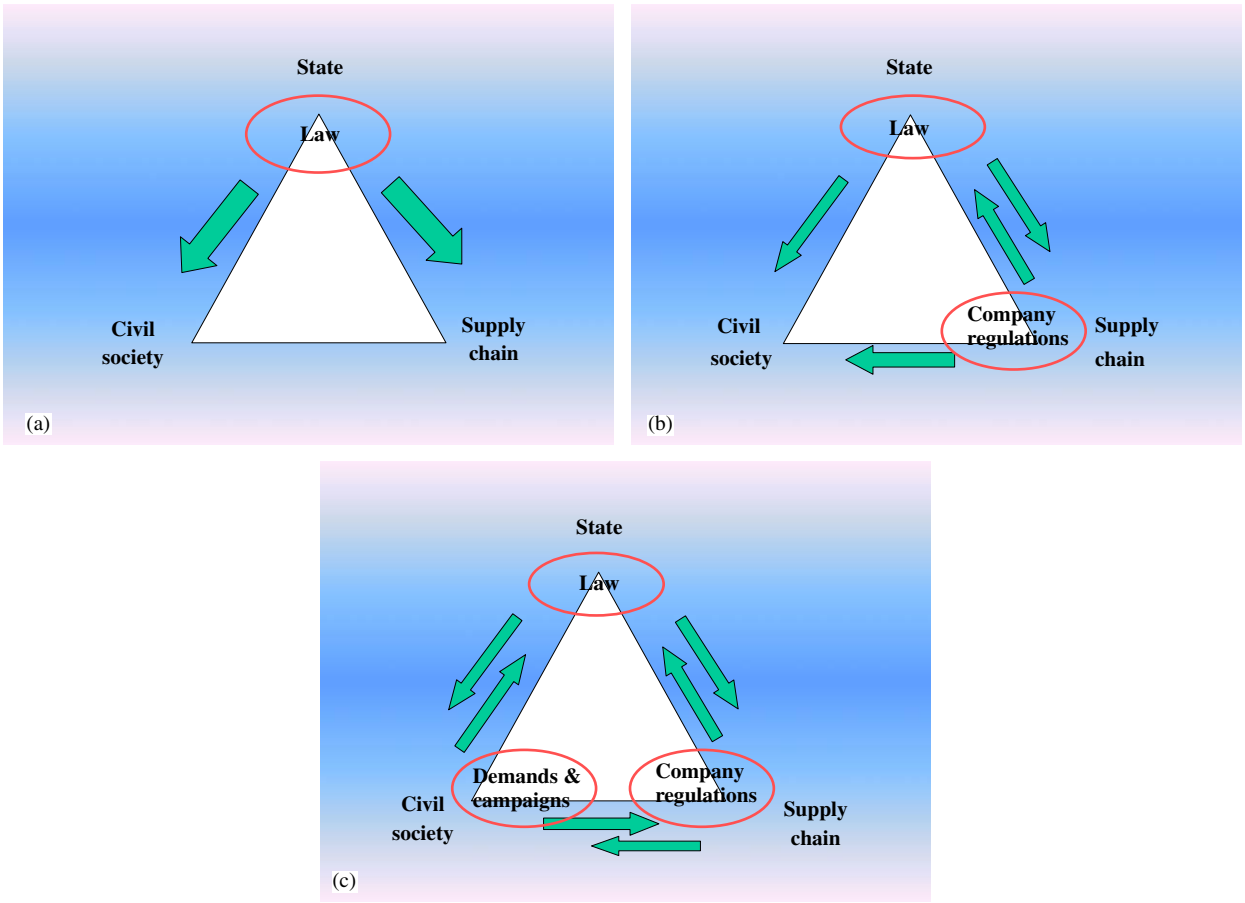

Fig. 1 (a) The 'traditional' model: food law frames the relationship between state, supply chain and civil society. (b) The 'modern duality' model: state law and company regulations. (c) The 'triangular dynamic' model of food law and governance.

where and when), civil society and popular pressure also frame food governance and law (Fig. 1c).

Each model has clear characteristics and lays emphasis on different social forces. The 'traditional' model is statist in that the legal framework is conceived as mainly set by Government, subject to due democratic process. In this model, public health is protected by the creation and maintenance of food standards. Meat, for example, can bring life-giving nutrients or contaminants, hence the role of government is to set and deliver compositional and hygiene standards. This benign state conception was articulated by the conservative English historian Arthur Bryant in 1929:[10] "[Conservatism] regards it as the duty of the modern State to ensure to the subject pure air and water, to see that his food is unadulterated, and to assist him to maintain himself and his family in sickness and old age. It lays it down as a cardinal principle that every citizen shall have a right, so far as is humanly possible, to a good education, open spaces, and healthy conditions of life. The modern State is the assurance company which assures these benefits to its citizens." (p.17) In the last quarter of the 20th century, it should be noted, UK conservatism shifted from this one-nation statist policy towards neo-liberalism.[11]

Many health-related food standards are still set, albeit at international rather than national level, for instance for residues and levels of acceptable contamination of foods. For Europeans, the EU has this role, but increasingly this is circumscribed by Codex Alimentarius Commission's role. Codex, a joint World Health Organization and Food and Agriculture Organization body, sets global standards with and for over 140 member states, and has major legal weight under World Trade Organization rules.

Although few could question the importance of national state role in legal processes, the nation state's role has been altered by more than just increasing internationalization of food law. The emergence of unprecedented levels of concentration in food sectors[12,13] (both within national markets and across borders) has generated a new force framing actual legislation and quasi-legal

regulations. The growth of cross-border food trade, through regional blocs such as the European Union (EU), the North American Free Trade Agreement (NAFTA) and Mercosur in Latin America, has enabled these food companies to exert enormous influence on what food is grown, and how, and in what food gets to end consumers, where and at what price — all of which has health implications.

A key mechanism by which corporations exert regulatory power is through international buying groups. Through their own regulatory structures such as EUREP, a worldwide consortium of companies working to its standards, they set the terms and conditions for food production.[14] EUREP, which began in Europe but now includes giant companies worldwide, sets pesticide residues, labelling and agricultural and process standards. It illustrates the dualism in standards-setting, proposed in Fig. 1b.[15] On the one hand there is the centuries-old system of public health law, albeit in new more internationalized formation, set by and theoretically accountable to democratic processes, and policed by state bodies. And on the other hand, there exists a parallel system of rules and regulations set by company contracts and specifications, policed by company buyers and inspectors, working increasingly to inter-corporate governance, and applying principles of traceability and 'due diligence' often to levels beyond those demanded by the state.

If the 'traditional' model is statist, the second model is characterized by marketization, industry self-regulation and guidelines in place of but sometimes backed by law. Indeed industry standards may sometimes be tougher than the state's. Equally, corporate interests are not backward in using consultation processes and other opportunities to ensure their interests are not damaged by formal state legislative proposals.[16,17]

In the duality model, who triumphs? One school argues that, bowed by the enormous purchasing power of the modern corporation, the 'modern' lean, facilitative state, is weak; de facto agency capture occurs.[16] Others suggest that food companies are more concerned about meeting consumer needs, and invest vast sums attempting to frame food culture to suit their product 'offer'. The law is unimportant in a world where advertising and its myriad variations such as texting, product placement, sponsorship shape consumer wants. In the UK food adspend is nearly £0.5 bn annually, 100 times government spend on food protection.[18] John Rawls' much cited equation of rights and responsibilities[19] does not easily fit in a world where McDonalds and Coca-Cola each spend over $2 bn a year on marketing, collectively four times the entire annual budget of the World Health Organization.[20] The issue is not whether consumerism is in ascendancy over citizenship but whether both are subsumed by marketization. Crucially, there is a question as to whether existing democratic institutions are accountable or whether a 'consumer votes' reality is replacing older notions of food governance.[21]

Against this view, the 'triangular dynamic' model proposes that both the other models underplay active civil society processes and pressures countering both agency capture and mainly dirigiste state legal processes. Consumer movements are not new. Indeed, part of the pressure that led to the great period of food law reform in the mid 19th century (discussed below) was active demands for legal rights to better food. This tradition of active legal demand has been a key feature of modern consumerism in general,[22,23] and of food activism in particular.[24]

Labelling: an illustration of the tension over law and health

Food labelling illustrates the long tension between interest groups over public health and wider social issues. In market theory, labels are a key mechanism for achieving efficiency. Informed consumers can decide on their food and thereby health. Labelling assumes rational choice. Consumers are invited to send signals through the point of sale to the supply chain. Since food and agricultural products entered the General Agreement on Tariffs and Trade (GATT) in 1994, there is no country whose regulations can be a legal 'island'. For countries already committed to facilitation of cross-border food trade such as the European Union, the Australia–New Zealand compact on food standards, or the North American Free Trade Agreement, issues such as labelling have taken centre stage in policy-making. They are key to the neo-liberal policy package in which unnecessary laws (including food regulations)[25] are deemed a burden on efficient production; sensible risk assessment and management procedures can prevent the vast bulk of consumer protection and safety problems; and therefore information at point of sale is a key to consumer choice. Moreover, labelling and other forms of consumer information are a core demand of the consumer movement, one of the four basic consumer rights articulated by President John F Kennedy in 1962, expanded to Consumers International's eight consumer rights.[26,27]

In reality, far from being a neutral mechanism, since the 1980s food labelling has been itself a battleground over what goes into the label, the format, verifiability, size, impact, and authority.[28,29] Different states have evolved their own rules. Different interest groups have argued for their concerns to be labelled: ethics, animal welfare, nutrition, environmental impact, residues, allergens, and more. Public health issues have been high profile in this evolving process. Content labelling came first — with the EU setting new standards by labelling additives with 'E' numbers. This was designed to assuage consumer worries about this modern form of adulteration, but in fact the E system exacerbated concerns.[30,31] Nutrition labelling was proposed from the early 1980s by public health bodies but has only been introduced slowly, meeting great resistance from processed food industries.[32,33]

In the European Union (EU), the creation of the Single Market from the mid–1980s brought new agreement on the necessity of labelling. There was considerable tension over how extensive that labelling might be. Should labels include ingredients? If so, should these be just listed or be given by weight? After two decades, the EC adopted quantitative ingredients declaration (QUID). Should it include nutrients? If so, which? In which format? Food NGOs have been vociferous for two decades in this battle over the nature and extent of labelling, arguing that consumer acceptability is the key criterion.[24]

In the UK, the Food Standards Agency backed a 'traffic lights system' — green, amber and red — developed originally by a public health NGO in response to a 1984 Committee on Medical Aspects of Food Policy (COMA) report calling for consumer labelling on fats. According to FSA, consumers find traffic lights simplest and easiest to aid discrimination between products,[34] but the food industry rejected the system, fearing discrimination against items such as confectionery and soft drinks. Manufacturers instead introduced — even before the FSA's decision-making process was completed — their own Guideline Daily Amounts (GDA) system, giving foods' contribution to a national total daily intake. They too argued that consumers found their system easiest to use.

This decade-long 'negotiation' between state, companies and consumer interests over nutrition labels — and where they should be located, on front or back of packets — boiled up into the open when Tesco, the largest food retailer in the UK (and world's fourth largest), took a lead in introducing GDAs in 2006.[35] Seven leading food manufacturers — Cadbury Schweppes, Mars/Masterfoods, Danone, Kellogg, Kraft, Nestlé, PepsiCo — quickly followed suit. Five of these put GDA labels on front of packet and two put them on the back. A fissure then followed between other UK retailers (but not Tesco) and food manufacturers.[36] Consumer groups united to accuse industry of a cynical pre-emptive strike before the Government's FSA had even finally decided on the traffic lights scheme, and of deliberately creating confusion.[37] The third largest UK food retailer, J Sainsbury, meanwhile adapted the UK Government's wheel of health (its equivalent to the US Dept of Agriculture's pyramid) when giving its labelling information. The UK's Food and Drink Federation, a 150 year old industry alliance, was overt in its defiance, insisting that '[t]he industry is committed to helping people construct a balanced diet by appropriate use of labelling backed by consumer education.'[38]

Even this short account suggests the complex dynamics between interest groups, and how the law or voluntary regulations in lieu of law are fraught with tension. But the examples also show how public health is but one factor in the policy cacophony. Nutritional information became a battleground, the outcome of which is still uncertain. Equally, the example suggests the influence in policy-making of civil society organizations for whom public health is but one interest.

Since the food crises of the late 1980s, civil society organizations worldwide have achieved a voice beyond their actual resources; they may be small and have limited finance but they have totemic influence. They bring subtle but divergent positions to the public health legal discourse. Consumerist organizations such as the Bureau Européen des Unions de Consommateurs (BEUC) see openness as key to making markets work; their role is to deliver the consumer side of the European economic vision. Heart health groups, on the other hand such as the European Heart Network (EHN), are more focussed on nutrient labelling as a health promotion tool, citing EU health commitments. Ecologically inclined consumer organizations focus more on food quality.[39]

For all interest groups, the challenge of labelling is how their constituency's interests can best be defined. What do consumers want or need to know? Is health a characteristic of particular food products or the process of their production? Genetic modification (GM) and residues of agrichemicals (pesticides) have been test cases for the latter view. After a long policy debate, the EC decided to on a moratorium on GM foods within the EU, and labelling of ingredients above a low threshold.[40] But in the case of pesticide residues it opted not to declare residues but to allow positive declaration

of foods supposedly residue-free marshalled by organic labelling rules, run in concert with organic food bodies. In practice, few foods are contaminant free and another principle comes into play: the proportionality of risk.

Food, health and the law: a long march?

As the evolving policy debates on an apparently simple issue such as food labelling suggests, the history of the relationship between the law, food supply chains and public health is in fact deep and complex.[22,41] The UK's system of trading standards laws, insisting that food is accurately sold and traded, can be traced to the 13th century. All cultures have such concordats, written or unwritten. Morality and ideology are part of this picture. In his seminal essay on the transition from the 'moral economy' of feudalism to the more individualist harshness of industrial capitalism, the English historian E.P.Thompson showed how the reactions by the English populous shaped and ultimately began to tame the new moral regime's harsher edges.[42,43] The late 18th and early 19th century individualized world of industrial towns which replaced feudalism fundamentally altered food linkages between people, place and community. In the new order, access to money determined who was fed. Riots and dissent were one response to this shift of public framework. Another was the creativity of the organized working class in developing the co-operative movement as an alternative food economy determined to deliver safe, health-enhancing, affordable food for ordinary people.[44] Alongside that social experiment was another legal channel of effort, the pursuit of generalized rights to pure food under the law. This, as we now consider, took most of the 19th century for England.

The role of food law is, on the surface, simple and good: to protect the public and to ensure that market relations are fair. Since the late 19th century UK food law has had as its core principle the statement that: '[f]ood shall be of the nature, substance and quality demanded.' First written into the 1875 Act, this wording was retained as the core ethos of the Food Safety Act 1990, enacted speedily in response to the 1988–90s food safety crisis. But the law disguises a complex history of struggle between the forces being discussed in this paper.

The modern English system of anti-adulteration laws came into existence over the 19th century after routine adulteration was exposed from the 1820s (see Table 1).[45] The first person comprehensively to produce evidence of the systematic adulteration of food in the UK was Frederick Accum in 1820. Accum's own words suggest that he, like Thompson, knew morality and ideology were intimately wrapped up in food and health law. In his 1820 Treatise on Adulteration, he wrote: '[t]he man who robs a fellow subject of a few shillings on the highway is sentenced to death' …but 'he who distributes a slow poison to the whole community escapes unpunished'.[46] His Treatise was heavily attacked and a year later he had to flee the country, on a charge probably trumped up by his opponents.[47]

Accum was a solitary scientist confronting food-related ill-health. Such figures fit the 'great people make history' analysis of progress. In fact, the breakthrough in legal structures emerged in the 1850s. The work of Dr Arthur Hassall of the Analytic Sanitary Commission and Dr Thomas Wakley editor of *The Lancet* is justly celebrated.[48] They were not so much solitary scientists appealing to rights, more a well-orchestrated campaign to take the issue of adulteration to the public.[45] Believing that science should serve the public good, in a remarkable series of reports in 1851–1854, analysing 2500 different food items, they ran what was essentially a campaign for food law reform. Working closely with *The Times*, they created the evidence, altered the public mood and thought about political processes that might deliver public health protection. Like Accum, they were aware of the ideological dimension to the public health task, but they organized to confront it. To achieve institutions, resources (local taxes) and personnel to monitor and improve public health through food entailed confronting the dominant policy framework of *laissez-faire*. They believed that the state not fate should redress imbalances determining life chances and quality when eating.

They argued too that legal change required appropriate institutional infrastructure. They were not alone. In England, key public health personnel had been empowered at the local level even before the landmark 1848 Public Health Act. In 1833, the role of Public Sanitary Inspectors was created, a role only revised in the 1950s with the creation of the Public Health Inspector and again in the 1970s with their reformulation as Environmental Health Officers. The 1848 Public Health Act established the institutional architecture for modern public health, with Local Boards of Health charged to appoint Officers of Health (later Medical Officers of Health; now, loosely, Directors of Public Health who oversee the health infrastructure including dietary issues); also Inspectors of Nuisances; and Local

Table 1 The long legal march to remove adulterated food in the UK, 1820–1899

1820	Frederick Accum publishes 'Treatise on Adulteration', the first exposure of routine adulteration. Accum presents his findings with an appeal that this is a consensual issue of equal import to all. He is scandalized and calls for action.
1821	Accum flees the country, accused of damaging library books in the Royal Society of Chemistry (of which he had been librarian). This was probably an orchestrated attack by his opponents.
1820–1850	There are various Parliamentary attempts to legislate against bad food but none succeed.
1840	Parliamentary select committee is set up to inquire into the circumstances affecting the health of the inhabitants of large towns with a view to improving sanitary arrangements for their benefit. Its report published in 1842. The third and last volume by Edwin Chadwick, a civil servant, is entitled 'General Report on the Sanitary Condition of the Labouring Population of Great Britain.'
1848	1st *Public Health Act* is passed following a Royal Commission report of 1845 which proposes that local authorities be given powers to enforce sanitary arrangements. The Act creates a general Board of Health which can empower Local Boards of Health either if conditions are bad enough or if enough rate-payers call for one. The principle of prevention emerges.
1851–1854	Dr Thomas Wakley the editor of The Lancet works with Dr Arthur Hassall whom he set up in the impressive sounding Analytical Sanitary Commission. Hassall (chief analyst and sole author of the Commission's reports) tests 2,500 food items in 1851-54, reported by the Lancet.
1855	A Parliamentary Select Committee inquiry into food adulteration is set up.
1860	1st *Food and Drink Act* is passed. This allows for summary proceedings and creates the role of Public Analysts to inspect and report on food.
1861	Food industry creates The Grocer, as a journal to resist the attacks coming from consumer-friendly reformers and to defend laisser-faire. (It is still publishing weekly.)
1868	*Pharmacy Act* forbids sale of injurious drugs.
1872	An *Amendment* provides for the creation of a public analysts (who have created the Society of Public Analysts in the same year) and an inspectorate but this is unenforceable because the prosecution has to prove knowledge (*mens rea*) by the vendor that goods were adulterated.
1873	Judges of the Court of Queen's Benches decide in favour of consumers by abolishing *mens rea*. They impose liability on food businesses (who are decidedly unhappy).
1875	*Sale of Food and Drugs Act* repeals the 1860 and 1872 Acts and removes business liabilities; a triumph for trade lobbies but engenders furious public interest reaction. Principle is that '[f]ood shall be of the nature, substance and quality demanded.'
1879	*Amendment to 1875 Sale of Food and Drugs Act* makes food business liability enforceable.
1887	The *Margarine Act* confirms the principle of business liability.
1899	The *Food and Drugs Act* 1899 formalizes liability.

Surveyors. The post of public analyst — the work of Hassall in the 1850s — was formalized in the 1960s. Today, these personnel exist, albeit reshaped, but have less influence over the drivers of food supply and health. That shaping occurs either at regional or at the global level of food governance, where corporate and multilevel state power tends to be focussed.

The emergence of the European level of food and health law

Many European and industrialized countries have not dissimilar traditions and histories to the UK's; they are often hidden behind the apparent rationality of national systems of food rules, regulations and laws. Famously, Germany had its *Rheinheitsgebot*, a law dating from 1516 governing purity of beer and other products. This was often described as a consumers' friend positing, as it did, that beer could only be made with simple and restricted ingredients; no added sugar, for instance, was permitted. The principles were purity of ingredients and simplicity of recipe. At the same time, the *Rheinheitsgebot* was in part created to benefit barley growers and to keep merchants offering foreign wheat and rye out of the lucrative beer market. The law, as we know, may be an arbiter of health and commerce, but it is not necessarily unsullied by commercial drivers.

Whatever the compromises they represent, laws such as the *Rheinheitsgebot*, like the laws of other European Union Member States (MS), was overtaken by the *Single European Act* 1986 introducing a new food and drink framework. All European MS food laws, including alcohol, were swept away in the new Single European Act's creation of the single market.[49] After two decades of trying to create a

new legal framework on a product-by-product basis, by the mid-1980s the European Commission instead realized a different policy route and adopted a 'horizontal' framework that came into effect in 1992 (see Table 2). The 1988 Cecchini report for the EC, at the time the largest economic study of its kind, calculated the advantages of the single market. It argued that savings for the food industry from removing national differences would be significant.[50] The pursuit of 'euro-recipes' for food products as diverse and culturally resonant as jam and sausages — both mired in 15 years of fruitless negotiation — was abandoned and replaced by the new approach in which a diversity of products and processes were permitted — to allow different EU countries' traditions to co-exist and be

Table 2 The creation of a European food and public health law regime, 1980-2000s

1957	Treaty of Rome creates legal basis for trade alliance of 6 founding Member States.
1970–1980s	Attempts to harmonize EU member State food legislation by creating euro-recipes for different food products.
1980–1990s	Persistent food safety crises in Europe (additives, pesticides, hormones, food irradiation in the 1980s; animal health in the 1990s). Specific crises in France (hormone residues in meat 1980), Spain (toxic olive oil 1981ff), Austria (ethylene glycol added to wine 1985), Sweden (pesticides 1986), UK (salmonella, 1988ff) Belgium (dioxin in poultry meat 1999), Germany (BSE found 2000), the Netherlands (foot and mouth disease in 2000).
1985	UK Food and Drink Federation publishes advice to 'housewives' (sic) to be more careful with hygiene in the home.
1986	First case of bovine spongiform encephalophathy (BSE) in England. Leads to a EU decade of BSE crises in Portugal, Finland, France, Germany, Austria, Italy, UK, Ireland.
1986	*Single European Act* is passed. This prepares for liberalization of food trade within the European Union. It prepares the policy ground for the '1992' Single market process.
1987	London Food Commission publishes *Food Adulteration and How to Beat it* with first independent account of food poisoning, 'new' adulteration and public health. European NGOs begin working in an informal alliance on food safety. MEPs see the issue as opportunity to hold the European Commission and national Member States to account.
1988	UK Health Minister Mrs Edwina Currie MP blames salmonella on contamination in eggs. This leads to European press outcry and collapse of sales. Minister forced to resign, but evidence shows she is correct.
1988	Cecchini Report argues that European food industry will benefit from sweeping away 'unnecessary' food regulations hindering trade.
1988–1989	Wide-scale public debate about food safety — whose fault and responsibility is it? Active alliance of NGOs and media attack the impossibility of individual self-protection.
1990	UK Conservative Government passes *1990 Food Safety Act* passed placing onus on business to ensure food is safe.
1990	EC imposes restrictions on live cattle exports.
1992	*Maastricht Treaty* gives the EC powers for 'the prevention of diseases.'
1996	*Amsterdam Treaty* toughens the Maastricht powers to enable 'a high level of human health protection be ensured in the definition and implementation of all Community policies and activities.'
1996	20 March — UK Dept of Health announces that 'BSE has jumped to humans.' This is global news. Government discredited.
1996	European Parliament sets up enquiry as to why EU system of veterinary protection has not worked. The report embarrasses EC President Jacques Santer to come to the Parliament to make an unprecedented apology and promise of reform.
1997	Report produced by Prof Phil James outlines the role for a new UK Food Standards Agency. This is presented to new Prime Minister Tony Blair on the day after the landslide election of Labour Government committed to tackle food safety institutional reform.
1999	The entire EC Commission resigns, in part undermined by food safety crises.
1999	Report from 3 Professors (James, Kemper and Pascal) recommends the creation of a new EU Food and Public Health Authority, modelled in part on the US Food and Drug Administration.
2000	EC *Food Safety Directive* proposes new EU *General Food Regulation (law)* and the creation of a new European Food Safety Authority.
2002	EU *General Food Law*2002/178. EFSA starts work.
2004	European parliament votes to create a new European Centre for Disease Prevention and Control.
2005	Traceability along food supply chain becomes EU law.

traded across internal borders — as long as they were safe and could be traced. The current legal focus on traceability and consumer information addressed above was part of that legal policy package.

It was a British Commissioner who was charged with introducing this ambitious policy change. Lord (Arthur) Cockfield was successful in driving through the Single European Act (SEA) of 1986 but he lost his job for his pains. Although a British Conservative, and although Mrs Thatcher was one of the first MS leaders to sign the SEA, she recalled Lord Cockfield as a sacrifice to the immediate reservations that began to be expressed by the New Right and the populist press; even then British distaste was being expressed for the supra-national European edifice. In 1988, Mrs Thatcher repositioned herself as the leading eurosceptic with her speech at Bruges.[51]

But the deed was done. The new legal architecture for the world's largest consumer market of 12 MS in 1987—25 MS by 2005 and still expanding — was in place, and generated the tensions which still characterize food and public health governance. What can national public health bodies do in a regional and globalizing food system and in a world where disease patterns are not immediate in following food consumption? Unsafe food is quick to show results; malconsumption's illhealth effect may take decades and not be product-specific. This poses a challenge for what is meant by public health.

Europe's 'classical' tradition of public health implied a strong state with the capacity to alter the material circumstances determining health such as housing, air, water, food, factory conditions.[52] Sometimes referred to as sanitarianism, this approach could no longer be applied by a supranational federation of states such as the EU, especially one committed to give priority to economic liberalization. The function of the state in the mercantilist single market is facilitative rather than dirigiste or interventionist. Hazard Analysis Critical Control Point (HACCP) and risk analysis have replaced closure orders and re-engineering. Risk management is the core tool for assessing public health standards in supply chains. In environmental policy, too, risk analysis has been linked to liability (e.g. in the Environmental Liability Directive 2004/35/CE 21 April 2004).

The EU also proposed investment in 'social cohesion' as part of the new legal policy package. This has advanced social and human rights, but compared with the emphasis on economic support and the removal of barriers to trade, public health progress and investment has been slow. The Common Agricultural Policy receives €45 billion a year, just under half the total EU budget whereas the new public health Action Programme receives €312 millions over five years (for projects, health information, statistics). When EC public health legal gains have been introduced, they have sometimes been in response to crises.

The food corporate sector was quick to use the '1992' process to rationalize factories, invest in pan-European distribution and diversify product ranges. But the advantages they gain from the single market jaded with the BSE crisis, particularly once variant Creutzfeld Jakob Disease (vCJD) was shown in 1996 to have 'jumped' to humans. Until then, proponents of public health had to argue — and still do — against those who see health as a fig leaf for protectionism, an excuse for old-style statist intervention which might add unnecessary burdens on industry. The BSE and other food safety crises challenged that ideology both in and outside the European Commission. In 1997 a European Parliament inquiry accused the EC of maladministration, leading to an unprecedented apology from EC President Jacques Santer and the resignation of the whole Commission shortly after.[53,54]

The BSE crisis led to a strengthening of the weak Maastricht Treaty health goals with the 1996 Amsterdam Treaty, consolidated in the Treaty of Nice of 2000. Civil society groups actively promoted a reinvigorated role for the state in the Amsterdam Treaty, angry at the advantages previously give to cross-border trade and the corporate sector. Article 152 Article of the Amsterdam Treaty requires that 'a high level of human health protection be ensured in the definition and implementation of all Community policies and activities.' EC action should be directed towards 'improving public health, preventing human illness and diseases and obviating sources of danger to human health' rather than simply 'the prevention of diseases' signified by the Maastricht Treaty.

Despite the welcome strengthening in the Amsterdam Treaty, no health audit of the Common Agricultural Policy, still by far the largest budget of the EU, has yet been conducted.[55,56] The lobby to implement Article 152 across food supply has been weak.[56,57] The budget of DG-Sanco — responsible for consumer and public health affairs — is small compared to others, and DG Agriculture's dwarfs all others.[55]

Conclusions

This paper has proposed that food sits at the intersection of a complex relationship between

public health and the law. Seemingly simple issues such as labelling descend into tortuous struggles between different interests. Voluntary schemes vie with mandatory ones. Europe may subscribe to human rights but has yet fully to apply human rights codes to food poverty, for instance.[58] The long struggle to win the legal right that all food should be presumed to be health-enhancing or not adulterated and unhealthy is not a new public health demand. Nor is it restricted to affluent societies.[59] But today's complex supply chain and myriad food products — with hypermarkets stocking over 20,000 food items — means that choice takes policy precedence over food products' cumulative health impact.

The three models of food, health and law presented here are each plausible, but the 'triangular dynamic' model allows most easily for the *public* role within public health. As was shown for labelling, adulteration and the evolution of EU food law, neither the traditional model (Fig. 1a) nor the modern duality model (Fig. 1b) adequately portrays ebbs and flows in the (im)balance of health forces. If the traditional model implies a 'top down' Hobbesian state or Arthur Bryant's paternalist conservative state, the duality model assigns equally monodirectional power to corporate food giants.[60] This is a Naderite analysis of policy dynamics: large corporations 'conspiring' to exploit 'little guys'.[23,61] Modern food multinationals are certainly immensely powerful, but they have Achilles' heels; health can be one. Much depends on whether companies listen to the evidence. Some do, but how extensively is unclear.[62] Also, sole companies however powerful cannot tackle an entire food culture, any more than individuals can shift whole populations. The case for a more proactive state in tackling NCDs and creating new legal frameworks is emerging. Tackling obesity, for instance, requires collaborative action and a firm commitment to change markets, not just abandon public health to them, leaving consumer behaviour to the whim of 'choice' which can be moulded by powerful consciousness industries.[3,63,64]

Timing, persistence, good evidence, movements, the forging of arguments and bodies in unlikely alliances, all these can help force even powerful food companies to engage with a public health rather than an individualist approach. The threat of legal change — for instance legal controls over food advertising or the imposition of fat taxes — has brought hitherto reluctant players to the negotiating table on childhood obesity.[65,66] Companies which for years steadfastly denied the diet-(ill)health link now see 'healthy' food as a business opportunity, as long as this remains in niches rather than a demand across all foods. In the past, as today, the offer of 'pure' food could be presented as both moral and good business. How deep a corporate social responsibility approach to tackling food and health, short of legislation, remains to be seen.[20] The role of civil society bodies campaigning for legal change is undoubtedly a key element in this evolving policy process.

Good health requires a good food culture, but this is hard to legislate for. Public health laws cannot deliver on their own; they require a complement of institutions, movements and policies as well. Today's drivers of good food supply are mainly regional or global. The EU General Food Law 2002 is more important, as is the 1994 General Agreement in Tariffs and Trade (GATT) which brought food and agricultural commodities into world trade rules, than national laws which in fact have to be redesigned to accommodate them. The 1994 GATT, for instance, created a new legal structure including disputes settlement procedures, provisions for redress, fines and binding judgments, and most importantly a new legally sanctioned international institution, the World Trade Organization. In the 1990s, too, patent laws began to invoke intellectual property rights throughout the food chain, from seeds to food processes.[67] The modern food legal architecture, in offering a narrow conception of public health as food safety, has left public health legal frameworks unable to address what is necessary.

Good dietary health requires a positive environment which the law has difficulties in legislating for. The principle appears to be *de minimis*. As the Wanless reports showed for the UK, cheap food policies carry externalized cost burdens from diet-related ill-health.[68,69] Self-regulation may fit ideologically but has a weak evidence base of effectiveness. Voluntary codes of conduct — on advertising, marketing to children, labelling, product designs — indicate that some food companies might move in a healthier direction, but motives as with the C16th *Rheinheitsgebot* may not be entirely altruistic. Large investment in brands,[70,71] the pursuit of market share, and thin policy thinking such as that 'there is no such thing as bad foods, only bad diets' are at stake.[62,72]

In this fluid situation, public health groups are growing in confidence, and some food industry advisors recommend industries 'bend' a little in order not to lose control over marketing and brand-power.[73] It remains to be seen whether the new coalitions of interest between public health professionals, campaigners and civil society organizations grow in influence as they demand legal rights to protect public health, or whether new offers in the name of

corporate social responsibility suffice to defuse public health tensions. Whichever scenarii emerge, tensions over food law are likely. The policy question is: which interests will triumph in that process?

References

1. Van Zwanenberg P, Millstone E. *BSE: risk, science, and governance*. Oxford, New York: Oxford University Press; 2005.
2. WHO/FAO. Diet, Nutrition and the prevention of chronic diseases: report of a Joint WHO/FAO Expert Consultation. *WHO Technical Report Series: Technical Report 916*. Geneva: World Health Organisation/Food and Agriculture Organisation of the United Nations; 2003.
3. WHO. World Health Report 2002: reducing risks, promoting healthy life. Geneva: World Health Organisation; 2002.
4. Held D. *Global transformations : politics, economics and culture*. Cambridge: Polity Press; 1999.
5. Held D, Koenig-Archibugi M. *Global governance and public accountability*. Oxford: Blackwell; 2005.
6. Lang T, Heasman M. Diet and nutrition policy: a clash of ideas or an investment? *Development* 2004;**47**(2):64–74.
7. Goodman D, Watts MJ, editors. *Globalising food: agrarian questions and global restructuring*. London: Routledge; 1997.
8. Fold N, Pritchard B. *Cross-continental food chains: cross-continental food chains*. London: Routledge; 2005.
9. Burch D, Goss J, Lawrence G. *Restructuring global and regional agricultures : transformations in Australasian agri-food economies and spaces*. Aldershot: Ashgate; 1999.
10. Bryant A. *The spirit of conservatism*. London: Methuen & Co. Ltd.; 1929.
11. Cockett R. *Thinking the unthinkable: think-tanks and the economic counter-revolution, 1931–1983*. London: Harper Collins; 1994.
12. Vorley B. *Food Inc.: corporate concentration from farm to consumer*. London: UK Food Group; 2004.
13. Lang T, Heasman M. *Food wars: the global battle for mouths, minds and markets*. London: Earthscan; 2004.
14. EUREP. *EurepGAP: the global partnership for safe and sustainable agriculture*. Brussels: EUREP; 2006.
15. Barling D, Lang T. Trading on Health: Cross-continental production and consumption tensions and the governance of international food standards. In: Fold N, Pritchard B, editors. *Cross-continental food chains: cross-continental food chains*. London: Routledge; 2005. p. 39–51.
16. Avery N, Drake M, Lang T. *Cracking the codex: a report on the codex alimentarius commission*. London: National Food Alliance; 1993.
17. Rothstein H. Risk management under wraps: self-regulation and the case of food contact plastics. *Journal of Risk Research* 2003;**6**(1):61–74.
18. Lang T. Food and Health Wars: a modern drama of consumer sovereignty, Economic, and Social Research Council, and Arts and Humanities Research Board Cultures of Consumption Programme, Cultures of Consumption Working Papers series, no 14. London: Birkbeck College ESRC Cultures of Consumption programme 〈http://www.consume.bbk.ac.uk〉, 2004.
19. Rawls J. *A theory of justice*. Cambridge, MA: Harvard University Press; 1971.
20. Lang T, Rayner G, Kaelin E, Crossley R, Backman P. *The Food Industry, Diet, Physical Activity and Health: a review of reported comittments and practice of 25 of the world's largest food companies, measured against the goals of the World Health Organisation Global Strategy on Diet, Physical Activity and Health*. London: City University Centre for Food Policy; 2005.
21. Gabriel Y, Lang T. *The unmanageable consumer*. London: Sage; 1995.
22. Cranston R. *Consumers and the law*, 2nd ed. London: Weidenfeld and Nicolson; 1984.
23. Gabriel Y, Lang T. *The unmanageable consumer: contemporary consumption and its fragmentation*, 2nd Edn. London: Sage; 2006 (2nd Edn.).
24. Lang T. Going public: food campaigns during the 1980s and 1990s. In: Smith D, editor. *Nutrition scientists and nutrition policy in the 20th century*. London: Routledge; 1997. p. 238–60.
25. Better Regulation Task Force. *Make it simple make it better*. London: Better Regulation Task Force (now Better Regulation Commission of the UK Government); 2004.
26. Kennedy JF. Special Message on Protecting the Consumer Interest: Statement read by President John F Kennedy Thursday, 15 March 1962. Washington, DC, 1962.
27. Consumers International. *Consumer rights*. London: Consumers International; 2006.
28. Black AE, Rayner M. *Coronary Prevention Group. Just read the label : understanding nutrition information in numeric, verbal and graphic formats*. London: HMSO; 1992.
29. Lang T. The contradictions of food labelling policy. *Information Design Journal* 1995;**8**(1):3–16.
30. Millstone E. *Food additives*. Harmondsworth: Penguin; 1986.
31. London Food Commission. *Food adulteration and how to beat it*. London: Unwin Hyman; 1987.
32. Cannon G. *The politics of food*. London: Century; 1987.
33. Nestle M. *The Politics of Food*. Berkeley, CA: University of California Press; 2002.
34. Food Standards Agency. *Food labelling: signposting*. London: FSA; 2006.
35. Mowbray S. The Green Light for GDA Labels? *The Grocer* 2006;**229**(7742):38–9.
36. Wiggins J. Retailers clash with food companies over nutritional labelling scheme. *Financial Times* February 11 2006, p. 2.
37. Wiggins J. Food companies go their own way on labelling. *Financial Times* February 9 2006, p. 17.
38. Mowbray S, Doult B. Industry jumps the lights. *The Grocer* 2006;**229**(7741):4–5.
39. Harrison R, Newholm T, Shaw D, editors. *The ethical consumer*. London: Sage; 2005.
40. EC. Regulation (EC) No 1830/2003 of the European Parliament and of the Council of 22 September 2003 concerning the traceability and labelling of genetically modified organisms and the traceability of food and feed products from genetically modified organisms and amending Directive 2001/18/EC (OJ No L.268/24, 18.10.2003). Official Journal 2003;L:268/24.
41. Fallows SJ. *A user's guide to British food law*. Bradford: Horton; 1991.
42. Thompson EP. The moral economy reviewed. In: Thompson EP, editor. *Customs in common*. Harmondsworth: Penguin; 1993. p. 259–351.
43. Thompson EP. The moral economy of the English crowd in the eighteenth century. In: Thompson EP, editor. *Customs in common*. Harmondsworth: Penguin; 1993 [1971]. p. 185–258.
44. Birchall J. *Co-op: the people's business*. Manchester: Manchester University Press; 1994.

45. Paulus I. *The search for pure food*. Oxford: Martin Robertson; 1974.
46. Accum F. *A treatise on adulterations of food and culinary poisons*. London: Longman; 1820.
47. Coley NG. The fight against food adulteration. *Education in Chemistry* 〈http://www.rsc.org/Education/EiC/issues/2005Mar/Thefightagainstfoodadulteration.asp〉 2005(March).
48. Coley NG. The fight against food adulteration. *Education in Chemistry (of the Royal Society of Chemistry)* 2006; 〈http://www.rsc.org/Education/EiC/issues/2005Mar/Thefightagainstfoodadulteration.asp〉.
49. Commission of the European Communities. Single European Act. Official Journal 1986;OJ L 169 of 29.06.1987(29 June 1987).
50. Cecchini P, Catinat M, Jacquemin A. *The European challenge 1992: the benefits of a single market*. Aldershot: Wildwood House; 1988.
51. Thatcher M. speech to the College of Europe in Bruges (Belgium), 1988.
52. Porter D. *Health, civilisation and the state. A history of public health from ancient to modern times*. London: Routledge; 1998.
53. European Parliament. Report on alleged contraventions or maladministration in the implementation of Community law in relation to BSE. Rapporteur: Mr Manuel Medina Ortega. 7 February. DOC EN
54. Santer J. Speech at the Debate in the European Parliament on the report into BSE by the Committee of Enquiry of the European Parliament. Speech 97/39 〈http://europa.eu.int/abc/doc/off/bull/en/9701/p203001.htm〉, 1997.
55. Elinde LS. *Public health aspects of the EU Common Agricultural Policy*. Stockholm: Statens Folkhalsoinstitut/National Institute of Public Health; 2003.
56. Lang T. European Agricultural Policy: is health the missing link? *Eurohealth* 2004;**10**(1):4–8.
57. Lang T. EU Food and Nutrition Policies and their impact on health. Report for EU Main Public Health Issues project, co-ordinated by Société Francaise de Santé Publique for the Commission of the European Communities. Paris: Sociéte Francaise de Santé Publique, 1998; EU Food and Nutrition Policies and their impact on health. Report for EU Main Public Health Issues project, co-ordinated by Sociéte Francaise de Santé Publique for the Commission of the European Communities. Paris: Société Francaise de Sante Publique.
58. Eide WB, Kracht U, editors. *Food and human rights in development, Vol I: legal and institutional dimensions and selected topics*, 1st ed. Antwerp, NL: Intersentia; 2005.
59. Farmer P. *Pathologies of power: health, human rights, and the new war on the poor*. Berkeley, CA: University of California Press; 2005.
60. Korten DC. *When corporations rule the world*, 2nd ed. Bloomfield CN: Kumarian Press Inc.; 2001.
61. Nader R. *Unsafe at any speed; the designed-in dangers of the American automobile*. New York: Knightsbridge Publishing; 1965/1991.
62. Langlois A, Zuanic PE, Faucher J, Pannuti C, Shannon J. *Obesity: re-shaping the food industry*. London: J.P. Morgan Global Equity Research; 2006. p. 112.
63. WHO. Obesity: preventing and managing the global epidemic. Report of a WHO Consultation. WHO Technical Series 894. *WHO technical series*. Geneva: World Health Organisation; 2000.
64. WHO. *Global strategy on diet, physical activity and health*. Geneva: World Health Assembly; 2004.
65. Strnad J. "Conceptualizing the "Fat Tax": The Role of Food Taxes in Developed Economies." Working Paper, September 2002. *Working paper*. Palo Alto, CA: Stanford Law School; 2004.
66. Caraher M, Landon J. The impact of advertising on food choice: the social context of advertising. In: Shepherd R, Raats M, editors. *The psychology of food choice*. London: CABI; 2005.
67. Abbott FM. *The Doha Declaration on the TRIPS Agreement and Public Health and the Contradictory Trend in Bilateral and Regional Free Trade Agreements. Occasional Paper 14*. Geneva: Quaker United Nations Office; 2004.
68. Wanless D. *Securing our future health: taking a long-term view*. London: H M Treasury; 2002.
69. Wanless D. *Securing good health for the whole population*. London: H M Treasury; 2004.
70. Lury C. *Brands: The logos of global economy*. London: Routledge; 2004.
71. Aaker DA, Biel AL. *Brand equity and advertising: advertising's role in building strong brands*. Hillsdale, NJ: Lawrence Erlbaum Associates; 1993.
72. Langlois A, Adam V, Powell A. *Food Manufacturing: obesity the big issue*. London: J P Morgan European Equity Research; 2003.
73. Henley Centre. *Fat is a strategic issue*. London: Henley Centre; 2004.

Public Health (▮▮▮▮) ▮, ▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on "Food, the law and public health"

Tim Lobstein[a,b,*]

[a]*International Obesity TaskForce, London*
[b]*Science Policy Research Unit, University of Sussex, Falmer, Brighton, Sussex BN1 9SH, UK*

The word 'law' can be taken in two ways: it can refer to the use of legislation as a means of shaping social interactions (and, in the present case, as a means of shaping the food supply and the running of the market) or it can refer to the use of the law — i.e. the courts, criminal or civil cases, etc. in the defence of, in the present case, consumers' rights to good health. Both the creation of laws and their implementation need to be considered when examining their potential impact on people's health.

In opening the debate, Professor Lang refers to a triangular relationship between the individual, the industry (food producers, shippers, marketers) and the state. In the simplest model, the state hands down legislation to control the relations between supplier and consumer, and can do this in a manner that benefits one or the other, but only with difficulty both. The tension between wealth generation and health protection often leads to conflicts of interest between consumer and producer, and hence a degree of tension within the triangular model.

There are, however, some complexities that need mentioning. The first is that legislation and regulation is formed through a complex process, usually involving those likely to be affected by the resulting laws and regulations. Producers have the upper hand in this process: put crudely, a primary aim of industry is to capture the regulatory process through lobbying, party funding and through their membership of the very regulatory bodies that should be holding them to account.

The current political climate favours the producers in the triangular relationship, with an emphasis on deregulation, 'a light regulatory touch', reduced 'red tape', market freedom and 'consumer choice'—this latter most often being a misnomer for producer choice (i.e. a producer's freedom to put poor quality, or unhealthy, goods on the market). 'Consumer choice' also has the implication that it is the consumer's own fault if he or she makes the wrong choice—e.g. consumes fatty, sugary foods in excess, and becomes ill as a result.

The effect of deregulation and the passing of responsibility onto consumers is that the second meaning of the word 'law' has greater significance—consumers can and should consider using the law, in so far as it can be used, to defend their right to health and the means to achieve healthy lifestyles.

Litigation is not used widely in the UK, especially when compared with the USA where private enforcement is a common alternative to public policy-making. The use of civil law has a distinct advantage in the level of proof required—'on the balance of probability' rather than 'beyond reasonable doubt'. For consumers in Britain to defend their rights to health using civil law they need to have American-style access to class actions and group liability facilities—i.e. to be able to prosecute the industry as a group of consumers, and to hold a group of companies liable collectively rather than having to prove each one's liability separately.

*Corresponding author.
E-mail address: T.J.Lobstein@sussex.ac.uk.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.012

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Public health, private right, and the common law

Roger Brownsword[a,b,*]

[a]*King's College London, The Strand, London WC2R 2LS, UK*
[b]*University of Sheffield, UK*

Introduction

What is the relationship between the common law and public health? Do decisions or developments in the common law impact on public health? Are the impacts negative or positive, patterned or unpatterned, direct or indirect? Three thoughts occur initially.

First, where the question is in the form of 'How does A relate to B?', the answer rather depends on how A and B are defined. Unless we settle what we mean by 'common law' and 'public health', any account of their relationship will be unanchored and unhelpful.

Secondly, it is tempting to think that there is only a distant relationship between the common law and public health. Whereas the common law of contract is geared for commerce and the protection of economic interests, the common law of tort is geared for the protection of private interests in person, property, and reputation. So, while the law of contract famously protected Mrs Carlill's economic expectation when the Carbolic Smoke Ball failed to live up to the promise of its producers,[1] it did nothing for the general health of Victorian England.[2] Similarly, in *Donoghue v Stevenson*,[3] while the claimant was judged to have an arguable case for compensation, this did not directly avail other consumers and nor did it forestall the obesity crisis of several decades later.

Thirdly, however, we might entertain the opposite thought. Prompted by remarks such as those of George Bush who, shortly after becoming the governor of Texas, declared that the reform of the tort regime was a top priority, because class actions were proving too effective in holding polluters to account,[4] we might think that the common law is a trump card in advancing public health objectives.

Following these initial thoughts, the paper is in two principal parts. In the first, I deal with definitional issues and then, in the longer second part, I formulate three views—functionalism, smart regulatory theory, and protectionism—that maintain that it is not the business of the common law to advance public health objectives.

My conclusion is that there are two focal questions we need to keep firmly in sight. First, assuming that the State has a legitimate role in taking steps to improve public health, what are the limits of that role? Secondly, as a matter of legal technique, what is the best way of ensuring that the State fulfils its role, taking the public health measures that it is required to take and not exceeding the bounds of its legitimate function? In an ideal world, in a community of rights, the first of these questions will be actively and reflectively debated. I believe that, in general, it will fall to public law, not to the common law, to secure delivery of the State's public health obligations. However, in non-ideal circumstances, where there is serious regulatory failure, it is arguable that the common law should be developed as a responsive corrective mechanism.

*Corresponding author.
E-mail address: roger.brownsword@kcl.ac.uk.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.014

Definition, drugs and diet

What do we mean by the 'common law' and by 'public health'? Where does the common law fit within the larger picture of regulation and how, if at all, do the leading cases of the common law jurisprudence bear on the promotion of public health objectives?

Definition

Very broadly interpreted, we might take the 'common law' to refer to that family of (Anglo-American) law that is contrasted with the civilian families of law. In the present context, this might present an interesting question of comparative law, but it is not the question that I want to ask.[5] Taking a narrower, but still broad, definition, we might take 'common law' to refer to that body of law developed by the judges rather than by legislators. Again this does not yield the question I want to ask because it includes too broad a sweep of law, crucially modern administrative law as well as private law. I will take the 'common law' as referring to that branch of private law that concerns transactions and torts, effectively, the common law of obligations (contract, tort and restitution) with property necessarily in the background.

Defining public health is more difficult. Larry Gostin remarks that '[d]efinitions of public health vary widely, ranging from the utopian conception of the World Health Organization of an ideal state of physical and mental health to a more concrete listing of public health practices [such as preventing disease, prolonging life, and promoting physical health through focused community efforts].'[6] One thing is clear: although the health of a population might be disaggregated so that it is seen as the health of so many particular individuals that make up that population, it is the composite that is the focus for public health.

However, public health, so understood, has more than one referent. We might speak about both the state of the public's health and the conditions that contribute to the health of the public. Once we separate out these applications, it becomes possible to speak about a population being healthy despite poor public health provision and, conversely, a population being unhealthy despite good public health provision. In the most general terms, the vision for any public health agency must be one of healthy people in healthy communities.[7] A little more needs to be said about both the state of public health and the conditions for public health.

(a) The state of public health

Let us assume that there are a number of agreed criteria by reference to which we can assess the health of an individual. If we generalize this approach, we can assess the health of a larger population. This is not quite the same as assessing the state of public health in that population because this assessment needs to take account not only of the level of health of the living but also mortality rates. What are the prospects for young children? What is the average life expectancy? What proportion of that average life expectancy is affected by morbidity? With answers to these questions, we have a sense of the level of public health enjoyed by the population, and, for that matter, as between different socio-economic sets of the larger population.[8] This is not a precisely calibrated measure (especially where quality of life judgments are involved).[9] However, provided that the criteria are constant, we can judge whether the state of public health in 21st century England is an improvement on that in Victorian England, as we can compare the state of public health in contemporary England with that in, for example, contemporary Germany.

(b) The conditions for public health

Where the state of public health seems to be improving, or where it is superior in one population to another, how are such trends or variations to be explained? An obvious line of inquiry leads us to the background living conditions, the conditions for the well-being of the population. If water is contaminated, the air polluted, and if medication is in short supply, there will be individuals who suffer a deterioration in their health. In principle, it could be any member of the population that is adversely affected. Conversely, where clean water is available, where pollution is reduced, and where medication is available, the background environment changes in a way that is conducive to the health of all members of the population.

Even with the benefit of favourable background conditions, there might be further ways in which the state of health of the population could be improved by re-directing adverse life-style habits. Where the problem arises from an individual's choice of life-style, then rectification calls for either a change in the background conditions (by making the option either impossible or less attractive) or direct intervention in relation to the particular individual. The price that we pay is that there is some diminution of personal choice.

Carlill and drugs; Donoghue and diet

To return to the common law, to the heartland of Contract in *Carlill* and to Torts (negligence in particular) in *Donoghue*. In both cases, the courts ruled in favour of the claimants judging that the defendants were in breach of their obligations (in *Carlill*) or at least had an obligation in relation to which they needed to account for their actions (in *Donoghue*). But, these cases are primarily about the correction of a private wrong and the question is whether precedents of this kind tell us anything about the role of the common law in relation to public health.

Although contract and tort share a concern with correcting private wrongs, their function is not quite identical. A legal system will set out a catalogue of wrongs, largely relating to interests in one's physical integrity and one's property, and require wrongdoers to correct (usually by compensation) the wrongs that they inflict. The object of the exercise, exemplified by torts, is to return victims to the status quo. In the case of contract, however, the law presents persons with the opportunity to enter into legally secured transactions that will change the status quo in ways that contractors judge to be mutually beneficial. Thus, the function of contract law is not to restore the status quo but to protect the expectation that contractors have in relation to the change for which they have bargained.

If *Donoghue* is about the protection of status quo interests, *Carlill* is about the protection of the transactional expectation. In the former, the damage happens to concern the health of an individual; in the latter, the disappointed expectation concerns a promised sum of money which contingently is linked to the performance of a health care product. The decisions in both cases might have had some general deterrent effect, impacting positively on the conditions for public health (the marketing of health care products and the safety of food and drinks) and, quite possibly, leading to a marginally better state of public health. But this looks more like a secondary effect than the primary purpose of common law standard-setting and decision-making.

Public health is not the common law's business: three views

The thrust of the discussion thus far is that the promotion of public health is not really the business of the common law. Private law is for the adjustment of private relations. There are, however, a number of different views that converge on this general position. These views, the views of functionalists, smart regulatory theorists, and protectionists, need to be individually identified. For although there is a degree of convergence, these views are not identical.

Functionalism

For functionalists, the law is a body of doctrine, each principal organ of which has its own specialized function. As Hart argued, when a layer of public law secondary rules begins to be developed, we find a key stage in the evolution of a legal system as the intersection of primary and secondary rules.[10] Primary rules have a different function to secondary rules; contrary to the Austinian view, the law is not entirely about crime and punishment. Legal systems are unified and integrated but they are also functionally differentiated, having both public and private dimensions.

According to modern functionalists,[11] the specialized task of the common law is to correct private wrongdoing; the common law is about corrective justice. As Lorraine and Ernest Weinrib put it:[12]

> Under the corrective justice approach, private law is the operation of public reason on the bipolar relationship of plaintiff and defendant. The distinguishing feature of private law is that the liability of the defendant is simultaneously a liability to the plaintiff. For private law to be an exercise of public reason, there must be a publicly available justification not merely of why the law takes something from the defeated defendant or gives something to the victorious plaintiff, but why in every case liability consists in the law's giving to one party what it takes from the other. Moreover, this publicly available justification must be consistent with the institutional framework of private law: since courts administer private law, the justifications they deploy must draw on facts and embody reasons that are within their limited institutional competence. Complex calculations and assumptions of omniscience are excluded.

Not only this, within the common law of obligations, there is a further specialism, contract being concerned with commutative justice, tort with corrective justice, and restitution with the reversal of unjust enrichment. Such further differentiation, however, does not break the basic bipolar pattern.[13] On this view, it is not the

function of the common law to promote the background conditions of public health, nor to enforce foreground interventions. The brief for the courts in *Carlill* and *Donoghue* was to correct the wrongdoing, not to engage in instrumental policy-based reasoning.

We can assume that functionalists would approve of the restrictive approach taken to the common law of nuisance in *Marcic v Thames Water Utilities Limited*.[14] Mr Marcic suffered from repeated external sewer flooding at his home. When the sewers were first laid in the 1930s, they were adequate. As ever more properties connected to the system, it became overloaded. Mr Marcic expended some £16,000 in constructing garden flood defences but, despite repeated complaints to his local authority, no steps were taken to remedy the underlying infrastructural problem. Mr Marcic commenced legal proceedings against Thames Water, the statutory sewage undertaker, claiming that the defendants were liable under the common law tort of nuisance.[15] The House of Lords held that the common law claim would effectively by-pass the statutory scheme for the provision of sewage services and therefore it was not available.

Although the emphasis of the House of Lords' reasoning is on the closed nature of the statutory regime, functionalists would endorse the reluctance of the House to encourage the use of the common law, and the law of nuisance in particular, as a means to put pressure on public service providers or public regulators. Two elements of this reluctance are worth highlighting.

If a court backs a claim such as that made by Mr Marcic, this will have a distributive impact. If Thames Water must apply its resources to remedy the underlying problem in Mr Marcic's area, then these resources would not be available to spend elsewhere. For the courts to intervene in this happenstance way would be arbitrary, rewarding the litigious (who are not necessarily the most eligible for relief)[16] and would set in motion unpredictable redistributive effects.[17] Far better that the Director should agree additional funding for remedial works with Thames Water, making allowance for the costs incurred in setting the sewerage charge. Indeed, prompted by widespread floods, such a process had begun, and remedial work was carried out for the benefit of properties including that of Mr Marcic.

The second reservation in *Marcic* echoes the first in that it expresses a nervousness about straying across the boundary that divides the private from the public. It is a concern about how well the common law groundrules that are developed for the correction of private wrongdoing travel, once they are carried into a claim against a public body. Where it is alleged that a regulator or public provider has failed to act reasonably, there is a difficulty about overlapping public law (judicial review) and private law jurisdictions.[18] In *Marcic*, the standards developed in the common law of nuisance for cases where the defendant, while not actually creating the nuisance, has nevertheless allowed it to continue, do not travel well across the public boundary. In *Marcic* itself, Thames Water were required by statute to permit properties to connect, even if this meant that the system became overloaded. They did not have a free hand in raising money to carry out remedial work which they were otherwise willing and eager to undertake. In every sense, *Marcic* is a caution against muddying the common law waters.

Two important corollaries to the functionalist view that the common law should play a limited corrective role in a larger effective regulatory system should be noted. First, it has to be emphasized that it is not the functionalist brief to argue against public health initiatives. Public health, like any public good, needs to be regulated; this is a task for public law not for common law. Secondly, although functionalism has a view about what is functional and what is dysfunctional, it does not set out to theorize the systematically dysfunctional. Crucially, where the system of public regulation is dysfunctional,[19] we have left the well-ordered world of the functionalist and it remains to debate the role of the common law in such a dysfunctional world.

To develop this latter point, let us suppose that a public law strategy for public health is in play. In line with the functionalist view, regulators do not think of the common law as a resource for public health. Suppose that a regulatory agency is charged with monitoring the medicines and therapies available both in the public health system and in the private marketplace. The mission of the agency is to supervise and license these health care products, ensuring that patients and consumers are properly informed and are not exposed to undeclared or unreasonable risks. What happens if one of these products or services slips through the regulatory net and harms the consumer? What if we have the kind of horror story narrated by Alicia Mundy in *Dispensing with the Truth*[20] on the tragedies brought about by the Fen-Phen diet drug? These tragedies might have been averted had American Home Products not been so economical with the truth in relation to the risks associated with the drug, and had the prevailing culture at the regulatory agency been less concerned with assisting the pharmaceutical companies to bring their

products to market and more concerned with product safety. Once the lawyers were able to make the right connections between the knowledge of the producers of Fen-Phen, the properties of the drug, and the damage done to the complainants, AHP had little choice but to make compensatory settlements with individual and mass tort claimants. The tort system comes out of Mundy's account rather well and public regulation rather badly. So far as the FDA is concerned we have a familiar tale of regulatory capture. The agency is either not willing or not able to distance itself from the interests of the pharmaceutical companies. This arises, in part, from the influence that the companies exert directly over the agency and, in part, from the indirect influence that is exerted via the political branch over resourcing.

The Fen-Phen story is by no means unique. The story of the COX-2 inhibitor, Vioxx, now unfolding in claims on both sides of the Atlantic, has a familiar ring to it.[21] It is not just dangerous drugs that can slip past the regulatory sentries. There are instances in which the task of monitoring a product or a state of affairs that is a matter of concern to public health is charged to a public agency, but where a hazard gets through the public health net and, having caused damage, it is left to the tort system to sound the alarm bells. That the tort system played a key role after BSE, tobacco, asbestos and thalidomide seems undeniable.

Some would argue that tort has the potential to operate as a corrective against larger political failure, for example where there are problems about expressing views about the public interest through ordinary political channels. Taking what Donald McGillivray and John Wightman term a pluralist approach,[22] we might agree with the functionalist that tort should not be distorted. Assuming that there is no real evidence of regulatory failure, it is right that the courts reject attempts to disrupt the regulatory process by use of the common law. However, where there is evidence of serious regulatory failure, then if tort seems an effective way of keeping those who threaten public health in line, we might be tempted to prefer the more responsive approach. If the common law does the job, then why not make use of it?

The smart regulatory view

Unlike the functionalist view, the smart regulatory view has no blueprint that allocates a distinctive task to each segment of law.[23] On the contrary, the smart philosophy is precisely one of 'what works works'; and, although legal historians might see the development of legislative strategies to promote public health as a response to the shortcomings of the common law, on the face of it, the modern common law works quite well. As Gostin puts it:

> A vast potential for using tort litigation as an effective tool to reduce the burden of injury and disease exists. Attorneys general, public health authorities, and private citizens resort to civil litigation to redress many different kinds of public health harms: environmental damage (e.g., air pollution or groundwater contamination); exposure to toxic substances (e.g., pesticides, radiation, or chemicals); unsafe pharmaceuticals, vaccines, or medical devices (e.g., diethylstilbestrol [DES], live polio vaccines, or contraceptive devices); hazardous products (e.g., tobacco, firearms, or alcoholic beverages); and defective consumer products (e.g., children's toys, recreational equipment, or household goods).[24]

However, the actuality is rather different; for the potentiality conceals a litany of well-rehearsed limitations that afflict the general effectiveness of private law actions.[25] Potential claimants will often be unaware of their legal position and they will be deterred from inquiring because of the fear of costs. One-shot individual litigants will do much less well than repeat-players.[26] One-off claims, unless they are class claims, might deliver a remedy for the particular claimant but they do little to remedy a more general problem. The doctrinal hurdles put in front of claimants are serious. Even if the adoption of product liability regimes removes the need for the claimant to prove a lack of reasonable care, there are causation requirements that are notoriously problematic where there is an asymmetry of information between the parties.[27] Studies indicate that there is a significant underuse of the common law. In some instances, the parties concerned have alternative ways of dealing with their disputes and grievances, but, in many instances, the victims of wrongdoing simply do not come forward to take legal action.

The realization that regulatees might not make as much use of the common law as one might expect is not, however, the key to smart regulatory thinking. Smart regulatory theory thinks laterally about the options available to regulators, acting on the insight that we do not always find in the law the most effective regulatory strategy. If regulators wish, for public health reasons, to reduce the amounts of alcohol and tobacco consumed, they might spearhead their strategy, not with law, but with a campaign designed to cultivate a culture that treats binge-drinking and smoking as

anti-social. According to the smart regulatory view, there is no resistance to the pursuit of public health objectives and nor is there any principled opposition to the use of the common law for such purposes. The reason why public health will rarely be the business of the common law is simply, that it will not work. To rely on the common law, which characteristically operates reactively and ex post, will almost certainly offend the canons of effective, efficient, and economical regulation.[28]

There is an array of public law measures available to regulate for the sake of public health objectives. Regulators might seek to enforce public health standards by using the criminal law or by authorizing conduct under licence. However, this is only half the story;[29] and, if we conceive of regulation in terms of 'the sustained and focused attempt by the state to alter behaviour thought to be of value to the community',[30] then it is those strategies beyond the law that represent the more interesting half of the smart regulatory story.

Lessig identifies four regulatory modalities, namely: the law, social norms, the market, and architecture (or, code in the West Coast sense).[31] Seat belts is one of his examples:

> The government may want citizens to wear seatbelts more often. It could pass a law to require the wearing of seatbelts (law regulating behavior directly). Or it could fund public education campaigns to create a stigma against those who do not wear seatbelts (law regulating social norms as a means to regulating behavior). Or it could subsidize insurance companies to offer reduced rates to seatbelt wearers (law regulating the market as a way of regulating behavior). Finally, the law could mandate automatic seatbelts, or ignition-locking systems (changing the code of the automobile as a means of regulating belting behavior). Each action might be said to have some effect on seatbelt use; each has some cost. The question for the government is how to get the most seatbelt use for the least cost.[32]

Smart regulators will consider direct and indirect strategies, choosing and combining strategies in whichever way promises the optimal ratio of regulatory input to desired regulatory output.

From the standpoint of effectiveness, the attraction of code or design is undeniable. Let us suppose that the public health objective is to improve the quality of the nation's teeth. Public education programmes enjoy some success; teeth are cleaned more assiduously, diets are adjusted, and decay is reduced. But the burden on the dental budget for routine treatment is too high. A pricing approach also enjoys some success: vouchers are issued for free dental services but, once a person has used their vouchers, they have to pay the full market rate. This encourages many to pay more attention to their daily flossing. However, if fluoride were to be introduced into the water supply, this would radically transform the state of the nation's teeth; and, from a regulatory perspective, the beauty of fluoridation is that it is very difficult to avoid consumption of the treated water. Not only does this approach score well for effectiveness, its running costs are minimal because it presents regulatees with few options for non-compliance. The uncommon thing about code is that it excludes the possibility for deviance. If the start-up costs are not prohibitive, it seems to be the perfect solution. Smart regulators will gravitate towards a designed solution wherever they have the know-how to put it in place. The way to make the nation healthy is to design things in such a way that there is no option other than to be healthy.

The thought that design might be the answer, but that it involves the elimination of choice, sets instrumental thinking on a collision course with the values of personal autonomy; and this takes us to the third of the views that asserts that it is not the business of the common law to promote public health.

Protectionism

Protectionism reaches back to simpler societies. As these less-cluttered communities multiply, it becomes apparent that group life needs a degree of regulation. Public power is reluctantly conceded and the public sphere is confined to the minimum. On this account, there almost is no such thing as (organized) society. Private entitlement is paramount and private law is at the heart of any legal regime.[33]

Unlike the functionalist and the smart regulatory view, protectionism is suspicious of public projects, including public health missions.[34] The underpinning ideology of the common law is one that privileges private entitlement and, at the same time, restricts the State to a minimum role, adding an extra layer of security for the protection of private interests. To treat it as the business of the common law to advance public health objectives is to view the relationship between the public and the private in a wholly back-to-front way. The common law is a red light, not a green light, for public health projects.

Protectionism is liable to be busy. Effective public health intervention necessitates considerable

impingement on private interests, whether in the form of reporting, testing, or quarantining.[35] There is no such thing as free public health: a price must be paid in terms of the concession of private right.

If a utilitarian philosophy characterizes much public health thinking, then protectionism resists this tendency by insisting that the community should also take individual rights seriously. Developments, such as the UK Biobank,[36] promise to give protectionists fresh cause for concern. For, if those who regulate for public health operate with an improved understanding of the significance of a person's genetic make-up in conjunction with lifestyle, then the private sphere might be squeezed as interventions are directed at genetic make-up, lifestyle and environment in an attempt not only to improve the conditions of public health but also to produce a superior state of public health. When such new understanding is coupled with smart regulatory thinking, protectionists will fear that their resistance to public management of their lives will be by-passed by measures that simply design-in public health.

While protectionists will rely on public law mechanisms to review the operations of public bodies, there is no reason why they should not also utilize the common law. If the State decides that a programme of compulsory vaccination is essential, objectors might challenge such a decision by way of judicial review. However, let us suppose that someone challenges the legality of vaccination, arguing that, without his consent, a trespass to the person is committed.[37] Or let us suppose that Mr Marcic brought an action in contract or restitution against those house-owners who were connected to the same sewerage system but who did not suffer from flooding and fouling because (and only because) the pressure point in the system was at the lower levels. Why, Mr Marcic might plead, should I have to expend large sums of money and suffer this unpleasantness in order that you have quiet enjoyment of our common sewerage system? If we were all behind a Rawlsian veil of ignorance,[38] not knowing where we would connect in the sewerage system, would we agree to the present arrangement? If not, private rights are not being taken sufficiently seriously.

There is a great deal more to be said about protectionism. One short final point must suffice. Protectionism, as presented, tries to carry forward a philosophy of negative rights, essentially of the right to be left alone so long as one does no harm to others. However, my own view is that such a one-sided philosophy is no more defensible than crude utilitarianism. Far more defensible is a view that encourages cooperation by recognizing both negative and positive rights.[39] This is a community that is designed for cooperation. The individual is by no means erased; but in such a community of rights, there is a degree of solidarity. Mr Marcic's hypothetical plea for a fair sharing of the burdens of the sewage system already bears the imprint of such thinking. If generalized, it would aid the protectionist in some respects; but it would also prevent the protectionist from free-riding on public goods.

Conclusion

There is a great deal of unfinished business in thinking through the relationship between public health and the common law.

First, assuming that it is accepted that the State has a legitimate role in taking steps to improve public health, the community needs to make a provisional judgment as to the limits of that role. At what point does the State act beyond the scope of its legitimate jurisdiction? Is the State ever justified in removing options from individuals for the sake of public health or requiring individuals to participate in public health projects against their inclination? It is not just a matter of seeing to it that members of the community have healthy constitutions. The State must act within the terms of an agreed constitution for health.

Secondly, what is the best way of ensuring that the State fulfils its role, taking the public health measures that it is required to take and not exceeding the bounds of its legitimate function? In an ideal world, in a community that is committed to the protection and promotion of human rights, it will fall to public law, not to the common law, to set and secure delivery of the State's public health obligations.

Thirdly, though, we live in imperfect worlds. Where a community of rights is plagued by systemic regulatory failure, it needs to be put back on track. In non-ideal circumstances, where there is regulatory failure, the common law might be pressed into service as a responsive compensatory or corrective mechanism, not for private wrongdoing but for public failure.

Perhaps, then, rather than saying that there is unfinished business here, it would be more accurate to say that we have not yet started. We need a constitutional settlement for public health and we need it quickly; for only then will there be an adequate frame of reference for regulators to respond appropriately to the opportunities and challenges presented by rapid biotechnological

development.[40] It will only be then that we can begin to articulate an appropriate role for the common law, whether as principal or bit player.

Acknowledgements

I am particularly grateful to the Nuffield Trust who sponsored the series in which this lecture featured, to Robyn Martin and Richard Coker for both the invitation to give the lecture and (in Robyn's case) much background material, to my colleague, Maria Lee, for helpful suggestions in developing the central ideas in this paper, to Jonathan Montgomery who orchestrated an extraordinarily helpful after-lecture discussion, and to all who participated in that discussion. Needless to say, the usual disclaimer applies.

References

1. *Carlill v Carbolic Smoke Ball Company* [1893] 1 QB 256. The Smoke Ball Co had advertised an offer to pay £100 to anyone who contracted influenza after buying one of their smoke balls and using it in the specified way. The claimant had bought a smoke ball and used it according to the instructions but had nevertheless contracted influenza. She sued for damages for breach of contract.
2. For a wonderful account, see Simpson A. Quackery and contract law: the case of the carbolic smoke ball. *Journal of Legal Studies* 1985;14:345.
3. [1932] All ER 1. The claimant suffered from gastro-enteritis after drinking ginger beer from an opaque bottle which turned out to contain a decomposed snail. The ginger beer had been bought for her by a friend, and so she could not sue for breach of contract. She sought damages in tort from the manufacturers of the ginger beer.
4. See Kennedy RF Jr. *Crimes against nature*. London: Penguin Books Ltd; 2004. p. 13.
5. See da Lomba S, Martin R. Public health powers in relation to infectious tuberculosis in England and France: a comparison of approaches. Med Law Int 2004;6:117.
6. Gostin LO. *Public health law*. Berkeley: University of California Press; 2000. p. 13.
7. Compare, Gostin LO, note 6 above, p. 320–1.
8. See Department of Health. *Tackling health inequalities: a programme for action*, July 2003.
9. See Macbeth HN, editor. *Health outcomes*. Oxford: Oxford University Press; 1996;
   Teeling Smith G, editor. *Measuring health: a practical approach*, Chichester: Wiley; 1988.
10. Hart HLA. *The concept of law*. Oxford: Clarendon Press; 1961.
11. Seminally, albeit qua ''formalism'', see Weinrib EJ. *The idea of private law*. Cambridge, MA: Harvard University Press; 1995.
12. Weinrib LE, Weinrib EJ. *Constitutional values and private law in Canada*, In: Friedmann D, Barak-Erez D, editors. *Human rights in private law*. Oxford: Hart Publishing; 2001. p. 43, 46–7.
13. See ibid, 47.
14. [2003] UKHL 66. For comment on *Marcic* and the equally restrictive decision in *Transco plc v Stockport MBC* [2003] UKHL 61, see Lee M. Private nuisance in the House of Lords: Back to basics. *KCLJ* 2000;15:417.
15. Mr Marcic also pleaded, unsuccessfully, a Human Rights Act point; but this is not directly of relevance to the present discussion.
16. Some householders, for example, experienced internal fouling and flooding.
17. See especially Lord Hoffmann's judgment at paras 63 and 64.
18. See *Stovin v Wise (Norfolk County Council, Third Party)* [1996] 3 WLR 388; on which, see Convery J. Public or private? Duty of care in a statutory framework: *Stovin v Wise* in the House of Lords. *Modern Law Review* 1997; 60: 559.
19. Compare Kennedy, note 4 above, for the way in which the US Environmental Protection Agency has been hobbled by the Bush administration. Tellingly, Eric Schaeffer, former chief prosecutor with the Agency, remarks: 'The EPA is no longer a public health agency. It's become a country club for America's polluters'. p. 34.
20. New York: St Martin's Press; 2001.
21. Frith M. Exposed: how drugs giant pushed Vioxx Painkiller. The Independent, August 22, 2005, p. 1;
    Burleigh J. Vioxx firm may settle with drug claimants. The Independent, August 27, 2005, p. 28;
    and see, too, Prosser D. Class action offers hope in the legal battle against Goliath. The Independent, August 27, 2005, Save and Spend p. 3.
22. McGillivray D, Wightman J. Private rights, public interests and the environment. In: Hayward T, O'Neill J, editors. *Justice, property and the environment*. Aldershot: Ashgate; 1997. p. 144 at 154. Also, Steele J. Private law and the environment: nuisance in context, *Legal Studies* 1995; 15:236.
23. Generally see Gunningham N, Grabosky P. *Smart regulation*. Oxford: Clarendon Press; 1998.
24. Gostin LO. op cit, note 6 above, 270 (footnotes and references omitted).
25. Compare Biegel S. *Beyond our control*. Cambridge, MA: MIT Press; 2003 [Chapter 4].Cappelletti M. Alternative dispute resolution processes within the framework of the world-wide access-to-justice movement. *Modern Law Rev* 1993;**56**:282.
26. Famously, see Galanter M. Why the 'Haves' come out ahead: speculation on the limits of legal change. *Law Society Rev* 1974;9:95.
27. The relaxation of standard causation principles in *Fairchild v Glenhaven Funeral Services* [2002] 3 WLR 89, does not assist claimants who need the co-operation of better informed defendants if the right causal link is to be established.
28. In order to deliver on the 3Es, the first smart lesson is to recognise the limits of single instrument approaches; and the second lesson is to be aware of the range of regulatory instruments and the importance of putting in place an optimal mix: see Gunningham and Grabosky, note 23, above. For a review of the state of the (post-regulatory) art, see Scott C. Regulation in the age of governance: the rise of the post-regulatory state. In: Jordana J, Levi Faur D, editors. *The politics of regulation*. Cheltenham: Edward Elgar; 2004. p. 145.
29. For more on the regulatory range within the law, see Brownsword R. Regulating human genetics: new dilemmas for a new millennium. *Med Law Rev* 2004;12:14.
30. See Yeung K. *Securing compliance: a principled approach*. Oxford: Hart Publishing; 2004. p. 5.

31. Lessig L. *Code and others laws of cyberspace*. New York: Basic Books; 1999 [Chapter 7];
Lessig L. The law of the horse: what cyberlaw might teach. *Harvard Law Rev* 1999;113:501, 507–14. For further development, see Murray A, Scott C. Controlling the new media: hybrid responses to new forms of power. Modern Law Rev 2002;65:491.
32. Code, at 93-94.
33. Compare the account in Nozick R. *Anarchy, state, and Utopia*, Oxford: Basil Blackwell; 1974.
34. Compare George V, Wilding P. *Ideology and social welfare*. London: Routledge & Kegan Paul; 1976.
35. Compare Gostin LO, op cit, note 6 above, at 20.
36. See http://www.ukbiobank.ac.uk; and McHale JV. Regulating genetic databases: some legal and ethical issues. *Medical Law Rev* 2004; **12**: 70, 72–73.
37. Compare Jacobson v Massachusetts 197 US 11 (1905).
38. Rawls J. *A theory of justice*. Oxford: Oxford University Press; 1973.
39. Compare the general thesis in Gewirth A. *Reason and Morality*. Chicago: University of Chicago Press; 1978;;
as later elaborated in *Community of rights*. Chicago: University of Chicago Press; 1996.
40. Brownsword R. Reproductive opportunities and regulatory challenges. *Modern Law Rev* 2004;**67**:304.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on "Public health, private right and the common law"

Jonathan Montgomery[a,b,*]

[a]*Healthcare Law, University of Southampton, University Road, Southampton, Hampshire, SO17 1BJ, UK*
[b]*Hampshire and Isle of Wight Strategic Health Authority*

The discussion addressed civil litigation as a catalyst for challenging regulatory failure, giving the examples of litigation in relation to BSE and McDonalds. The vagaries of using litigation as a formal tool because of access to justice issues (limited public funding and the resistance of English law to class actions), and lack of confidence in the courts to deal with complex issues of causation (possibly manageable with a specialist judiciary), were noted. The experience of tobacco litigation in the UK was seen as indicating a limited role for civil law at this stage.

The discussion also considered the role of litigation and no-fault compensation in relation to vaccination. Are such schemes a matter of private law rights where a compensation scheme is a remedy for defects in the tort system? Or should they be seen as the quid pro quo for exercising pressure to act as good citizens? The French experience was see as an example of the latter, and the English Vaccine Damage Payments Act 1979 as an example of the former.

Consideration was given to issues of regulatory failure in relation to pharmaceuticals, including the unfolding Vioxx situation. This has not been seen in the UK as indicating regulatory capture by the industry. However, there might be a case for introducing a tiered compensation scheme where 'unsafe' (because inadequately tested) drugs would be strictly controlled. Drugs where there were no indications of problems could be marketed provided risks of unknown problems were underwritten by no-fault liability. Where research had shown safety over extended usage, then fault based liability would be appropriate. This could provide a mechanism for early availability of some drugs needed for public health purposes, while protecting those who take them from additional risks from such early release.

Disease transmission offered some interesting questions, including whether it was most effectively seen as a private, criminal or public law matter. Only the latter could operate in advance of harm (although there are examples of criminalizing risky behaviour rather than requiring proof of harm caused, for example under Section 19 of the Public Health (Control of Disease) Act 1984).

Discussion around the protectionist model included exploration of the nature of the private rights to be protected. In relation to fluoridation, is the issue an important principle of liberty whereby enforced consumption of fluoride is equivalent to an assault? Or is the question one as to whether the demand for the provision of unfluoridated water is a self-regarding act (and not amenable to regulation under a Millian framework[1]) or another-regarding act where it is in principle open to regulation. If the latter (which is perhaps

*Corresponding author.
E-mail address: j.r.montgomery@soton.ac.uk.

[1]Mill JS., On Liberty 1859.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.015

strengthened by recognition that the supply of all tap water depends on a generally available system) then it is legitimate to consider the relative values of the choices which are claimed, to see whether the anti-fluoridation claim looks trivial in comparison with the health benefits.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Health and Human Rights

Christine Chinkin

London School of Economics, Houghton Street, London WC2A 2AE, UK

Introduction

International human rights law has a good deal to say about matters of health. Even a cursory examination of the leading instruments shows us article 25 of the Universal Declaration of Human Rights (UDHR): everyone has the right to a standard of living adequate for the health and well-being of himself and his family; and article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR): states recognize the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The rights of especially vulnerable people to health care are also identified, for example in The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), article 12: states are to take all appropriate measures to eliminate discrimination against women in the field of health care to ensure equality of access to health care services. There are further particular measures with respect to the health care of pregnant and lactating women, and provisions relating to children, most notably The Convention on the Rights of the Child (CRC), article 24, the right of the child to enjoyment of the highest attainable standards of health and facilities for the treatment of illness and rehabilitation of health. There are provisions on health in conventions on the rights of migrant workers and their families[1] and rights not to be discriminated against in access to health care.[2]

Similarly at the regional level, instruments such as the European Social Charter and the African Charter on Peoples' and Human Rights provide for a right to health care and health services.

What is important about these instruments is they are international treaties creating legally binding obligations, making clear that the right to the highest attainable standard of physical and mental health is now well entrenched within the canon of international human rights law. The instruments have been supplemented by a range of soft law, non-binding institutional mechanisms, for example the establishment in 2002 by the UN Commission on Human Rights of a special rapporteur on health. This position provides a link between the UN human rights machinery and other UN agencies more obviously associated with health, self-evidently the WHO but also FAO, UNICEF, and UNHCR.

Given the existence of international specialized agencies, the question must be what the body of human rights law entails for issues of public health, or, to put it another way, what is the value added of including health within human rights law? Why locate health care issues within this international legal framework when they might appear to belong more properly to social, economic, and political policy-making?

The most immediate answer to this question is that international human rights law moves an issue

E-mail addresses: c.chinkin@lse.ac.uk, cchinkin@umich.edu.

[1]Convention on the Protection of the Rights of all Migrant Workers and Members of their Families 1990.

[2]Convention on the Elimination of Racial Discrimination 1966.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.016

on from the realm of policy making, and clarifies both that states have legal obligations, and correspondingly that individuals have entitlements.

> Characterisation of a specific goal as a human right elevates it above the rank and file of competing social goals, gives it a degree of immunity from challenge and generally endows it with an air of timelessness, absoluteness and universal validity.[3]

These are grandiose words. This can only work if framing the issue of the highest attainable standard of health as a legal right provides useful and practical guidance to decision, policy and lawmakers. In the particular context of health care this seems overly optimistic, and objections to such value-added are immediate and obvious.

First, the provisions are general in the extreme. What precisely is the right to which everyone is entitled? What possible legal content can be determined from an obligation to secure the highest attainable standard of physical and mental health? What does 'highest attainable standard' mean—highest if all possible resources are so allocated? Or highest once other allocations—those for education, defence, transport—have been made? Must 'highest' be read as an absolute standard or as a relative concept in accordance with the social and economic conditions within the locality? What is the point of legal obligation or entitlement if the content is indeterminate and open-ended? What is the yardstick for measuring compliance or indicators for success?

These linguistic concerns lead to a second, often repeated criticism of a right to health, that such rights are simply not justiciable, that is they are neither suited for, nor capable of, judicial determination and assessment. From this perspective social and economic rights are denied the legal quality of rights, that category being reserved to the traditional civil and political rights such as the right to life, freedom from torture, or liberty. This ideological position is especially strong within the United States, a state that alone in the world is not a party to any international treaty containing economic and social rights.

Third, even if economic and social rights are accorded the status of human rights, this is a weak body of law with few mechanisms for enforcement or implementation and with only weak remedies.

Fourth, and more conceptually, human rights law emphasizes individual entitlement whereas health issues relate more properly to the collectivity; one person's health needs cannot be considered in isolation from the broader societal picture.

The concept of individual rights raises further questions: How can the entitlement of one individual be weighed against that of another? How can conflicts between rights be resolved? How can individual human rights contribute to the provision of public goods and services? Finally, human rights provisions provide no priorities, no specified levels of spending, nor any time frame for their achievement. They offer a vision of open-ended entitlements, without the corresponding assertion of legally determined and determinable specified obligations.

In this paper I will discuss how international human rights law has attempted to respond to these critiques, and give some content, meaning and force to the provisions as tools in health decision-making. I do not claim that human rights law is the only tool, or even the most important one, but rather a useful addition to those of other disciplines. In particular, since human rights law is a branch of international law, it can and should be considered as a relevant factor in other areas of international decision-making, for example in the context of development, the environment and protection of international property rights. Increasingly its relevance to collective security is recognized, for example with respect to the negative health implications of economic sanctions by the Security Council and the security implications of pandemics such as HIV/AIDS.

International law is general and abstract. It provides standards that must be implemented at national level and against which national standards can be measured. Thus the focus of the international human rights bodies has been to develop a workable framework of state obligations with respect to the right to health from the bare bones international provisions, to be used within national law and policy making. I will indicate techniques adopted by these bodies, notably the UN human rights treaty bodies and the European Court of Human Rights, and offer illustrations of their application by the Constitutional Court of South Africa, a country where the right to health is constitutionally guaranteed. From these I suggest that while there is a long way to go, international human rights law can make a positive contribution to our understanding of what individuals can expect from the state with respect to health guarantees.

[3]Alston.

At international level

Committees of independent experts are elected through the UN to supervise and monitor the implementation of the human rights treaties. The most active committees in the context of health have been the monitoring Committees for ICESCR (CESRC) and CEDAW. Based on ongoing constructive dialogue with individual states through the self-evaluation system of state reporting, each of these Committees has drawn up a General Comment on the normative meaning of the right to health. The UK is a party to both these treaties and has reported regularly to both Committees.

CESCR has explained that the right to health is a broad concept that denotes both individual freedoms and positive and negative state obligations. Among the freedoms are the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. In this way the Committee has importantly linked health rights with traditional civil and political rights, thereby debunking the argument that these two sets of rights are distinct. With respect to obligations, the Committee has relied on three concepts: the concept of a minimum core obligation; the concept of progressive realization of rights; and the concept of a layered typology of obligation.

The Committee has emphasized that 'the highest attainable standard of health' does not, and cannot, equate to a right to be healthy. What the state must provide is minimum core services—primary essential health care. This minimum obligation must be understood in a broader socio-political context to encompass access to minimum essential food, shelter, sanitation and water, provision of essential drugs and equitable distribution of health facilities, goods, and services. A central aspect of the minimum core obligation is the prohibition of discrimination on the basis of sex, religion, ethnicity, race, and sexuality and the guarantee of equality of access to health services.

Human rights law requires rejection of discriminatory laws and practices, for example forcible sterilization of a particular sector of the population. It also demands addressing how an individual's entitlements are to be met, and the structural socio-economic factors that undermine entitlements, such as the distribution of power and the impact of culture, factors that play heavily in creating health needs and in the unequal distribution of services. This requires an audit of services, for example a gender audit to determine the differential impact of policies and practices, and steps to redress disparity through ensuring substantive and not merely formal equality. This may require examination of the gendered health impact of cultural practices such as female genital mutilation, cultural pressures that cause high rates of anorexia among adolescents within the west, or social exclusion of widows, or child marriages. The relationship between cultural and traditional practices and gendered power imbalance must also be unpacked. Gender relations have many health dimensions, for example violence against women, inability to insist upon safe sex because of the subordinate role of women, and attitudes that impact most heavily on the health of women, girl babies, and children. CEDAW requires states to take appropriate measures to modify social and cultural patterns of conduct with a view to eliminating practices that are based on the inferiority of one sex.[4]

In so doing, we must look at how gender discrimination intersects with other forms of discrimination. A case before the American Commission on Human Rights[5] involved the 'massive, compulsory and systematic [Peruvian] government policy that emphasized sterilization for modifying the reproductive behaviour of the population, especially of poor, indigenous, and rural women.' This practice constituted a violation of the American Convention on Violence against Women and the non-discrimination provisions of the American Convention on Human Rights. In settlement, the government agreed to modify discriminatory legislation and policies that did not recognize women as autonomous decision makers, to conduct training courses for health personnel in reproductive rights, violence against women, human rights, and gender equity, to pay compensation and to take action against the medical personnel involved.

However this agreement made no reference to the fact that the sterilization programme was directed at indigenous people. Mrs. Mestanza and her husband had been harassed by health care officials for having more than five children, harassment directed at their social status and indigineity. To be an effective response to the social and health needs of indigenous peoples, targeted measures were needed to ensure that the additional subordination of indigenous people did not prevent indigenous women from benefiting from changed policies on women's reproductive rights.

[4]Article 5.

[5]Mestanza Chavez v. Peru Inter-American Commission, Case 12.191 Report No 66/00.

The second concept developed by the CESCR is the progressive realization of rights. Unlike civil and political rights, such as the right to life or liberty, economic and social rights need be achieved only progressively.

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[6]

The CESCR has stressed that progressive realization does not deprive the obligation of meaningful content. It provides for flexibility to take account of economic realities, while simultaneously imposing an obligation to move as expeditiously and effectively as possible towards full realization.

Any deliberately retrogressive measures would require careful consideration. The Committee has expressed concern to China that funds allocated to public health have decreased, and that the health care system that had previously delivered health services to rural areas had diminished. Focus on progressive realization raises three issues that states should take into account: the need for disaggregated data to determine whether there is backward movement in particular areas (or for particular peoples) in the context of an overall general improvement in implementation of the right; the need for empirical determination of the real impact on the enjoyment of rights of policies such as privatization; and willingness to seek (and give) international assistance and cooperation.[7] This last is an unusual requirement, explicitly applicable only to economic and social rights.

In relation to its third concept, the CESCR has responded to concerns that states' obligations are indeterminate and imprecise, through adoption of a methodology that unpacks states' obligations through a multi-layered breakdown whereby states must respect, protect, fulfil and promote all human rights. The CESCR and CEDAW have developed this typology through examples in their respective General Comments.

The obligation to respect human rights is often called the negative state obligation: the state must not intrude in a way that interferes directly or indirectly with an individual's pursuit of health goals. It includes a state's obligation to refrain from impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments. In the context of women it requires states not to obstruct women's access to health services, by requiring them to have husbands' permission to attend clinics, barring access to reproductive health services because they are unmarried, or criminalizing health procedures required by women thus causing them to seek unsafe care outside the state's health structures. The obligation to protect is the positive obligation to protect individuals' rights against the acts of third parties, including that of non-state actors. This requires positive legal and social measures, for example violence against women, including effective legal remedies, gender-sensitive training of health care officials in recognizing and responding to violence, fair and protective procedures for hearing complaints, trauma and rape counselling, including for refugees, asylum seekers, and trafficked persons. It also requires a range of positive rights. For example the UN Code of Conduct for Law Enforcement Officials requires law enforcement officials to ensure the health of people under their protection, including attention to immediate medical needs.[8] It also includes rejection of discriminatory laws and customs. The obligation to fulfil is a further positive obligation to take the appropriate legislative, judicial, administrative, budgetary, economic, and other measures to address health care issues. This should be done through a national health policy, and beyond such a policy to include comprehensive and joined up attention to a broad range of relevant issues: inheritance laws, rape laws, laws on domestic violence, and an administration of justice system that does not deter reporting of crime. The obligation to fulfil requires attention to training and education programmes for health care officials, police and prison staff, immigration officers, and teachers. It also requires states to support civil society groups that campaign on health care issues, including when they challenge government action, and to encompass them within the legal protection asserted for human rights defenders. Finally the obligation to promote is forward looking and denotes a long-term obligation. It requires states to take actions that maintain and restore the health of the population, for example through provision of research and supporting people in making informed choices so as to promote healthy lifestyles.

The typology can be applied to vulnerable groups within the population. Officials should ask what is

[6]Article 2 ICESCR.
[7]Article 6.
[8]In accordance with article 2.

needed at each stage to respect, protect fulfil and promote children's health, or that of the elderly, or of legal and illegal immigrant populations, to build up appropriate matrices of the state's obligations. It also reinforces the indivisibility, interdependence and interlocking of human rights affirmed at the 1993 Vienna Conference on Human Rights. The right to health builds upon and complements other rights such as the right to life, to education, to receive information, to participate in public affairs, to freedom of expression (including sexual expression), to shelter, to food, to privacy, and to protest. Such rights must be guaranteed on a basis of substantive equality. It requires health aspects to be taken into account in the implementation of all policies and for state agencies (law enforcement, housing, social security, immigration, transport authorities) to take account of the health entitlements of those with whom they have dealings.

The CESCR and CEDAW have adopted a four-fold classification against which provision of health services can be assessed. Health facilities, services and goods must be:

- Accessible—spatially, temporally, and physically. Information about health services must also be accessible and account should be taken of social factors such as women's higher rate of illiteracy and often immobility, and the need for information to be available in the languages of immigrant populations. There must be no obstacle to accessing health services.[9]
- Acceptable and appropriate—ethically and culturally.[10]
- Affordable.
- Remedies, including legal remedies must also be accessible, available, affordable, and appropriate.

These criteria should be satisfied throughout an individual's life cycle so that attention is given to ensuring the different accessibility needs of the elderly, of adolescents, and of migrant workers. This might require different transport arrangements, different opening hours and addressing particular obstacles at different times of life.

[9]For example the International Court of Justice found that one effect of the Israeli Security Wall was to cut off Palestinians from medical facilities. It found that as a result of the enclosure of one town, the caseload of a UN hospital had fallen by 40%. Legal Consequences of the Construction of a Wall in the Occupied Palestinian Territory 2004.

[10]The ICJ did not address this issue in the Wall case but it seems that when health facilities can only be accessed by going through military check points and at times allowed by military officials they are neither acceptable nor appropriate.

At European level

Despite their amplification of the meaning of the right to health, the UN Human Rights treaty committees can only offer guidance in the forms of General Comments and context/state specific Concluding Comments at the final stage of the state reporting process. They do not make decisions that are binding upon states. The regional human rights systems, for example the European Court of Human Rights, offer more effective enforcement systems and show how needs can be transformed into justiciable rights, and abstract principles into actionable claims. Despite being modelled on the UDHR, the European Convention is limited to civil and political rights. It has no provision on the right to health. The right to health is included in the European Social Charter, which is not subject to the jurisdiction of the European Court at Strasbourg and was not brought into UK law by the Human Rights Act, 1998. It would seem therefore that the right to health would not arise under the Strasbourg jurisprudence.

This is not the case however as the European-Court has not let the lack of a specific provision deter it from addressing issues of health. It has adopted a teleological approach to interpretation of the Convention, to give effect to it as a living instrument that can be adapted to conform to changing social conditions and demands. In this way it has taken account of health needs within the framework of other convention rights, giving effect to the premise that the right to health is both a free standing right and a component of other rights, including civil and political rights.

A human rights framework requires the decision-maker to ask whether an individual's right is violated, and to think broadly about the nature of those rights. The Court has done both these things and has given judgments directed at health officials with respect to medical treatment,[11] and to other public officials. The Court has not used the language of 'respect, protect, fulfil and promote' but in many instances it is clear that it has been guided by these principles.

Cases show how health issues are read into a broad range of provisions. In *D v. UK*,[12] an individual, jailed in the UK, had been treated for HIV/AIDS. On release he was to be deported to St Kitts. He challenged deportation on the basis that there would be no available treatment in St Kitts and that he would die without treatment. He

[11]For example it has examined the requirements and restraints imposed by the right to life.

[12](1997) 24 EHRR 423.

argued that the state's positive obligation to protect life would be violated by the direct causal link between his proposed expulsion and his anticipated earlier death. The European Court did not decide the right to life point, but did find that the proposed deportation would be in violation of article 3 of the European Convention.[13] The certainty of discontinuation of treatment and of suffering in conditions of destitution culminating in painful death, constituted inhuman treatment. This decision does not require that the state provide treatment, but that it must not take actions in violation of article 3. However in subsequent cases the Court has emphasized the particular circumstances of this case, and has not allowed it to be extended, for example to allow for a successful claim for asylum.

In *Feldbrugge v. The Netherlands*[14] the European Court held that the right to a fair hearing[8] was violated by proceedings that barred the applicant from continuing to receive a health insurance allowance. In *Open Door Counselling and Dublin Well Women v. Ireland*[15] the Court held that a governmental ban in Ireland on information regarding legal abortions in Britain violated the right to impart and receive information and made services inaccessible.[16] In *Guerra v Italy*[17] the Court found a violation of the right to respect for private and family life[18] through the government's failure to warn the local population of dangers associated with a chemical factory. It considered that serious harm to the environment may affect the welfare of persons and deprive them of the enjoyment of their homes in such a way as to damage their private and family life.

Lopez Ostra v. Spain[19] concerned a Spanish town with a heavy concentration of tanneries. A waste treatment plant began operating without a licence, and fumes caused health problems. Local residents were rehoused for a time free of charge, and then the applicant and her family returned to their flat. The plant was later partially closed by the authorities, although treatment of waste water contaminated with chromium continued until it was finally closed completely. The Court's task was to find a fair balance between the competing interests of the individual and the community, and to establish whether the national authorities had taken the necessary measures to protect the applicant's right to respect for her home and private and family life. Although the authority had taken some positive measures, the Court decided that its actions were insufficient to satisfy the Convention's requirements.

Two points are of particular interest. The Convention contains neither a right to a clean environment nor a right to health, but both concepts were brought within the notion of family life. Further, although the acts complained of were those of a private company, the state was held liable for its failure to regulate those activities in a way compatible with the applicants' human rights, in that the state failed to protect the applicant's rights against the acts of a third party. It was also not required that the level of interference amounted to a serious endangering of health. It was enough that the individual is prevented from enjoying his or her home.

The state continues to have obligations even when it has privatized services. *Fadeyeva v. Russia*[20] concerned the largest iron smelter in the USSR. The former Soviet Union had taken measures to alleviate adverse health consequences for the local population, including establishing a sanitary zone around the plant, but these were inadequate and not properly implemented. In 1993 the plant was privatized. The applicant lived near the plant. The Russian courts awarded him a commitment to resettlement, but resettlement never occurred. The European Court held that there must be a minimum level of severity to constitute a violation of article 8, and that severity is measured with reference to context including duration, severity, and environmental conditions. Most importantly, although the state no longer owned or controlled the plant, it was in a position to evaluate pollution and to take reduction measures. It had not taken adequate measures to assist the applicant.

South Africa

The South African Constitutional Court has offered guidance on how judges can contribute to greater understanding of states' obligations with respect to the right to health, and of the appropriate division of tasks between the judiciary and other branches of government. Unlike many Bills of Rights contained within national constitutions, the SA Constitution includes economic and social rights. Section 27 provides that everyone has the right to have access to health care services, including

[13]The prohibition of torture and cruel, inhuman and degrading treatment.

[14][1987] ECHR 18 (27 July 1987).

[15](1992) 15 EHRR 244.

[16]Article 10.

[17](1998) 26 EHRR 357.

[18]Article 8.

[19]1994, A 303-C.

[20]App No 55723/00, 9 June 2005.

reproductive health care, and that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights.[21] No one may be refused emergency medical treatment. The Constitutional Court has had twice to consider the impact of this guarantee.

The first case is that of *Soobramoney v. the Minister of Health*.[22] The appellant had chronic renal failure requiring regular renal dialysis, without which he would shortly die. He was refused admission at the state hospital because he did not meet criteria for admission under guidelines the hospital had implemented because of shortage of resources. He appealed to the courts, contending that his constitutional right to emergency medical treatment construed with the right to life required the hospital to provide ongoing treatment for his illness, and that the state had to make additional funds available to the hospital to enable it to do so. The Constitutional Court rejected his claim, recognizing the reality that rights, such as the right to health, are limited by resources. The requirement that no-one be refused emergency medical treatment is phrased negatively, that is it applies to treatment urgently needed to avert harm in the case of an emergency or sudden unforeseeable catastrophe. It does not include ongoing treatment of chronic illness for the purpose of prolonging life.

This might appear an untenable distinction from the perspective of the individual, but his needs must be seen in the light of the needs of the population at large. The population needs to be reassured that they will not be left untreated in the event of disaster. What is all important is that the hospital has guidelines, including budgetary allocations that are reasonable, non-discriminatory, made in good faith and are applied fairly and rationally.

The state is not responsible for the absolute health of any one individual. So long as there is no discrimination and there is a rational health policy, the consequence may be that the entitlement of an individual is subjected to wider public health concerns of the allocation of resources and priorities. In this case the guidelines allowed dialysis machines to be available for a larger number of patients who might be cured, rather than simply being kept alive in a chronically ill condition.

Judge Albie Sachs explained that in an open and democratic society based upon principles of dignity, freedom and equality, the rationing of access to life-prolonging resources is integral to, rather than incompatible with, a human rights approach to health care. Health care rights have to be considered not only in a traditional legal context structured around autonomy, but in a new analytical framework based on human interdependence. When rights are shared and interdependent, striking appropriate balances between the equally valid entitlements of a multitude of claimants should not be seen as imposing limits on rights but as defining the circumstances in which the rights may be most fairly and effectively enjoyed.

There is a troubling aspect that is implicitly acknowledged, although not fully considered. Human rights laws can ensure that the allocation of resources is not carried out in a way that is discriminatory. However poverty is not a recognized head of non-discrimination in international law, and in reality this may be the determining factor in access to treatment. In this way the commitment to reduce poverty under the Millennium Development Goals is linked to human rights. But human rights discourse gives us no way to resolve conflicts between different individual entitlements.

Soobramoney also demonstrates limits on the role of the judiciary. Judges do not, and should not, set health policy or priorities, but review government policy for its conformity with the Constitution. This was the issue in the second South African case, *Treatment Action Campaign* (TAC).[23] The background is the HIV/AIDS crisis in South Africa where there are some 5 million infected people. The case concerned the failure of the SA government to provide anti-retroviral drugs to HIV positive pregnant women to prevent transmission of HIV to their babies, except in a few selected pilot areas. This policy was challenged by the TAC, a coalition of SA AIDS-related organizations. It also challenged the government's failure to have a reasonable policy on access to the drug. The Court asked: is the policy of distributing the drug on such a restrictive basis reasonable? Does the government have a comprehensive policy for prevention of mother/child transmission?

The SA Constitutional Court held that restricting access to the drug in the public health sector was unreasonable and unconstitutional. Important too was the failure to guarantee the rights of the child through providing basic health services to fulfil the child's right to health.

The case was brought by a campaigning body, showing both the role of activism and that what is cast as an individual entitlement can be made to work on behalf of a wider group, including in this

[21] The wording is a close copy of ICESCR, article 2.

[22] (1997) 12 BCLR 1696.

[23] (2002) 10 BCLR 1033.

instance the unborn. Further, it brings human rights law into the fight against HIV/AIDS. Human rights law can provide assistance in protecting victims against discrimination on grounds of their illness, in providing for the allocation of resources on a rational, predetermined basis, and in providing a framework for development aid and policies.

However the case also exposes the limitations of law. Courts deal only with those cases that come before them; it might be argued that other issues should have been given this same constitutional emphasis, such as treatment of malaria, provision of clean water or the high incidence of rape. The concentration of attention that occurs through litigation necessarily impinges upon a government's determination of priorities, even while the court asserts that its task is limited to review of those policies. There was no guarantee that the government would respond to the Constitutional Court's requirements in the HIV/AIDS case. Legal remedies are limited in their effect and are directed only to the case at hand. Certainly delivery of anti-retroviral drugs would minimize transmission to unborn children of HIV positive mothers but it does nothing to combat transmission to those mothers, or to address the social conditions making women vulnerable to infection. The legal remedy is minimized unless accompanied by other social and medical steps. Human rights law must be used as part of concerted efforts across legal social and economic programmes for such objectives as the empowerment of women, and the lessening of a culture of violence and of cultural practices that make women the major victims of the pandemic in southern Africa.

Conclusion

Steps have been taken across a range of arenas to give substance to the open-ended, imprecise human rights standards pertaining to health. Viewing health care issues through a human rights lens brings the individual to the fore and is a counterbalance to other perspectives, such as those of economists who see health through the prism of the globalized economy, or of politicians who see it as a matter of welfare needs or security, or of law enforcement officers who perceive it as going soft on crime. Human rights provides an alternative and complementary language for thinking about issues, for example HIV/AIDS as a rights issue not a health issue, and a language of obligation that states have signed up to and understand. The qualities it brings to any analysis of policy is rejection of arbitrariness, impunity and lack of accountability and promotion of transparency and accountability. But these qualities must be balanced against the downsides of a rights approach, including issues of resources, the possibility of conflicting rights and continuing state centred focus. Human rights can never be an exclusive lens but it remains a useful and instrumental additional one.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on "Health and human rights"

J.V. McHale

Faculty of Law, University of Leicester, University Road, Leicester, LE1 7RH, UK

Is it the case that human rights are of help in framing health law, in structuring responses to major public health risks, in maintaining screening programmes or in determining what information should or should not be available to public health researchers? Over the years the applicability of human rights in health care law has come under considerable scrutiny, most recently in the UK through the Human Rights Act 1998 and consequent litigation. But of course long before human rights was a glint—or should it be a stye in New Labour's eye—human rights were an issue in a much a broader arena.

Professor Chinkin's paper outlines the impact that human rights principles have had through international law upon individual states. In so doing she confronts head-on the most immediate comment thrown up by sceptical observers—is human rights analysis, while like motherhood and apple pie something we would support in practice of limited assistance in the health care context? In principle are human rights really any use in health law in general, or in public health law in particular. One criticism of course is that human rights analysis is too abstract to be of any effective assistance. Professor Chinkin notes this scepticism but illustrates a number of ways in which, operating at an international level and via the European Convention of Human Rights, human analysis can impact upon health law issues.

Professor Chinkin suggests ways in which human rights law may help to structure delivery of health rights: minimal essential provision, equality of discrimination etc. She notes the potential of human rights instruments for promoting health rights at a global level. Health lawyers are increasingly engaging with issues of globalization and health. Disease is of course no respector of borders. To deal effectively with global pandemics we need to try to achieve global solutions. International human rights approaches may help us to structure appropriate responses to such crises. But do they effectively assist to structure responses within individual states? Of course this raises the fundamental issue of whose rights these are anyway, and this was raised in the lecture discussion. Individual conceptions of rights need of course to be placed in the context of the rights of others and indeed in the broader community context. But while rights may provide the framework in resolving specific dilemmas, they have limitations. Can rights which the balance on whether, for example, new-born children should be required to be vaccinated against their parent's objection? Do rights really have any role in situations of typhoid or cholera epidemic? Can human rights analysis effectively survive an emergency situation or does it break down totally?

What about responsibilities as well as rights? States may be regarded as having responsibilities in the public health arena, but what of individual responsibility certainly the rhetoric of individual responsibility for health has gained currency in government circles. Schools are criticized about the provision of school dinners, but should parents be policed as to what they include in children's lunch bags? In the public health arena, as Professor Chinkin notes, rights collide. So for example, economic, social and cultural rights to health may collide with privacy, the right to life, the

E-mail address: jean.mchale@leicester.ac.uk.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.017

prohibition on torture, inhuman and degrading treatment. What lessons can we draw?

(i) In public health law, global problems will require global solutions—human rights may help to structure our responsibilities but do not solve problems where resources are few and states are poor.
(ii) Individual states have to wrestle with rights and responsibilities, public health needs and individual choices, they have to be responsive to other values in a multi-cultural society.
(iii) The recognition that 'health' issues go far beyond traditional health law.

Larry Gostin has suggested that 'Public Health law should be seen broadly as the authority and responsibility of government to assure the conditions for the population's health'.[1] But, as he recognizes, the problem is 'how to balance the collective good achieved by public health regulated with the resulting infringement of rights and freedoms'.

I leave you with one thought. Yes Gostin is right, but surely all health law is a balance of rights, risks and consequent regulation. Do we need a subset of public health law, and is it really possible to define it?

[1]Gostin L. Public Health Law: Power, Duty and Restraint. University of California Press, 2000.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

The contribution of human rights to improving public health

David Feldman[a,b,c,*]

[a]*Faculty of Law, University of Cambridge, 10 West Road, Cambridge, CB3 9DZ, UK*
[b]*Downing College, Cambridge*
[c]*Constitutional Court of Bosnia and Herzegovina*

Introduction

Human rights began to contribute to the legal regulation of medicine and research after World War II when the Nuremburg Tribunals, trying doctors accused of conducting experiments on prisoners in concentration camps, developed legal principles to protect the autonomy of individual patients and research subjects. Thereafter human rights lawyers gave increasing attention to the state's responsibility for public health. Coping with threats to health came to be seen as a right-governed sphere.

The resulting international debate over health rights has highlighted the division between the economically developed and undeveloped worlds over access to health resources, and the conflict between social rights and market freedom (reflected by the partly competing, partly complementary, objectives of the World Health Organization and the World Trade Organization). As governments have become less enthusiastic about rights in the face of terrorism, international discussion of public health has tended to avoid the language of rights, replacing it with other kinds of rhetoric.

In the United Kingdom the only human rights to have been made directly enforceable are civil and political rights within the European Convention on Human Rights (ECHR).[1] Legal protection for public health stems from enforcement of public health statutes which advance the same goals as health rights, with some incidental protection from Convention rights. As politicians show little enthusiasm for giving legal status to social rights, their main influence has been in political argument, as a guide to the interpretation of statutes and Convention rights, and as relevant but non-determinative factors to be taken into account in decision-making.

Models of rights and their implications for ways of protecting public health

One can distinguish between three forms of rights relating to health. The most straightforward model concerns the physical integrity and moral autonomy of individual human beings. People are normally free to make choices that others would regard as irrational, as long as they are mentally competent. Everyone is in principle free to refuse treatment;

*Corresponding author. Faculty of Law, University of Cambridge, 10 West Road, Cambridge, CB3 9DZ, UK.
E-mail address: djf41@cam.ac.uk.

[1]See European Convention for the Protection of Human Rights and Fundamental Freedoms (1953) and Human Rights Act 1998, s. 1.

doi:10.1016/j.puhe.2006.07.018

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

the right is an assertion of the priority of liberty over paternalism and moralism.

In international law, rights to bodily integrity and autonomy are reflected not only in customary international law (as established by the Nuremburg Tribunals), but also in the positive law of treaties. Interfering with autonomy may infringe the right to be free of torture and inhuman or degrading treatment.[2] Acting on a person's body or mind without consent may amount to an attack on moral integrity, protected as an aspect of the right to respect for private life.[3] Interference may however be justified in the wider public interest in order to protect society against a significant risk to health. When deciding whether interference is justified, a primitive proportionality test is used. Fluoridation for example compromises bodily and moral integrity to a relatively minor extent and carries little risk of harm, but it can offer significant protection against oral disease. The likely benefits outweigh the likely harms. Immunization is more intrusive and can have risks for the person immunized. These considerations are usually sufficiently weighty to militate against imposition by the state of compulsory immunization, although the state remains free to campaign to persuade people to be immunized.

The second model of health rights concerns states' limited obligation to provide health services. When Jamie B., suffering from terminal leukaemia, challenged the decision of Cambridge Health Authority not to fund an experimental form of treatment which offered some hope for her condition and was available at considerable cost, the Court of Appeal treated the right to life as just one factor to be taken into account in making a polycentric decision affecting people's interests.[4] The authority's obligation was only to make a rational decision.[5] The right to life (at any rate before the Human Rights Act 1998) could not require the state to provide any life-prolonging treatment reasonably available if medical professionals considered that it offered too small a chance of significant benefit to be worthwhile.

There can be little doubt that the same conclusion would be reached under the Human Rights Act 1998. The positive obligations of the state have been limited to a duty to take reasonable steps to offer medically appropriate treatment to patients who are in the custody of the state or otherwise unable to make decisions for themselves, although it is probable that the right to life would now have to be taken into account more explicitly when giving reasons for the decision. Article 2 does not confer a right to receive medical treatment on demand, although it might possibly include a right not to have life-prolonging treatment withdrawn against one's wishes once it has been begun.

The important point here is the centrality of the judgment of medical professionals to the scope of an individual's positive right to receive treatment. The needs of the individual patient cannot be the sole measure of appropriateness. In Jamie B.'s case the health authority denied that cost was the determining factor, but the imperatives of sound allocation of medical resources ensure that cost and the needs of other patients are relevant to the appropriateness (in a social rather than individually-directed sense) of a patient's preferred form of treatment. This can be seen in relation to the availability of transplants[6] and in vitro fertilization.[7]

Another model of health rights is the promotion of good health. Social action to promote health aims to improve individual health by persuading people to change their behaviour rather than by administering treatment. Action aimed at smoking, eating and exercise is for an individual's welfare, but society benefits from the reduction in levels of morbidity and mortality and the associated social and economic costs. There is a limit to the moral duty of society to help people to improve their lives. This limit flows from recognizing people as having moral autonomy.

Information about threats to health

People can only take responsibility for themselves within the limits of their knowledge about risks. We have a right to receive information about known threats to health. This is conceptualized as an aspect of the right to respect for private and family life,[8] with a correlative positive obligation imposed on the state to supply the information.[9]

[2]Article 3 of the ECHR.

[3]Article 8 of the ECHR.

[4]*R. v. Cambridge Health Authority, ex parte B* [1995] 1 WLR 898, [1995] 2 All ER 129, CA.

[5]It could not be shown that the Health Authority had breached any of the principles set out in *Associated Provincial Picture Houses Ltd. v. Wednesbury Corporation* [1948] 1 KB 223.

[6]*R. v. Secretary of State for Health, ex parte Walker* (1987) 3 BMLR 32.

[7]*R. v. Ethical Committee of St. Mary's Hospital, Manchester, ex parte H* [1988] 1 FLR 512, [1987] NLJ Rep 1038.

[8]Under the ECHR Art. 8 and the Human Rights Act 1998.

[9]See *L. C. B. v. UK* (1998) 27 EHRR 212. The state might have been required to give information of its own motion to parents of daughter conceived after the applicant's exposure to radiation on Easter Island if the state had information at that time about likely effects. See also *McGinley and Egan v UK* (1998) 27 EHRR 1, where there was found to be a positive obligation to make

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

When information is held by a private person or body, human rights do not easily impose an obligation of disclosure. Public international law does not normally impose human-rights-related obligations on private citizens and organizations, only on states. In municipal law the extent of such an obligation depends on whether the legal order gives horizontal effect to rights and obligations. In Canada rights[10] do not have horizontal effect; in the UK Convention rights apply only against public authorities; in South Africa the Constitutional Court has allowed a degree of horizontal effect, although it is not yet clear how far this goes.

A private person or body may seek to rely on other rights to set against any duty of disclosure of risk. Tobacco manufacturers for example might argue that a duty to disclose infringes the right to avoid self-incrimination, the negative aspect of freedom of speech (the right not to speak unless one wants to do so), and the right to protect confidential information. However, such rights are weak in this context. The privilege against self-incrimination arises only in relation to a threat of criminal proceedings, not to a risk of civil liability and still less to protect undeserved commercial reputation. The right not to speak is at first sight more significant, but it is not clear why artificial bodies should be entitled to assert autonomy rights. As Shiner notes,[11] consumers do not assert (and probably do not have) a right *not* to know about risks associated with products which producers can 'borrow' to form the basis of a right to withhold the information.[12] The right to protect confidential information never really gets off the ground, because the right is qualified, and any loss of confidentiality is likely to be justified by the public interest in receiving the information.[13] These issues were raised by lobbyists for the tobacco industry during the passage of the Tobacco Advertising and Promotion Bill,[14] and the Parliamentary Joint Select Committee on Human Rights concluded that they did not justify the claim that requiring information to be provided violated human rights of the companies.

Human rights law does not require states to impose an obligation of disclosure. Whether there is the political will to impose one will vary from society to society depending on the importance of commercial freedom relative to other rights. In economically liberal societies, there is a tendency to allow commercial organizations not to disclose risks for health-protection purposes far more readily than to allow them not to disclose financial details for tax-collection purposes.

It is therefore entirely proper that the regulation of commercial silence has been extended. Products must carry information about ingredients, and medicinal products carry information about side-effects. There is a movement towards standardizing these requirements. Human rights are increasingly taken into account by international bodies whose primary function is to open international markets, such as the arbitral tribunals of the World Trade Organization. Together with the educational and campaigning work of consumer organizations, it is easier for governments to justify regulation, and for people to obtain the information they need to make sensible decisions about protecting their health.

Programmes offering protection to members of the public

Programmes such as one of immunization work for the community only so long as a significant proportion of the community is prepared to compromise bodily integrity and accept a level of risk. Sometimes the focus is principally on the community, such as programmes to reduce smog, provide clean water, or improve dental health. These measures aim to confer what economists call 'public goods', that is, they are 'non-rival' (in the sense that one person's consumption of the good does not limit the amount available to others) and 'inexcludable' (if the good is provided it must be available to all). The community benefits, and individuals may benefit more or less depending on their circumstances.

Where the principal beneficiary of a right to health is the community, the nature and scope of the obligation imposed on state institutions needs to be determined. One can best formulate the scope of a communal right by starting with the relevant obligation and working inductively from it.

(*footnote continued*)
information available under Article 8 when the government exposed people to hazardous activities, but by a bare majority the court held that this had been done by way of the procedure before the Pension Appeal Tribunal.

[10]Under the Canadian Charter of Rights and Freedoms.

[11]Shiner R. *Freedom of commercial expression*. Oxford: Oxford University Press; 2003. p. 206–7.

[12]See also Barendt E. *Freedom of Speech*, 2nd ed. Oxford: Oxford University Press; 2005.

[13]See, *mutatis mutandis*, *Lion Laboratories Ltd. v. Evans* [1985] QB 526.

[14]Considered by the Parliamentary Joint Select Committee on Human Rights, 2001-02, 8th Report, *Tobacco Advertising and Promotion Bill*, HL Paper 59, HC 474, and 14th Report, *Scrutiny of Bills: Private Members' Bills and Private Bills*, HL Paper 93, HC 674.

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

This methodology allows the substance of the obligation, and hence of the right, to change progressively over time as society's social and economic resources develop. Of course it can also retreat with recession and social upheaval.

We can see this reflected in the ways health rights have been formulated in international human-rights treaties. In the Universal Declaration of Human Rights in 1948 the General Assembly of the United Nations proclaimed an aspirational code of human rights and enjoined 'every individual and every organ of society…to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition….'[15] The UDHR did not include a right to health as such. Instead, Article 25.1 asserted, 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in case of…sickness [and] disability…in circumstances beyond his control.' Under Article 28, 'Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.'

The primary right was to a standard of living adequate to permit provision for health and well-being. There was no obligation on the state to provide mechanisms for treating illness. The state's main obligation was to ensure that people who could not help themselves received resources to allow them to obtain help, whether from the state or private sector. Societies were to be organized so as to make possible the full realization of rights. Arrangements and policies that interfered with the realization of rights would not be conducive to the social and international order envisaged by Article 28.

The object was to promote rights by progressive measures. There was an acceptance that advancing good health depends on developing economies to increase social wealth, whether through individual autonomy and responsibility or through state and international action. This linked health-related rights directly to development. It was logical, therefore, to assert in the International Covenant on Economic, Social and Cultural Rights[16] not only that people have a right to an adequate standard of living but also that there is a right to the continuous improvement of living conditions.[17] It is not surprising that there was an overwhelming vote by the UN General Assembly in 1986 to adopt a Declaration on the Right to Development expressing the inter-relationship in normative terms.[18]

International treaties have since shown a gradual strengthening of the normative element in health rights. The attitudes of the Council of Europe states which negotiated the original version of the European Social Charter (ESC)[19] moved beyond those in the UDHR. This was partly a reflection of social and economic reconstruction of world markets after World War II, and partly a consequence of the character of the Council of Europe as a regional association of prosperous, liberal-democratic western European states. The Preamble to the ESC[20] stated that the states parties were 'resolved to make every effort to improve the standard of living and to promote the social well–being of…their-…populations', and they agreed to 'accept as the aim of their policy…the attainment of conditions in which rights and principles could be effectively realized'. These rights and principles included[21] the right to safe and healthy working conditions, sufficient remuneration for a decent standard of living, the right to benefit from measures enabling the highest possible standard of health attainable, and the right for anyone without adequate resources to social and medical assistance. In addition, the ESC provided for the social right to protection of health by imposing obligations to remove so far as possible the causes of ill-health, provide facilities for the promotion of good health, and prevent epidemic, endemic and other diseases.[22] It is noteworthy that different facets of health rights were separated more fully, and identified more concretely, than in the UDHR. In addition, the right to protection of health was distinguished from the obligation of states to ensure that any person who is without adequate resources be granted assistance and care.[23]

[15]Universal Declaration of Human Rights (UDHR), preamble, final paragraph.

[16](1966), Article 11.1.

[17]This link between development, peace and human rights has been made explicit by Figueres. See Figueres J. Some economic foundations for human rights. A paper for the International Conference held in Tehran in 1968. UN doc. A/CONF.32/L.2, 8 February 1968, reprinted in Ian Brownlie and Guy Goodwin-Gill (eds.), *Basic documents on human rights,* 4th ed. Oxford: Oxford University Press; 2002. pp. 832–47.

[18]General Assembly Resolution 41/128 of 4 December 1986. Only the USA voted against this.

[19]Concluded in 1961.

[20]Fourth paragraph.

[21]Part I of the ESC.

[22]Part II, Article 11. The UK has accepted the obligations imposed by Article 11 of the original 1961 version of the ESC, which are the same as those in the revised 1996 version.

[23]Under Article 13 of the ESC.

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

Fifteen years later in the International Covenant on Economic, Social and Cultural Rights (ICESCR),[24] the formulation of the right to health was different again. This resulted from the global, rather than regional, character of the Covenant, but the ICESCR also incorporates developments in attitudes towards the responsibility of the state for health. Article 12.1 recognizes 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' Article 12.2 provides that, to realize this right, steps must be taken to combat infant mortality, to improve hygiene, to prevent and control disease and to assure medical treatment in case of sickness.

These provisions give rise to four reflections. First, health-related human rights go beyond ensuring that care is available in the event of sickness. With the mounting costs of medical care, the most constructive and cost-efficient use of public resources is likely to be achieved by providing conditions that allow the best chance of maintaining health and avoiding sickness. Secondly, one aspect of that endeavour is helping people take responsibility for their own health. To that end, subsidiary rights come into play, including a right to information about threats to health. Thirdly, the question arises as to the extent to which autonomy might be limited to advance a public benefit. The Helsinki Declaration on experimentation[25] provides guidance on medical experimental ethics. Programmes of immunization create a tension between individual autonomy and collective health protection, as a certain coverage of the population is needed in order to provide security for the population as a whole. If the invasion of physical integrity is minor, the effectiveness of the immunization high, and the risk of side-effects small, the balance will favour overriding the subject's autonomy and encouraging immunization. A programme of compulsory immunization is then justifiable in human-rights terms. The closer one goes to coercing immunization in the public interest, the more the balance will favour guaranteed compensation if the risk from immunization materializes. If those who suffer in the public interest receive appropriate support and compensation from the state, it does not seem to me to subject people to inhuman or degrading treatment or to a lack of respect for their private lives to press them into being immunized.

Fourthly, achieving the conditions for improving standards of health is a progressive task and depends on resources being available for substantial infrastructure projects. When the global economy is strong, the only obstacle to progressively realizing rights is competition with other goals that may affect the priority given to health. National and international economic cycles go down as well as up. The idea of a right to continuous improvement of living conditions[26] takes no account of this, and it is questionable whether it can properly be regarded as a substantive legal right. Nevertheless, it may give rise to procedural obligations on policy-makers to give proper consideration to the issues, and to justify the proposed solutions publicly and rationally by reference to the importance of improving living conditions

Public health and human rights in national law

A number of countries have included in their constitutions rights related to public health. Ireland's 1937 Constitution contained Directive Principles of State Policy, and this was taken up in the Indian Constitution of 1947 and in the 1993 and 1996 South African Constitutions. In the UK, the nearest approach to such constitutional provision is the indirect protection of health by some rights under the Human Rights Act 1998.

In Ireland the courts have taken seriously the injunction of the Constitution that Directive Principles are not justifiable. So far as they have been used, it has been to limit the scope of express and judicially enforceable rights elsewhere in the Constitution. Judges argue that the express rights cannot be interpreted as including social rights because that ground is covered by the Directive Principles, which are clearly stated not to be judicially enforceable.

The position in India is similar in that the Constitution provides that the Directive Principles are not to be enforceable. However, judges have gradually moved beyond the restrictive approach of the Irish courts. The Supreme Court of India treats the Directive Principles as aids to interpretation of the express and enforceable constitutional rights. Unlike the Irish approach, this has extended their range. Thus, the right to life under Article 21 of the Constitution has been held to encompass the right to clean air and water, allowing judges to make

[24]Under the auspices of the United Nations in 1976.

[25]Drawn up by the World Medical Association in 1964 and subsequently revised.

[26]Article 11.1 of the International Covenant on Economic, Social and Cultural Rights.

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

orders to curb pollution.[27] The Supreme Court has held[28] that the onus was on tanneries to establish that their effects were environmentally benign. Tanning is an important source of foreign exchange for India, but the Court rejected the argument that such benefits could be balanced against harm to the environment, because the environment is essential to the right to life.[29] The Court recognized that sustainable development was accepted internationally as the best way to combat world poverty. The 'polluter pays' principle was essential to sustainable development, and the precautionary principle required courts to place the burden on developers to show that developments do not harm the environment in order to protect the right to life.[30]

These developments allow the courts to influence the process of decision-making by making environmental health rights an essential part of policy-making processes, aided by the loosening of procedural requirements, particularly a relaxation of the rules of *locus standi* to allow people to sue in the public interest even if they would gain no direct advantage from the litigation.[31]

The Indian linkage between the environment and the right to life shows the potential for constructive constitutional adjudication to support public health. This has been developed in South Africa, where the 1996 Constitution gives social and economic rights the same constitutional status as civil and political rights. The Constitutional Court of South Africa has held that social and economic rights are justiciable, although the Court takes account of separation of powers issues when deciding what remedies to award.[32] As a result, their practical impact is very similar to that of the Directive Principles in India: they serve both as an interpretative tool to guide the application of civil and political rights, and as a set of constitutionally relevant considerations to which executive and legislative bodies must give appropriate weight when making policy and drafting legislation.

In South Africa, as in India, this is politically controversial and has significant economic implications. The Constitutional Court[33] has held that the Government was violating the right to access to health care[34] by not making single doses of the anti-retroviral drug Nevirapine available to mothers and their new-born babies in public hospitals to minimize the risk of mother-to-baby transmission of HIV unless they were part of a government-supported research study. The Court did not accept that section 27(1) gave rise to an individual right to a core service irrespective of resources. The government could only be required to act within its available resources, and the substance of the right was limited by those resources.[35] Nevertheless, the State had to take progressive action to realize the right, and the Court would guarantee that democratic processes were protected in order to secure accountability for the government's decisions.[36] While the Court was not equipped to make wide-ranging factual inquiries and could not easily adjudicate in fields where its orders would have 'multiple social and economic consequences for the community',[37] it carefully examined the government's reasons for the policy and concluded that the government's concerns did not support denying single, neonatal doses of the drug. The government had sufficient supplies for such doses, but had been worried about the cost of counselling and testing on a long-term basis for people in receipt of the drug, which was irrelevant to a policy relating to single doses.[38] The Court therefore ordered the government to remove the restrictions on the use of single, neonatal doses of Nevirapine in public hospitals to prevent

[27]For example to stop pollution of the Ganges, to stop quarrying in Mussoorie, to close industrial sites which were producing pollution damaging the Taj Mahal, and to require the State to provide roads in inaccessible areas. Setalvald AM. The Supreme Court on Human Rights and Social Justice: changing perspectives. In: Kirpal BN, et al., editors. *Supreme but not infallible: essays in honour of the supreme Court of India*. New Delhi: Oxford University Press; 2000. p. 232–55 at 248-252, citing *Mohini Jain v. State of Karnataka* AIR 1992 SC 1858 and *Unni Krishnan J. P. v. State of Andhra Pradesh* AIR 1993 SC 2178, *M. C. Mehta v. Union of India* (1991) 2 SCC 353, *A. P. Control Board v. M. V. Nayudu* AIR 1999 SC 812, and *State of H. P. v. Umed Ram* 1986 SC 847 respectively [Chapter 13].

[28]*Centre for Environmental Law WWF-I v. Union of India* (1999) 1 SCC 263.

[29]Under Article 21.

[30]See Salve H. Justice between generations: environment and social justice, in: Kirpal BN, et al., editors. *Supreme but not infallible: essays in honour of the Supreme Court of India*, pp. 360-380; on the connection between the Clean Air Act, the Clean Water Act, and judicial decisions on constitutional rights [Chapter 18].

[31]See Desai AH, Muralidhar S. Public interest litigation: potential and problems. in: Kirpal BN, et al., editors. *Supreme but not infallible: essays in honour of the Supreme Court of India*, p. 159–92 [Chapter 10].

[32]See *Soobramooney v. Minister of Health, Kwa-Zulu-Natal* 1998 (1) SA 765 (upholding a policy of not making scarce renal dialysis resources available to people with chronic renal failure who also suffer from other serious illnesses making them a very low priority for transplants).

[33]*Minister of Health and others v. Treatment Action Campaign and others* 2002 (1) SA 721.

[34]Under section 27 of the Constitution.

[35]*Minister of Health and others v Treatment Action Campaign and others* 2002 (1) SA 721, paras. [31], [35].

[36]Ibid., para. [36].

[37]Ibid., paras. [37]-[38].

[38]Ibid., para. [49].

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

mother-to-baby HIV transmission, and to make provision for counselling and testing to be progressively extended across public hospitals. The court thereby required government to have regard to health rights as part of a rational process of policy-making without supplanting the government's role in determining the socially optimal allocation of scarce resources.

In England and Wales, the Human Rights Act 1998 has so far made little impact in this area. The first attempt to use the Act for public health came in *Marcic v. Thames Water Utilities Ltd.*[39] Mr. Marcic's property was regularly flooded with foul water sewage. He claimed an injunction restraining Thames Water from allowing their sewers to be used in such a way as to cause flooding. The claim was based on the tort of nuisance and on the Human Rights Act 1998, alleging a violation of his right to respect for his home under Article 8 and of his right to property under Article 1 of Protocol No. 1 to the Convention.

In the House of Lords, Lord Nicholls of Birkenhead pointed out that there was a statutory scheme for regulating the water industry. Mr. Marcic had not complained to the Office of Water Services, and the Secretary of State had not exercised his power under the legislation to order Thames Water to undertake remedial work. Lord Nicholls was not prepared to allow the statutory scheme to be evaded by relying on Convention rights, when the scheme was potentially capable of offering adequate protection to those rights. The rights relied on were qualified rights, and the European Court has allowed a significant 'margin of appreciation' to states in deciding how to give effect to rights in the field of environmental law. A reviewing court had a subsidiary role.[40] The statutory scheme struck a reasonable balance between the competing interests.[41]

Unlike Indian and South African courts, the House of Lords declined to require the public authority to show that it had properly considered the relevant rights. If this means that the undertaker's system of priorities for major remedial works was non-justiciable, the result is curious. On ordinary administrative law principles, a court can review the assessment of a public body of its priorities to ensure that the body has taken relevant considerations into account in its decision. Where a decision adversely affects legal rights, the public body must normally explain its reasoning with enough clarity and specificity to allow the court to make that assessment. Were that not so, there could be a violation of the claimant's right to have his legal rights determined by an independent and impartial tribunal.[42] It would be odd if a claimant were to be less well protected when a public body's ordering of priorities put Convention rights at risk than when the body was affecting ordinary legal rights. Nevertheless, the decision indicates that our courts are at present likely to be less prescriptive than Indian courts in cases where social rights to 'public goods' are in issue.

Our courts have traditionally had faith in our political system to deliver reasonable legislation and enforce it fairly. Indian courts tend to regard themselves as one of the least corrupt and partisan parts of the state apparatus and have accordingly been more willing to intervene in public health matters. UK courts have been more hesitant about substituting their own assessments of polycentric resource-allocation issues for those of political or administrative bodies. There is no reason to suppose that the courts are ready to change that stance significantly in the light of the Human Rights Act. For example, in *D. v. UK*[43] the European Court of Human Rights held that it would violate Article 3[44] to deport an immigrant who had been convicted of a drugs offence and was dying of AIDS to St. Kitts, where no treatment for AIDS would be available. In *Bensaid v. UK*[45] the Court made clear that *D.* was an exceptional case, and it would not violate Article 3 to return to Algeria, where appropriate treatment might not be available, an immigrant who had been suffering from schizophrenia. The risk to health in *Bensaid* was more speculative than in *D.* and so the risk of reaching the Article 3 threshold was less pronounced. Such decisions clearly could have a major impact on health care. In *N. v. Secretary of State for the Home Department*[46] the Court of Appeal considered Article 3 where the claimant, a woman to be returned to Uganda, was suffering from AIDS-related diseases and would be unlikely to receive life-prolonging treatment there. The majority held that *D.* was limited to 'very exceptional' cases 'where there are compelling humanitarian considerations in play', because only then would it be appropriate to apply the Convention extra-territorially (that is, taking account of conditions in a country outside the UK in deciding that it

[39][2003] UKHL 66, [2004] 2 AC 42, [2003] 3 WLR 1603.

[40]See *Hatton v. United Kingdom* Eur Ct HR Grand Chamber, App. No. 36022/97 on noise pollution from increasing the number of night flights at Heathrow Airport.

[41]Although at paragraphs [44]-[45] Lord Nicholls expressed concern about the fact that there was no compensation if the flooding was external to the house rather than in the house.

[42]Article 6.1 of the ECHR.

[43](1997) 24 EHRR 423.

[44]The right not to be subjected to torture and inhuman or degrading treatment or punishment.

[45](2001) 33 EHRR 205.

[46][2004] 1 WLR 1182.

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

would violate a Convention right to remove a person from the UK).[47]

There has been a reluctance to impose extensive, positive, legal obligations on the state in the formation of health-care policy. Nevertheless, there are signs that the courts may be becoming more demanding. In *R. (Ullah) v. Special Adjudicator*[48] the House of Lords held that, in immigration and removal cases, the courts can always take account of the effect on Convention rights of the conditions that a person would face if removed from the UK. In *R. v. North and East Devon Health Authority, ex parte Coughlan*,[49] the Court of Appeal developed the principle that public bodies must honour legitimate expectations which they have engendered in relation to the care of individual patients.

This presents difficulties for health authorities wanting to make efficient use of resources, and the courts have been ambivalent about applying the principle to control local government policy and spending on care homes. It is clear that the power is there, but judges are not consistent in the intensity with which they will scrutinize the reasons for decisions.[50] These are not simply human rights issues, and matters have to be decided in ways that are constitutionally proper. The constitutional implications are particularly concerned with the separation of powers: who has ultimate authority to decide how human rights are to be secured, and how resources are to be deployed?

Our courts are only beginning to come to terms with these questions. They have to be re-thought in the light of the Human Rights Act 1998. The jurisprudence of the Supreme Court of India has developed progressively,[51] and the Constitutional Court of South Africa has had the benefit of the Indian experience. The UK's constitutional system, without directive principles embodying social rights, gives less support to judges wanting to develop such rights in our law, and there is less scope for public interest litigation under the Human Rights Act than in India because of the strictness of standing test under the Act, which requires the claimant to be a victim of the alleged violation of the right.[52]

The argument needs to be made in the UK that one can achieve a good deal by taking social and economic rights into account properly on administrative law principles. We then need to give our judges time to determine the implications of the 1998 Act for our constitutional structure.

Conclusion: joined up thinking and the place of human rights in international programmes of public health

The right to development in international law has proved difficult to implement, at least through legal machinery. The emphasis remains on self-determination and equality of sovereign states and democracy. This makes joined-up planning in the field of development difficult, as states are free to pursue their own interests and, in democracies, must account to their electorates for their decisions.

The Copenhagen Declaration on Social Development[53] accepted that social development was essential to people's aspirations. Participants committed themselves to social, cultural and economic methods of fostering the conditions needed for development, including the eradication of poverty.[54] Commitment 6 was to promote and attain 'the highest attainable standard of physical and mental health, and the access of all to primary health care, making particular efforts to rectify inequalities relating to social conditions'. At national level, this was to be achieved by economic and social means, but also by giving effect to the Convention on the Rights of the Child,[55] as well as fostering health education,[56] expediting efforts to achieve the goals of the Alma-Ata Declaration,[57] and providing sanitation and drinking water, nutrition education and preventive health programmes. Commitment 7 included a commitment to 'take all necessary measures to ensure that communicable diseases…do not restrict or reverse the progress

[47]See Dyson LJ at para. [46], and also Laws LJ at paras. [36]-[37].

[48][2004] UKHL 26, [2004] 2 AC 323, [2004] 3 WLR 23.

[49][2001] QB 213, 2000 2 WLR 622. Decided before the Human Rights Act 1998 came into force but clearly with one eye on its impending effects.

[50]See e.g. *R. (Birmingham Care Consortium) v. Birmingham City Council* [2003] LGR 119; *R. v. Barking and Dagenham LBC, ex parte Lloyd* [2001] LGR 421; *R. v. Gloucestershire County Council, ex parte Barry* [1997] AC 584; *R. v. East Sussex County Council, ex parte Tandy* [1998] AC 714.

[51]The Court underwent a period of restraint in its approach to separation of powers issues, and only started to forge a new role for itself in social and environmental issues in the late 1970s and 1980s. See Desai and Muralidhar, *op. cit*.

[52]See Feldman D. Public interest litigation and constitutional theory in comparative perspective. *Modern Law Review* 1992; **55**: 44; Miles J. Standing in a multi-layered constitution. In: Bamforth, N., Leyland P, editors. *Public law in a multi-layered constitution*. Oxford: Hart Publishing; 2003 [chapter 15].

[53]*Report of the World Summit for Social Development*, 6–12 March 1995, UN doc. A/CONF.166/9, 19 April 1995, para. 7.

[54]Commitment 2.

[55]para. (c).

[56]para. (l).

[57]para. (m).

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

made in economic and social development' in Africa particularly.

It is remarkable that human rights did not figure prominently among the tools proposed at Copenhagen for achieving social development. This remains true 10 years later. Boyle[58] has noted that human rights agencies have taken on board the challenges of poverty, discrimination and conflict, as well as impunity, democratic deficits and institutional weaknesses,[59] but that other agencies are not making human rights part of their core thinking. As he points out, the 'much praised' report of the Africa Commission 'is silent on human rights', and there was little mention of human rights obligations in Make Poverty History, Live8 or G8. Tasks are described in terms of targets or objectives,[60] rather than in normative language.

We are facing the difficulty of turning social aspirations into social realities. Perhaps all that can be done for substantive rights is to extend the bounds of those civil and political rights which most states seem prepared to concede to their populations, and to build enforcement arrangements gradually. Campaigners, courts and lawyers can use health-related social and economic rights procedurally to keep public health high on the political agenda and to insist that policy-makers take public health rights into account and justify policies publicly by reference to standards contained in the rights. Even if we cannot immediately realize health rights, we can require state bodies to take them systematically into account in making policies and laws.

Law must take account of economic realities. National courts and tribunals must respect the limitations on their competencies and their relationships with other institutions. But, as the Indian and South African experiences make clear, legal methods including the creative use of human rights standards can encourage state bodies to give proper weight to public health in policy-making and law-enforcement, and to formulate policies rationally. If nothing else, that might help, over time, to improve the quality of public-health decision-making in this country and elsewhere.

[58]Boyle K. The links between human rights and other things. In: Morison J, et al, editors. *Judges, transition and human rights cultures: essays in Memory of Stephen Livingstone*. Oxford: Oxford University Press; 2006.

[59]OHCHR Action Plan 2005.

[60]Like fulfilling the target (see Copenhagen Declaration, Commitment 9, para. (l)) of providing 0.7% of GDP for official development assistance as soon as possible.

Please cite this article as: David Feldman, The contribution of human rights to improving public health, Public Health (2006), doi:10.1016/j.puhe.2006.07.018

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on ''The contribution of human rights to improving public health''

Jane Wright

Human Rights Centre, Department of Law, University of Essex, Wivenhoe Park, Colchester, Essex, CO4 3SQ, UK

The essential challenge in the field of public health is how to balance the interests of the individual and society. Professor Feldman had postulated that the role of rights discourse in relation to social/welfare rights, a relatively weak normative area, is to ensure that the processes for determining priority of resource allocation are rational and fair. Conversely, certain 'negative' aspects of autonomy, the right to be left alone, are well protected by civil and political rights: citizens have an absolute right to be free from torture and inhuman and degrading treatment and a qualified right to private life. The general consensus of discussion was that this dichotomy is appropriate. Resources are finite. What is important is that appropriate factors are taken into account in determining priorities so that health-related rights have an important role to play in the procedure of resource allocation.

Some concern was expressed that the discussants appeared to prioritize the interests of the individual (this prioritization was manifested by the focus on autonomy) over the collective welfare of society as a whole. In response the point was made that the state may infringe the right to private life under Art 8(2) ECHR, where it can demonstrate a sound justification for so doing. The language of regional and international human rights instruments is replete with references to the possibility of state interference with one's bodily integrity or liberty being justified on the grounds of: the protection of health (Art 8(2)ECHR); to prevent the spread of infectious diseases (Art 5(e) ECHR; liberty of movement may be curtailed in order to protect public health or morals (Art 12 ICCPR).

An important dimension of public health is the promotion of good health, rather than the treatment of bad health. Professor Feldman suggested that it is important for public health that individuals are encouraged to take responsibility for their own health and in order to do this effectively they require information. The question of whether private corporations or individuals should be required to disclose risk (as soon as they become aware of such risk) that may impact on health is important and was discussed at some length. Currently, some areas are subject to regulation (for example, in relation to foodstuffs information about ingredients is required), but, generally, it seems to be the function of tort law to provide redress ex post facto. This is too late—litigation will frequently be a sticking plaster that is applied after harm to health may have occurred on a wide scale. Concern was expressed by the discussants that it is questionable whether public health goals are adequately served without further regulation regarding the disclosure of risk. It was noted also that not only is information required, but access to services and commercial outlets that will assist in the development of a healthy lifestyle are required: the worst areas of urban deprivation lack basic shopping facilities providing fresh foods for example.

E-mail address: jeaw@essex.ac.uk.

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.019

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

The limits of law in the protection of public health and the role of public health ethics

Robyn Martin

Centre for Research in Primary and Community Care, University of Hertfordshire, College Lane, Hatfield, Hertfordshire, AL10 9AB, UK

Introduction

This paper examines ways in which the legal concepts of duty and power might be used for the benefit of the public health, and the role of public health ethics in relation to these duties and powers. The discussion is placed within a framework of risk regulation. Risk is a notion which has been much examined in social science and epidemiology but until recently, has not been a concept which law has addressed to any real degree. A quick glance at government websites suggests that contemporary government in the United Kingdom is preoccupied with the notion of risk, and in particular regulatory frameworks for the assessment of risk.[1] The concept of risk has now entered into our legal vocabulary to enable new kinds of public duties, creating the potential for using risk regulation as a public health legal tool.

Law and the notion of duty

Traditional approaches to duty in law

For the purposes of this discussion I will assume 'duty' to mean an obligation which has as a correlative the right or claim of another to ensure that the obligation is carried out.[2] Law is the most powerful tool we have for the articulation and imposition of duties. Legal duties can be imposed on public bodies, private bodies and individuals. They can be enforced by a range of remedies, including criminal sanctions, civil liability, licensing or abatement. Legal duties can be imposed by statute, by regulations under statute or by the common law.

The more straightforward and specific the duty, the more efficacious the law is in stating, managing and enforcing the duty. For example under the Public Health (Ships) Regulations 1979, the master of a ship must notify the port authority of any suspected infectious disease or death on board ship, and this report must be made not more than 12 h and not less than 4 h before arriving in port. This is a simple duty, with no discretion, no ambiguity, and of course no reference to ethics. Law overrides autonomy, privacy, and individual rights.

More often though, duties cannot be so precisely defined and contain exercises of discretion. Section 52 of the Health and Safety at Work Act 1974 states that, 'It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at work of his employees'. Under the National Health Service Act 1977, it is the duty of the Secretary of State to provide, to such extent as he considers necessary to meet all reasonable requirements, services such as medical

E-mail address: r.m.martin@herts.ac.uk.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.020

and dental healthcare provision. Inherent within these duties is a requirement that a body or an individual make a judgment call on what is required to satisfy the duty. Typically however, legislation does not address assessment criteria. Rarely was it acknowledged in the parliamentary debate which led to the passing of laws, even where the word risk was used, that what was required was an assessment of risk. Interpretation of what is required to satisfy the duty has been left to the courts.

The Court of Appeal considered the legal meaning of risk in relation to the duty imposed by Section 3 of the Health and Safety at Work Act in the Science Museum case.[3] The Act states that it shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment are not thereby exposed to risks to their health or safety. The museum was prosecuted when it failed to maintain its air conditioning system. Such failure might result in a risk of Legionnaires Disease. No evidence was brought to show that anyone had contracted Legionnaires Disease. Had the museum exposed persons to a risk to their health?

The Court suggested that 'risk' differs from 'danger', and gave an example. Imagine a loose object on a roof near a pavement. That loose object constitutes a risk. If the object falls towards the pavement, at that point there is a danger. If the object hits someone on the pavement, that constitutes a harm. A risk is something that contains the possibility of danger. So the existence of unhealthy water in the air cooling system was like the object on the roof, it presented a risk. The Museum was therefore guilty of an offence under the Act.

This was not exactly a sophisticated analysis, but it does represent the beginning of the engagement of law with the notion of risk. We could also note that social scientists have since expressed similar views on the meaning of risk. Giddens for example notes that:

> ...we must separate risk from hazard or danger. Risk is not, as such, the same as hazard or danger. A risk society is not intrinsically more dangerous or hazardous than pre-existing forms of social order—life in the Middle Ages was hazardous but there was no notion of risk.[4]

Gidden's analysis differs from that of the Court of Appeal however in that he acknowledges that risk cannot be assessed without recognizing values. 'There is no risk which can even be described without reference to a value', values such as how people might choose to live their lives, and what risks they are prepared to take in exchange for access to what benefits. If the risk of Legionnaire's disease cannot be eliminated from air conditioning systems, should we close down public museums to eliminate the risk? Or are there values in the existence of museums that we might be prepared to weigh against the risks?

The base line of risk acceptability differs from context to context.[5] For health and safety legislation the norm is 'as far as reasonably practicable'.[6] Pollution legislation tends to use guidelines such as 'best available technique not exceeding excessive cost'.[7] The Department of Health in relation to medicines uses a higher threshold level of 'no observable adverse effects'.[8] The levels of acceptable risk vary not in response to differing quantitative measurement but rather because in different contexts different values come into play. Those values are often debatable. A terminal cancer patient may well be prepared to take a risk higher than 'no observable adverse effect' for the opportunity to take experimental but potentially life extending drugs.

A new type of legal duty

Acts such as the Health and Safety at Work Act represent old style legislative approaches to standard setting. In recent years we have see a new generation of legislation which has more overtly adopted the language of risk. The Management of Health and Safety at Work Regulations 1999 state: 'Every employer shall make a suitable and sufficient assessment of the risks to the health and safety of his employees to which they are exposed while they are at work...for the purpose of identifying the measures he needs to take...'.[9] The Control of Substances Hazardous to Health Regulations 2002 state that 'an employer shall not carry out any work which is liable to impose an employee to any substances hazardous to health unless he has... made a suitable and sufficient assessment of the risk ... and of the steps that need to be taken...'.[10] The Civil Contingencies Act 2004 imposes duties on specified public bodies 'from time to time to assess the risk of an emergency occurring'.

In this new kind of regulation there is overt recognition that the duty is not just a duty to assess the actual level of risk but also to assess what is an acceptable level of risk. These are enforceable legal duties and any breach will have serious consequences for the duty holder. It is a requirement of good law that it can be understood by those required to obey it. Determination of what is

acceptable will require some scientific and probability analysis, and probably some form of economic cost/benefit analysis. It will also require a determination of what we as a society are prepared to accept in the way of risks to achieve the industrial or health benefits which flow from the risk creating activity. That of course is a question about values.

Risk and public health

It has been said by Beck[11] among others that we now live in a 'risk society', a society of technological complexity that absolutely no-one completely understands, and which gives rise to a range of possible futures. Unlike earlier societies which accepted the future as fate, a risk society is 'preoccupied by the future' and wishes to explore it in order to control it.[4]

More importantly we now face a new kind of risk. Earlier societies which lived according to tradition were preoccupied with what Giddens has called external risk, risk of events outside our control but which are predictable, such as storms, earthquakes, plagues, bad harvests, diseases. There is no responsibility for preventing these external risks, only for dealing with the consequences of risk, and increasingly the state tended to take a paternalistic responsibility for risk consequences. The National Health Service and the welfare state were developed in response to risk. As the HM Treasury risk portal states, 'Governments have always had a critical role in protecting their citizens from risk'.[12]

Legislation provided the regulatory form of this paternalistic political commitment. Very detailed duties were imposed by legislation, in which the state determined the acceptable level of risk and set out legal duties accordingly.

Over time the type of risk we face has changed and has become closer to what Giddens categorizes as manufactured risk, risk which we have ourselves have created through the expansion of science and technology. Having historically taken on responsibility to protect its citizens from risk, governments cannot now argue that in this new risk environment they have no risk management responsibility. Indeed the less that individuals understand about the technology which drives their environment, and the less individuals feel in control of their environment, the more they are looking to governments to manage risk. Risk management in our contemporary society is no easy task. Over manage and the state is accused of scaremongering and infringement of human rights; under manage and the government is accused of negligence and bowing to economic forces. Recent governments have adopted a dual strategy in relation to risk responsibility; both to embrace responsibility and to delegate it.

An example of embracement is the government's Risk Programme[13] which states that government departments need to ensure 'further embedding of risk in the core processes of government'. The government sees itself firstly as a risk regulator with responsibility for legislating legal duties and standards, secondly in a stewardship role in relation to industrial risks, and thirdly as responsible for the identification and management of risks.

At the same time there has been a concerted effort to delegate risk both up and down. Delegation up has primarily been to European level where there has developed a very significant body of directives, treaties and conventions, particularly around new technologies, by which the EU has taken responsibility for determining acceptable levels of risk.

Delegation down has taken three forms: the creation of regulatory bodies to manage risk, delegation to the private sector; and delegation to the individual.

The Health Protection Agency is an example of a regulatory body. It is a non-departmental public body set up to advise and support the Department of Health. The Health Protection Agency Act[14] and Management Statement[15] give considerable emphasis to the role of the HPA in risk management. Another such regulatory body is the Health and Safety Executive, which has as its function 'responsibility for the regulation of almost all the risks to health and safety arising from work activity in Britain':

> In our role as a regulator and with powers of discretion, the assessment of risk that we undertake requires us to… go beyond the confines of the undertaking and look at the impact of our proposed action on society.[6]

Delegation to the private sector is reflected in health and safety legislation requiring employers and industry to make assessments about risks to health from their activities. This is not an open-ended risk assessment. These risk assessments focus on the prospect of harm to individuals within the parameters of the legislation. Delegation to the individual can be seen in the Department of Health White Paper, Choosing Health,[16] which suggests that 'People's lifestyles decisions are personal ones and they do not want Government to take responsibility away from them'. 'We (the government) will bring together messages that raise

awareness of health risks with information about action that people can take themselves to address those risks'.

Wherever the legal duty lies, recognizing the process as one of risk assessment enables the inclusion of qualitative risk factors in the determination of levels of acceptability of risk. This will require consideration of factors such as whether the risk is voluntary or involuntary, value judgments in the measurement of risks against benefits, and health inequalities—who has real choices about risk taking. Risk assessment needs also to take cognisance of who bears health risks and who takes the benefit of those risks, and the patterns of distribution of risk across society.

Public health law

Much law with relevance for public health such as environmental law and occupational health law has been subject to recent reform and has been developed to recognize both the role of risk assessment in the protection of health and the allocation of clear responsibilities for the process of assessment. However our core public health legislation remains untouched by the concerns of the risk society.

The duties set out in the Public Health Act 1984, which is not a 1984 Act as such but a consolidation of 19th century legislation, are of the simple, paternalistic kind. There are duties on medical practitioners to notify the local authority in relation to specified notifiable diseases; duties on landlords to disinfect lodgings, duties on individuals not to expose others to specified diseases; duties in relation to the disposal of dead bodies and duties in relation to canal boats. These duties are inflexible. They cannot be used for new and unforeseen threats to health and they allow for little discretion in their application. Yet they may well place the duty holder in a position of conflict in relation to other duties such as duties of confidentiality, duties in relation to discrimination, or duties to respect human rights.

Legislation could provide duties in relation to the protection of public health such that they are sufficiently flexible to protect against unpredictable threat, and such that impositions of duty take into account other duties, values and the context of their application. If we were to take duties of notification for example, we could require in our legislation that public health officials make risk assessments as to which health threats warrant notification. The way law is currently framed, there is a non-discretionary duty to notify some particular notifiable diseases, and no legal duty to notify other threats to public health.

New Zealand is undertaking major reform of its public health law and has issued a consultation paper on law reform which proposes a different approach to notification.[17] A general obligation would provide that any condition, disease, risk factor or other matter of public health concern be reported to the relevant authority. A 'condition', the paper explains, is a broader concept than disease, and would include matters such as clusters of symptoms and post-disease abnormalities. Guidance would be given in the regulations as to what particular issues warrant being notifiable at a given time and these regulations would be sufficiently flexible to take account of newly emerging public health threats. The paper proposes that legislation be drafted in an 'empowering style', to ensure, through means that respect privacy as far as possible, the availability of accurate, comprehensive and timely information on risk factors of public health significance, and of factors contributing to trends in incidence of adverse health conditions.

Public health law reforms in other jurisdictions have also proposed redesigning law to recognize the risk assessment component of public health duties. The discussion paper on reform of public health law in Western Australia[18] suggests that law should take 'a new approach driven by risk', and that 'the new Health Act should be driven by the philosophy of minimizing risk to the public's health'. The paper proposes publishing policies and guidelines detailing risk assessment criteria to assist in the exercise of public health duties and powers.

Most significantly the proposed laws in these jurisdictions would make clear the value framework of public health legislation, listing fundamental principles that would guide any exercise of discretion. Principles governing New Zealand law would recognize the rights and values in contemporary NZ: personal autonomy, freedom, privacy and human dignity, justice, equality, community, well being and interdependence. The Western Australian discussion paper notes that 'there is a strong case for new public health legislation to incorporate a set of objects that will direct the Act', and proposes a range of underpinning principles including sustainability, personal liberty and the precautionary principle.

These are principles familiar to us all but not as issues of law. They are rather principles of ethics, principles which have been considered as secondary, to be consulted when there are gaps in the law. In the reform proposals these principles would be embedded in law to assist in providing an explicit

methodology for assessing risks to public health. Other jurisdictions have also reformed their public health legislation to recognize risk and to make clear that the exercise of law must take place within a framework of ethics. Spanish health law[19] states in its preamble:

> The aim of this bill is to set out a legal framework for the co-ordination and co-operation of the public health authorities in the exercise of their respective functions in order to guarantee equity, quality and social participation...

There is enormous potential for the use of risk regulation in public health. Law which recognizes that much public health practice constitutes an exercise of risk assessment would reflect the realities of public health, providing a more useful public health tool. We could look to developments in environmental law as a way forward, but the most important starting point would be to include in our legislation a statement of the values and principles which we agree as a framework for public health practice to provide a framework in which risk assessment decisions are to be made.

Law and the notion of power

I will take as a shorthand definition of power that to say someone has a legal power is to assert that others thereby have a legal obligation to act, or not act, in certain ways.[20] Coercive powers have always constituted a major tool in public health law. English[21] public health legislation contains a range of coercive powers including powers of entry into premises, powers of compulsory medical examination and powers of compulsory detention. Powers by their very nature carry with them an element of discretion.

Under S.36 of the Public Health Act 1984 there is power to order compulsory medical examination if

- there is reason to believe that one of a groups of persons, though not suffering from a notifiable disease, is carrying an organism that is capable of causing it

and

- that in the interests of those persons or their families, or in the public interest, it is expedient that those persons should be medically examined.

Exercise of this power requires a risk assessment, although the law is not framed in the language of risk. Similar powers of compulsory examination and detention also exist in relation to mental illness. While there has been significant scholarship around the nature of the risk assessment in the exercise of powers over persons lacking legal capacity, little attention has been given to the role of risk assessment in relation to public health powers. Challenge of mental health powers has resulted in a rethinking of both the processes and the philosophy of powers to infringe the autonomy and liberty of individuals, acknowledging the inherent risk assessment role. The Scottish consultation paper on mental health law[22] recommended the inclusion in legislation of criteria for determining the extent to which a person may be at risk or present a risk to others. The resulting legislation[23] makes clear the ethics principles which are to govern this risk assessment exercise. In this new type of law, there is no tension between the exercise of compulsory legal powers on the one hand, and protection of rights, autonomy and dignity on the other. Ethics are embedded in the exercise of law, such that failure to consider ethics makes the exercise of law invalid. Could we frame public health law to bring rights and ethics into the fold of public health powers?

The starting point would be to reject the medicalization of public health debate which pits hard science in the form of probability and objectively collated disease data, against the soft sciences of philosophy, sociology and ethics. Rather we would recognize that a power is an assertion of a moral claim of priority of particular values, for example that the health of the population has moral precedence over the freedom of movement of an individual with infectious disease. The importance of stating the ethics and values within the legal framework of the power then becomes clear.

Recognizing that public health powers are about asserting moral claims, we can look again to the risk assessment inherent in the exercise of a power, not as a matter of measurement but as a matter of balancing moral considerations. We need to be clear about what moral considerations we, in our culture and in our time, consider to be relevant to the debate.

Again we can turn to the New Zealand proposals. Compulsory powers in the proposed NZ public health law would fall under the umbrella of 'Care and Management' both of persons with communicable disease who pose a risk to others, and persons who are infirm and neglected', who pose a risk to themselves. We can see a different philosophy here. Whereas the compulsory powers under our Public Health Act are to be exercised for the

benefit of the healthy, and propose only exclusion and not care of the infectious person, the NZ proposals work from a starting point that public health officials owe duties of care to both the healthy and the ill.

The guiding principle of exercise of NZ powers would be 'the least restrictive alternative'.[24] Exercise of compulsory powers under our Public Health Act is also subject to the doctrine of 'least restrictive alternative', not in the legislation itself but externally, through the European Convention for the Protection of Human Rights. The European Court of Human Rights, in a case against the Swedish government in relation to legislation similar to our own,[25] found that the detention of a person who was HIV positive was an infringement of his human rights, in part because it was not the least restrictive way to deal with the risk. Our Public Health Act, unlike the Swedish legislation, has no lesser restrictive alternative powers. We have no legislative powers of compulsory counselling, treatment or quarantine.

The compulsory powers to made available under NZ legislation would range from compulsory counselling, compulsory supervision, through quarantine and detention, to compulsory treatment. The overarching decision would be one of risk assessment: were there 'reasonable grounds to consider that the person presents a significant health risk to the general public' in accordance with the principles of values and ethics stated in the legislation. This risk assessment framework provides mechanisms for achieving a balance between the need to deal with threats to population health, and the protection of the rights and the dignity of the individual, recognizing ascending levels of intervention to correspond with ascending levels of risk.

Limits of our current public health law

There are many ways in which our current public health law fails to deliver in providing a legal framework for public health protection. Our law is premised on the assumption that public health law serves to protect the healthy, and its primary mechanism is exclusion of the ill, who are often in the case of communicable disease the most vulnerable members of society. Our law fails to provide clear objectives for the exercise of the law, or to make clear the lines of responsibility for public health protection. It fails to make clear that public health legislation is about risk regulation, and does not provide risk assessment criteria. Our law is inflexible in that it fails to provide mechanisms for emerging risks to health. Most importantly our law puts public health officials in a position of conflict between the exercise of public health powers and duties on the one hand, and principles of ethics and human rights on the other.

Law is only one tool in the protection of the public health. Traditionally it has been understood that law does the compulsory things, and ethics provide a framework for good practice. Until the development of domestic human rights law, which brought some but not all essential ethics principles into the legal fold, ethics remained a desirable but unenforceable framework for practice.

By adopting the language and scholarship of risk into law, we can incorporate the principles of ethics which underpin law. There will be no universal, international agreement of what those principles should be. They will depend on our cultural values. Asian or African societies for example may well choose different ethics principles favouring protection of the community over autonomy and individual rights.[26] We cannot emulate reforms in other jurisdictions for our public health law reform. We need to make our own call on our underlying principles and philosophies. We can however emulate them in marrying law and ethics in a framework of risk regulation.

Conclusion

Law has traditionally been seen as positivist, to be drafted as clearly as possible and to include little discretion. This old style of law has not proved sufficiently flexible or sufficiently sensitive to operate effectively in the domain of public health. We have been prompted to address the issue of public health law reform by concern about new and unpredictable infectious diseases, and by the reform of the International Health Regulations. These pressures provide an opportunity to think about what we could provide in the way of legal support for public health practice.

We have much detailed law which has relevance to health, such as law on food, the environment and occupational health. What we do not have is an umbrella piece of legislation which sets out our overall public health objectives, our public health priorities, or our public health guiding principles. We need legislation which makes clear what we consider to be our primary public health functions and law which allocates responsibility for those functions. We need legislation that makes clear our public health values, so that we can make decisions on issues of acceptability of risk, recognizing that

public health practice is an exercise in risk assessment. We need legislation that is as much concerned with the care of those who are ill as with protecting the healthy. We have an opportunity to build ethics into the framework of public health law. Good public health practice needs good law, and good law is ethical law. We should bear this in mind in our process of public health law reform.

References

1. The Department of Health website has a portal on risk research and has published on-line documents on risk (see Department of Health. Communicating About Risks to Public Health. 1999; Department of Health. Risk Literature and the Public. 1993). The HM Treasury site has a Risk Programme, a 'comprehensive programme of change to improve risk management across government' (December 2003), as well as a portal on risk guidance. The Health and Safety Executive has a portal for its publications on risk.
2. See Hohfeld WN. In: Cook WW, editor. *Fundamental legal conceptions*. New Haven and London: Yale University Press; 1919.
3. *R v Board of Trustees of the Science Museum* [1993] ICR 876.
4. Giddens A. Risk and responsibility. *Modern Law Review* 1999;62(1):1–10, 3.
5. Fisher E. Drowning by numbers: standard setting in risk regulation and the pursuit of accountable public administration. *Oxford Journal of Legal Studies* 2000;20(1): 109–130.
6. Health and Safety Executive. *Reducing risks, protecting people*, 1999.
7. Pollution Prevention and Control Act 1999.
8. Intergovernmental Liaison Group on Risk Assessment. Use of Risk Assessment in Government Departments 1999; 15–19.
9. Section 3.
10. Section 6.
11. Beck U. *Risk society: towards a new modernity*. London: Sage; 1992.
12. http://www.hm-treasury.gov.uk.
13. HM Treasury. *The risk programme: improving government's risk programme*. Final Report to the Prime Minister, December 2004.
14. Health Protection Act 2004.
15. Health Protection Agency. Management Statement, January 2004.
16. Department of Health. Choosing health: making healthy choices easier, 2004.
17. Ministry of Health New Zealand. Public health legislation: discussion paper. Promoting Public Health, Preventing Ill Health and Managing Communicable Diseases, November 2002.
18. Department of Health, Western Australia. New Public Health Act for Western Australia: A Discussion Paper, June 2005.
19. Spanish National Health System Cohesions and Quality Act 2003.
20. See Dworkin R. *Taking rights seriously*. London: Duckworth; 1981.
21. Scotland and northern Ireland have similar powers.
22. New Directions—Report on Review of the Mental Health (Scotland) Act, 1999.
23. Mental Health (Care and Treatment) Act 2003. As well as looking to medical evidence, the person exercising the power must consider principles of non-discrimination, equality, respect for diversity, informal care, participation, respect for carers, least restrictive alternatives, benefit and child welfare.
24. Western Australian proposed reforms also recommend incorporating the principle of 'least restrictive alternative' into the legislation.
25. *Enhorn v Sweden* [2005] ECHR 56529/00. See Martin R. The exercise of public health powers in cases of infectious disease: human rights implications. *Medical Law Review* 2006; 14(1): 132–43.
26. Philippine public health legislation of 1999 begins with a public health mandate which includes: the promotion of the health and well-being of every Filipino, the prevention and control of diseases among populations at risk, the protection of individuals and families exposed to hazards and risks that could affect their health, and the treatment of individuals at risk. Philippine law prioritises compulsory treatment powers over personal autonomy.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Commentary on "The limits of law in the protection of public health and the role of public health ethics"

Angus Dawson

Centre for Professional Ethics, Keele Hall, Keele University, Staffordshire, ST5 5BG, UK

Any adequate account of 'public health' should contain at least three key features.[1] The first is that the focus of public health interventions is upon a population of unspecified individuals. Second, public health action requires collective effort in the sense that improvements in public health cannot be brought about by any single individual acting alone. This is one reason why much public health activity must be the preserve of the state. Third, public health activity is primarily focused on reducing or eliminating the risk of harm. This is why public health interventions can be contentious. It may be that the disagreement is about whether the risk is real (an epistemic dispute) or it might be over whether the risk provides sufficient justification for interference in other people's lives (an ethical dispute). A vital aspect of this ethical dispute arises from the fact that much public health activity is concerned with the *prevention* of harms. For this to be the basis of policy, judgments need to be made about what sort of things are harmful, and such judgments in turn can only be made against a background theory of what it is to lead a good life. A common (and plausible) feature of such a background theory will be that health is important, and factors that interfere with it, should be prevented or removed. Water fluoridation to reduce dental caries, vaccination against infectious disease, banning smoking in public places, might all be justified by such a conception of the 'good life'.

Law played a significant role in relation to public health through the great reforms of the mid-19th century. These statutes, particularly the Public Health Acts, provided the framework for vigorous intervention in response to the threat from contagious disease in an age with poor social conditions and without the aid of preventive measure such as vaccination,[2] and are the backbone of present day public health powers. Martin subjects these to astute criticism. The relevant statues are very specific in the sense that they name particular diseases and particular types of establishment. They give permission for certain interventions, and provide for compulsion in some cases. This approach is flawed in that the degree of specification means that new threats to health remain outside of their scope until government chooses to add them to the list of specified diseases. Such a statutory approach has the advantage of clarity and arguably ensures the greatest transparency where restrictions in liberty or the requisitioning of property are necessary. However, this also provides a basis for critics to argue that public health can be too easily tempted to sacrifice the interests of the individual for the common good.[3]

Martin considers more recent developments in the law relevant to public health: first, the growth of discretionary powers, second, the new kind of

E-mail address: a.j.dawson@peak.keele.ac.uk.

0033-3506/$ - see front matter
doi:10.1016/j.puhe.2006.07.021

statutory regulation that more explicitly uses the language of risk and, thirdly, the role of public health ethics. Can these developments provide sufficient support for public health activity to meet the objections above?

Firstly, talk of *risk* of harm as well as *actual* harm is helpful in thinking about public health. This is because much public health is concerned with reducing or preventing risks to health. This means we can take a step away from waiting until harm is caused and then seeking compensation. Discretionary powers such as those discussed in the Science Museum case can mean that an individual or body might be found liable for a failure to remove a risk of harm, even if no one was actually harmed.[4] This idea might be applied to public health.

Secondly, where 'the [relevant] duty is not just a duty to assess the level of risk but also to assess what is an acceptable level of risk', the relevant individual or body with the particular duty to deliberate about the nature of the risk is placed under a more rigorous burden. This again is helpful as the focus moves away from the question 'is the risk sufficiently likely to happen?' Instead the focus is on a judgment of 'acceptability' of that risk as well as its likelihood. This requires a range of issues to be taken into account relating to the possible risks and benefits of the intervention, including an unavoidable role for normative values. What counts as 'acceptable' is likely to change over time so the relevant duty will impose the need for constant review. As Martin illustrates, this opens up the possibility of acrimonious debate about the nature of risk and the sorts of risks that are acceptable. On a more positive note, there is no reason why such assessment of risk cannot include preventive action. On the face of it, an 'unacceptable' risk might result from the failure to take action. For example, a failure to promote routine childhood vaccination for serious contagious diseases increases the risk of harm. This suggests that it might well be possible to have a public health statute that would impose duties to promote public health, not just seek to remove threats once they have emerged.

The most original aspect of Professor Martin's paper is her consideration of the role that public health ethics, or values more generally, might play in public health law. This is a natural step once we see that values are necessary in any deliberations about action in response to risk. I offer two cautions to this approach here.

The first is that the area of ethics is a minefield of contested theories and principles. The law must take care as it chooses a path through this danger. Perhaps the dominant approach in contemporary bioethics is a form of liberalism derived mainly from the work of Mill and Feinberg.[5] This approach fits very well with the traditional common law. However, is such liberalism useful when it comes to public health? I am sceptical. What we need in public health is an ethical approach that is familiar with and accepting of the concepts of prevention and collective action. It is unclear whether classical liberalism can incorporate such notions into its view of the world. This does not, however, necessarily require a defence of one particular moral theory as such concepts may be defended using a range of theories such as consequentialism, contractarianism, and republicanism, but also certain forms of deonotology focused on prima facie duties.[6] It is an advantage if law can remain (relatively) neutral about which approach is best.

The second caution is in relation to the way the courts are likely to treat any ethical and pragmatic principles. There will always be a tendency towards reification of principles, as jurisprudence is built up around them. Even the principle of 'the least restrictive alternative' might actually be insufficiently flexible. Such a principle seems to suggest that we should always prioritize liberty over other values. However, is it clear that we should? This looks like a background commitment to liberalism that in turn needs to be justified. Respecting people's autonomy is an important ethical principle, but it is only one amongst many.[7] Banning smoking in public places restricts people's autonomy, but it may be justified by appealing to the idea that in this case other values take priority. Such a ban might be justified by arguing that it is a means of positively promoting health, particularly a population's health.

What is most important in thinking about ethics in relation to public health is that the ethics are relevant to public health practice. Public health is about population health; therefore the focus must be on the interventions that can make a difference to improving the population's health as a whole. Most interventions of this type require collective action. One important way to justify such interventions is through an appeal to the idea of public goods. We can think of public goods, following Klosko, as being characterized by two main properties: nonexcludability and dependence upon cooperation by a large number of people.[8] 'Nonexcludable goods' are those where no one can be excluded from the benefits of the existence of the relevant good, even when they have not contributed towards bringing it about. In addition to these two aspects

of public goods suggested by Klosko I would add another proposed by Rawls.[9] Public goods must also be indivisible: that is, they cannot be broken down or divided up into individual or private goods to be distributed amongst the members of a group or population.[10]

The creation and maintenance of such public goods may well result in inconveniences or injustices in relation to some individuals, but this may still be justified given the benefits. For example, a population where fewer people smoke is a better place for children to grow up. A ban on smoking in public is only justifiable if these values take priority over the individual liberties of smokers. Public health activity is involved in many such contentious activities. The important thing is that such interventions can be justified in at least some cases. Where this is the case, the law may play an important role in attempting to reduce or remove risks to health.

Public health is an important issue. Governments can do a lot to influence and improve a population's public health. The law is one, although not the only, means of action.[11] Law has had a troubled relationship with public health, but we can see some hopeful signs for the future. One aspect of this is the broader conception of what is relevant to deliberation about risk, and another is the explicit consideration of values within public health law. Both developments are welcome as they allow the reality of public health work to be reflecting in the legal framework. However, public health law needs to be careful to reflect actual public health practice and ensure that the concept of prevention is given adequate legal support.

References

1. For discussion of the first two issues, see: Verweij M, Dawson A. The meaning of ''public'' in public health. In: Dawson A, Verweij M, editors. *Ethics, prevention, and public health*. Oxford: Oxford University Press, forthcoming.
2. Except, of course, for smallpox.
3. See the sometimes brutal debate over the US Model Emergency Powers Act in, for example, Hodge JG, Gostin LO. Protecting the public's health in an era of bioterrorism: the Model State Emergency Health Powers Act; Annas G. Terrorism and human rights. In: Moreno JD, editors. *In the wake of terror: medicine and morality in a time of crisis*. Cambridge, MA: Bradford Book/MIT Press; 2003.
4. R v Board of Trustees of the Science Museum [1993] ICR 876.
5. See, for example, Mill JS. *On Liberty*. Reprinted 1974. Harmondsworth: Penguin; 1959. Feinberg J. *Social philosophy*. Engelwood Cliffs, NJ: Prentice-Hall; 1973; Feinberg J. *Harm to others*. Oxford: Oxford University Press; 1984.
6. See Bayer R, Fairchild AL. The genesis of public health ethics. *Bioethics*, 2004;**18**(16):473–92; Scanlon TM. *What we owe to each other*. Harvard: Harvard University Press; 2000. Jennings B. Public health and civic republicanism: toward an alternative framework for public health ethics. In: Dawson A, Verweij M, editors. *Ethics, prevention, and public health*. Oxford: Oxford University Press, forthcoming; Ross, WD. The right and the good Oxford: Clarendon Press, 1967.
7. Dawson A, Garrard E. In defence of moral imperialism: four equal and universal prima facie duties. *Journal of Medical Ethics* 2006;**32**(4):200–4.
8. Klosko G. Presumptive benefit, fairness and political obligation. *Philosophy Public Affairs* 1987;**16**(3): 241–59: 242–3.
9. Rawls, *A theory of justice*. Oxford: Oxford University Press; 1971.
10. For more on public goods, see Dawson A, Herd protection as a public good: vaccination and our obligations to others. In: Dawson A, Verweij (Eds) Ethics, prevention and public health. Oxford; OUP, forthcoming.
11. See Lawrence O. Gostin's essay in this series 'Legal foundations of public health law and its role in meeting future challenges' for some discussion.

Public Health (▮▮▮▮) ▮, ▮▮▮–▮▮▮

ELSEVIER

PUBLIC HEALTH
JOURNAL OF THE ROYAL INSTITUTE OF PUBLIC HEALTH
www.elsevierhealth.com/journals/pubh

Conclusion: Where next?

Robyn Martin[a,*], Richard Coker[b]

[a]*Centre for Research in Primary and Community Care, University of Hertfordshire, College Lane, Hatfield, Hertfordshire, AL10 9AB, UK*
[b]*London School of Hygiene and Tropical Medicine, Department of Health and Public Safety, Keppel Street, WC1E 7HT, UK*

Defining public health law

As a consequence of the paucity of scholarship on public health law, the focus and boundaries of public health law have been far from clear. British law schools which offer 'Health Law' programmes at undergraduate and postgraduate level have addressed almost exclusively issues pertaining to the treatment of the individual patient, issues that are easily identifiable and easily defined. Few health law programmes have ventured into the obscure and unbounded terrain of public health law because of difficulties of knowing where to start, what to include, what to exclude, and what constitutes the essence of public health law. Graduates of both law and public health programmes will probably have had little exposure to public health law, and so have very limited understanding of what law can do for public health, of how law can work for the benefit of public health, of the limits of what law can achieve, or of the principles of human rights and ethics which are relevant to public health law. The papers in this series have provided a very useful beginning to the process of mapping public health law.

In his lecture on the Foundations of Public Health Law, Larry Gostin sets the scene by proposing a definition of public health law which focuses on state responsibility for the public's health. In his definition, 'public' addresses both the public nature of the body on which health obligations are imposed, and the public nature of the recipients of health obligations. The core elements of public health law are thus positive and negative: the powers and duties of the state, in collaboration with other bodies, to assure the conditions for people to be healthy, and the limits on those powers. Gostin then unpicks his definition, and in this context he examines which legal tools might be used to achieve public health goals. It is the diversity of available tools that will intimidate legal scholars who have traditionally focused their research on narrowly defined areas of law. Knowledge of public health law requires understandings of taxation law (the power of the state to tax and spend), law regulating use of information (the power to alter the informational environment), occupational health, traffic and environmental law (the power to alter the built environment), the economic, political and social context of law (the power to alter the socio-economic environment), public and administrative law regulatory tools (direct regulation of persons, professions and businesses) and tort law (indirect regulation through the tort system).

The breadth and depth of this definition was acknowledged in the post lecture discussion after Gostin's paper and is developed in John Harrington's commentary. Harrington points out that the state centred nature of Gostin's definition might be placed in a wider setting of legal pluralism,

*Corresponding author.
E-mail address: r.m.martin@herts.ac.uk (R. Martin).

0033-3506/$ - see front matter © 2006 Published by Elsevier Ltd on behalf of The Royal Institute of Public Health.
doi:10.1016/j.puhe.2006.07.022

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022

recognizing the role of other legal orders such as the cultural community norms of particular groups within the wider population. While group norms operate more effectively in a libertarian environment, the state retains a role in guaranteeing the procedural rights of individuals. Two particular tensions within the operation of public health law were noted. The first is the tension between the demands of population health in a society which prides itself on its liberalism and its democracy, and the second is the limitations on effective, utilitarian public health practice imposed by the strengthening role of human rights within legal systems across the world. Such tensions which were once debated within the realm of ethics will become, with legislative reforms, issues demanding legal resolution.

The content of public health law

Subsequent lectures addressed particular themes and issues in the sphere of public health law.

Martin McKee and Elias Mossialos's paper on Health Policy and European Law examines a dichotomy arising from Gostin's definition: while the state has responsibility enshrined in law for the health of its citizens, European law also protects the free movement of people and trade between European states. Health governance systems across Europe are both independent and interdependent; they are not regulated by European law yet much of what they are mandated to do is governed by European law. Neither threats to health nor the means to treat ill health are confined by legal borders.

Recognition that responsibility for public health could not be left entirely to individual states within Europe came with the explicit mention of 'public health' in the Maastricht Treaty in 1992, where Article 129 set out a limited framework of Community responsibility based on encouragement of cooperation between states where necessary for the prevention of disease. More promisingly, Article 129 also required that health protection requirements be included in other Community policies, and the Treaty of Amsterdam in 1999 purported to ensure a high level of human health protection in the implementation of Community policies.

This has however done little to resolve allocation of responsibility for health, and as McKee and Mossialos point out, there is little coherence in the approach taken by the Community for the protection of health and in the provision of health services. It has fallen to the European Court of Justice in cases brought before it, through procedural doctrines of direct effect and supremacy of national law, to impose a European dimension on the regulation of health. The dichotomy between state and Community responsibility for health is not yet resolved, and McKee and Mossialos call for explicit treaty competence in relation to health systems.

In his commentary on this paper Govin Permanand notes that in interpreting European law, the European Court of Justice, an unelected body, is in effect making European health policy in this legislative vacuum. This is not ideal but what is the alternative? The role of an 'open method of coordination' as a form of European Union governance was considered, but in the absence of clear indicators and agreed objectives, it is not clear what is to be achieved by the process. Permanand calls for a clear and shared European agenda on health, in order to create a European framework of public health. Would then the Gostin definition of public health, focusing on state sovereignty in relation to the health of its population, need reconsideration?

In the third paper in the series looking at Communicable Disease Control, Richard Coker adopts the Gostin definition of public health law in order to examine the effectiveness of law in combating infectious disease. He traces the development of laws governing communicable disease in England and Wales, looking particularly at evolving (and regressing) approaches to human rights protections. Differing protections at different times were explained by changing perceptions of health risk and changing social mores. In particular he examines the move in application of the law from exercise of compulsory state powers based on threats to health, to exercise of powers predicated on the anticipated health behaviours of persons with disease. Health behaviours have been made even more prominent by the use of criminal law proscribing the intentional or reckless causing of physical harm to others, to prosecute persons who knowingly or recklessly behave in ways which might result in the transmission of the AIDS/HIV virus. Such prosecutions under the criminal law raise the question of how the purpose and objectives of public health law fit with the objectives of criminal law. The criminal law objective of imprisonment of a person who has offended the law was achieved, but what of the public health consequences of imprisonment? Clearly a further examination of the Gostin definition of public health law will need to address relationships and hierarchies with other species of law, and indeed the appropriateness of compartmentalizing laws is called into question.

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022

Even more complex is the role of national laws in relation to migrant populations. As with the umbrella of European law, national law cannot remain sovereign on issues of health with relevance beyond state borders. The newly drafted WHO International Health Regulations will have implications for national law, and will place both obligations and constraints on states in relation to their public health laws.

John Porter's commentary on the Coker lecture examines the role of fear of disease in attitudes to civil liberties, in particular to the civil liberties of persons seeking to enter state territory. Porter suggests that infectious disease control provides a useful lens for examination of wider questions on public health law. Why and when does the state wish to exert controls over individuals in the context of health? For whose benefit? Should the health of persons within the state be prioritised over the heath of outsiders? Public health law needs to be reformed to incorporate answers to these questions.

Tim Lang then examines in his paper the role of public health law in one example of non-communicable disease, disease associated with foods, their manufacture and their promotion. Lang points out that the relationship between the food production system and law is problematic. The rate of change within the food supply chain is such that the law has not been able to keep pace, and it continues to be the case that legal behaviour of the corporate food manufacturers and marketers has negative consequences for public health. The focus of food law is no longer only on noxious food products which cause immediate harm, but also on poor quality food products which will cause future health harms. More than most other areas of law, food laws are caught up in philosophical arguments about liberty and choice.

In his paper, Lang examines three conceptions of the relationship between food and law. In the traditional conception, the state has responsibility for setting the legal framework of food production. This approach complies with the Gostin definition of public health law as law clarifying state responsibilities for health, and also raises the issue highlighted by McKee and Mossialos, that much law regulating food products is outside the hands of nation states and is dictated at European and international level. The second approach sees a duality in food governance in which the state and food corporations compete for regulatory power. Again power and control is not contained within state boundaries. The growth of cross-border food trade has enabled food companies outside the UK to regulate what food is grown, how it is marketed and how it is priced. This has resulted in a parallel system of rules provided by means of company contracts and policed by major corporate purchasers, often resulting in higher standards than required by legislation. The role of law is thus diminished in face of the power of marketing. The third conception posits a three party model in which the public as well as the state and the food producers frame food governance. The consumer market is more visible in food regulation than in any other area where law might play a role. If either of the two latter conceptions best represents the role of law in protection of food health harms, how can they be reconciled with the Gostin definition in which public health law is confined to the role of the state in the regulation of the conditions for health? Or does the power of the public in influencing food content and availability also satisfy the 'public' element of Gostin's brief, by giving the public as a body a role in food governance? Lang illustrates the complexity of these approaches in his examination of food labelling, where there continues to exist a tension between law and voluntary regulation.

Lang concludes that food sits at the intersection of a complex relationship between public health and law, and one in which the role of human rights has not yet been clarified. A good food culture is difficult to legislate for, and public health law may not be a sufficient tool to achieve it. This is one area where law cannot be seen as a separate, positivist process, but rather law must exist, and cooperate with, the dynamic of the environment in which it operates.

Tim Lobstein in his commentary on Lang's paper picks up on another aspect of the Gostin definition of public health law. 'Law' means the use of legislation to shape social interactions, but can also include the means of protection of consumers' rights to good health. The process of law-making is complex, and in the context of food law, lobbying and commercial interests are influential. This can result in a tension between wealth generation and health protection, favouring a conception of food regulation outlined in Lang's third model, in which market choice is allowed to play a role in food governance. The acceptance of some public responsibility for the food market, through both purchasing power and private litigation, puts the 'public' back into public health law. However, as Lobstein points out, the English system of procedure, which does not provide the same access to group or class litigation as the American model, inhibits the power of the public to enforce consumer standards in the food industry.

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022

Common law, in particular tort law, was proposed by Gostin as a mechanism of indirect regulation of health, and Roger Brownsword in his paper considered how common law might be used to protect health. He asks, if exercise of the common law impacts on health, does it do so positively or negatively? Does it do so in a patterned or unpatterned manner? Does it impact directly or indirectly? While common law cases can be cited which have consequences for public health, Brownsword considers whether or not public health is the common law's business, and posits three conflicting views. The first is that each specific organ of law has its own specialized function, in the case of the common law the function being corrective justice, and that as such the role of specific organs of law in wider regulation should be limited. This argument would echo the concerns of Coker that the criminal law has done more public health harm than good by prosecuting persons who transmit the HIV/AIDS virus. The second view is that there is no systematic allocation of distinctive tasks to different organs of law, and that if one organ works effectively outside its remit, then it is not a tool that should be discarded. Concerns arise of course when there is an overlap of possibly conflicting laws which might equally apply. The third view argues that for all that Gostin imposes public health obligations on the state, it is the individual ideology of protectionism which underpins our legal system. On such a view, the role of the state in public health will necessarily be limited, and the common law gives power to the people to initiate their own public health legal measures.

This tension between the individual and the state, as exemplified by the tension between common law and public law, has yet to be resolved. Brownsword joins the call for public health law reform so as to provide an adequate frame of reference to enable regulators to respond to public health concerns.

In his commentary, Jonathan Montgomery examines a range of attempts to use the common law for public health purposes, ranging from tobacco and obesity litigation to litigation around harmful pharmaceutical products to fluoridation. He asks what are the rights to be protected by private actions? If what is sought to be protected is liberty, then perhaps common law, which operates without evaluating the protection sought against other possible benefits, is an appropriate mechanism. If the common law is a reflection of self-regarding rather than other-regarding behaviour, then mechanisms other than common law, which enable a wider evaluation of comparative harms and benefits, might be more appropriate.

International human rights law was the subject of the paper by Christine Chinkin. Chinkin poses the question, 'What is the added value of including health within human rights?' A preliminary answer is that incorporation of a human right into international law raises that right above the level of other human rights and policies, to give it validity and some immunity from challenge. In the process this makes clear that states have obligations and that individuals have entitlements in relation to health. But how useful are international human rights? International laws are framed in general terms, and it is not clear exactly what would satisfy standards such as 'highest attainable standard of physical and mental health'. International laws are neither justiciable nor capable of judicial determination. They have few means of enforcement. Yet they do provide standards against which national health policies, activities and interventions can be measured. If public health law is about the state's obligations to provide the conditions for health as Gostin proposes, then international human rights law provides a workable framework for the formulation of state law and policy on health.

Chinkin's paper examines in particular the workings of the monitoring committees for ICESCR and CEDAW in positing a normative meaning to the right to health. The right to health encompasses individual rights and freedoms, such as the right to control one's own body, as well as both positive and negative state obligations. State obligations contain three components. The first is a minimum core obligation to provide the services that are needed for people to be healthy: essential health care, food, sanitation, and shelter, as well as protection from discrimination. The second component is the progressive realisation of rights whereby states must move effectively towards full realisation of rights. The third component consists of a methodology for unpacking state obligations to determine what is needed by the state at each stage to protect and fulfil particular rights in relation to particular sections of population. This involves building on other rights such as the right to life, education, information or privacy in the development of a right to health. Chinkin examines attempts by nation states, such as South Africa, to formulate more precise rights to health and the extent to which such rights are in fact justiciable. She concludes that there is benefit to framing health rights within law in that it provides an alternative and complementary language for debating health issues, so helping to ensure that health policy analysis is free from arbitrariness, lack of accountability and absence of transparency.

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022

Jean McHale's commentary on Chinkin's paper looks at whether international human rights norms effectively assist to structure responses in individual states. The issue of whose rights are at stake and how those conflicting rights are to be balanced remain unresolved, as does the issue of conflicting rights. McHale draws some lessons from the debate. Firstly, while human rights do assist in structuring our responsibilities, they do not solve problems of poverty and lack of resources. Secondly the obligations of states in relation to human rights and state responsibilities need to be responsive to a multi-cultural society. And thirdly, issues of health go way beyond what is classified, even within the Gostin definition, as health law. If this is so, do we need, or benefit from, a classification of a body of law as public health law?

David Feldman's paper also addresses the role of human rights law in protecting health, and he looks in more detail at the nature of health rights. Feldman examines three models of rights related to health which govern Gostin's obligation on the state to prove the conditions for health. The first model is concerned with the obligation of the state to protect the physical integrity and moral autonomy of the individual. This protection is reflected in both customary international law and the positive law of international treaties through protection of respect for private life. However the right to private life is not absolute, and must be balanced against wider public interests such that any interference with private life must be proportional to the risk posed.

The second model relates to the obligation of the state to provide health services, protected by conventions on the right to life. In particular the European Convention for the Protection of Human Rights and Fundamental Freedoms as it is reflected in domestic UK law by the Human Rights Act 1998 imposes a positive obligation on the state to offer appropriate medical treatment to individuals who are in the custody of the state or who lack capacity to make their own decisions. However again the rights of the individual are not absolute and cannot be viewed in isolation. The needs of others will be relevant to the allocation process.

The third model is the obligation of the state to promote good health. A tension arises between this state obligation and the recognition of the moral autonomy of the individual. To achieve a balance between the state's obligations and individual autonomy, the state must recognize some responsibility for information about threats to health. The extent to which law protects the right to information is exemplified in the debate about tobacco advertizing, where the limitations of human rights law in protecting the right to information have become apparent.

Feldman suggests a fourth, and more aspirational model of rights in relation to health, in the possibility of the right to health. The starting point of international instruments in the protection of rights, the Universal Declaration of Human Rights, does not include a right to health as such. Rather Article 25.1 states that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services…'. This does not impose a duty on the state to provide such services, only to ensure that people who cannot help themselves have the resources to enable them to find help. Thus there is an obligation on the state not in relation to individuals but in the way it organises its society, so as to make possible the full realisation of rights. Since then other treaties have gradually strengthened health rights by, for example, requiring states to make every effort to improve the well-being of their populations, including the right to healthy working conditions, the right to social support and the right to benefit from measures enabling the highest possible standard of health attainable.

Rights enshrined in international law have proved difficult to implement, given the precedence of state sovereignty. However such rights do serve the purpose of keeping public health high on the political agenda, requiring state policy makers to justify their policies by reference to international standards.

In her commentary on Feldman's paper, Jane Wright looks at the balance between the interests of the individual and those of society. There is unequal protection for different rights. Some rights, such as the right not to have others interfere with one's body, are well protected while others, such as welfare rights, benefit from weak protection mechanisms. Perhaps this is inevitable and appropriate given the finite nature of resources, provided that human rights law serves to provide a framework for the prioritising of rights. The language of rights instruments does specify circumstances where individual rights may justifiably be infringed for the common good.

Wright noted that the discussion after the Feldman paper raised the question whether public health goals can be served without further regulation around the disclosure of risk. Individual responsibility is meaningless without risk information, and without access to the services and facilities necessary to counter risks to health.

The issue of law and risk is picked up in the final paper by Robyn Martin. Martin notes that while the

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022

notion of risk has been much examined in the fields of sociology and epidemiology, law has not addressed risk to any real degree. However contemporary government in the UK, as elsewhere, is now much occupied with risk, and increasingly the concept of risk is entering into our legal vocabulary.

Martin's paper examines the legal tools of duty and of power to consider the extent to which law might incorporate the language and mechanisms of risk. She notes that many areas of health regulation with wider relevance to public health, such as occupational health and environmental protection, have developed law which recognizes that health protection obligations are not absolute. Compliance with such duties requires a level of risk assessment consisting not only of quantitative analysis of probability and cost/benefit, but also a qualitative analysis of values which will dictate acceptability of risk.

Our core public health law however, which was first drafted in the 19th century, fails to recognize the risk assessment element of public health practice and so fails to provide a useful tool for public health practice. More worryingly, the absence of risk language from public health law excludes from the imposition of public health duties an analysis of relevant norms and principles of ethics which are essential to the application of good law. Other jurisdictions which have undertaken the process of public health law reform have proposed public health law which recognizes risk as an element of imposition of legal duties, and have included in their proposed law the criteria for assessment of risk. This has enabled public health ethics to be brought within the fold of law and to govern the exercise of law.

Similarly in relation to the exercise of public health powers, public health officials must make judgments which encompass risk assessments, for example when deciding whether to compulsorily examine a person suspected of carrying disease, or to detain a person who creates a risk of disease transmission. Law reform in the area of mental health has engaged with risk language, and law reform proposals in other jurisdictions have introduced risk assessment methodologies into laws which provide public health powers. Again this has served to ensure that core public health law is governed by principles of human rights and ethics, not as moral norms of behaviour, but as prerequisites for the application of law.

If, as Gostin proposes, the content of public health law includes the limitations on the power of the state to constrain the autonomy, privacy, liberty and proprietary interests of the individual, then law which recognizes principles of social justice not as matter of respect but as a matter of obligation, is essential. This echoes Gostin's conclusion that constraints on what can be done in the name of public health, which were once debated within the domain of ethics, should in the context of contemporary public health, demand legal resolution.

Angus Dawson in his commentary on Martin's paper invokes some words of caution about amalgamating ethics with law. Ethics is a minefield of contested theories. Liberalism as a principle of ethics has been dominant in bioethics, but is less appropriate as an overriding principle of public health law. What are needed are ethical principles more pertinent to prevention and collective action. Other ethical principles can be used to defend the interests of public health, but perhaps it would be best for law to remain neutral as to the appropriate governing values. Dawson's second caution is to the manner in which courts treat principles of ethics; there will always be a tendency towards reification of such principles. Even principles such as 'least restrictive alternative' might be insufficiently flexible when interpreted by law.

Any ethics applied to public health must be relevant to public health practice. Ethics principles which are rarely discussed in the context of bioethics such as the non-excludability of, the dependence on, and the indivisibility of public goods might be more appropriate to public health, but these principles are more difficult to pin down in legislative form. Law is only one of the many tools available for the protection of public health. Open acknowledgement of the role of risk in public health law is a step forward, but care must be taken to preserve the role of prevention in any law which governs public health practice.

Reforming public health law

What is undisputed in the course of these papers is that public health law in the United Kingdom, as with the public health law in many other jurisdictions, is in urgent need of reform. Current public health legislation fails on many fronts. It is administratively cumbersome, it fails to provide measures which are needed, and it provides obligations and offences which have no evidence base and which are no longer appropriate. Perhaps of more concern, our public health law no longer reflects either contemporary medical science or contemporary notions of social justice.

Law which is jurisprudentially flawed is bad law, and bad law can cause more harm than having no

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022

law at all. For a long time, the poor state of our public health law failed to trouble us because of the belief that advances in antibiotic medicines and vaccines, and health benefits that accrue from improved social conditions, would be sufficient to control infectious disease, making law practically redundant. Two recent developments have made it clear that we were mired in a false sense of legal security. The first event was the emergence of new communicable diseases, often the result of our approaches to food processing, for which no vaccine or medication was available. Secondly, the rise in non-communicable diseases, the consequence of our changing lifestyles, has proved untreatable by vaccine or medication. When the time came to apply old laws to these new challenges our legislative tools were found wanting.

Elsewhere in the world, governments have begun the process of public health law reform. All states will need to undertake some revision of their public health laws by 2012 to comply with the requirements of the new International Health Regulations, but it would be unfortunate if this resulted only in a tweaking of laws which are essentially flawed. The public health statutes which served us so well in the nineteenth century drawing on 19th century scientific understandings within a 19th century social, cultural and political context, no longer have the capacity to assist us in dealing with contemporary public health concerns .

As we come to a reawakening of the importance of public health endeavour as an essential component of the state's mandate to protect the health of its citizens, so we must again recognize, as did the 19th century social reformers, that such endeavour needs the underpinning of law. Our public health law no longer reflects our society, its values or its needs. It is vital that reform is undertaken as a matter of urgency.

Please cite this article as: Robyn Martin, Richard Coker, Conclusion: Where next?, Public Health (2006), doi:10.1016/j.puhe.2006.07.022