ARTICLES

MANAGED CARE AND THE HEALTH OF A NATION

RENÉ BOWSER* & LAWRENCE O. GOSTIN**

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* Assistant Professor of Law, University of Illinois College of Law. B.A., 1985, University of Maryland, College Park; M.A., 1987, Northwestern University; J.D., 1994, Stanford University Law School; LL.M., 1999, Georgetown University Law Center.

** Professor of Law, Georgetown University Law Center; Professor of Law and Public Health, the Johns Hopkins University School of Hygiene and Public Health; Co-Director, Georgetown/Johns Hopkins Program on Law and Public Health; Advisory Committee on HIV and Sexually Transmitted Disease Prevention, Centers for Disease Control and Prevention; Board on Disease Prevention and Health Promotion, Institute of Medicine, National Academy of Sciences. B.A., State University of New York at Brockport; J.D., 1974, Duke University School of Law; LL.D. (hon.), 1994, State University of New York.
INTRODUCTION

Public health is a social good that has foundational importance for the achievement of nearly all other human goods. Absent public health interventions that reduce premature mortality and morbidity, the central goals of the American constitutional system—“freedom and welfare” are unattainable. Individuals cannot enjoy good health, long life and the freedom to assess their life situations and evaluate the possibilities of changing them without communal efforts to protect and promote community health. Public health is similarly indispensable to political communities. Populations require reasonable levels of health as a

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1. For a definition of the term “public health,” see infra Part I.A.
3. See Amartya Sen, Individual Freedom as a Social Commitment, N.Y. REV. BOOKS, June 14, 1990, at 49, 53. Sen argues that if individual freedom, including the positive freedom to live without premature mortality, is accepted as a social value, then the state of public health and the epidemiological environment deserve increased attention.
prerequisite for engaging fully in the social interactions of a community, participating in the political process, or generating wealth and assuring economic prosperity. But acting alone, individuals cannot assure even minimum levels of health; meaningful protection and assurance of human health requires organized and sustained community effort to affect health status.

We claim, therefore, that maximization of public health represents a central, perhaps overarching philosophical value. Public health maximization derives both from Kantian traditions—respecting individual worth, self-respect and autonomy—and utilitarian traditions stressing the pursuit of human happiness. Public health maximization, of course, requires adequate resource allocations to public health. Both the public and private sectors must be committed to promoting communal health promotion and protection. Dialogues on how much public health is desirable, who will supply it and how these activities will be financed occur naturally within a democratic process. But in recent decades, the American political process has disfavored public health services compared with allocations to personal medical services and, consequently, a general disregard for public health promises to be a central distinguishing feature of American health policy in the last quarter of the twentieth century. Suffice it to say that the nation’s public health system and, derivatively, overall societal welfare have suffered.


5. Although individuals may be able to contract or procure personal medical services and many of the necessities of living, only the community as a whole can protect the environment, promote sanitation, clean air and surface water or regulate food, drinking water, safe roads and consumer products.

6. Kantian philosophy emphasizes that individuals are freely choosing, independent selves and that what is most essential to personhood is not the ends that we choose, but our capacity to choose them. See, e.g., JOHN RAWLS, A THEORY OF JUSTICE 560 (1971); MICHAEL J. SANDEL, DEMOCRACY’S DISCONTENT: AMERICA IN SEARCH OF A PUBLIC PHILOSOPHY 11-12 (1996); IMMANUEL KANT, On the Common Saying: This May Be True in Theory, But It Does Not Apply in Practice, in KANT’S POLITICAL WRITINGS 61-92 (Hans Reiss ed., 1970).


8. See DAN E. BEAUCHAMP, THE HEALTH OF THE REPUBLIC: EPIDEMICS, MEDICINE, AND MORALISM AS CHALLENGES TO DEMOCRACY 4 (1988) (suggesting that a healthy republic is not solely achieved by a strong sense of communal welfare, but is also the result of a vigorous and expanded democratic discussion about the public’s health).
Today, the public health system is seriously deficient. The public health infrastructure has seriously deteriorated and state health departments are unsure about how to secure the resources needed to sustain their activities. Further, a number of communities are unserved by anything comparable to a local health department and considerable variability in quality exists among those that are. Furthermore, dwindling government resources have forced some state and local public health departments to eliminate preventive services and have precluded them from fulfilling safety-net and community needs assessment and surveillance responsibilities.

Less obviously, public health is structurally deficient. The entities most closely associated with the health of people are not necessarily government, but rather private sector institutions. Private sector health care and public health can be thought of as part of a circular continuum, defined at one end by direct patient care and at the other by population-based interventions. Because population-based interventions improve human health and decrease the demand for individual health care services, the private sector health care system has an obvious stake in public health. Yet, taking a myopic view, society has artificially assigned population-based activities to government and personal medical services to the private sector. Considerations of this sort become more important as the trend toward managed care in the United States continues to grow into a torrent, radically reshaping the practice of medicine, as private employers and state and local governments struggle to curtail rising health care costs. Thus, no matter how much we as a society invest in government

9. The public health infrastructure is broadly defined as the capacity of public health agencies to carry out their mission to protect and promote the public health and to perform their core functions with respect to this mission. See Kristine M. Gebbie, Comment, Rebuilding a Public Health Infrastructure, 21 J.L. MED. & ETHICS 368 (1993); William L. Roper, Edward L. Baker, William W. Dyal & Ray M. Nicola, Strengthening the Public Health System, 107 PUB. HEALTH REPS. 609, 610 (1992).

10. See infra Part III.

11. See COMMISSION ON PUB. HEALTH, INST. OF MED., HEALTHY COMMUNITIES: NEW PARTNERSHIPS FOR THE FUTURE OF PUBLIC HEALTH 33 (Michael A. Stoto, Cynthia Abel & Anne Dievler eds., 1996) [hereinafter HEALTHY COMMUNITIES].

12. Public health activities, of course, are undertaken outside of government. Health care providers, for example, offer health education, testing and screening, as well as counseling and partner notification. Providers also have a legal obligation to report certain injuries and diseases to the health department. See Terence L. Chorba, Ruth L. Berkelman, Susan K. Safford, Norma P. Gibbs & Harry F. Hull, Mandatory Reporting of Infectious Diseases by Clinicians, 262 JAMA 3018, 3024-25 (1989).

13. Approximately 90 million insured Americans receive health care from managed care plans, including more than 25% of Medicaid beneficiaries and 10% of Medicare beneficiaries. See HEALTHY COMMUNITIES, supra note 11, at 15.
public health, private sector managed care will become critical in achieving the human good of health.

Managed care provides missed opportunities for improving human health because managed care organizations are responsible for the health of defined populations and are increasingly being held accountable for outcomes by employers, consumers and other payers. Of course, the medical care supplied by managed care organizations is an important condition for people to be healthy since medicine can prevent disease, restore function and even offer a cure. But more fundamentally, managed care has changed the health care delivery system from an individualistic approach to a more population-based way of thinking, that, according to conventional wisdom, has led to an increased interest in prevention and education to ensure that enrollees remain healthier. This general understanding also suggests that managed care organizations have a stake in public health maximization. The population from which health plans obtain members is fairly mobile as switching by enrollees among competing health plans is becoming increasingly common. But simply because an individual in the community is not now a plan member, or has left the particular plan, does not mean that she or he will not become a member at a later time. Thus, from a long-run perspective, improving overall community health allows managed care organizations to minimize the acceptance of risk.

The consequence of this assumption, from a utilitarian and freedom-centered social ethics perspective, is that a deliberative effort should be made to secure managed care’s cooperation in expanding public health activities. This issue is fraught with complexity, however, and implicates a host of theoretical, historical, economic and pragmatic questions. First, from a theoretical perspective, constitutional law and theories of community and democracy point to government as the entity responsible for the protection and assurance of health. But, are there normative reasons why government should be the exclusive provider of public health, or, alternatively, may government encourage, fund, regulate and oversee private activity? Second, managed care’s role in public health is a historical question. Has the private sector historically made any important contributions to public health that could serve as a guide to a modern

15. See infra Part I.B.
managed care environment? Third, understanding the theoretical issues involving managed care and public health requires a discussion of economic incentives. Is it economically feasible for managed care plans organized for profit to pursue social ends where this pursuit has the short-term potential of conflicting with the presumptive shareholder’s desire to maximize profit? Finally, the role of managed care in promoting community health requires pragmatic and empirical inquiries. What are the most effective and workable methods of increasing managed care’s involvement in public health?

We conclude that while government retains primary responsibility for public health, substantial improvements are possible if the private sector assumes significant obligations. Government has a duty to provide for the public safety and, when health emergencies threaten a community, citizens will look to the local health officials instead of the administrators of a managed care plan for protection. Further, even assuming that society could parcel out public health responsibilities to different managed care entities, the sum total would not equal public health readiness or provide on-going assurance that community health needs are met. But through well considered delegations, incentives and regulations, managed care can complement governmental public health activities. We attempt to particularize this claim by suggesting concrete methods for including managed care in public health.

This Article is organized in eight Parts. Part I systematically examines the perceived confluence of interests between public health and managed care. But because public health is a poorly understood concept, we first describe its activities and explain its importance to the security and well-being of society. Having established its foundational importance to individual and community welfare, we argue in Part II that public health activities should be maximized. Part III focuses on the challenges facing public health and provides the background for understanding why collaboration with managed care in some form is necessary to maximize public health. Part IV establishes government’s obligation to assure that conditions for people are healthy based on constitutional law and theories of community and democracy. Next, we explore whether there are any

16. See Edward L. Baker, Robert J. Melton, Paul V. Stange, Mimi L. Fields, Jeffrey P. Koplan, Fernando A. Guerra & David Satcher, Health Reform and the Health of the Public: Forging Community Health Partnerships, 272 JAMA 1276, 1277 (1994). The authors argue that government responsibilities will increase substantially because of the need, among others, to assist private providers, in the case management of individuals previously served by health departments, to respond to crises and to argue the public health perspective in national debates. See id.
rigorous theoretical arguments against including the private sector in public health provision. Finding none, we turn to the historical and empirical evidence of the state and the private sector in public health as an aid in shaping a vision of public health and managed care.

The next three Parts examine methods of increasing managed care’s involvement in public health. Part V examines privatization. As a general matter, delegating public health functions should lead to increased efficiency and cost-savings, but delegations that infringe on constitutional rights such as liberty and privacy must be carefully scrutinized; the same is true for delegations that have the potential for presenting a conflict between the public and private interests. Mindful of these legal and constitutional constraints, we advocate delegating concrete services under certain circumstances to managed care: personal medical services and clinical prevention. We further argue in favor of supplementing public health’s provision of other services: surveillance, health promotion, counseling services and education.

Part VI examines regulation. Government regulation is problematic because it not only consumes economic resources, but also infringes on property interests. Further, if regulation increases premium prices, smaller employers are less likely to provide health insurance, compounding the public health problem of the uninsured. While anecdotal evidence of the adverse health consequences of managed care has led to regulations of media-driven theme issues such as physician gag rules and drive-through deliveries, state legislatures and the federal government have traditionally been reluctant to enact comprehensive health reforms that substantially raise costs to providers and employers. As a practical matter, we suggest that government require plans receiving Medicaid and Medicare contracts to engage in community-wide public health activities. We further argue that the market can play a role in regulating managed care if purchasing coalitions recognize that community-wide interventions can reduce medical utilization and result in lower premiums.

18. See infra Part V.B.
19. See Lawrence O. Gostin, Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America, 39 ST. LOUIS U. L.J. 7, 42-43 (1994). While federal and state regulation of consumer rights is much discussed, see, e.g., Robert Pear, H.M.O. Group Backs Controls G.O.P Rejects, N.Y. TIMES, July 14, 1998, at A5, A12 (Senate Republicans have proposed legislation protecting patients’ rights, drawing a battle line with Democrats, who have sought more sweeping protections, including the right to sue managed care companies), neither the American public nor its political leadership has perceived the deterioration in public health as an issue warranting government regulation of managed care organizations to promote community-wide public health.
Part VII explores incentivizing the private sector through favorable tax and other treatment. Because public health is a social good that all members of society share the responsibility of providing,20 we argue that providing incentives to health plans to perform functions that they should undertake voluntarily is incompatible with the goal of increasing corporate social responsibility21 for public health. Some pressing public health needs exist, however, that the private sector cannot provide without government incentives. We assert as a guiding principle that government assistance should be provided when cooperation would substantially threaten long-term profits.22 A concrete example is the “prisoner’s dilemma”23 that exists when society asks competing health plans to share proprietary information that would be useful to public health officials in tracking the prevalence and incidence of disease, injury and risk behavior in the community.

Finally, in an attempt to encourage managed care organizations to assume social obligations as a matter of conscience, Part VIII advances theories of ethical and social responsibility for public health. Philosophical and legal thinkers have intensively debated whether corporations bear moral obligations. We argue that they do and, therefore, reject the model that corporations owe no social duties other than maximizing shareholder profits. Taxpayers are the principal investors in the health care system and are owed a return in the form of better community health. Similarly, no individual enrolled in a managed care plan can escape the health risks present in the community. Maximizing the

20. See, e.g., Gostin, supra note 19, at 14. Individuals bear a significant responsibility for their own health. Moreover, illness, injury and disease have become societal, as well as personal problems, and their solution is a collective as well as an individual responsibility. See also HEALTHY PEOPLE 2000: CITIZENS CHARTING THE COURSE 2 (Michael A. Stoto, Ruth Behrens & Connie Rosemont eds., 1990) [hereinafter HEALTHY PEOPLE 2000] (asserting that achieving national health objectives requires commitment of resources from all levels of government, industry and non-profit organizations).

21. Courts and commentators have long debated the meaning of the social responsibility of a corporation. Some argue that corporations should be more responsible by taking into account all the constituencies their operations affect and, further, that they should assume responsibility for broader societal problems. Others, however, argue that corporations should be concerned exclusively with maximizing the profits they can earn within the law. For a good overview, see LEWIS D. SOLOMON, DONALD E. SCHWARTZ, JEFFREY D. BAUMAN & ELLIOT J. WEISS, CORPORATIONS LAW AND POLICY 85-123 (3d ed. 1994). For purposes of this Article, our foremost concern is not whether managed care has a social obligation, but, rather the extent of its responsibilities. See infra Part VIII.

22. See infra Part VIII.

23. As usually formulated, the prisoner’s dilemma involves two players, each having two choices: either cooperate or defect. Each player must choose without knowing what the other will do. Regardless of what the other does, defection yields a higher payoff than cooperation. But, the dilemma is that if both defect, both do worse than if both had cooperated. See generally ROBERT AXELROD, THE EVOLUTION OF COOPERATION 3-24 (1984).
health of an enrolled population, therefore, ethically obligates managed care plans to assist, at a minimum, in reducing community-wide preventable injury, health risks and environment harms.

I. THE FOUNDATIONAL IMPORTANCE OF PUBLIC HEALTH

A. DEFINING PUBLIC HEALTH

Public health is an elusive concept whose definition has evolved as health risks inherent in communal living have been identified and techniques for their diagnoses and prevention developed. The Institute of Medicine proposed one of the most influential contemporary definitions of public health: “Public health is what we, as a society, do collectively to assure the conditions for people to be healthy.”

More recently, the U.S. Department of Health and Human Services suggested that public health includes activities that prevent epidemics and the spread of disease; protect against environmental hazards; prevent injuries; promote and encourage healthy behaviors; respond to disasters and assist communities in recovery; and assure the quality and accessibility of health services.

Although incapable of precise definition, standard accounts of the field of public health suggest that it has the following characteristics: government responsibilities to the community; the well-being of the population; the relationship between the state and the community at large;

24. As early as 1920, public health was defined broadly, including most social and behavioral aspects of communal life. At that time, C.E. Wilson defined public health in terms of preventing disease, prolonging life and promoting health and efficiency through organized community effort for (a) the sanitation of the environment; (b) the control of communicable infections; (c) the education of the individual in personal hygiene; (d) the organization of medical and nursing services for the early diagnosis and preventive treatment of disease; and (e) the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these efforts to enable every citizen to realize his birthright of health and longevity.


26. Adopted Fall 1994 by the Public Health Functions Steering Committee, United States Department of Health and Human Services. The Committee elaborated ten essential public health functions: monitor health status to identify and solve community health problems; diagnose and investigate health problems and health hazards in the community; inform, educate and empower people about health issues; mobilize community partnerships to identify and solve community health efforts; enforce laws and regulations that protect health and ensure safety; link people to needed personal health services and assure the provision of health care when otherwise unavailable; assure a competent public health and personal health care workforce; evaluate effectiveness, accessibility and quality of personal and population-based health services; and research for new insights and innovative solutions to health problems. See Baker et al., supra note 16, at 1276-82.
and a broad range of services that are designed to identify, prevent and ameliorate health threats within society.\textsuperscript{27} Public health is inherently interventionist and uses a broad and eclectic set of scientific, behavioral, social, and environmental methods to measure the incidence and prevalence of injury and disease and to prevent morbidity and premature mortality.\textsuperscript{28}

Public health, to be sure, includes personal medical services. Access to high quality, cost-effective health care is an important determinate of human health.\textsuperscript{29} Yet, it is important to observe that most researchers believe that access to personal medical services makes only a modest contribution to the health of the community.\textsuperscript{30} Surveillance and control of epidemic diseases, alteration in the design of products to reduce injuries, safe food and water, reduction in behavioral risks such as smoking and many other public health interventions have helped reduce morbidity and increase life expectancy.\textsuperscript{31} Further, roughly half of all deaths in the United States are attributable to social, environmental and behavioral risks which are, in part, preventable. Chief among these external causes of death are tobacco, diet and activity patterns, alcohol, microbial agents, toxic agents and firearms.\textsuperscript{32}

Public health activities are not a panacea for the improved health and vitality of the nation. Public health has a limited understanding of how structural factors such as poverty, class and alienation contribute to poor health outcomes.\textsuperscript{33} Public health, moreover, is only beginning to develop

\textsuperscript{27} See generally \textsc{Law, Science and Medicine} 485 (Judith Areen, Patricia A. King, Steven Goldberg & Alexander Morgan Capron eds., 1996).


\textsuperscript{29} See generally \textsc{The Nation’s Health} 5 (Philip R. Lee, Carroll L. Estes & Liz Close eds., 5th ed. 1997).

\textsuperscript{30} See, e.g., Gostin, supra note 19, at 14 & n.28.

\textsuperscript{31} See \textsc{Future of Public Health, supra} note 25, at 19-31.

\textsuperscript{32} See J. Michael McGinnis & William H. Foege, \textit{Actual Causes of Death in the United States}, 270 \textsc{JAMA} 2207 (1993). The principal causes of death in biological and clinical terms are heart disease, cancer, cerebrovascular disease and pulmonary diseases. See id. at 2207. Of course, social, environmental and behavior factors contribute to the prevalence of these diseases.

\textsuperscript{33} See generally Larry Gostin, \textit{The Interconnected Epidemics of Drug Dependency and AIDS}, 26 \textsc{Harv. C.R.-C.L. L. Rev.} 113, 121-31 (1991); Samuel R. Friedman, Don C. Des Jarlais & Claire E. Sterk, \textit{AIDS and the Social Relations of Intravenous Drug Users}, 68 \textsc{Milbank Q.} 85, 86 (Supp. 1 1990) (noting that public health’s experience in dealing with intravenous drug use demonstrates how powerful external forces associated with drug use, including poverty and alienation, are poorly understood and, therefore, difficult to take into account when fashioning policies designed to achieve the goal of behavior modification).
scientifically accurate measures of the efficacy of interventions. Frankly, the mechanisms of health, and health improvement, in the population are complex and not well understood. Still, a great deal of evidence suggests that a broad array of what we call public health activities, in the public and private sectors, can make a great deal of difference in the overall health and well-being of populations.

Finally, public health programs are more cost-effective than personal medical services. At the margin, each dollar spent on prevention services is estimated to eliminate the need to spend several dollars on personal medical services and to reduce lost productivity. For instance, many expensive injuries such as smoking-related lung cancer ($29,000), spinal cord injury-induced quadriplegia ($570,000) and liver transplant for alcoholic cirrhosis ($250,000) are preventable. Expansion of public health prevention programs are, therefore, justified not only by their reduction in morbidity and mortality, but also by their economic savings.

B. MANAGED CARE’S STAKE IN PUBLIC HEALTH

Healthier communities are obviously important in reducing the utilization of health care resources, which is of central importance in fulfilling managed care’s promise to contain utilization and costs while maintaining or promoting quality of care. Further, by serving a healthier overall enrolled population, managed care can potentially better serve the hard cases—the seriously ill suffering from heart disease and breast cancer, the mentally ill, the elderly and the poor—groups whose special challenges managed care has often failed to meet. Finally, from an

34. See HEALTHY COMMUNITIES, supra note 11, at 38-39.
36. See COMMISSION ON MONITORING ACCESS TO PERSONAL HEALTH CARE SERVICES, INST. OF MED., ACCESS TO HEALTH CARE IN AMERICA 2 (Michael Millman ed., 1993) (noting that population-based strategies in areas such as the environment, pollutants, health education, occupational health and injury control could potentially “save more lives and have a greater impact on quality of life than programs to extend health services.”).
38. See Gostin, supra note 19, at 16.
39. See id.
40. See, e.g., Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 442 (1997); Johnathan B. Oberlander; Managed Care and Medicare Reform, 22 J. HEALTH POL. POL’Y & L. 595, 625 (1997).
ethical perspective, by using fewer additional resources and allocating existing ones better, managed care can indirectly assist in promoting justice by ensuring that health care does not exhaust resources required for other ends of justice such as housing, nutrition and education.\footnote{See generally Brock & Daniels, supra note 4, at 1191-92.}

On a more pragmatic level, public health officials, academics and the medical establishment are now focusing on a number of shared interests between the managed care system\footnote{Managed care deviates from the traditional health care delivery system by substituting pre-arranged fee structures and utilization procedures for fee-for-service billing. The proliferation of managed care entities has resulted in a host of confusing organizational structures. The most common form is the Health Maintenance Organization (HMO) which provides both hospital and medical service coverage to its members in exchange for a pre-paid fixed monthly fee. Except for emergency and out-of-area services, members are “locked in” the HMO’s closed network of participating providers. The “lock-in” feature distinguishes HMOs from Preferred Provider Organizations (PPOs) and HMO point-of-service plans (POS), which do not restrict the member to a specific provider network. Instead, these plans provide consumer financial incentives such as reduced payments or increased benefits to seek care from participating providers. Independent Practice Associations (IPAs) are similar to PPOs. The primary difference is that most IPAs focus on capitation contracts with HMOs, while PPOs generally focus on discounted fee-for-service arrangements with insurance plans or self-insured employers. See generally HEALTH CARE CORPORATE LAW: MANAGED CARE (Mark A. Hall & Will S. Brewbaker III eds., 1996) [hereinafter MANAGED CARE].} and the public health system\footnote{The public health system is the organized system of federal, state and local governmental authorities with primary responsibility for the community. See FUTURE OF PUBLIC HEALTH, supra note 25, at 165 (summarizing the various organizations that comprise the public health system, including governmental and nongovernmental entities).} and are advocating for managed care’s collaboration in expanding public health services. By their accounts, managed care organizations are concerned with improving and maintaining the health of a defined population, which is fully compatible with public health’s concern with the health of broad populations, and recognize that disease prevention and health promotion are cost-effective.\footnote{See PREVENTION AND MANAGED CARE, supra note 14, at 4-9.} Market forces also play a role in fostering collaboration as scarce resources in a fiercely competitive environment are perceived to encourage managed care plans to seek new allies to take advantage of efficiencies of scale, especially as the patients, resources and services are transferred from public health agencies to private health plans through Medicaid and Medicare contracting.\footnote{See generally Paul K. Halverson, Glen P. May, Arnold D. Kaluzny & Thomas B. Richards, Not-So-Strange Bedfellows: Models of Interaction Between Managed Care Plans and Public Health Agencies, 75 MILBANK Q. 113, 113-14 (1997).} Thus, in order to thrive in an increasingly competitive environment, managed care organizations must protect their subscribers from preventable illness, a traditional mission of public health.\footnote{See generally William L. Berry, Howard P. Greenwald & Philip M. Nudelman, Managed
Managed care’s involvement in prevention and public health, however, is much more complex than these assumptions suggest. Theory and practice potentially collide when we first consider managed care and prevention. In practice, the financial incentives offered to primary care physicians directly and indirectly affect physician behavior and often dictate the amount of preventive services provided. For instance, if a managed care plan structures a capitation arrangement to primary care physicians such that clinical preventive services like vaccinations, mammograms and diagnostic tests for prostate and cervical cancer are included in the base capitation, primary care physicians have no financial incentive to provide these services because the cost comes directly out of their pocketbooks.47 Conversely, if we assume that these services are carved out of the capitation payment and compensated on a fee-for-service basis, a physician’s incentive to provide clinical preventive services changes in favor of providing these services.48 Further, rapid turnover of patients due to changes in health plans potentially limits the provision of preventive services. With a stable number of covered lives, a health plan might routinely screen for and treat hypertension to avoid the long-run financial risk of treating and hospitalizing a stroke victim with undiagnosed hypertension. But as members move into and out of plans, managed care plans are, arguably, less likely to consider long-term financial risks.49

There are, in short, defects in the claim that managed care is prevention-oriented. Managed care certainly provides preventive services,50 but as we have demonstrated, whether the theoretical cost-effectiveness of prevention translates into incentives for managed care to work with public health in providing preventive services is a much more complicated question. Further, while everyone gains value from prevention and healthy communities, health care is just another business for many of managed care’s for-profit managers and shareholders. Short term profit maximization rather than enrollee health maximization is their

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48. See id. at 1027-28.
49. From an economic perspective, health plans may perceive that the cost to them, in present value terms, of an enrollee developing a preventable disease or injury in the future is small. Accordingly, preventive care and early treatments will not be provided if a plan applies a high discount rate to future expenses.
50. See Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512, 1516 (concluding that HMO enrollees consistently received more preventive tests, procedures and examinations than did indemnity plan enrollees).
likely goal. From this perspective, a rational decision maker would choose to “free ride” on those public health services provided by other health plans or by the government.

But even if we are less sanguine about the practicability of voluntary public health cooperation, managed care’s organizational structure has the undeniable potential to vastly improve community-wide public health activities and, therefore, should not be ignored. Through economies of scale, large health plans may be better positioned than local health departments to provide systematically clinical prevention services such as mammograms, pap smears, childhood immunizations, and health education in such areas as smoking cessation, nutrition, risk reduction, and stress management. Further, health plans may be well-placed in their communities to engage in surveillance, enabling them to identify clusters of injuries and diseases among their populations. Most health departments lack the personnel, laboratories and information systems to identify and respond effectively to the great variety of health risks facing populations. At the same time, however, managed care organizations are developing the capacity to identify clusters of diseases and injuries within the enrolled population and discover their causes through investigation. This information is critical for public health policy development and community needs assessment.

Managed care obviously has a stake in public health. But this recognition does not address the issues of how to achieve a redistribution of resources that focuses more on prevention and community public health services.\(^5\) The reality is that managed care’s norms and practices

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51. Halverson and his colleagues usefully identify three models of public health/managed care interaction that could potentially assist in maximizing public health. See Halverson et al., supra note 45. In the opportunistic model, the health plan and public health agency form a transitory alliance that allows for the exchange of information and expertise that will assist each entity in pursuing its goals. See id. at 116-17. These alliances form when a managed care plan begins enrolling Medicare beneficiaries who were served previously by a local health department or, alternatively, when a local health department seeks to develop a managed care plan to serve some of its clients. See id. The managed care plan benefits by acquiring skills in managing the care of vulnerable populations, using surveillance techniques for disease identification and from “designing and managing health promotion and disease prevention interventions.” Id. At the same time, the opportunistic model allows the public health agency to “acquire skills in projecting and managing costs of service delivery; conducting cost-effectiveness analyses for services needed by clients; negotiating service contracts; performing case management and utilization review.” Id.

Under the Shared Services Model, the health plan and health agency jointly produce some good or service that is needed by both organizations. Examples include agreements to share the costs of, say, public health media messages, childhood immunization databases or community health surveillance projects. The health plan potentially benefits by improving the management of enrollees’ care or projecting costs associated with new enrollees. The health department gains by being in a better
emphasize short run profits, while returns on investment in community health are profitable in the long run.\textsuperscript{52} The basic power or obligation of organized society to protect and preserve the health of populations, however, provides justification for government to change the incentive structure, or reorder private preferences to maximize aggregate societal welfare.

II. PUBLIC HEALTH MAXIMIZATION AS A SOCIETAL VALUE

The prevention of injury, disease and disability and the promotion of health are among the most important social goals to be sought by government. Health is basic to all human endeavor and, therefore, may be regarded as a foundational justification for government action. Without a certain level of health, a person cannot pursue a livelihood, exercise fundamental rights and privileges or achieve personal satisfaction, happiness and better personal relationships.\textsuperscript{53} Health is also one of the more important aspects of personhood; a person’s self-identification, dignity and status in society are often connected with that person’s vitality and ability to function.\textsuperscript{54} As one of us has said elsewhere, the government’s failure to act is conspicuous when illness or disease are preventable, or when pain and disability can be alleviated. Persons whose illness and suffering might have been prevented or lessened through reasonable government interventions may understandably claim that they count less, that their dignity is undermined by governmental inaction.\textsuperscript{55}

Human health takes on a special meaning and importance in democracies.\textsuperscript{56} Human health is indispensable not only to individuals but, just as important, to political communities. Without at least reasonable levels of health, populations cannot fully engage in the social interactions of a community, participate in the political process, generate wealth and assure economic prosperity.\textsuperscript{57} A healthy workforce is more productive, a
healthy student body is more capable of learning and a healthy population is more capable of working toward social goals. Public health, then, becomes an overarching value because a minimum level of human functioning is a prerequisite for doing all the things that are essential to communities—social, political and economic.

Further, as expressed in William H. Foege’s classic phrase, “the philosophy of public health is social justice.”

Public health makes possible the highest state of health for the greatest number of people and, further, promotes equity among various social groups, protects vulnerable populations and compensates persons for disadvantages in health and health care. No one would claim that the American health care system provides for equality of opportunity as disparities in access are particularly sharp and enduring for persons with low socioeconomic status, the uninsured and persons in minority racial and ethnic groups. It follows, then, that the equitable and fair access values achieved by public health become even more important as they provide a modicum of justice in the distribution of health services.

This is not to suggest that the political commitment to public health must be absolute. What constitutes “enough” public health (How much? What kinds of services? How will services be paid for and distributed?) remains a political question. 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 fair political process. The ability of public health work to attract support is, however, essential to its success. The great sanitarian Herman Biggs remarked that “public health is purchasable”; but because

60. See, e.g., Nancy E. Adler, Thomas Boyce, Margaret A. Chesney, Susan Folkman & S. Leonard Syme, Socioeconomic Inequalities in Health: No Easy Solution, 269 JAMA 3140, 3143-44 (1993).
how much we are willing to buy is limited, public health will always turn on allocational decisions.\footnote{Lawrence O. Gostin, Scott Burris & Zita Lazzarini, The Law and the Public Health: A Study Of Infectious Disease Law in the United States, 99 COLUM. L. REV. 59, 68 (1999).}

To many, the value of human health and the government’s obligation to assure the conditions for health are received wisdoms. Once these ideas are accepted, discourse should be limited to exactly how public health is maximized. What specific actions are necessary for achieving the goal and who has primary responsibility for taking those actions? Public health maximization, however, is not universally accepted as an overriding social goal. To some, public health ought not to be a societal goal at all because it would lead to excessive government intervention and irrational outcomes.

Influential thinkers like Philipson and Posner, using economic models, suggest that government’s role is broadly to inform individuals about the consequences of risk behaviors, but the choice to engage in those behaviors properly rests with the individual.\footnote{See generally THOMAS J. PHILIPSON & RICHARD A. POSNER, PRIVATE CHOICES AND PUBLIC HEALTH: THE AIDS EPIDEMIC IN AN ECONOMIC PERSPECTIVE (1993). For comprehensive critiques of Philipson and Posner’s economic analysis, see, for example Bayer et al., supra note 28, at 83; William N. Eskridge, Jr. & Brian D. Weimer, Economics in an AIDS Perspective, 61 U. CHI. L. REV. 733 (1994); David Charny, Economics of Death, 107 HARV. L. REV. 2056 (1994).} Under this view, traditional public health activities aimed at ending an epidemic may be ineffective because they fail to account for the individual’s own cost-benefit calculations.\footnote{See PHILIPSON & POSNER, supra note 65, at 13.} For instance, individuals who engage in risky behavior will respond to the threat of, say, HIV infection by modifying their behavior if, according to their own cost-benefit analysis, such behavior changes maximize their individual utility.\footnote{See id.} Such a claim suggests, by extension, that individuals who continue to engage in risky behaviors do so because they have determined that the benefits outweigh the costs.\footnote{See id.} An “optimal” level of infection is reached and the epidemic is stabilized when uninfected individuals take a rationally determined level of greater precaution as the risk of infection increases.\footnote{See id. Philipson and Posner state: [A] level of disease considerably greater than zero may be economically optimal simply because many people demonstrate by their behavior... that they consider the cost of reducing the risk of the disease to zero... to be greater than the expected cost, in disease, disability, and death, of the risk itself. Id.} Thus, these scholars posit that governmental...
interventions to interfere with the free interplay of market forces virtually always produce less economically efficient outcomes.70

Philipson and Posner’s objection becomes less forceful in light of the fact that their rationality argument is impossible to verify scientifically. A more fundamental flaw of their analysis is that it ignores the psychological and moral intricacies of human behavior, especially in matters of health.71 The economic model fails to recognize that “rational” choices are typically not free but, rather, are constrained by structural factors such as poverty, gender, race, peer pressure influence, interpersonal relationships or acculturation.72 Often, individuals who choose high risk behavior are ignorant of the risks or have little power to resist the behavior (for example, individuals in abusive relationships or persons physically dependent on drugs).73 Moreover, when such choices produce negative health consequences, intervention can be justified on the grounds of increased efficiency.74 Charny has shown that legal interventions to protect the improvident or impulsive can increase social welfare by, among other things, limiting opportunities to victimize individuals who exercise questionable judgment.75

In sum, confronted with a public health crisis that presents a high risk people will die or become sick, a compelling case for public health intervention can be made based on the state’s duty to protect the

70. See id. at 3.
71. The claim that private action through rational decisionmaking provides the optimal level of infection lacks content because it generates no testable hypotheses. See Charny, supra note 65, at 2058-59. And by reducing choice to a “one-dimensional utility calculation [the judgment] . . . stunts reflection on the full range of ethical considerations that should–and do–govern persons’ decisions.” Id. at 2056. Amitai Etzioni has expressed a similar view. He suggests that individuals exist only in social contexts and to understand truly individual choice, one must study the social collective and the forces that form and transform it. See AMITAI ETZIONI, THE MORAL DIMENSION: TOWARD A NEW ECONOMICS 181 (1988).
72. See INSTITUTE OF MEDICINE, AIDS AND BEHAVIOR: AN INTEGRATED APPROACH 88-98 (Judith D. Auerbach et al. eds., 1994) (summarizing evidence from behavioral research demonstrating that a number of factors impinge on behaviors related to HIV transmission).
74. See Charny, supra note 65, at 2066.
community health and the existence of a comprehensive and systematic approach that public health officials have a basis for believing will work. This conclusion is especially true when one considers the Philipson and Posner alternative—a laissez-faire acceptance of the status quo based on an untestable and normatively constricted free market rationality hypothesis.

III. THE DETERIORATION OF THE PUBLIC HEALTH SYSTEM

To say that public health is central to the constitutional values of freedom and welfare, or that it furthers justice, is not to say that the current public health system is an unqualified success. Theoretical justifications for public health maximization are one thing, actual public health practice in the real world is another. Despite numerous historical achievements, American society has allowed the public health infrastructure to deteriorate seriously. As a result, the current system is limited in terms of its ability to confront immediate crises, such as infectious disease epidemics; enduring problems, such as injuries and chronic illness; and emerging challenges, such as toxic by-products of modern society transmitted through air, water, soil or food.

Recently, the U.S. Department of Health and Human Services (HHS) conceptualized the public health infrastructure in terms of four components: resources, competencies, systems, and relationships. These collectively determine the ability of state and local public health agencies to protect and improve the health of the community. Yet, on all of these scores, the American public health system is performing poorly.

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76. The public health infrastructure is the foundation used to support the planning, delivery and assessment of public health activities and practices. See United States Dep't of Health & Hum. Servs., Healthy People 2010: Public Health Infrastructure Final Draft National Objectives (1998) [hereinafter Healthy People 2010] (on file with the authors). See also Future of Public Health, supra note 25; Gebbie, supra note 9; William L. Roper et al., supra note 9, at 610.
77. See, e.g., Gostin, et al., supra note 64.
78. See Future of Public Health, supra note 25, at 19.
79. See Healthy People 2010, supra note 76.
80. Resources include human capital, physical capital, scientific knowledge and adequate financing. See id. at 2.
81. Competencies include the skills, management and leadership abilities of the public health workforce. See id. at 1-2.
82. Systems include, among other things, management, administrative, laboratory, health information and surveillance networks needed to provide both a structure to health agencies and the information needed to design, manage and assess public health programs. See id. at 1.
83. Relationships refer to cooperative arrangements between local, state and national providers of public health and, more broadly, include arrangements with members of the community, such as managed care and other health organizations. See id. at 2.
84. See id. at 1.
and, for that reason, securing a role for managed care in public health has evident appeal.

Society has failed to allocate adequate resources to public health services. National spending on community-based public health services, geared toward promoting health and preventing disease among the population, amounted to thirty-six dollars per capita in 1995, and the national investment in public health was estimated at one percent of total health care spending. The preponderance of public health expenditures was devoted to personal medical services with only a small fraction going to prevention of the root determinates of illness, disability and death, or to the development of modern health information networks, surveillance systems and laboratories. While federal resources for public health have increased slightly, overall spending is not keeping pace with the challenges posed by the range of immediate and impending crises and ongoing problems in public health.

The structure and composition of the public health system make it poorly prepared to cope with most major public health risks, including those of microbial, environmental and behavioral origin. Federal, state and local government public health activities are disorganized with no clear lines of responsibility and accountability or coordination of services. Public health issues such as substance abuse, personal medical services and environment services are often handled by different public health, social service and environmental agencies. These agencies have faulty lines of communication between them, and are frequently confused about

85. See Elders, supra note 37, at 2293.
86. See Kay W. Eilbert, Mike Barry, Ron Bialek & Marc Garufi, Measuring Expenditures for Essential Public Health Services, in PUBLIC HEALTH FOUNDATION, at 17 (1996). The authors base their figures on a survey of nine states. These results are consistent with other research findings indicating a declining trend in expenditures for public health. During the past two decades, public health funding has declined from 1.2 cents of the national health dollar to 0.9 cents. See Baker et al., supra note 16, at 1277. The national investment in public health was estimated at 11% of GDP in 1988. See Centers for Disease Control and Prevention, Estimated National Spending on Prevention: United States, 1988, 41 MORBIDITY & MORTALITY WKLY. REP. 529, 531 (1992).
87. See Eilbert et al., supra note 86. Expenditures for personal health services comprised 54% of a total of $11.2 billion spent in 1995 for public health-related agencies in Arizona, Illinois, Iowa, Louisiana, New York, Oregon, Rhode Island, Texas and Washington. Nationwide, the Institute of Medicine estimates that public health departments allocate roughly three-fourths of available resources to personal medical services. See FUTURE OF PUBLIC HEALTH, supra note 25, at 181.
88. In 1995, federal government expenditures for health services and supplies, including Medicare, military and veterans programs grew to $314.44 billion, of which only $3.78 billion were for public health activities. See UNITED STATES BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES 1997, 113 tbl.156 (1997).
89. See FUTURE OF PUBLIC HEALTH, supra note 25, at 31-32.
which agency has the responsibility to confront a particular public health threat.\textsuperscript{90}

Public health leadership is weak and unstable while medical specialties, which offer higher compensation and status, are apt to develop and retain the best leaders.\textsuperscript{91} Rapid turnover is a problem as the median tenure of state public health officers is roughly two years.\textsuperscript{92} Further, public health officials are under-valued and misunderstood by politicians and the public. Additionally, as a general matter, public and political interest in public health is low and the ability of public health officials to act as leaders suffers from this disinterest.\textsuperscript{93}

Further, public health systems are deficient. Health departments lack the capacity in terms of laboratories, surveillance, outreach programs and information systems to identify and respond effectively to the great variety of health risks facing populations.\textsuperscript{94} “[T]he few disease surveillance systems that exist are fragmentary and uncoordinated, resulting in late or no detection of disease outbreaks and preventing evaluation of specific problems.”\textsuperscript{95} As a result, health departments have relatively few tools to gather information about health threats in a timely manner, which is essential for effective interventions.

Finally, the relationships between many of the key institutions in society are not adequately developed in order to support the public health infrastructure. Public health, to a large degree, has failed to foster successful intergovernmental and community relationships. Cooperative relationships between public health entities and the private sector are rare. A recent survey shows that less than half of the health departments in a jurisdiction served by a managed care plan have any formal or informal relationships with a health plan.\textsuperscript{96} Intergovernmental relations have been

\textsuperscript{90}See id. at 83.

\textsuperscript{91}See id. at 31-32, 139; Gostin, supra note 19, at 16.

\textsuperscript{92}See id.; FUTURE OF PUBLIC HEALTH, supra note 25, at 119.

\textsuperscript{93}The Institute of Medicine summarizes the view of public health leaders by one state legislator. “They’re eunuchs! They’re consummate bureaucrats.” FUTURE OF PUBLIC HEALTH, supra note 25, at 85.


\textsuperscript{96}See Halverson, et al., supra note 45, at 123. The reasons given for the lack of coordination were: a myopic focus by the health department and/or the plan; no overlap between service areas; differences in populations served; differences in organizational missions and values; and lack of
characterized as “turf guarding.” Community participation in public health is low because of the lack of a sustained dialogue between public health leaders and members of the public, who are essential in creating the political will to fund and promote public health.

As the public health infrastructure buckles under the weight of existing needs, new and emerging health threats may precipitate total collapse. One particularly forbidding challenge is to control the spread of emerging, resurgent and drug resistant infectious diseases. With the eradication of smallpox, the control of polio and the dramatic declines in tuberculosis in North America and Europe during the mid-twentieth century, many scientists concluded that the era of contagium was coming to a close. Yet in 1992, the Institute of Medicine, reporting on emerging diseases, stated that a “small minority, mainly infectious diseases specialists, have for years warned of the potential for serious epidemics and our lack of preparedness for them. In what can only be called a general mood of complacency, these warnings have gone largely unheeded.” Infectious diseases are a leading cause of death worldwide and in the United States. Yet, in addition to complacency, the control of such diseases is hampered by the fragmented and insufficient surveillance systems, inadequate health information networks and antiquated laboratories, we described above. HIV is the most nefarious of the new microbes that have come to be known as emerging pathogens. However, other new infectious diseases have been fodder for news accounts and have created well-publicized regional panics: an interstate outbreak of Escherichia Coli 0157:H7 linked to undercooked hamburger from a national fast food franchise; an outbreak of adult respiratory

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97. See FUTURE OF PUBLIC HEALTH, supra note 25, at 99.
98. See, e.g., HEALTHY PEOPLE 2000, supra note 20, at 22. See also COMMITTEE ON USING PERFORMANCE MONITORING TO IMPROVE COMMUNITY HEALTH, INST. OF MED., IMPROVING HEALTH IN THE COMMUNITY: A ROLE FOR PERFORMANCE MONITORING (1997).
99. See, e.g., COMMITTEE ON EMERGING MICROBIAL THREATS TO HEALTH, INST. OF MED., EMERGING INFECTIONS: MICROBIAL THREATS TO HEALTH IN THE UNITED STATES (1992) [hereinafter EMERGING INFECTIONS].
100. Id. at 32.
102. The World Health Organization and the U.S. Centers for Disease Control have reported a resurgence of ancient and new viruses, drug-resistant bacteria and protozoans, ranging from streptococcus-A, E. Coli bacteria, cryptosporidium and hantavirus to Legionnaire’s disease, Lyme disease, AIDS and multi-drug resistant tuberculosis. See CENTERS FOR DISEASE CONTROL & PREVENTION, ADDRESSING EMERGING INFECTIOUS DISEASE THREATS: A PREVENTION STRATEGY FOR THE UNITED STATES (1994); EMERGING INFECTIONS, supra note 99.
103. See generally CENTERS FOR DISEASE CONTROL & PREVENTION, Multi-State Outbreak of...
distress syndrome in the Southwest caused by undetected hantavirus; the largest waterborne disease outbreak in U.S. history caused by the parasite, cryptosporidium.

Besides these pestilences “that crash down on our heads from a blue sky,” the public health system is struggling to control diseases once thought to have dwindled or disappeared but which have adapted to changes in society and the environment and re-emerged in deadly forms. For instance, multi-drug resistant tuberculosis has increased significantly since the mid-1980s. A 1992 survey in New York City found that thirty-three percent of tuberculosis cases had organisms resistant to at least one antituberculous drug, and nineteen percent had organisms resistant to both of the most effective drugs. Further, we have witnessed a marked rise in penicillin-resistant community-acquired pneumococcal infections, especially among children in day care settings. By the early 1990s, roughly one in every ten strains of pneumococcus was resistant to every known antibiotic except one. Hospital-acquired (nosomial) infection

104. In the Spring of 1993, the health departments of four states in the southwestern United States received reports of several cases of a severe respiratory disease. The disease struck mainly young, healthy adults nearly half of whom were Native Americans. Laboratory evidence subsequently implicated a previously unknown rodent-borne hantavirus thought to be transmitted by exposure to rodent excreta (particularly that of deer mice) in aerosol form. The disease was termed hantavirus pulmonary syndrome (HPS). By the end of the year, 32 of the 53 persons reported to be diagnosed with HPS had died. See George A. Gellert, Preparing for Emerging Infections, 370 Nature 409, 409 (1994); Centers for Disease Control & Prevention, Hantavirus Pulmonary Syndrome, United States 1993, 43 Morbidity & Mortality Wkly. Rep. 45, 45-47 (1994).

105. Cryptosporidium was emerging as a health threat while the monitoring and detection capacity of the public health systems was diminishing. See James M. Hughes, Emerging Pathogens: An Epidemiologist’s Perspective on the Problem and Priorities for the Future, 164 W.J. Med. 21 (1996). For a comprehensive analysis of the threats posed by microbial agents and the factors contributing to disease emergence and reemergence see EMERGING INFECTIONS, supra note 99.


109. See Hughes, supra note 105.

110. Vancomycin is the only antibiotic that can combat all strains of pneumococcus. It is clear
also remains a persistent public health problem and is a deadly reminder that the war against infectious diseases has not been won.\footnote{The Centers for Disease Control estimates that five percent of hospital patients acquire a nosocomial infection, resulting directly or indirectly in 80,000 to 100,000 deaths a year, about 32% of which are preventable. \textit{See} Centers for Disease Control, \textit{National Nosocomial Infections Study} (1984), \textit{in Healthy People 2000}, \textit{supra} note 20, at 166.}

Public health is clearly in trouble:

[H]ealth departments are closing; technology and information systems are outmoded; trends in emerging and drug resistant diseases overwhelm resources; and there is chronic under investment in training and development, leading to a public health workforce that lacks the capacity to address emerging threats and adapt to changes in the health care market.\footnote{\textit{Id.} at 2.}

To address these problems, the American public health system requires more adequate and secure financing, inspired leadership and a new vision.\footnote{Some public health leaders have called for the “reinvention” or “revitalization” of the public health systems. \textit{See}, e.g., Philip R. Lee, \textit{From the Assistant Secretary for Health, US Public Health Service}, 272 JAMA 1315, 1315 (1994).}

\section*{IV. PUBLIC HEALTH AND GOVERNMENT}

The foregoing discussion suggests the existence of significant problems in the public health system. This Part of the Article concentrates on the role of government in the American public health system and concludes that government has ultimate responsibility for promoting and protecting community health. The origins of government responsibility can be explained in terms of constitutional design, theories of democracy and public health history and practice. From a constitutional perspective, federal powers in public health rest largely on the commerce power and the taxing and spending power. At the state level, government responsibility is based on the police power. Theories of democracy and political communities explain government responsibility in terms of the communal provision of security and welfare. Throughout the history of the United States, it has been government in all of its various forms that has taken principal responsibility for public health.

To make these claims, however, is not to deny that democratic societies should make room for private provision. The proper role of
government in exercising its responsibility for public health, whether as a facilitator, convener, a funder or a force for identifying and intervening to reduce public health threats, is a theoretical and pragmatic question that we examine in detail in Parts V through VII.

A. THE ROLE OF GOVERNMENT IN THE CONSTITUTIONAL DESIGN

The Preamble to the Constitution reveals the influence of republican ideals of government as the wellspring of communal life and mutual security:

We the People of the United States, in Order to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity, do ordain and establish this Constitution for the United States of America. 114

The common defense and the general welfare could not have been conceived solely in terms of physical security, for perhaps the principal threat to civil society during the framing era was epidemic disease and other forms of ill-health. 115 It seems likely that the preservation of public health was one meaning of “the common good” that all the framers shared. 116

The constitutional design reveals a plain intent to vest power in government at every level to protect community health and safety. By its very first sentence, the Constitution provides sole legislative or policy making authority in the Congress, 117 and the first enumerated legislative power is expressly to provide for the “common Defense and general Welfare of the United States.” 118 From a federalist perspective, the federal

114. U.S. CONSTITUTION, preamble.
115. See infra text accompanying notes 144-51.
116. See Wendy E. Parmet, Health Care and the Constitution: Public Health and the Role of the State in the Framing Era, 20 HASTINGS CONST. L.Q. 267, 312 (1993). Professor Parmet concludes after an examination of public and private roles during the framing era: “Despite the disagreement and uncertainty over the actual meaning of ‘the common good,’ it seems likely that the preservation of public health . . . was one meaning that all would share. Tradition and practice pointed to it. Theorists such as Montesquieu supported it. So did popular political discourse.” Id.
117. See U.S. CONSTITUTION, art. I, § 1 (“All legislative Powers herein granted shall be vested in a Congress of the United States”).
government possesses broad enumerated powers that enable it to enter the field of health protection and promotion. Through the constitutional power to regulate interstate commerce, for example, it can directly control risk behavior in many realms. Through its power to tax, government can provide funding for public health services and incentives for safer behavior. Through its power to spend, it can set a broad range of health and safety requirements as a condition for the receipt of federal funds.

legislation regulating the advertising of tobacco products and warning labels was intended “to avoid 'diverse, nonuniform, and confusing cigarette labeling and advertising regulations with respect to any relationship between smoking and health.'”

119. See U.S. CONST. art I, § 8, cl. 3 (The Congress shall have the power “To regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes”). Prior to the New Deal, the federal government assumed a limited role in public health. See infra note 171. During the New Deal, President Franklin Delano Roosevelt sought to expand the Commerce Clause to provide Congress the broad power to legislate for the general welfare in areas traditionally under state and local control. Initially hostile to broad congressional legislation, the Court reinterpreted the Commerce Clause effectively to give the federal government national police powers. See, e.g., NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1 (1937) (upholding the National Labor Relations Act); Stewart Mach. Co. v. Davis, 301 U.S. 548 (1937) (upholding employers’ tax to fund unemployment compensation under the Social Security Act of 1935); Helvering v. Davis, 301 U.S. 619 (1937) (upholding tax to fund old-age benefits under social security).

The expansive interpretation of the commerce clause has enabled national authorities to reach deep into realms of state public health power and has significantly diminished the force of the Tenth Amendment. The courts have upheld exercises of the Commerce Clause in the fields of environmental protection, see New York v. United States, 505 U.S. 144 (1992); food and drug safety, see United States v. Sullivan, 332 U.S. 689 (1948) (upholding Congress’s commerce clause power to regulate the labeling of medicine that has completed an interstate shipment and is being held for future sales in purely local or intrastate commerce); and other public health matters, see Hillsborough County, Florida v. Automated Med. Labs., 471 U.S. 707 (1985) (upholding federal regulation of collection of blood plasma from paid donors).

The Supreme Court’s decision in United States v. Lopez, 514 U.S. 549 (1995), possibly signals a shift in the Court’s view about the appropriate balance of federal and state powers under American federalism. In Lopez, the Court held that Congress exceeded its commerce authority by making gun possession within a school zone a federal offense. See Lopez, 514 U.S. at 558-59. Concluding that possessing a gun within a school zone did not “substantially affect” interstate commerce, the Court declared the statute unconstitutional. The question Lopez leaves open is the constitutionality of social and public health regulation of purely intrastate activity.

120. The taxing power, while affording government the financial resources to provide public health services, has another equally important purpose. The power to tax is also the power to regulate risk behavior and influence health-promoting behavior. Virtually all taxes achieve ancillary regulatory effects by imposing an economic burden on the taxed activity or providing economic relief for certain kinds of private spending. The taxing power is a primary means for achieving public health objectives. As Fox and Schaffer observe, “tax law and health policy come together” to affect fundamentally the health of the community. Daniel M. Fox & Daniel C. Schaffer, Tax Policy as Social Policy: Cafeteria Plans, 1978-1985, 12 J. HEALTH POL’Y & L. 609, 610 (1987). See also generally Daniel M. Fox & Daniel C. Schaffer, Tax Administration as Health Policy: Hospital, the Internal Revenue Service, and the Courts, 16 J. HEALTH POL’Y & L. 251 (1991) (describing how IRS policies toward nonprofit hospitals affected the health care of the indigent).

Congress has often taken a “categorical” approach to public health, voting funds for particular groups or specific diseases such as maternal and child health services, venereal disease control,
Despite the congressional exercise of the commerce and spending powers, the duty to defend health and safety lies primarily with the states. Under the Constitution, the states are the repositories of powers not specifically delegated to the federal government. Chief Justice Marshall was apparently the first to employ the rubric “police power” to describe the residual powers of the states. The police powers provide state government with near plenary authority to act for the health, safety and welfare of society. According to well established constitutional principles, state police powers embrace, at least, reasonable regulations designed to protect the public health, and the Supreme Court has “distinctly recognized the authority of a State to enact . . . health laws of every description.” Further, in deference to state legislative
decisionmaking, the courts have rarely struck down state public health regulations on the grounds of federalism.\textsuperscript{126}

The police powers have enabled states, and their subsidiary municipal corporations, to promote broadly and to preserve the public health in areas ranging from injury and disease prevention to sanitation, waste disposal and water and air pollution control. Police powers exercised by the states include vaccination,\textsuperscript{127} isolation and quarantine,\textsuperscript{128} inspection of commercial and residential premises,\textsuperscript{129} abatement of unsanitary conditions or other health nuisances,\textsuperscript{130} regulation of air and water contamination as well as restriction on the public’s access to polluted areas,\textsuperscript{131} extermination of vermin,\textsuperscript{132} fluoridation of municipal water supplies,\textsuperscript{133} and licensure of certain occupations.\textsuperscript{134}

From a Constitutional perspective, only the government—whether federal, state or local—can collect taxes and expend public resources and only the government can require members of the community to submit to inspection and regulation. The Constitution provides no residual power in the private sector to protect and assure health other than by purely voluntary means. To the extent that the private sector utilizes public funds


\textsuperscript{127} See Jacobson, 197 U.S. at 34.


\textsuperscript{134} See \textit{Amsel v. Brooks}, 106 A.2d 152 (1954) (statute regulating the practice of dentistry is designed to serve the public health and is not an unreasonable or arbitrary exercise of police power).
or demands compliance with health and safety standards, it does so principally through delegated governmental authority.

B. THE RESPONSIBILITIES OF GOVERNMENT IN DEMOCRACIES

The role of the private sector, then, simply is not found in the constitutional design. Theories of democracy and community help to explain the primacy of government in matters of public health. Why is it that a political or governmental entity possesses principal, if not sole responsibility to protect and promote public health? The essential functions theory provides a starting point for this analysis. Certain goods or goals are viewed as so “essential” that the public sector must provide them. Those frequently mentioned include public health and safety, environmental protection and national defense. These inherently governmental responsibilities are perceived as nondelegable or nearly so.135 We never question whether it is the appropriate role of government to provide “essential” services;136 it is an expectation and part of the “social contract.”137

Walzer makes a basic observation about the nature and purposes of political communities. “Membership is important because of what the members of a political community owe to one another . . . [a]nd the first thing that they owe is the communal provision of security and welfare.”138 Public health, according to Walzer, is the “easy” case of a general communal provision because public funds are expended so as to benefit all

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135. See Martin E. Gold, The Privatization of Prisons, 28 Urb. Law. 359, 366-70 (noting that fire prevention, police protection and corrections were contracted out at the rate of only 1% in 1989 because “they are strongly perceived to be core responsibilities of government”).

136. McQuillin provides an excellent description of the origin of the “essential function” theory by examining the police system. As colonists formed cities, they soon became aware of the need for self-protection. At first, citizens took turns serving as the night watch. Later, local governments assigned the duty to specified citizens on a rotating basis and fined those who did not serve. Eventually, those individuals of means paid other citizens to serve as their substitutes; but because of these shortcomings, municipalities hired permanent police forces and citizens began to perceive police protection as an essential good to be provided by the state. Thus, society needed government to provide this good, government complied and the public subsequently developed the expectation that it alone would do so. 1 EUGENE McQUILLIN, MUNICIPAL CORPORATIONS §1.15 (3d ed. 1964).

137. As generally understood, social contract theory posits that individuals give obedience or consent to society with the understanding that society will provide protection when needed. See Parmet, supra note 116, at 316. Social contract theory is usually associated with the writings of Thomas Hobbes, John Locke and Jean Jacques Rousseau. The common thread is that there is an exchange among the contracting parties; if the government does not provide the benefit, the individual is no longer obligated to participate in communal life. See Lloyd L. Weinreb, Natural Law and Justice 84 (1987).

138. Walzer, supra note 63, at 64.
or most of the population without any specific distribution to individuals.\textsuperscript{139} Contrasting public health with medicine, the former is most often a general provision, while the latter is most often particular.\textsuperscript{140}

Moreover, the population, or electorate, legitimizes systematic community activity for the public health. Public health activities in a democracy cannot be funded, organized or implemented without the assent of the people.\textsuperscript{141} It is the government that possesses the sole authority to empower, regulate or implement activities designed to protect or promote the general health, safety and welfare of the population. It is the public that bands together to achieve social goods that could not otherwise be achieved absent collective action, and it is the public, or electorate, that provides the legitimacy or authority for government to act for the common welfare.\textsuperscript{142}

C. \textbf{HISTORICAL AND EMPIRICAL EVIDENCE}

Legal scholar James Tobey, writing over seventy years ago, observed that \"[t]he protection and promotion of public health has long been recognized as the responsibility of the sovereign power. Government is, in fact, organized for the express purpose, among others, of conserving the public health and cannot divest itself of this important duty.\"\textsuperscript{143} Although the history of American public health is a vast topic that can only be briefly surveyed here, our examination shows that American local, state and federal governments have indeed assumed the primary responsibility for ensuring the health of the nation.

\textsuperscript{139} See id. at 65-66.

\textsuperscript{140} Public health, by its nature, stresses a shared bond among members of the political community. Any individual of means can contract or procure personal medical services. Yet, no single individual, or group of individuals, can assure his or her health. Meaningful protection and assurance of human health requires communal effort. The community as a whole has a stake in the protection of the environment, hygiene and sanitation, clean air and surface water, uncontaminated food and drinking water, safe roads and products, and control of infectious disease. Each of these collective goods, and many more, are essential for human health. Yet, these goods can be secured only through organized action on behalf of the population.

\textsuperscript{141} The Constitution gives the people control over the laws that govern them by requiring that statutes be affirmed personally by legislators and a president whom the people have elected.

\textsuperscript{142} Walzer argues that every set of political officials is at least putatively committed to securing health for the population; and every set of members of a political community is committed to bear the necessary burdens (and actually does bear them). \"The first commitment has to do with the duties of office; the second with the dues of membership.\" WALZER, supra note 63, at 68.

Colonial health regulation, which reaches as far back as the seventeenth century, included conditions of travel at sea, isolation and quarantine, inoculation with smallpox pus, sanitary controls on dead fish, animals and garbage, and quality controls on bread, meat and drinking water. The remnants of medieval feudalism along with the paternalism of sixteenth and seventeenth century mercantilism created a strong sense of community responsibility among the European settlers in North America. In support of the general welfare, public health activities were considered one of the primary responsibilities of the state.

Public bodies acted in cases of necessity and were prepared to subordinate the freedoms of individuals for the sake of the common welfare. Beginning in 1647 the Massachusetts Bay Colony regulated pollution of the Boston Harbor, and five years later Boston passed a series of ordinances dealing with the construction of privies, prohibitions on dumping rubbish onto roads, lots or streams and regulations ordering businesses such as butchers to keep their establishments clean. Further, in 1701, the Massachusetts Bay Colony passed laws for the isolation of smallpox patients and quarantine of ships, and by the end of the eighteenth century, major cities had established permanent councils to enforce isolation and quarantine laws.

144. See John Duffy, The Sanitarians: A History of American Public Health 35-50 (1990) (During the yellow fever epidemic of the 1790s, individuals with infectious diseases were subject to quarantine laws and detained in pesthouses in almost every major city; boards of health and “health officers” were created to implement the laws, even against the resistance of major businessmen.).


147. See id.

148. See Duffy, supra note 144, at 12.

149. Cities establishing permanent councils included Boston, Philadelphia, New York and Baltimore. See id. at 12-13. Elsewhere, the responses were ad hoc: Cities failed to establish continuing organizations or committees to assure compliance with regulations or to identify readily public health hazards. Lacking a standing bureaucracy, citizen volunteers performed the work whenever a city established a committee to address a public health threat. See Hanlon & Pickett, supra note 24, at 30. This pattern of emergency citizens committees organized to carry out public health measures emerged as a response to the unreadiness of civil authorities to address these crises. Eventually, however, volunteer activism paved the way for a shift to government responsibility for responding to civic crises. See Schwartz, supra note 145, at 119. As the number of inhabitants in the colonies increased, municipal authorities became more active in the health and welfare of the citizenry; private wells gave way to public wells and elementary public aqueducts and water systems began to appear. See id.
Following the American Revolution, public health authorities passed legislation establishing permanent local boards of health. The watershed event was a yellow fever epidemic that caused the abandonment of the national capital in Philadelphia. With the formation of local health boards, state public health laws proliferated in the late eighteenth and early nineteenth centuries; the police power to protect the public health was delegated, early on, to local boards at the municipal level. At the federal level, public health regulations were nonexistent, instead, the first federal response to health, at all, consisted of a meeting of the First Congress in 1788 to consider the establishment of hospitals for sick and disabled seamen.

The nineteenth century marked a critical turning point for state-funded public health initiatives. The sanitation movement emerged during the early nineteenth century in response to epidemic diseases (e.g., cholera, smallpox, yellow fever, and tuberculosis). Local sanitary surveys, such as the Shattuck Report in Massachusetts, assessed the health effects of

150. Boston is commonly credited with organizing the first permanent board of health in 1799, with Paul Revere as its chairman. Philadelphia, New York, Baltimore and Petersburg, Virginia, also established local boards during roughly the same period. These boards commonly performed functions such as sewer construction, drainage of marshes, interment of the dead and seawall construction. See Duffy, supra note 144, at 39-41.

151. See Hanlon & Pickett, supra note 24, at 30. With the municipal government in disarray, voluntary agencies assumed responsibility for containing the epidemic. In New York City, an emergency citizens committee composed of physicians and business leaders was formed in 1793 based on the fear that the city was not adequately addressing the epidemic. Acting as an extralegal form of government, the committee supervised quarantine and isolation and internal sanitation procedures. See Duffy, supra note 144, at 39. The yellow fever epidemic further served to restructure the manner in which American municipal governments dealt with pestilence. For instance, New York City appropriated $11,600 for contagion control during the 1798 epidemic. When the disease returned the following year, the City Council took the additional step of ordering the evacuation of numerous blocks in the dock area. The return of the disease prompted a reorganization of the Health Office. Duties were divided between the Health Officer of the Port, responsible for quarantines, the Resident Physician, responsible for reporting the presence of contagious diseases, and the Health Commissioner, responsible for overall administration of the Health Office. See Schwartz, supra note 145, at 22. During the 1805 epidemic, New York City’s response was more coordinated and rapid as, in addition to repeating the earlier evacuation measures, the city established temporary hospitals and employed visiting physicians to care for the sick in their homes. See Duffy, supra note 144, at 44-45.

152. See, e.g., Wendy E. Parmet, AIDS and Quarantine, The Revival of an Archaic Doctrine, 14 Hofstra L. Rev. 53 (1985)

153. See Tobey, supra note 143, at 133.

154. The Fifth Congress eventually passed legislation providing for “the temporary relief and maintenance of sick or disabled seamen in the hospitals or other proper institutions now established in the several ports of the United States, or in ports where no such institutions exist, then in such manner as he [the Secretary of the Treasury] shall direct.” An Act for the Relief of Sick and Disabled Seamen, ch. 77, 1 Stat. 605-06 (1798).


156. The foundation for the sanitary movement in the United States was laid in 1850 with the
decaying waste, foul air and an immoral lifestyle. This was a period in which local government began to expand sanitary regulation to improve sewage, drinking water and garbage disposal. The sanitation movement also influenced public opinion about public health: “Sanitation changed the way society thought about health. Illness came to be seen as an indicator of poor social and environmental conditions, as well as poor moral and spiritual conditions . . . . Sanitation also changed the way society thought about public responsibility for citizen’s health. Protecting health became a social responsibility.”

The Civil War and its aftermath led to another critical turning point in state sponsored public health activities. As with all wars, the greatest killer of soldiers was disease rather than combat wounds. Public consciousness of the importance of sanitation and contagious disease control lead to the creation of special agencies as a method of handling public health concerns. Accordingly, in the post-war period, Massachusetts established a state board of health in 1869, followed by California (1870), the District of Columbia (1871), Virginia and Minnesota (1872), Maryland (1874) and Alabama (1875). These boards did not
have an immediate impact. Indeed, by 1900, only three states spent more than two cents per capita for public health services. Aggressive public health policies remained confined to local city politics with each city making its own rules.

The Progressive era, during the late nineteenth and early twentieth centuries is often regarded as the high water mark of local government regulation, principally in the form of sanitary controls introduced by city and state boards of health. This was a complex period when public health activities were influenced by many factors. There were remarkable successes in bacteriology inspired by the pioneering work of Koch and Pasteur and the subsequent discoveries of Dubos, Fleming and Waksman. W.T. Sedgwick, a familiar name in sanitary and bacteriologic research in Massachusetts, remarked, “‘before 1880 we knew nothing; after 1890 we knew it all; it was a glorious ten years.’” Bacteriology became an ideological marker, sharply differentiating the “old” public health, mainly the province of untrained amateurs, from the “new” public health, which belonged to scientifically trained professionals. The flush of Service constituted a system of public hospitals for the care of merchant seamen. Since these workers had no local citizenship, the federal government provided for their health care. See FUTURE OF PUBLIC HEALTH, supra note 25, at 62. As part of the reorganization, Congress authorized the U.S. Public Health Service to investigate the causes and spread of disease, study sewage, sanitation and water pollution, publish health information and inspect all immigrants arriving at Ellis Island. For a detailed account of the U.S. Public Health Service, see RALPH C. WILLIAMS, THE UNITED STATES PUBLIC HEALTH SERVICE, 1798-1950 (1951).

160. See Fee, supra note 120, at 232.
161. See id.
162. Fee argues that local interests still shaped public health, because localism was generally characteristic of civic affairs at the time and was supported by constitutional constraints on federal power. States’ actions likewise tended to support local property interests. See id. at 231. Among municipalities, New York City assumed a leadership role in 1866, by creating an organized administrative apparatus. In passing the New York Metropolitan Health Bill of 1866, the city restructured the New York City public health infrastructure from a haphazard system to an efficient administrative structure that investigated outbreaks of communicable diseases, inspected tenements, provided vaccinations against smallpox and distributed leaflets on infant care and precautions against diphtheria. The New York City statute was the most complete piece of health legislation at that time and led to the creation of new municipal and state health departments. See ROSEN, supra note 155, at 223-24.
164. Fee, supra note 120, at 237 (citation omitted).
165. Elizabeth Fee & Dorothy Porter, Public Health, Preventive Medicine, and Professionalism: Britain and the United States in the Nineteenth Century, in A HISTORY OF EDUCATION IN PUBLIC HEALTH: HEALTH THAT MOCKS THE DOCTORS’ RULES 15, 33 (Elizabeth Fee & Roy M. Acheson eds., 1991). The age of bacteriology saw the discovery of the bacteriologic agents of many major contagious diseases such as anthrax, tuberculosis, diphtheria, typhoid and yellow fever. See ROSEN, supra note
enthusiasm regarding scientific discovery during this period justifies the analogy that just as the sanitary movement generated local health departments, the bacteriology movement generated the impetus for the health department laboratory.  

As public health began to embrace medicine and science, the identification and treatment of infectious persons took on a new importance. Legislatures enacted disease reporting requirements, while public health agencies traced sexual contacts and established clinics for the treatment of diseases. It was clear, however, that identifying and treating the infectious person him- or herself were insufficient. Sanitary and hygienic conditions aggravated by industrialization and immigration were seen as powerful cases of ill-health. The health risks associated with urban growth were thought to demand a collective, governmental response in the form of expanded sewer systems, creative drain designs and improved garbage collection, as well as other hygienic measures. “Public health once again became a task of promoting a healthy society.”

Unquestionably, the Great Depression provided the stimulus for an active federal role in public health. The New Deal and the Social

155, at 309. New York City again led other municipalities in public health activities by systematically applying the new science of bacteriology: it established a division of bacteriology and disinfection in the City Health Department. Other state and local health departments rapidly followed New York’s lead. See id. at 310.

166. See FUTURE OF PUBLIC HEALTH, supra note 25, at 65.

167. See, e.g., SCHWARTZ, supra note 145, at 152-53. The New York City Department of Health called for voluntary notification of tuberculosis cases in 1893, but physicians were uncooperative. Reporting was made mandatory the following year. See id. See also FUTURE OF PUBLIC HEALTH, supra note 25, at 66.


170. FUTURE OF PUBLIC HEALTH, supra note 25, at 66.

171. A strong government role in ensuring social welfare was not an important social value during the late nineteenth century and early twentieth century and the modest federal efforts in public health activities are reflective. All the same, Congress did pass important legislation such as the Food and Drug Act of 1906, which established controls on the manufacture, labeling and sale of food and drugs. Congress also established the U.S. Public Health Service under the leadership of the surgeon general, which, among other things, established demonstration projects in rural health and programs for the control and prevention of venereal diseases. The Sheppard-Towner Act of 1921 provided funds for prenatal and child health clinics. This act was the first to establish direct federal funding of personal health services. See generally Fee, supra note 120, at 246.
Security Act of 1935 increased financing for the Public Health Service and provided federal grants allowing the states to establish and maintain public health services.\textsuperscript{172} The federal largesse stimulated several public health trends including: the development of community programs to control specific diseases and services targeted at specific populations; the expansion in the number of local health departments; an increase in the number of trained public health personnel; and the provision of medical care by health departments.\textsuperscript{173} In addition, a national health agency, the Department of Health, Education and Welfare (the precursor to the Department of Health and Human Services) was created in 1953.\textsuperscript{174}

The Great Society in Lyndon Johnson’s administration, to a somewhat lesser extent, represented another critical departure point in the development of an active federal role in public health. Federal support for the “war on poverty” provided funds for public health services by offering financial and technical assistance to local health departments in the areas of maternal and child health, family planning, immunization, venereal disease control and tuberculosis control.\textsuperscript{175} Other federal programs, however, bypassed public health departments in favor of new agencies to “mediate” between the federal government and local communities.\textsuperscript{176} For instance, the Comprehensive Health Planning Act of 1967 allowed federal funding of neighborhood or community health centers, which although governed by local boards, relied on the federal government for policy and program direction.\textsuperscript{177} At the same time, the states expanded their capacity to engage in classic public health activities including the collection of vital statistics, communicable disease reporting, venereal disease investigation, milk pasteurization and school hygiene standards.\textsuperscript{178}

\begin{itemize}
\item \textsuperscript{172} In 1934, local health departments or other forms of public health were established in only 541 out of the 3,071 counties in the United States. But, by 1942, 1,828 counties had health units headed by a full-time public health officer. \textit{See id. at 246-47.}
\item \textsuperscript{173} \textit{See id. at 247.}
\item \textsuperscript{174} In 1912, the Marine Hospital Service was renamed the United States Public Health Service. The U.S. Public Health Service operated under the Treasury Department until 1938. In 1939, a Federal Security Agency was created to encompass most of the federal government’s health, education and welfare services. On April 11, 1953, this agency assumed cabinet status and was renamed the Department of Health, Education and Welfare. \textit{See ROSEN, supra note 155, at 443-44.} Today, the U.S. Public Health Services includes the Centers for Disease Control; the National Institutes of Health; the Food and Drug Administration; the Health Resources and Services Administration; the Alcohol, Drug Abuse, and Mental Health Administration; and the Agency for Toxic Substances and Disease Registry. \textit{See FUTURE OF PUBLIC HEALTH, supra note 25, at 165.}
\item \textsuperscript{175} \textit{See FUTURE OF PUBLIC HEALTH, supra note 25, at 165.}
\item \textsuperscript{176} Neighborhood health centers and community-based mental health services are examples of programs established independently of local health departments. \textit{See Fee, supra note 120, at 258.}
\item \textsuperscript{177} \textit{See FUTURE OF PUBLIC HEALTH, supra note 25, at 68.}
\item \textsuperscript{178} \textit{See id.}
\end{itemize}
Public health activities, both federal and state, are pervasive in the late twentieth century. As the Institute of Medicine has recently summarized, the federal government surveys the population’s health status and health needs, sets policies and standards, passes laws and regulations, supports biomedical and health services research, helps finance and sometimes delivers personal health services, provides technical assistance and resources to state and local health systems, provides protection against international global health threats, and supports international efforts toward global health.\textsuperscript{179}

Federal regulation now reaches broad aspects of public health, such as air and water quality, food and drug safety, tobacco advertising, pesticide production and sales, consumer product protection and occupational health and safety.\textsuperscript{180} Moreover, states exercise jurisdiction in virtually all areas of public health ranging from surveillance, disease reporting and control of injury and disease, to sanitation and hygienic conditions in schools, childcare and restaurants.\textsuperscript{181}

These brief historical observations demonstrate the ubiquity of health regulation and underscore the historic governmental authority in public health. We have seen that the earliest expressions of concern for public health came not from the federal government, or even the states, but from the rapidly growing eastern cities whose very existence depended on collective efforts to protect the population from the spread of infectious diseases. Next, the dawn of bacteriology represented a critical juncture in government responsibility and signaled the beginning of an expansive role by the states in public health and the creation of state and local boards of health. Later, the progressive political atmospheres characterizing the New Deal and Great Society agendas provided a major stimulus for an active and continuing federal commitment to public health.

Clearly, public health has been the almost exclusive domain of government. But, the deterioration of the public health infrastructure, combined with the growth in managed care and its population-based orientation, suggests that the purely governmental model of public health may be anachronistic. Private industries are providing what typically have been considered government services in virtually every capacity.\textsuperscript{182} State

\textsuperscript{179} Id. at 165.
\textsuperscript{181} See id.
\textsuperscript{182} Examples include airports, zoning control, prisons and adoption services, among others. See SAVAS supra note 17, at 70-74 (cataloging 157 city and county services contracted out to the private
and local public health departments are actively seeking ways to maximize available funding and resources, including delegating public health functions to managed care organizations.\textsuperscript{183} Evidence suggests that most of the delegations are accomplished through formalized contract.\textsuperscript{184} Is the regulation and promotion of public health yet another area where privatization should prevail?

V. PRIVATIZATION OF PUBLIC HEALTH

As we have demonstrated, constitutional theory, theories of community and democracy, and public health history and practice all point to government as the entity responsible for the protection and assurance of health. Government alone possesses, at least, two powers necessary for public health. First, government is exclusively authorized to tax citizens and to expend public resources for the communal good.\textsuperscript{185} Government powers to tax and spend are essential to public health not only because they are methods of raising revenue and choosing priorities, but they also permit government to structure incentives for private behavior affecting health.\textsuperscript{186} Second, government retains exclusive power to compel individuals and organizations to submit to inspection, monitoring, and regulation for the public’s health and safety. Federal, state and local governments, for example, can approve pharmaceuticals, set standards for safe conditions of work and abate nuisances in restaurants, bathhouses and adult cinemas.\textsuperscript{187}

Standing by itself, government responsibility for public health is certainly a necessary condition for public health maximization. But it is not a sufficient one. Indeed, acting alone, there is much that government cannot do to promote and protect the health of the population. Government is not nearly as closely associated with people and their health as managed care organizations, which have numerous and on-going clinical encounters with the majority of Americans. From this perspective, managed care is clearly better positioned to observe personal choices, obtain information on rates of illness and injury from specific causes and

\textsuperscript{183} See Halverson et al., \textit{supra} note 45.
\textsuperscript{184} See \textit{id}. at 125 (“Our survey of 63 local health departments uncovered evidence of this phenomenon, as we found that more than three-quarters of existing relations with managed care plans are formalized by contract.”).
\textsuperscript{185} See \textit{supra} text accompanying note 120.
\textsuperscript{186} See Fox & Schaffer, \textit{supra} note 120.
\textsuperscript{187} See \textit{supra} text accompanying note 121.
identify health risks in the community. Further, managed care organizations, as a general matter, possess greater expertise in providing cost-effective personal medical services and clinical preventive services than government and are likely to be more flexible in their approaches to public health problems. Yet, despite these advantages, managed care has few incentives to provide community-wide public health services.

Obviously, societal aspirations for health should be advanced, if we can devise creative ways to encourage managed care to enter the field of public health and undertake those activities that it does best. In this part of the Article, we consider privatization and suggest that significant gains can be obtained by contracting out to managed care those public health functions that can be performed more efficiently than government. A consequential value, then, of privatizing public health is to increase the “dollar efficiency” of what government does. We further claim that there are no insurmountable legal or constitutional obstacles to privatization and particularize this claim by demonstrating that constitutional rules provide relatively few constraints on the government’s ability to encourage, fund, oversee and regulate private public health activities. Based on the few constraints that do exist, however, we intentionally draw the line between permissible and impermissible privatization approaches in public health. Finally, we anticipate and address reasonable arguments about the potential negative effects of privatizing public health from communitarian and progressive theories of government.

A. DEFINING PRIVATIZATION

What we mean by privatizing public health is contracting out to managed care organizations those public health activities that government currently undertakes, but which managed care has a comparative advantage in providing. Our understanding of privatizing public health

188. Privatization generally refers to the removal of an institution or program from the local, state or federal government and turning it over to a private corporation. See generally SAVAS, supra note 17. The term privatization has been employed to describe a wide array of activities, but is most frequently used to describe: the sale of a government-owned enterprise to the private sector (divestiture); the diversion of control from the government to the private sector by contract, whereby the government buys the good or service from the private sector; or, the lease of a government asset to another party. See, e.g., Ronald A. Cass, Privatization: Politics, Law and Theory, 71 MARQ. L. REV. 449, 456-59 (1988). The literature, both academic and policy, is pervasive and the various privatization proposals are based on different assumptions about the nature of the problem that privatization can solve. For instance, those advocates who favor privatization out of a belief in autonomy and free markets want private enterprise to do more and seek to limit the size and role of government. See id. at 451. Other privatization advocates, less concerned with the size of government, focus on the “dollar efficiency” of what government does. Lawrence thoughtfully summarizes the most
encompasses the following activities: (1) providing personal medical services; (2) offering clinical prevention services, such as immunizations and health screenings; (3) conducting surveillance and epidemiological investigations; and (4) facilitating disease prevention, health promotion and education. The direct, and exclusive, provision of these services by government, in our view, represents a misallocation of resources. Other public health functions, however, such as policy development, regulation, licensing and compulsory testing, among others, require a government presence and typically preclude private sector involvement. Moreover, such functions often require resources and expertise that managed care cannot easily provide or acquire.

Harnessing managed care’s cost-effective provision of these services should result in efficiency gains and system savings should result that can be used to meet unsatisfied community health needs. Our approach begins with an inquiry into what government currently does in each area, and from that foundation we explain how managed care will likely perform the activity more cost-effectively.

1. Personal Health Services

Public health subsumes personal medical services as one of many conditions necessary for community health, and local health departments are increasingly providing medical services to the indigent and uninsured as more of these individuals become dependent on the public health system to meet their health care needs. Nearly all state and local health agencies provide some type of personal health service, whether inpatient care or ambulatory services, such as school health, maternal and child health, obstetrical care, home health services to elderly house-bound individuals, tuberculosis control, chronic disease control and sexually transmitted disease (STD) and family planning clinics. Providing such “safety net” functions to indigent or pregnant women is viewed by many as

common normative bases for privatization: pluralism, interest representation, flexibility of private agencies, easing the transition to full government responsibility after the identification of a market failure, expertise and cost. See David M. Lawrence, Private Exercise of Governmental Power, 61 Ind. L.J. 647, 651-57 (1986).


190. See, e.g., HEALTHY COMMUNITIES, supra note 11, at 18-19; FUTURE OF PUBLIC HEALTH, supra note 25, at 95-98.
a responsibility of government in a society that does not afford universal access to health care. 191

Directly providing personal health care services drains scarce resources, 192 however, and seriously jeopardizes the public health system’s ability to serve as stewards of the basic health needs of entire populations and to avert impending disasters. 193 As a result, with few resources and seemingly limitless unmet needs, public health officials have little opportunity to engage in thoughtful community needs assessment and often develop policy as a hurried response to public outcry about the latest public health crisis. 194 On this account, then, are there any justifications for public health’s direct provision of personal health services? After all, public health’s quintessential role is developing population-based strategies to identify health risks and to improve behavioral, environmental, social and economic conditions that affect the health of wider populations. 195

The standard response is that providing medical services to persons with contagious diseases, sexually transmitted infections and HIV/AIDS is a means of preventing or ameliorating epidemics. But, assuming that these observations are true, we maintain that these objectives can be accomplished more efficiently by contracting with the private health care system. This is emphatically not to say that public health departments should provide no personal medical services. Instead, we suggest that while community health departments could choose to continue to fulfill their roles as provider of last resort for the uninsured and the indigent, or operate clinics in underserved areas, downsizing the direct delivery of medical services is essential to improving the health of the nation.

In theory, managed care organizations are structured to provide cost-conscious medical services and begin with the assumption that only cost-effective care should be given, even though the typical American desires

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191. See, e.g., FUTURE OF PUBLIC HEALTH, supra note 25, at 97.
192. See HEALTHY COMMUNITIES, supra note 11, at 46. The Institute of Medicine reports that 69% of the expenditures of local and state health departments are used to provide personal health care services. Those personal health services are often funded by state and federal sources, such as Medicaid, and the revenue stream is used to pay for administrative and other functions, including care for the uninsured. See id.
193. See FUTURE OF PUBLIC HEALTH, supra note 25, at 2.
194. See Gebbie, supra note 9, at 370.
195. There is no neat dividing line between medicine and public health, but the methodologies, practices, and services are distinct. See, e.g., ELIZABETH FEE, DISEASE AND DISCOVERY: A HISTORY OF THE JOHNS HOPKINS SCHOOL OF HYGIENE AND PUBLIC HEALTH 1916-1939, at 2 (1987) (“Public health is oriented toward the analysis of the determinants of health and disease on a population basis, while medicine is oriented toward individual patients.”).
all care that is marginally beneficial so long as someone else absorbs the cost.\textsuperscript{196} Cost-effectiveness is generally achieved by providing incentives to physicians to supply medically necessary care only and, through the use of coverage rules, treatment protocols and utilization review procedures that explicitly constrain the options available to physicians and patients.\textsuperscript{197} Further, economies of scope (as opposed to scale)\textsuperscript{198} are generally thought to be achieved in integrated delivery systems through “one stop shopping,” which allows for a seamless continuum of care and produces lower administrative costs.\textsuperscript{199} Thus, even though there is much debate about the quality of care provided,\textsuperscript{200} most commentators agree that managed care promotes the social goal of “dollar efficient” provision of health services,\textsuperscript{201} and has become the nation’s de facto national health policy.\textsuperscript{202}

\textsuperscript{196} See Barry R. Furrow, Managed Care Organizations and Patient Injury: Rethinking Liability, 31 GA. L. REV. 419, 424 (1997).


\textsuperscript{198} Economies of scope exist if the cost of producing all outputs together in one business is less than that of producing each output in a separate business. Economies of scale exist if increases in productivity or decreases in cost result from increasing the size or scale of a business. See generally, e.g., PAUL A. SAMUELSON & WILLIAM D. NORDHAUS, ECONOMICS (13th ed. 1989).


\textsuperscript{200} For a discussion of these concerns, see infra text accompanying notes 285-88.

\textsuperscript{201} Whether managed care can continue to live up to cost-cutting expectations is a topic of increasing debate. Some commentators suggest that managed care has lowered health care costs by enrolling younger, healthier members, a practice known as “cherry picking.” But, as older and chronically ill individuals join managed care plans, the costs of providing care are expected to rise. See, e.g., Derek C. Angus, Walter T. Linde-Zwirble, Carl A. Sirio, Armando J. Rotondi, Lakshmipathi Chelluri, Richard C. Newbold III, Judith R. Lave & Michael R. Pinsky, The Effect of Managed Care on ICU Length of Stay: Implications for Medicare, 276 JAMA 1075, 1075 (1996) (suggesting that as plans enroll older and potentially sicker patients, there will be a temptation to cut back on referrals and hospitalizations to minimize costs); Andreas G. Schneider & Joann B. Stern, Health Maintenance Organizations and the Poor: Problems and Prospects, 70 NW. U. L. REV. 90, 98-99 (1975) (“Because it is at financial risk for the health of its enrollees, an HMO will seek to limit its enrollee population to ‘low risk’ individuals, i.e., those persons whose health is good and who are therefore unlikely to utilize services at a high rate.”). Further, anecdotal evidence suggests that some managed care plans artificially lowered prices to gain market share in the past and are now beginning to raise premiums. See, e.g., Peter T. Kilborn, Health-Maintenance Groups Are Seen Entering a Troublesome New Phase, N.Y. TIMES, Nov. 22, 1997, at A1.

A more sophisticated argument emphasizes consumer preferences. Increases in medical technology, drugs and new procedures are alleged to account for most of the increases in health care costs. Yet, the argument goes, even if managed care operates as its advocates foresee, society will remain willing to pay for enhanced medical capabilities and, therefore, the savings from managed care may be a once-and-for-all variety rather than a reduction in the steady-state of growth. Joseph P. Newhouse, An Iconoclastic View of Health Care Cost Containment, 12 HEALTH AFF. 155, 162-63
In contrast, public health departments are often perceived as quite inefficient and inflexible in the provision of personal health services. Current congressionally mandated categorical programs, such as those involving HIV/AIDS, frequently require duplicative administrative services at the local level. System savings can be achieved by reducing these administrative inefficiencies and increasing flexibility in the use of existing funds. Besides bureaucracy, public health agencies (and government, in general) lack private sector productivity standards and accountability measures to insure efficient and cost-effective provision of services. Further, the prevention, diagnosis and treatment of illness, sexually transmitted diseases, AIDS and tuberculosis are undertaken both by health care providers and health departments. For the reasons we have suggested, public health agencies are not necessarily optimally effective when providing these services and, thus, eliminating duplicative staffs and facilities would allocate resources more rationally.

To build a strong public health system, health departments need to be able to move away from providing personal medical care services to the indigent and uninsured and concentrate on population-based functions. To accomplish this task, public health departments should, in some circumstances, contract out personal and clinical health services to managed care plans either on a fee-for-service or capitated basis and use the savings to fund core public health activities. Substantial system savings have resulted in some jurisdictions: for instance, Ventura County in California reports a reduction in annual county costs for clinical services (Supp. 1993). While each of these claims has some degree of merit, managed care rationalizes the delivery of care and lowers costs in ways that fee-for-service delivery cannot.


203. See, e.g., FUTURE OF PUBLIC HEALTH, supra note 25, at 73-104.
204. See, e.g., Baker et al., supra note 16, at 1281.
205. See, e.g., SAVAS, supra note 17.
from $10 million in 1987 to $3.8 million in 1995.\textsuperscript{206} In Texas, the state department of health has increased the use of limited funds for population-based, essential public health services by shifting the state’s maternal and child health block grant to competitive bidding and performance-based reimbursement. As a result, state expenditures for maternal and child health services were reduced by twenty percent between fiscal years 1995 and 1996; and 568 positions funded by Title V and related general revenues were eliminated. Further, statistics show that the same number of patients were seen in both years.\textsuperscript{207} Other state and local health departments are increasingly contracting with managed care plans to provide specific services.\textsuperscript{208}

Managed care organizations should also be able to provide medical care to populations with specific health conditions such as tuberculosis, STDs and HIV/AIDS who currently receive treatment in categorical public health clinics. Managed care organizations are gaining expertise in handling these cases as health plans enroll increasing numbers of Medicaid patients.\textsuperscript{209} Minnesota even requires managed care plans to provide out-of-network services in these areas.\textsuperscript{210} Public health profits from contracting out these cases in several ways. First, there exist strong biological, clinical and epidemiological relationships among HIV, STDs, and tuberculosis,\textsuperscript{211} which require strategic thinking and a comprehensive

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\item[208] The Los Angeles County Department of Health Services, for example, has developed memoranda of understanding as a basis for negotiating with managed care organizations for the provision of medical services. See HEALTHY COMMUNITIES, supra note 11, at 25-26.
\item[209] By 1995, all states except Alaska had implemented some form of Medicaid managed care. Total enrollment in these programs nearly doubled in 1994 and increased by slightly over 51% in 1995. See Grogan, supra note 202, at 815. About 25% of Medicaid beneficiaries are enrolled in managed care plans. See HEALTHY COMMUNITIES, supra note 11, at 15.
\item[210] See HEALTHY COMMUNITIES, supra note 11, at 22.
\item[211] The relationship among these infectious diseases are so strong that the CDC recently reorganized its activities to include all these disease categories under one administrative unit. See CDC, CDC Advisory Committee on the Prevention of HIV Infection, External Review of CDC’s HIV Prevention Strategies (1994). See also CDC, Strategic Plan for Preventing Human Immunodeficiency (HIV) Infection (1992). As to the relationship between HIV and tuberculosis, see Lawrence O. Gostin, The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law, and Society, 54 MD. L. REV. 1 (1996) [hereinafter The Resurgent Tuberculosis Epidemic]. As to the relationship between STDS and HIV, see INSTITUTE OF MEDICINE, THE HIDDEN EPIDEMIC: CONFRONTING SEXUALLY TRANSMITTED DISEASES 229-31 (Thomas R. Eng & William T. Butler eds., 1997). An estimated four million people world-wide are infected with both HIV and tuberculosis. See
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approach to patient care. Managed care typically assigns complicated patients to “case management” whereby a case manager, in consultation with the primary care physician, reviews the treatment already given and designs a proposed course of future treatment. Managed care, then, can provide integrated management of complex, inter-related conditions in ways that categorical public health clinics cannot. Second, a single health plan can record and update the patient’s medical and treatment history, exchange information among affiliated providers, and provide counseling and education. With respect to tuberculosis control, persons with tuberculosis frequently come into contact with a number of categorical public health clinics and, without coordination, each may be unaware that a person is infected or failing to take prescribed drugs. Managed care, in theory, should eliminate some of these informational difficulties. Third, contracting out would eliminate the need for health professionals with the same skills in the public health department, thereby allowing a more efficient allocation of public health resources.

One qualification, however, is necessary here. For privatization to operate effectively, the managed care plan must be sensitive to the complex needs of the vulnerable populations the public health system has historically served and, thus, issues of race, ethnicity, culture, tradition, language, and socioeconomic status merit special attention. Studies have shown that members of ethnic and racial communities tend to seek medical services at a higher rate when health care is provided by physicians of the same cultural and racial background. But historically, large HMOs have tended not to recruit physicians with community ties. Moreover, because financial pressures are substantial in most managed

Hans Houweling & R.A. Coutinho, Acquired Immunodeficiency Syndrome, in OXFORD TEXTBOOK OF PUBLIC HEALTH ch. 12, supra note 189, at 1271. People with STDs such as syphilis, gonorrhea, chlamydia or herpes are three to five times as likely to become infected with HIV because they have open sores that the virus can enter easily. See id. at 1270.

212. See, e.g., Rosalind Resnick, Case Management Evolves Into a Quality Care Program, BUS. & HEALTH, Sept. 1992, at 51-56.

213. See generally The Resurgent Tuberculosis Epidemic, supra note 211.

214. See HEALTHY COMMUNITIES, supra note 11, at 18. Further, from an ethical perspective, principles of autonomy and beneficence require health services to be culturally relevant to the populations that receive medical care. While it is unrealistic to expect complete cultural sensitivity, medical care providers should, at a minimum, have the capacity to communicate in the language of those they serve. See Rosenau & Roemer, supra note 59, at 421.


216. See generally Chris Serb, Their World is the Ghetto, 71 HOSP. & HEALTH NETWORKS 46 (1997). But see Andrew B. Bindman, Kevin Grumbach, Karen Vranizan, Deborah Jaffe & Dennis Osmond, Selection and Exclusion of Primary Care Physicians by Managed Care Organizations, 279 JAMA 675 (1998) (study of California physicians failed to document that managed care organizations are disproportionately excluding minority physicians).
care plans, primary care providers have limited time to spend with patients and may be expected to see as many as 40 patients per day. A ten minute patient visit is probably insufficient to overcome language and cultural barriers and, at the same time, provide quality diagnosis and treatment.217

Although potentially quite a serious problem, there are ways to address and correct any cultural barriers that might exist between managed care organizations and health department clients. As we have emphasized throughout this Article, government ultimately retains the responsibility for assuring that the public health is promoted and protected and, therefore, is obligated to protect vulnerable populations. It can perform this assurance function by exercising oversight and sharing its experience with managed care. For example, the state could award personal medical services contracts on the basis of the number of existing community-based physicians under contract with the managed care plan, or provide that the recruitment of community physicians is a condition subsequent to the contract. Another promising route, endorsed by the Institute of Medicine, is to share the skills and experiences of public health staff who have worked with vulnerable populations during the transition period to managed care in order to assist clients in navigating the managed care system.218 Government can also address the problem by using consumer satisfaction as a criterion for contract renewal.

The state can also use its contractual relationship with managed care to foster cooperation in other areas. Health agencies can work with managed care plans to develop clinical guidelines for TB, HIV, and STD diagnosis and control, while also requiring plans to adopt community-wide prevention and control protocols for infectious diseases. Likewise, data-sharing agreements may offer public health agencies enhanced information on the diagnostic and treatment services offered by private health plans.219

2. Clinical Prevention

Public health agencies provide a number of clinical preventive services, such as immunizations and screenings, which are central to the

217. See, e.g., John Hornberger, Haruka Itakura & Sandra R. Wilson, Bridging Language and Cultural Barriers between Physicians and Patients, 112 PUB. HEALTH REP. 410 (1997) (lacking a common language or culture, communication difficulties among the patient and physician may compromise the patient’s care, potentially resulting in worse health outcomes).

218. See HEALTHY COMMUNITIES, supra note 11, at 18.

mission of the health care system. The appeal of prevention is straightforward. Avoiding disease before symptoms present themselves is clearly superior to having to suffer illness and try to repair the damage afterward. The CDC administers a grant program for state and local agencies to immunize both preschool and elementary school children against vaccine-preventable diseases such as poliomyelitis, measles, rubella, mumps, diphtheria, whooping cough, and tetanus. Screening services encompass vision and hearing, hypertension, cervical cancer, diabetes, sickle cell trait, lead poisoning, speech and language disorders, pap smears, and HIV antibody tests, among others.

The direct administration of clinical preventive services is another example of how health departments sometimes use the wrong tool to repair a community health need. Direct provision has high opportunity costs and, more fundamentally, managed care plans can perform these services more cost-effectively. Clinical preventive services are among the quality indicators that are the focus of the Health Plan Employer Data and Information Set (HEDIS), which many state and large businesses use to evaluate plans vying for contracts. Immunizations, mammograms, and cervical cancer and cholesterol screening are among the quality-of-care indicators in the most recent version of HEDIS. Managed care clearly has expertise in performing these services for large populations.

Further, a frequently voiced advantage of managed care and, in particular, integrated delivery systems, is that these organizations often possess economies of scale that result in lower administrative costs and

221. See id. at 124.
222. As a general matter, screening aims to detect an illness before symptoms present and the patient becomes ill and is often associated with health education and promotion. See Godfrey Fowler & Joan Austoker, Screening, in OXFORD TEXTBOOK OF PUBLIC HEALTH ch. 29, supra note 189, at 1583-84.
223. See FUTURE OF PUBLIC HEALTH, supra note 25, at 177.
224. The benefits to be derived from alternative uses of resources has put in question the screening programs sponsored by the National Health Service in the United Kingdom. See Fowler & Austoker, supra note 222, at 1586.
226. See National COMM. FOR QUALITY ASSURANCE, HEDIS 2.5: UPDATED SPECIFICATIONS FOR HEDIS 2.0 (1995).
227. An integrated delivery system furnishes patients with all levels and types of health care services, and coordinates case management and information flow. At a minimum, an integrated delivery system provides hospital, physician and ancillary services, thereby diminishing fragmentation of health care delivery. See Hitchner et al., supra note 199, at 274.
unit costs per vaccination or screening. To achieve economies of scale, integrated delivery systems typically use common administrative personnel, procedures, and information systems. And, because of the size of these networks, medical supplies and equipment can be purchased in volume or at heavily discounted prices.²²⁸ Economies of scale are further achieved through the efficient allocation of health care resources and manpower across the range of affiliated hospitals and other clinical facilities. For instance, unit costs are reduced by concentrating a particular specialty in one facility (for example cardiac care and diagnosis) while another facility performs another specialty, say, cancer treatment.²²⁹ Privatizing clinical prevention services, then, presents numerous opportunities for cost-effective provision of services and allows health departments to allocate resources to more productive uses.

3. Surveillance

The traditional definition of public health surveillance is “the ongoing, systematic collection, analysis, and interpretation of data on specific health events for use in the planning, implementation, and evaluation of public health programs.”²³⁰ Surveillance, public health investigation and epidemiologic research²³¹ are primary to the work of public health. These activities include reporting names of persons with certain diseases to state and local health departments, notifying sexual partners and other contacts, and surveying disease prevalence or risk behaviors in certain populations.²³²

Close, continuous surveillance promotes public health by (1) acting as an early warning system in detecting microbial, environmental, behavioral,

²²⁸. See id. at 286.
and other health threats;\textsuperscript{233} (2) concentrating resources in areas of greatest need;\textsuperscript{234} (3) promoting behavioral, social, and environmental changes to avert the spread of disease by identifying modes of transmission and providing health information to persons at risk;\textsuperscript{235} (4) helping assess public health measures by aiding evaluations of efficacy and cost;\textsuperscript{236} and (5) affecting legislation and altering social norms by providing accurate health information to citizens and policymakers.\textsuperscript{237}

Surveillance, in short, is the life blood of public health as it enables the public health system to identify health problems, inform the public, intervene, and influence funding decisions.\textsuperscript{238} Obtaining surveillance data, however, is resource intensive, while the existing public health surveillance infrastructure is resource poor. The federal government provides no resources to state and local health departments to support the national notifiable disease system,\textsuperscript{239} and support for applied research and control efforts has declined over the past decade for most infectious diseases.\textsuperscript{240} Most health departments lack the personnel, laboratories, and

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  \item \textsuperscript{233} Surveillance is the key to infectious disease control:
    A well-designed, well-implemented surveillance program can detect unusual clusters of disease, document the geographic and demographic spread of an outbreak, and estimate the magnitude of the problem. It can also help to describe the natural history of the disease, identify factors responsible for emergence, facilitate laboratory and epidemiological research, and assess the success of specific Interventions.
    \textit{EMERGING INFECTIONS, supra} note 99, at 1.
  \item \textsuperscript{234} Surveillance provides information for action and, therefore, only the highest-priority public health events should be under surveillance, and surveillance systems should meet their objectives as efficiently as possible. \textit{See PUBLIC HEALTH SURVEILLANCE, supra} note 230, at 158.
  \item \textsuperscript{235} Instead of locating infected individuals and meting out, on a case-by-case basis, treatment and person control measures, some scholars have suggested that government might achieve its purposes more effectively and less intrusively by focusing on population-based interventions such as health promotion and education, better nutrition and sanitation and improved environmental conditions. For an intriguing examination of the central ethos of "finding and treating the case," rather than ameliorating health problems in the population, see Geoffrey Rose, \textit{Sick Individuals and Sick Populations}, 14 INT'L J. EPIDEMIOLOGY 32 (1985).
  \item \textsuperscript{236} \textit{See PUBLIC HEALTH SURVEILLANCE, supra} note 230, at 158-72.
  \item \textsuperscript{237} \textit{See id.} at 15.
  \item \textsuperscript{238} \textit{See Gostin et al., supra} note 232, at 1922.
  \item \textsuperscript{239} Infectious disease surveillance activities have traditionally been based on notifiable disease reporting systems in which national, state and local authorities require physicians and laboratories to report selected infectious diseases. In 1992, 49 infectious diseases were considered notifiable at the national level. At the state level, considerable variability exists with no overlap between jurisdictions. \textit{See PUBLIC HEALTH SURVEILLANCE, supra} note 230, at 33. The system breaks down if any one step, diagnosis, reporting or follow-up investigation is not accomplished. \textit{See} Ruth L. Berkelman, Ralph T. Bryan, Michael T. Osterholm, James W. LeDuc & James M. Hughes, \textit{Infectious Disease Surveillance: A Crumbling Foundation}, 264 SCIENCE 368, 368 (1994).
  \item \textsuperscript{240} More than 95% of funds provided to states for infectious disease surveillance are limited to four categories: tuberculosis, HIV, STDs and selected vaccine-preventable diseases. \textit{See} CDC, \textit{ADDRESSING EMERGING INFECTION DISEASE THREATS: A PREVENTION STRATEGY FOR THE UNITED

information systems to identify and respond effectively to the great variety of health risks facing populations.\textsuperscript{241} A recent survey by the Council of State and Territorial Epidemiologists documents that only twelve states have a professional position dedicated to surveillance of waterborne and foodborne diseases.\textsuperscript{242} And as a result of the lack of funds and personnel, many public health agencies have been reluctant to add additional diseases to their list of notifiable diseases because of their inability to support the surveillance system by collecting, analyzing, and responding to reports of diseases.\textsuperscript{243}

The systematic acquisition of a broad range of personal health data by managed care organizations presents new opportunities and potential benefits for improving surveillance. In theory, managed care organizations have economic incentives to develop automated health information systems to facilitate storage, circulation, and the capacity to search and sort information seamlessly throughout the organization and beyond.\textsuperscript{244} Many managed care organizations now possess or are developing the capacity to aggregate individual health status information obtained from affiliated providers and analyze this information so as to (1) identify clusters of diseases and injuries; (2) identify outbreaks of new diseases within the enrolled population; and (3) through investigation, find out what caused them.\textsuperscript{245} Carefully planned surveillance and research conducted using managed care’s data can allow the public health system to identify, track, and evaluate health threats to populations more effectively.

Despite the promise for public health, managed care organizations possess few, if any, incentives to collect, store, and report information about the population’s health.\textsuperscript{246} Data sharing and cooperation can be accomplished through contract. We envision privatized surveillance as a

\textsuperscript{241} See, e.g., FUTURE OF PUBLIC HEALTH, supra note 25, at 19-34.

\textsuperscript{242} See Berkelman et al., supra note 239, at 368.

\textsuperscript{243} See id.

\textsuperscript{244} See M. Amatayakul, Making the Case for Electronic Records, HEALTH DATA MANAGEMENT, May 5, 1997, at 56-74. Such automated systems increase cost-effectiveness by allowing business managers, case managers, affiliated physicians and others responsible for financial and clinical oversight to have ready access to health records. See also, e.g., Lauren M. Walker, Guarding Patient Confidentiality Under Managed Care, MED. ECON., May 12, 1997 (discussing managed care’s extensive use of computer networks to handle patient records as a way of analyzing, collecting and organizing data).

\textsuperscript{245} We argue in Part VIII, infra, that government should provide grants, loans or other financial assistance to develop such information systems if the cost to individual plans are prohibitive.

\textsuperscript{246} Most of the health information currently collected is outcomes and quality-related measures, which are increasingly being demanded by purchasers. See infra text accompanying note 335.
collaborative process in which the state or local health department contracts with one or more managed care plans for the reporting of (1) clusters of diseases or injuries within the enrolled population, such as pediatric blood levels, the incidence of cancers, birth defects, or pulmonary diseases; (2) unusual diseases or conditions, e.g., Hantavirus, Cryptosporidiosis, or E. Coli, so as to act as an early warning system for detecting microbial threats; and (3) behavior risks such as smoking and alcohol abuse. Using this information, public health officials could allocate resources to those events that pose the highest risks, and facilitate future projections by tracking and monitoring the incidence, patterns, and trends of reported diseases and disabilities.

Contracting with managed care organizations to compile reports that identify clusters of diseases among their enrolled population is an extremely desirable strategy because these reports not only identify health risks in the community, but also provide the managed care plan with information that could serve as the basis for its own prevention strategies in avoiding future treatment costs. That is, if the plan detects a high incidence of, say, heart disease among its enrolled population, it will, in theory, have an economic incentive to engage in clinical prevention activities such as cholesterol and hypertension screening and to undertake health education and promotion in the areas of stress-reduction, diet and exercise.

Another benefit from engaging managed care in surveillance is the potential for strengthening the existing notifiable disease reporting system. As the Institute of Medicine suggests, surveillance of infectious diseases is a passive process and outbreaks of any disease not currently on the CDC’s list of notifiable illness may either go undetected or be detected well after an outbreak is underway. Even the mandatory reporting of communicable diseases has a long history of failure on the part of physicians to comply. Indeed, numerous studies indicate that the thorough reporting of communicable diseases varies, but, as a general matter, ranges from low to very low for most diseases in most locations. Privatizing surveillance should improve reporting by managed care plans because one of the opportunities (to be gained by contracting) is the development of a

247. As managed care becomes more involved in Medicaid and Medicare contracting, such data could be reported in terms of racial, ethnic, socioeconomic and other divisions to represent different levels of health status among groups. Public health surveillance activity has been criticized for overlooking the health status of subpopulations when incidence or prevalence figures are reported in simple totals or averages for the jurisdiction. See, e.g., HEALTHY PEOPLE 2000, supra note 20, at 24.

248. See EMERGING INFECTIONS, supra note 99, at 120.

249. See PUBLIC HEALTH SURVEILLANCE, supra note 230, at 222.
systematic, on-going relationship. This should facilitate educating managed care physicians about reporting requirements, developing easy reporting procedures, and providing financial incentives to report.250 By extension, surveillance of newly recognized diseases should also improve because if managed care plans are constantly communicating with the public health systems any unusual conditions would be brought to the attention of public health officials before there is a widespread epidemic.

In principle, then, contracting out select surveillance and monitoring activities to managed care has much to be said in its favor. Several qualifications, however, are in order. Substantial variability exists among managed care plans operating in different markets to deliver information useful to health departments,251 and, therefore, we reject an across-the-board privatization strategy in favor of a case-by-case approach. Further, commentators have suggested that it is unrealistic to expect that managed care can improve public health surveillance systems for two principle reasons, both related to cost-consciousness. First, managed care’s well-documented shift of care from inpatient to ambulatory settings has arguably reduced the quality of patient records.252 Second, managed care’s perceived reduction in the use of diagnostic testing has made it more difficult to recognize and monitor microbial threats, particularly low- or moderate-incident infections.253

While potentially serious, most of these issues or impediments are not insurmountable. Improvement in the quality of information captured and reported can be obtained, first of all, through the contract bidding process in which government can specify the types of information that must be collected and reported and thereby reward those plans that maintain complete and accurate records. Further, major purchasers are increasingly

250. The reasons most commonly cited by physicians for failing to report notifiable diseases are: the assumption that the condition would be reported by someone else; ignorance that reporting was required; uncertainty about how to report; concerns about confidentiality; and absence of incentives to report. See id. at 223.


252. Based on anecdotal evidence, patient encounter records maintained in physicians offices are typically poor because, under capitation, physicians have few incentives to record diagnoses, services and other patient information since payment is unaffected by this information. See Richard E. Dixon, Encounter-Level Data, Presentation Before the Institute of Medicine, National Academy of Sciences Forum on Emerging Infections, “Managed Care Systems and Emerging Infections” (Mar. 23-24, 1998).

253. See id.
requiring more complete patient encounter data, laboratory data, and pharmacy data, among others, so as to evaluate quality and outcomes. The issue of diagnostic tests is more complex. We make the initial observation that clinical practice patterns differ across providers and further research needs to be done before we can conclude that managed care systematically fails to order diagnostic tests for unusual conditions. For instance, a number of large HMOs employ infectious disease specialists who, among other things, direct infection control programs, run antibiotic review teams, and provide consultative patient care services. But assuming that a focus on cost-consciousness discourages proper work-up and testing, health agencies may still be able to work out an agreement with a managed care plan about what pathogens will be looked for and to what extent isolated pathogens will be referred to laboratories.

To be sure, contracting out surveillance activities is a complex undertaking for which we can give general directions only. But, collaboration with managed care in some form is essential if the public health system is to perform effectively the core functions of collecting, storing, and using information about the population’s health.

4. Health Promotion and Education

Nearly all health departments, state and local, engage in health promotion and education. Community-level interventions include: AIDS education; smoking, alcohol and substance abuse programs; family planning; violence reduction; injury prevention programs; and the treatment and prevention of poisoning.\(^{254}\)

Since most Americans receive their health care from managed care plans, it seems illogical to situate health care delivery separately from health education and promotion. Because health plans have continuous clinical encounters with large populations, health departments should seek to achieve the optimal delivery of health education and promotional messages by involving plans in these efforts. For instance, a health plan and a public health department might work together to target a broad segment of the community by cooperating in the design and management of health promotion and disease prevention activities that directly impact the health of a plan’s current enrollees. In addition, the two could share the cost of broader community-wide interventions.

\(^{254}\) See, e.g., HEALTHY PEOPLE 2000, supra note 20, at 82-96.
B. CONSTITUTIONAL REVIEW OF PRIVATIZATION

The previous section marshaled the arguments justifying privatization of public health on the grounds of efficiency, expertise, and cost-effectiveness. This section seeks to demonstrate that there are no per se constitutional impediments to privatization of public health, as we have defined it, since managed care organizations would be conferring a benefit to the public while refraining from the exercise of any legislative, regulatory, or adjudicative authority.

Managed care organizations can perform the public health functions of providing personal health and clinical prevention services, conducting epidemiological surveillance, and facilitating health education and promotion that we have advocated without affecting individual autonomy, privacy, or property. The vast majority of health care in the United States is provided by the private sector and, therefore, empowering managed care to provide personal medical services, clinical preventive services, and health education and promotion activities is consistent with the private delivery of preventive, diagnostic, and curative services. Therefore, no traditional government functions are exercised nor any individual rights constrained. Similarly, contracting out epidemiological surveillance is neutral with respect to individual rights because we envision such contracts to encompass the collection of data regarding the pattern of disease and injury in the community; the health department would retain responsibility for developing policy and allocating resources.

This important but limited role for managed care is consistent with the courts’ basic position that, as a threshold matter, privatization raises a constitutional issue only when government power is exercised by a private entity so as to deprive a person of life, liberty, or power under the behest of the state. Rulemaking, adjudication of rights, seizure of person or property, and licensing and taxation are generally recognized as government powers.255 Debate about the privatization of government services through contract such as we have proposed are largely political in nature (Will the profit motive provide incentives for the private sector to provide low-quality services? Is government by nature liberatory and the private sector repressive?) and the legal issues are largely secondary, involving only details.256

255. See Lawrence, supra note 188, at 648.
256. See id. at 647.
The United States Supreme Court has considered the privatization issue only in terms of delegating the legislative, regulatory, or judicial function to the private sector. In the seminal case of *Carter v. Carter Coal Co.*, the Court invalidated a congressional delegation of regulatory power to private parties on Fifth Amendment due process grounds. After the *Carter* decision, federal delegation decisions have upheld increasingly broad private delegations that have included rule-making and adjudication by private parties. Commentators generally agree, however, that the Court has failed to articulate a workable test to distinguish between statutes that properly delegate and those that do not. This is especially true because the Court has used other grounds such as state action and due process to avoid the issue altogether. Despite the doctrinal uncertainty, the rarity of the Court’s invalidation of a private delegation supports the conclusion that no per se constitutional bar exists.

At the state level, delegation cases are more common, and the decisions are even more unprincipled and often conflicting. Certain principles seem to emerge, however, from the existing state court decisions. First, it appears well-settled that a state may constitutionally

257. 298 U.S. 238 (1936).
258. The federal statute at issue made maximum hours and minimum wages agreed on by a majority of miners and producers binding on the others.
259. See, e.g., Sunshine Coal Co. v. Adkins, 310 U.S. 381, 397-99 (1940) (Bituminous Coal Act did not delegate its legislative authority to the coal industry since a congressionally created Coal Commission had authority and oversight over industry decisions regarding coal prices); United States v. Rock Royal Coop., 307 U.S. 533, 577-78 (1939) (statute providing that administrative determination concerning milk price was invalid unless two-thirds of area milk producers approved price held valid).
261. See, e.g., Lawrence, *supra* note 188, at 550.
262. See, e.g., Gibson v. Berryhill, 411 U.S. 564 (1973) (Court concerned with the potential due process violations that could occur when the state delegates to “private persons whose interests may be and often are adverse to the interests of others in the same business”).
263. See *Cass, supra* note 188, at 501.
264. See, e.g., Daniel R. Mandelker, Dawn Clark Netsch & Peter W. Salsich, Jr., *STATE AND LOCAL GOVERNMENT IN A FEDERAL SYSTEM* 598 (2d ed. 1983). The authors conclude that: “The nondelegation doctrine is alive and well in the state courts. Delegation of power objections are frequently made to state and local legislation, although a review of the state cases indicates that most delegations are upheld. State delegation cases are common but the decisions are unprincipled. Except for the conclusion that some state courts more frequently invalidate delegations of power than others, a principled basis for the application of the delegation of power doctrine is difficult to find.”
delegate the management of a government enterprise to the private sector as long as the government retains ultimate control. For instance, in *People v. Chicago Railroad Terminal Authority*, the state of Illinois upheld a statute providing that a railroad terminal authority could, contractually vest authority to supervise and manage terminal facilities in a committee that included interested railway company members. The Illinois court observed that the enabling legislation allowed the terminal authority to delegate administrative duties to “those who are presumably most familiar with the problems involved” and “in this we see no constitutional violation.” Significantly, although the statute allowed the terminal authority to delegate management policy to a board consisting of private company appointees, the authority retained ultimate control over the board as it could accept, reject, or modify the rules the management committee established.

While “management function” delegations appear safe as long as the government retains oversight, state courts have universally condemned statutes delegating rule-making power to private parties. The concern here is that only the legislature has express constitutional authority to authorize rule-making and moreover, courts fear that if this power is granted to private parties, there is the potential for the formulation of rules that benefit the private company for its own political or pecuniary gain.

266. See, e.g., id. at 558-63; George W. Liebman, *Delegation to Private Parties in American Constitutional Law*, 50 IND. L.J. 650, 711-16.
268. Id. at 317.
269. See id. at 316-317.
270. See, e.g., Industrial Comm’n v. C & D Pipeline, 607 P.2d 383 (Ariz. Ct. App. 1979) (prevailing wage law unconstitutionally granted the power to set prevailing wage for municipal contracts to unions); Hollingsworth v. State Bd. of Barber Examiners, 28 N.E.2d 64 (Ind. 1940) (unconstitutional to delegate barber’s hours to private group); State Bd. of Dry Cleaners v. Thrift-D-Lux Cleaners, Inc., 254 P.2d 29 (Cal. 1953) (overturning statute allowing board composed of six industry members and one member of public to set minimum rates).
271. This concern is not new. In his Second Treatise, John Locke argues that all civil authority is based on consent and that only representatives of the people could infringe on freedom and property. Writing on the legislative authority, Locke asserts that:

> The Legislative cannot transfer the Power of Making Laws to any other hands. For it . . . being but a delegated Power from the People, they, who have it, cannot pass it over to others . . . And when the people have said, We will submit to rules, and be govern’d by Laws made by such Men, and in such Forms, no Body else can say other Men shall make Laws for them. The power of the Legislative being derived from the People by a positive voluntary Grant and Institution, can be no other, than what the positive Grant conveyed, which being only to make Laws, and not to make Legislators, the Legislative can have no power to transfer their Authority of making laws, and place it in other hands.

JOHN LOCKE, TWO TREATISES OF GOVERNMENT 380-81 (2d Treatise 1960).
272. See Robbins, supra note 265, at 563. Following Carter and Gibson, some state courts have expressly decided private delegations under a due process analysis. See, e.g., Humane Soc’y v. New
or that are against the public interest. Further, courts have erected constitutional barriers to private bodies making criminal legislation. This prohibition is rooted in common law, which does not sanction the use of private coercive power. Third, state courts generally invalidate delegations of adjudicative power to private parties when there is no provision for judicial review. Again, the courts fear that private parties may arbitrarily or unreasonably exercise the delegated power. Judicial review provides a safeguard against such abuses.

Privatized public health, as we have proposed it, avoids the potential legal obstacles arising from a delegation of regulatory or judicial authority. In contrast, public health functions such as policy development, food and product regulation, licensing, compulsory testing and treatment, and quarantine and isolation, among others, implicate governmental powers and are constitutionally suspect when performed by private entities unless safeguards are in place that satisfy principles of procedural due process. Therefore, we intentionally omit these activities from our definition of privatization to avoid possible legal challenges, and because we are unconvinced of the value added by the private sector in these areas.

C. CONTRACTING OUT, COMMUNITARIANISM, AND ACCOUNTABILITY

Communitarian ideas about the importance of community voice and the expression and realization of community goals and identity have been used as a basis for criticizing privatization. Beauchamp cautions that managed care offers a sharp contrast to the role of public health as an expression of community and asserts that public health professionals must be “prophets of and guardians of the community” against uncontrolled

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273. See Robbins, supra note 265, at 563.
274. See Olinger v. People, 344 P.2d 689 (Colo. 1959) (voters of conservancy districts invalidly delegated authority to enact penal ordinances).
275. See Robbins, supra note 265, at 561.
276. See id. at 569.
277. Private security guards, for example, have the authority to detain suspects for ultimate arrest and to investigate. They have neither rulemaking or adjudicative authority. See Robbins, supra note 265, at 561-62.
market forces, which can subordinate the community to profit or market share.\textsuperscript{279} Halverson similarly suggests that health departments risk losing their visibility and leadership in the community by surrendering to managed care the responsibility for providing personal health services to populations traditionally served by the public sector.\textsuperscript{280} But, as the Institute of Medicine observes, the quality of public health leadership is low in too many communities, as is the public image of the local health department.\textsuperscript{281} Further, the deterioration of public health described in Part III scarcely situates the local health department as the center of civic pride and community participation. In other words, public health rarely acts as a vehicle for allowing a community’s sense of itself to be expressed as it is, say, in regard to institutions such as a particular non-profit community hospital or an historic site.

Yet, this Article contends that privatization and communitarianism are consistent for several reasons. First, privatization can better promote the communal vision of what a healthy community should be. If, as this Article suggests, the private sector is more efficient at providing certain services, public health will be able to devote more resources to fulfill those unmet needs for which the community demands a response. This could be anything from handgun and violence prevention to improved water quality. Second, privatization has the potential to increase participation and reduce bureaucracy. As previously explained, the communal efforts of the body politic are needed to protect and promote the health of the population. Yet, historically, communal efforts to protect and promote health have been synonymous with direct government intervention. Thus, a potential benefit of privatization is that additional members of the community would be included in the communal health protection effort.

Further, privatization, as we envision it, requires the government to act for the common good, and this entails ensuring that the resources and authority conferred to the managed care system are employed in ways that improve the health of the nation as a whole in a cost-effective manner. Public health, under this view, is an instrument and expression of the community, rather than “a set of services that can be performed by any efficient health care organization for a price.”\textsuperscript{282}

\begin{footnotes}
\item[280.] See Halverson, et al., supra note 45, at 132.
\item[281.] See FUTURE OF PUBLIC HEALTH, supra note 25, at 6.
\item[282.] Toby Citrin, Topics for Our Times: Public Health—Community or Commodity? Reflections on Healthy Communities, 88 AM. J. PUB. HEALTH 351, 352 (1998) (similarly expressing a vision that
\end{footnotes}
Similarly, reasonable people might object to the idea of privatized public health and argue that instead of improving, public health will suffer because managed care organizations will violate the public trust by seeking to maximize profits at the expense of quality. This is a serious argument and it concerns us, but we have found no rigorous theoretical arguments or empirical evidence to substantiate this claim. Serious scholarship has demonstrated the intellectual and ideological impoverishment of the association of the public sphere with justice and equality, and the association of the private sector with oppression and parochialism; the public sphere can be alienating, unresponsive, inefficient, corrupt and culturally repressive, while the private sphere can be more democratic and responsive. Further, such theoretical models of private sector abuses have little or no predictive value as they run the risk of being too general or are “erroneously abstract.”

As a general matter, the empirical literature on the private versus public provision of social welfare services does not support the claim that for-profit firms will sacrifice quality for profit. One can attempt to predict private sector behavior based on the argument that managed care has achieved cost containment only at the expense of quality. That argument has been widely chronicled, and need not be reiterated here. The empirical evidence on the quality effects of managed care is decidedly mixed and most of the data comes from single studies that are compellingly presented but whose validity is debatable. For these

284. Cass, supra note 188, at 470. Cass argues that to have content, positive theory must “steer between the risk of tautology (merely cataloguing what is without simplifying, or propounding a principle of such generality as to give no guidance) and erroneous abstraction (simplifying, but suggesting a principle that does not fit the data sufficiently).”
286. See generally, e.g., GEORGE ANDERS, HEALTH AGAINST WEALTH: HMOs AND THE BREAKDOWN OF MEDICAL TRUST (1996); Carolyn M. Clancy & Howard Brody, Managed Care: Jekyll or Hyde?, 273 JAMA 338 (1995).
287. See Furrow, supra note 40, at 435-42. Professor Furrow summarizes the results of the existing studies on treatment, survival and mortality, utilization of specialists and in-patient services and benefits to subscribers and concludes: “An indictment of managed care is . . . not justified at present. Individual disasters can be found, as with fee-for-service treatment of patients, but the premise of MCOs—that care can be ‘managed’ more efficiently without injuring patients—seems to be justified.” Id. at 442.
reasons, it would be a mistake to summarily reject privatization since there is no good basis for determining, a priori, whether privatization will be “liberatory” or “repressive”: The answer depends on the context and circumstances of the particular form of privatization.288

Finally, we address the issue of the political legitimacy of privatization. Thus far we have accepted the contractarian view that public health activities derive their legitimacy from the consent of the governed.289 How then, can government empower the private sector to perform public health functions without fundamentally undermining democratic values? A careful statement of the position, using the concept of legitimacy, would have to be made along these lines. The communal efforts of the body politic act to legitimize private sector public health activities because such provisions are based on the underlying legitimacy of the laws that empower the private sector to act.290 Further, when a private actor exercises governmental power, the state nevertheless retains the ultimate responsibility to assure the human good in question and to

288. See Peller, supra note 283, at 1005.
289. See supra text accompanying notes 141-42.
290. Some scholars, however, question the legitimacy of delegations of essential functions to the public sector. See Mays, supra note 278, at 68. Professor Mays expresses concern that since the purposes of private and public corporations are different, allowing private corporations to perform public functions is perverse:

   Once the line between ‘public’ and ‘private’ becomes meaningless and is erased, the various units of the Corporate State no longer appear to be parts of a diverse and pluralistic system in which one kind of power limits another kind of power; the various centers of power do not limit each other, they all weigh in on the same side of the scale, with only the individual on the other side. With public and private merged, we can discern the real monolith of power and realize there is nothing at all within the system to impose checks and balances, to offer competition, to raise even a voice of caution or doubt. We are all involuntary members, and there is no zone of the private to offer a retreat.

Id. (quoting Charles Reich, Greening of America 100 (1971)). This particular theory of pluralism assumes that the decisionmaking, policymaking and other discretionary functions of government will be placed in private hands. Besides the legal constraints placed on such delegation, this Article does not contemplate a wholesale abdication of the government role in public health. Central to our thesis is the proposition that government retains ultimate responsibility for community health, irrespective of the arrangements used to provide it. Additionally, allowing private sector participation in public health can actually increase pluralism as additional actors provide a “counterpoise to the potential rigidity and single-mindedness of government.”

Lawrence, supra note 188, at 652.

Further, Gary Peller argues that the distinction between public or private administrative alternatives has lost most of its ideological significance:

Our association of the public sphere with justice and equality was blind to the ways that the very conception of a universal, nondiscriminatory equal opportunity could serve to produce colonized institutions from which virtually everyone is alienated. Conversely, our association of the movement from public to private with parochialism or oppression ignored the ways that such social change could signify empowerment and a recovery of liberatory democratic values.

Peller supra note 283, at 1003.
protect the constitutional rights of those persons over whom the private actor exercises control. And from a historical and contextual perspective, the political community is frequently benefited since the fulfillment of the common good can often be accomplished through arrangements that provide the good or service more cheaply and efficiently. Economic theory, in particular, places no affirmative obligation on the public sector to provide public goods directly; the government can fund the activity with public revenues or user fees or it can allow the private sector to produce the goods or services under private ownership, through contract, or by regulation.

VI. REGULATION

Part V particularized our claim that society could, in theory, increase the efficient use of scarce resources by contracting out certain public health functions to managed care organizations. We suggested delegating concrete services under certain circumstances to managed care: personal medical services and clinical prevention. We also suggested supplementing public health’s provision of other services: surveillance, health promotion, counseling services and education services. In this Part, we try to construct a model of regulation of managed care as a means of maximizing public health. Our conclusion is that, as a general matter, government regulation is probably not feasible in the current political climate and would face significant problems from a social welfare perspective. As an alternative to government regulation, market-based approaches such as value-based purchasing by employers and government-based purchasing coalitions present a more promising avenue for encouraging managed care to pursue public health goals.

A. POLITICAL OBSTACLES

Public consensus about the existence of a social problem generally creates the necessary context for government regulation. Yet, arguably,
the American public and its political leadership have not perceived the
deterioration in public health as an issue warranting government regulation
of managed care organizations to promote community-wide public
health. Rather, the prevailing zeitgeist for regulation of managed care
organizations focuses primarily on consumer protection and quality of
medical care concerns. Supporters of managed care reform and
regulation push for increased patient access to physicians, greater appeal
rights, and enhanced ability to sue the organization directly for
malpractice.

Likewise, a systematic understanding of the political process
demonstrates that an issue must be identified and described with sufficient
urgency and poignancy to gain a place on the political agenda. In some
cases, such as the HIV/AIDS pandemic, the sheer magnitude and severity
of the problem forces political dialogue and action on this public health
issue. In other situations, such as managed care performed “drive-by
deliveries,” consumer outrage causes policymakers to view the problem as
a crisis. Victims and their horror stories resonate with the public and in
just a few months managed care reform has become similar in its populist
appeal to minimum wage and tobacco legislation.

Federal regulation of managed care for public health purposes is
absent from reform measures principally because the role of public health
in increasing human happiness and prosperity has typically received scant
consideration in political discourse on health policy. Indeed, health and
what it may or may not do for the population was not a major part of the
health care debate in 1993-94, although the Clinton proposal addressed
their preferences and to adapt and evolve in their choices. See Sunstein, supra note 2, at 2-40. See
also Robin L. West, Liberalism Rediscovered: A Pragmatic Definition of the Liberal Vision, 46 U.
Pitt. L. Rev. 673, 675 (1985) (rejecting state neutrality toward competing conception of the “good
life,” and arguing that “[a] state might alternatively define the nature of the good life by an empirical
examination of historical communities combined with a critical assessment of modern needs”).
Another reason to regulate is to combat scarcity. In seeking to maximize public health, government
can regulate managed care plans to increase the provision of scarce public health services. Scarcity is a
function of market failure; there is no market for public health and, therefore, government regulation is
appropriate. See Brennan & Berwick, supra, at 15.

295. Indeed, we have suggested throughout this Article that the public has no sense of what public
health is or of its importance in maximizing societal welfare.

296. For a survey of consumer protection bills pending in Congress, see Nicole Tapay, Karen
Pollitz & Jalena Curtis, Side-By-Side-Comparison of Proposed Federal Legislation For Consumer
Protection in Managed Care Plans, in Institute For Health Care Research And Policy, Georgetwon University Medical Center (1997).

297. See, e.g., Lizette Alvarez, Nasty, Costly Battle Shapes Up Over Managed Care, N.Y. Times,

From an ecological perspective, a society’s ill-health is a mirror: Disease reflects how a society produces and distributes wealth, creates conditions for human health (or its antithesis), constructs social norms, and organizes its peoples and communities. Inevitably, public health regulations going to the causes of injury and disease will challenge behavior that people enjoy, constitutes their moral vision, or makes them money. Further, the public health lobby is weak and disorganized—the Institute of Medicine has observed that “public health officials appear defensive and self-serving when they attempt to answer the criticisms of legislators or mobilize needed resources.”

Simply put, American society has failed to identify and describe the deterioration of the nation’s public health system and its negative effect on health as a problem of sufficient urgency and magnitude so as to attract broad coalitions capable of commanding attention and initiating a political discourse about the potential that managed care holds for public health, as well as the practicability of government regulations to realize that potential.

B. DESIRABILITY OF REGULATION

As we have seen, public health regulatory initiatives from the federal level are unlikely. But a related issue is whether we as a society want government to regulate managed care organizations for public health purposes in the first instance. Optimism about regulatory controls has been shaken in recent years. Today, government regulation is viewed by many as difficult to administer and corrosive to productive efficiency and innovative dynamism.

Entrepreneurs in modern America often take...
it as a matter of faith that government health and safety regulation retard economic development and should therefore be avoided. Further, regulation frequently leads to a decrease in cooperation between the private sector and government, or, alternatively, a co-opting of the regulatory agency by the regulatory subject.\textsuperscript{305} Considerations of this sort suggest that regulation for public health purposes could be costly for both managed care organizations and society.

Elementary economics suggests that premiums would likely rise, at least in the short run, if government sets prescriptive rules about the types of public health services managed care organizations must provide. Rising costs would likely price smaller employers, in particular, out of the health insurance market, thereby increasing the public health problem of the uninsured. Further, standards for community health provisions are difficult to write, require a high degree of specificity, and would most likely leave open to debate the question of whether the standards are being met in certain circumstances.\textsuperscript{306} We would, then, expect health plans to challenge specific regulations and administrative decisions in court, and comply with regulatory mandates only to the extent required by law. Likewise, measuring only certain dimensions of community benefit creates an incentive for health plans to disinvest in other dimensions, because they are not rewarded by regulators for these undertakings.\textsuperscript{307} Manifestly, these additional costs would diminish managed care’s cost containment abilities.

C. CONSTRAINTS ON THE ABILITY TO REGULATE

The federal government, as we have suggested, is unlikely to regulate because the deterioration in public health has not been identified and described in terms sufficient to galvanize national political action. Of course, the states may decide to act, but assuming that they do, the Employee Retirement Income Security Act of 1974 (ERISA)\textsuperscript{308} severely hampers their ability to impose requirements regarding what services

\textsuperscript{305} Elliot J. Weiss, Social Regulation of Business Activity: Reforming the Corporate Governance System to Resolve an Institutional Impasse, 28 UCLA L. REV. 343, 349 (1981) (current regulatory environment “threatens corporations’ vitality, the rule of law, and social cohesion generally”).


managed care plans must offer. To attain uniformity in the regulation of employee benefit plans, ERISA supersedes “any and all State laws insofar as they... relate to any employee benefit plan described in section 1003(a).”

Although ERISA was designed primarily to regulate private employee pension plans, it applies to most employee benefits, including health insurance. In interpreting ERISA, the Supreme Court has held that the words “relate to” should be construed expansively, so that the preemption applies to all forms of state action that might affect benefit plans. ERISA effectively prohibits states from mandating the terms of benefits that self-insuring employers provide and, for all practical purposes, bars the direct regulation of self-insured employee benefit plans. As a result, employer-provided health care benefits, are generally defined through the operation of market forces, typically free from either state or federal regulation.

For our purposes, the consequence of ERISA preemption is that states most likely cannot require managed care plans to provide public health benefits because such a requirement directly “relates to” the benefits the plan provides. Under these circumstances, public health mandates must come either from federal action or from market forces.

309. Id. at § 1144 (a).
312. See Ingersoll-Rand Co. v. McCleland, 498 U.S. 133 (1993). This broad interpretation of “relate to” has been narrowed somewhat by Blue Cross & Blue Shield Plans, 514 U.S. at 655-59.
313. See Margaret G. Farrell, ERISA and Managed Care: The Law Abhors a Vacuum, 29 J. OF HEALTH AND HOSP. L. 269 (1996). See also Wendy E. Parmet, Regulation and Federalism: Legal Impediments to State Health Care Reform, 19 AM. J.L. & MED. 121, 140 (1993) (“As long as ERISA is read to favor deregulation, state health care laws will remain vulnerable to preemption.”).
314. The major exception to ERISA preemption, what is commonly referred to as the “savings clause,” does not apply because requiring public health benefits does not constitute the regulation of insurance. The savings clause provides that the preemption does not supplant state laws regulating insurance or the business of insurance. See 29 U.S.C. § 1144 (b)(2)(A).
315. Commentators have argued that ERISA creates a regulatory vacuum. See Alan I. Widiss & Lawrence O. Gostin, What’s Wrong With the ERISA “Vacuum”? The Case Against Unrestricted Freedom for Employers to Terminate Employee Health Care Plans and to Decide What Coverage Is to Be Provided When Risk Retention Plans Are Established for Health Care, 41 DRAKE L. REV. 635 (1992). An ERISA “vacuum” exists because, while states are prohibited from regulating risk retention plans in order to, for example, mandate minimum health benefits or proscribe various forms of discrimination, ERISA itself fails to perform either of these functions. The ERISA vacuum leaves self-insured employers virtually free from federal and state regulation. See Lawrence O. Gostin & Alan I.
Of course, states can require managed plans receiving public contracts, especially Medicaid, to engage in public health activities. In recent years, because of competition, a number of managed care plans have been seeking to expand their market penetration by adding Medicaid beneficiaries as enrollees.\textsuperscript{316} Such Medicaid managed care contracts are operational in some form in forty-one states.\textsuperscript{317} As a practical matter, states could regulate managed care to provide public health benefits by inserting provisions into Medicaid contracts that require managed care plans to contribute specified levels of funding or resources to community-based public health practices.\textsuperscript{318} California HMOs enrolling Medicaid beneficiaries must establish memoranda of understanding that delineate public health services to be provided to Medicaid beneficiaries.\textsuperscript{319} For instance, memoranda of understanding developed between Los Angeles County and HMOs intending to participate in the Medi-Cal program detail specific tasks and responsibilities for family planning services, sexually-transmitted diseases, HIV counseling and testing services, immunizations, prenatal care, children with special needs, child health and disability prevention programs and tuberculosis.\textsuperscript{320}

The fragmentation of state health and insurance regulatory structures, however, presents one obstacle to such regulation. In most states, health care is typically regulated by insurance commissions that emphasize fiscal integrity over the quality of health services provided.\textsuperscript{321} Similarly, state Medicaid programs are often administered separately from the state health department, so oversight is informed by fiscal rather than medical concerns.\textsuperscript{322} Thus, in many states, additional legislative authority is required to increase the duties of state and municipal health departments before public health agencies can develop the ability to oversee managed care providers.

\textsuperscript{316} Some managed care organizations, however, are fleeing Medicaid as profits evaporate. \textit{See}, \textit{e.g.}, Raymond Hernandez, \textit{Some H.M.O.’s Pulling Away on Medicaid}, \textit{N.Y. Times}, May 8, 1997, at B5.

\textsuperscript{317} \textit{See} Halverson et al., \textit{supra} note 45, at 134.

\textsuperscript{318} \textit{See} id. at 130.

\textsuperscript{319} \textit{See} Managed Care and the Public Health Challenge of TB, \textit{supra} note 219, at 25.

\textsuperscript{320} \textit{See} HEALTHY COMMUNITIES, \textit{supra} note 11, at 26-27.

\textsuperscript{321} \textit{See} id. at 27.

\textsuperscript{322} \textit{See} id.
D. REGULATION THROUGH THE MARKET

This is not to say that collective action is not required to encourage managed care organizations to provide community public health services. Such action does not necessarily have to emanate from government. Market forces can play an important role in indirect regulation of managed care through the use of collective action on the part of employers and governmental entities purchasing health care. Effecting collective action through employers—and large governmental and nongovernmental purchasing cooperatives—avoids some of the problems inherent in government regulation because regulation based on contractual relations is generally more flexible and cost-conscious than laws enacted by government.323

Managed care organizations are currently self-regulated through the National Committee for Quality Assurance (NCQA).324 The NCQA issues “report cards” formulated by the Health Plan Employer Data and Information Set (HEDIS), which are evaluated by employers and used to compare plans in terms of value and accountability.325 Seven of the nine indicators of quality-of-care in the latest version of HEDIS are preventive.326 Further, in the Fall of 1996, the Foundation for Accountability, a coalition of purchasers and consumer organizations representing seventy million people, released a similar set of quality and effectiveness measures.327 Employers want such information to engage in value-based purchasing, to gain assurance that health plans are not sacrificing quality-of-care for cost and to create incentives for plans to improve quality.328 Value-based purchasing combines information on the

323. See Alain C. Enthoven & Sara J. Singer, Markets and Collective Action in Regulating Managed Care, 16 HEALTH AFF. 26, 31 (1997) (nongovernmental purchasing cooperatives can create customer/supplier relations based on contract that can demand performance that does not run afoul of the Fifth Amendment).

324. The NCQA was established in 1979 by the trade associations for HMOs, the Group Health Association of America and the American Association of Foundations of Medical Care. In 1989, the Robert Wood Johnson Foundation awarded the NCQA a grant to develop as an independent entity. See Margaret O’Kane, Outside Accreditation of Managed Care Plans, in THE MANAGED HEALTH CARE HANDBOOK 241-42 (Peter R. Kongstvedt ed., 2d ed. 1993).

325. See BRENNAN & BERWICK, supra note 294, at 159-62.

326. These include the incidence of low birth-weight infants, vaccination utilization, mammography, screening for cervical cancer and cholesterol, prenatal care and retina examinations for persons with diabetes. See PREVENTION AND MANAGED CARE, supra note 14, at 4-5.


328. See id.
quality of health care, including patient outcomes and health status, with information on cost.329

Employers have been the major forces for change in the health care marketplace. Major corporations, as well as business and health coalitions are increasingly banding together and using their market power to demand accountability and promote quality as well as cost.330 States have assisted by passing legislation that either permits or encourages the voluntary creation of alliances among purchasers of health care.331 A recent study funded by the Agency for Health Care Policy and Research shows that employers in some parts of the country are taking advantage of the leverage they have with health plans to increase public health measures, such as education and clinical prevention services among enrollees.332

Although in its nascent stages, those employers engaged in value-based purchasing have focused more on controlling their own costs through quality improvements and prevention among their enrollees than in requiring health plans to address health problems on a community-wide basis.333 Manifestly, managed care systems operating individually can contribute to public health (and lower payer costs) by initiatives such as compliance rates with cancer screening tests or immunization schedules for their enrollees. But managed care can also contribute to community health through activities such as sharing data on population health, which may be used to identify and create programs to address community needs, or through direct community intervention, such as participating in community efforts to change behaviors that present significant opportunities for health improvement. These activities also lower payer costs.

A critical challenge for governmental public health leaders, then, is educating employers and consumers of the benefits of “enlightened self-interest” that factors in the various aspects of community health in assessing value.334 In addition, Schleslinger and Gray emphasize that

329. See AGENCY FOR HEALTH CARE POL’Y & RES., THEORY AND REALITY OF VALUE-BASED PURCHASING, LESSONS FROM PIONEERS 1 (1997) [hereinafter VALUE-BASED PURCHASING].
330. Examples of such purchasing coalitions are the Pacific Business Group on Health, the Health Care Payers Coalition of New Jersey, the Buyers’ Health Care Action Group in Minnesota; the Employer Health Care Alliance Cooperative of Madison, Wisconsin; the Chicago Business Group on Health; the Business Health Care Alliance of Appleton, Wisconsin; and the Colorado Health Purchasing Alliance.
331. See Bruce Spitz, Community Control in a World of Regional Delivery Systems, 22 J. HEALTH POL’Y, POL’Y & L. 1021, 1024 (1997).
332. See VALUE-BASED PURCHASING, supra note 329, at 1-14.
333. See id. at 13.
334. See Schleslinger & Gray, supra note 307, at 163.
managed care plans located in communities with mature managed care markets appear more predisposed to provide community benefits and, therefore, recommend that the government indirectly stimulate the provision of community benefits by increasing the market share of nonprofit HMOs, encouraging the concentration of local markets by a limited number of plans—or increasing the market share of managed care in the community—so long as these changes maintain the local orientation of the plan.335 While these solutions require long range planning and political action, in the short run, the government can facilitate the provision of community-oriented services through purchasing decisions that require Medicaid and Medicare HMOs to provide a minimum level of community benefits.336

In sum, although we favor an indirect market-based approach over direct governmental regulation for social welfare reasons, we are aware that market failures do exist. In the foreseeable future, purchasing cooperatives are unlikely to cover everyone.337 Moreover, those that do exist have typically worked in isolation to control their own costs, rather than advancing to more sophisticated levels of community-wide interest. For nongovernmental structures to assist in providing incentives to health plans to carry out public health functions, public health institutions must document the effectiveness of public health interventions and generate support for population-wide public health activities. In the long term, indirect policies that foster consolidation so that each plan enrolls a substantial and fairly stable share of the local community present the most promising avenue for making managed care plans more community oriented.

VII. INCENTIVES

So far, we have examined privatization and regulation as methods of maximizing public health. Privatizing certain public health functions, in our view, efficiently allocates scarce public health resources and should, in theory, produce system savings based on the private sector’s demonstrated ability to deliver cost-effective clinical and medical services and its capacity to collect and disseminate critical health information for surveillance and community-needs assessment.338 In contrast,

335. See id.
336. Congress’ conditional spending power induces states to conform to federal regulatory requirements in eligibility and quality standards related to Medicare and Medicaid.
337. See Enthoven & Singer, supra note 323, at 31.
338. See supra Part V.
governmental regulation, we have argued, is neither politically feasible nor economically effective and, as an alternative, we have suggested that market forces such as employer-based purchasing coalitions can, in theory, encourage managed care plans to provide public health services to improve quality and lower costs.\footnote{339} Certainly, privatization and regulation both provide incentives to managed care; however, this Part examines the issue of how to encourage managed care plans to perform certain activities that assist public health, but which are not easily amenable to contract or regulation.

Obviously, cost considerations, competitive environments, and financial pressures limit managed care’s ability to fulfill some existing public health needs absent government incentives. Public health is, after all, a positive externality. A health plan that undertakes a public health activity raises the utility of everyone in the community, including that of shareholders of competing health plans. But, because of the free rider problem, health plans are unlikely to provide community-wide public health services, and certainly not the socially optimal amount. Further, managed care plans are increasingly subject to sharp margin compression in competitive environments and, in some circumstances, stock valuations have declined appreciably.\footnote{340} Price-competition further reduces the incentive for unilateral public health activity. Managed care plans are increasingly expected to compete for employers’ contracts on the basis of price, and facing a price-competitive marketplace, employers can be expected to switch plans from year to year.\footnote{341} Survey results show that consumers are also willing to change plans based on price.\footnote{342} Considerations of this sort suggest that the market provides few, if any, incentives for health plans to undertake community-wide public health activities because these services may be costly in the short-run and provide an uncertain return on investment.

This problem is not new and one possible way to improve matters is through government intervention. Government could subsidize certain community-health programs, allow tax deductions for certain expenses or devise other ways of rewarding community-minded behavior. But before

\footnote{339. See supra Part VI.}
\footnote{340. See, e.g., Donald W. Moran, Federal Regulation of Managed Care: An Impulse in Search of A Theory, 16 HEALTH AFF. 7, 8 (1997).}
\footnote{341. See Ezekiel J. Emanuel & Nancy Neveloff Dubler, Preserving the Physician-Patient Relationship in the Era of Managed Care, 273 JAMA 323, 327 (1995).}
\footnote{342. See, e.g., Karen Davis, Karen Scott Collins, Cathy Schoen & Cynthia Morris, Choice Matters: Enrollees’ Views of Their Health Plans, 14 HEALTH AFF. 99 (1995) (survey indicates that managed care enrollees have a high rate of voluntary and involuntary plan changing).}
we can begin to discuss concrete cases that might require government incentives, relevant norms must be identified to answer this question: Under what circumstances should government intervene? As a general matter, it is our claim that government should provide financial, tax and other incentives if a health plan will likely suffer long-term profit losses by unilaterally undertaking a valuable public health activity. The case for state involvement is strongest when long-term profits are at issue because some activities, such as community-wide clinical prevention and education, while having the potential for short-term losses, should be profitable in the long-run because they ensure a healthier pool of future enrollees.

A. Activities That Require Government Incentives

Performing laboratory-based surveillance and sharing proprietary health care information are key areas in which managed care’s profit-seeking patterns and practices provide formidable barriers to public health cooperation that prevent any plan from acting unilaterally, absent governmental coordination and assistance.

1. Laboratory-Based Surveillance

As we have emphasized, one of the major challenges for public health is to develop structures to increase the detection, reporting and monitoring of infectious diseases. Laboratory-based reporting is a critical component of the public health surveillance system and can have a substantial impact on reporting rates and the detection of outbreaks of diseases. One potential obstacle to involving managed care in public health surveillance, however, is the fact that diagnostic decisions under managed care are frequently made based on observed and reported symptoms, as opposed to laboratory-confirmed diagnosis. This clinical practice has arisen as a result of cost-containment efforts and is not likely to change due to competitive pressures. Because of this, government incentives are needed to encourage health plans to assist in the laboratory-based identification of outbreaks of communicable diseases.

343. See supra Part V.A.3.
344. See PUBLIC HEALTH SURVEILLANCE, supra note 230, at 37. Routine reporting of aggregate case counts is not enough to provide an accurate picture of disease activity. Laboratory-based surveillance is needed in many instances to confirm case reports and identify additional cases that otherwise would not be reported. See id.
345. See THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS, COMMUNICABLE DISEASE CONTROL IN A MANAGED CARE ENVIRONMENT 4.
Consider, for example a community that faces an outbreak of E. Coli and a particular health plan allows physician discretion in ordering culture tests to isolate the bacteria among all suspected cases. From a public health standpoint, collecting such data is critical in determining the incidence of the disease, discovering its origin and developing a containment strategy. Because public health departments do not have sufficient clinical encounters with large populations, they cannot perform this critical information gathering function. Thus, managed care’s cooperation is vital to achieving public health goals. But, as a general matter, plans may be reluctant to “carve out” laboratory analysis of symptom complexes, such as prolonged diarrhea or diarrhea with fever or pneumonia. Indeed, from a financial perspective, a large number, possibly 50% of the work-ups, could turn out negative, the plan could incur large expenses and, thus, be at a financial disadvantage in relation to other plans.

One solution is for the government to work with plans to reach an agreement about when specimens will be referred to laboratories, what pathogens will be looked for and to what extent isolated pathogens will be speciated or subtyped.\textsuperscript{346} Government intervention and assistance is needed because the economics of managed care dictate that no plan can undertake such action unilaterally and remain competitive.

2. Health Information

The public health need for health information databases is another area where incentives are likely required. As we have discussed, managed care organizations are increasingly developing comprehensive patient records and detailed case management information, which are critical elements in the development of a national health information infrastructure that would support all the essential functions of the health care system, including public health.\textsuperscript{347} Not surprisingly, those agencies concerned with public health have voiced the strongest demand for expanded health care databases (e.g., the U.S. Public Health Service, state and municipal health departments, community-based organizations, epidemiologists, biostatisticians, and academic schools of public health and hygiene).\textsuperscript{348}

\textsuperscript{346} See id. at 5.  
\textsuperscript{348} See Gostin, supra note 347, at 482.
These data would greatly assist public health in tracking and tracing sexually transmitted diseases, responding to clusters or outbreaks of bacterial or viral infections, identifying the initiation of risk behaviors such as smoking and perceiving patterns of harms such as child or spousal abuse, lead poisoning, radon and iatrogenic injuries, among others.349

Managed care would also benefit from health information databases because they would assist in identifying high-risk patients who might require case management and in developing clinical decisionmaking that takes into account historical medical information and the efficacy of treatments.350 But, because they operate in competitive environments, rival health plans have been unable and are unlikely to share what they perceive as sensitive, proprietary information.351 Further, technical problems and high costs limit managed care’s ability to assist in the development of health care databases.352

Financial incentives are appropriate because it is difficult to state a normative or ethical basis for demanding managed care’s assistance in achieving broader societal goals when cooperation would likely result in a long-term competitive disadvantage. Manifestly, requiring plans to cooperate in information sharing and the development of databases without the aid of a central authority to provide oversight and incentives presents the well-known prisoner’s dilemma. While the dissemination of such information is important to all plans, no plan will act without the cooperation of all plans. Government must assume a leadership role in, first, protecting the use of this information and, second, providing loans (technical and financial assistance) in building a health information infrastructure. Government, after all, retains the ultimate responsibility for the public health.

Financial incentives to managed care are not new. In its infancy, managed care, particularly HMOs, faced considerable opposition from organized medicine, restrictive state laws and difficulty in locating start-up funding.353 In 1973, the Nixon administration passed the Health

349. See id. at 483.
350. See Health Data in the Information Age, supra note 347, at 76-77.
351. See generally Gostin, supra note 347, at 470-84.
Maintenance Organization Act,\textsuperscript{354} which was intended to encourage the development of HMOs and act as a substitute for a more comprehensive health care reform.\textsuperscript{355} The Act provided for federal financial assistance,\textsuperscript{356} including grants, contracts, loans and loan guarantees to “federally qualified”\textsuperscript{357} HMOs. Between 1974 and 1980, the federal government contributed roughly $190 million to HMO development.\textsuperscript{358} The federal grants program expired in 1986.\textsuperscript{359}

In short, Congress has provided incentives to managed care organizations to further social goals in the past. Despite the current anti-managed care environment, there are strong reasons for Congress, under some circumstances, to provide incentives to encourage socially responsible behavior that assists in improving the health of the nation.

\textbf{B. SHAREHOLDER INCENTIVES}

Shareholder desires for maximum profits are, arguably, compatible with a commitment by managed care to public health. The presence of preventable health risks in communities served by a particular plan should be viewed as “contingent liabilities,”\textsuperscript{360} that the plan may potentially have to pay in the future in the form of treatment costs, especially in an environment characterized by switching among different plans. The conventional wisdom is that if enrollees are constantly switching among plans there is no incentive to invest in clinical prevention or education since the investment would be lost when a member changes to a competing


\textsuperscript{355} See BRENNAN & BERWICK, supra note 294, at 152.

\textsuperscript{356} See id. In addition to financial assistance the Act provided other incentives including: (1) Preemption of any state regulations serving as barriers to HMO formation; and (2) the equal dollar rule which required any employer with more than 25 employees to offer an HMO option as part of its health benefits and which prohibited the employer from charging less than was charged for indemnity insurance. Preemption of state regulation was especially important because many state laws enforced a ban on the corporate practice of medicine. \textit{See, e.g.}, MANAGED CARE, supra note 42, at §§ 1-15 to 1-18.

\textsuperscript{357} To be federally qualified, an HMO had to offer a minimum comprehensive benefits package (42 U.S.C. § 300e-1(1) (1994)); meet certain financial requirements (42 U.S.C. § 300e-1(8) (1994)); have a quality insurance system in place (42 C.F.R. § 417.107(h) (1998)); have grievance procedures (42 U.S.C § 300e(c)(5) (1994)); comply with community rating requirements (42 U.S.C. § 300(e)(b)(4) (1994)); and not impose pre-existing conditions limitations on members accepted for enrollment (42 C.F.R. §§ 417 et seq. (1998)).

\textsuperscript{358} See MANAGED CARE, supra note 42, at §§ 1-15 to 1-16.

\textsuperscript{359} See id.

\textsuperscript{360} A contingent liability is not presently fixed and absolute, “but will become so in case of the occurrence of some future and uncertain event.” BLACK’S LAW DICTIONARY 321 (6th ed. 1990).
Under these circumstances, plans are expected to supply less prevention and education than society would consider socially optimal.

From a long-term perspective, however, switching among plans provides a strong incentive for community-wide intervention because a specific plan can minimize the risk that this year’s new enrollees will be suffering from costly ailments which were preventable by actively promoting health in the community. This, of course, assumes that all managed care organizations are engaging in prevention. Thus, short-term losses can be translated into long-run profits. Further, several factors suggest that the covered populations in a geographic area are likely to become more stable, making it more difficult to switch.

Furrow emphasizes that the trend toward consolidation of health plans through mergers, the growth of large hospital networks and actions by employers to narrow the range of choices for employers all promote stability and enhance the incentives for managed care organizations to devote long-term attention to enrollee health. Further, as large networks assume responsibility for larger populations within the community, the gap between the number of covered lives and the community narrows. As this happens, managed care may well return to its origins as provider of coverage for a fixed population, where the health of the population is the central goal.

From this perspective, a rational profit-seeking shareholder should view information about community health as material to her investment decisions. As a result, besides describing profits and losses, stockholders should require health plans to disclose local and regional health conditions in their annual reports, and other financial documents, because the

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361. The closest analogy would be the area of human capital, in particular, where a firm invests in improving the quality of workers through training and education only to have constant turnover. The human capital analogy is inapposite, however, because health plans can still capture a return on the investment as discussed above.


363. But what if there were only one health plan within a community, would it necessarily perform community prevention? We suggest that it probably would not. Providing cradle to grave coverage decreases any incentive to invest in health promotion since the plan knows that if an enrollee does not die of lead poisoning at age eight, for example, she will die of something else—perhaps cancer at age 80. The lack of competitive pressures, as a monopoly, would allow the plan to charge more for its care, produce less care, reap greater profits, and invest less in research, physical plant and, certainly, prevention. Competitive health plans, on the other hand, lack this luxury. Managed care systems must begin to recognize that maximizing the community’s health status and minimizing community health risks are essential as they take on financial risk.

364. See Furrow, supra note 40, at 499.
potential future-arising health care costs due to unhealthy community conditions are important factors in long-term profitability.

To satisfy these contingent liabilities, stockholders could demand that management allocate a portion of profits to address preventable injury and morbidity in the community. We realize that numerous practical obstacles exist to this theoretical model that require thoughtful and creative solutions. First, we need better ways to measure the effectiveness of public health intervention in order to value the reduction in future health care costs. Second, commentators agree that shareholders rarely pressure management to pursue social goals because they receive financial benefits from a corporation’s disregard for larger community issues and, therefore, cannot be expected to exercise meaningful control over corporate behavior in this area.365 While this may be true when one is discussing an externality such as air or water pollution in which retrofitting and clean-up costs are a drain on profits, public health promotion is a different matter. Better community health leads to lower health care utilization and costs. Therefore, informed shareholders would likely be more willing to encourage plans to take a longer-term view and promote public health provided, of course, the problem of a stable membership is satisfactorily addressed.

VIII. SOCIAL OBLIGATIONS OF MANAGED CARE

As we have seen, constitutional law, theories of community and democracy, and public health practice all point toward the government as the entity responsible for the protection and assurance of health. There is much that government can do to fulfill this responsibility such as promoting public health partnerships with managed care, delegating certain public health functions, and regulating or providing incentives. Yet we claim that managed care has an independent social responsibility to act voluntarily and affirmatively for the health of the nation, absent the guiding hand of government.

Philosophical and legal thinkers have intensively debated whether for-profit corporations owe social obligations to the community. As a general matter, corporate theory, practice, and law absolve corporations of any obligation to promote social values.366 Further, the very idea of corporate social responsibility is so anathemic to some prominent theorists that they have recommended that directors who voluntarily use corporate resources

365. See Weiss, supra note 305, at 416.
366. See id. at 372.
to promote social goals should be held personally liable to shareholders for costs incurred.\textsuperscript{367} Although the case law is not so restrictive, neither is it supportive of the use of corporate assets to fulfill social needs.\textsuperscript{368} To avoid liability, directors must show that they reasonably believed their decisions advanced the corporation’s long-term profitability.\textsuperscript{369}

It is in this sense that voluntary involvement in public health finds its theoretical basis. Managed care organizations clearly benefit in the long run from healthier communities. Healthier communities reduce the utilization of health care resources, which is of central importance in fulfilling managed care’s promise to contain utilization and costs while maintaining or promoting quality of care, and also in legitimizing its role as a de facto rationer of health care. Thus, investment in community health is much more than charity; it is a sound business strategy.

In this Part, we view social responsibility from an ethical perspective, arguing that managed care organizations should, where possible, voluntarily undertake community public health activities based on moral principles. This claim is based on the substantial national investment in the health care infrastructure and public spending for biomedical advances, which managed care organizations routinely exploit for shareholder enrichment. Further, it is our claim that managed care’s acceptance of responsibility for an enrolled population presents an ethical duty to ensure the well-being of enrollees. The boundaries between medicine and public health are obfuscated, in this case, and managed care is ethically bound to accept responsibility for, among other things, patient care, health education and detection, and follow-up for injury and disease.

\section{A. WHOSE RETURN ON INVESTMENT—SHAREHOLDER OR TAXPAYER?}

The United States’ taxpayers have created an immense medical research establishment; one that most Americans view as a national asset.\textsuperscript{370} Although it is impossible to place a value on these public investments in biomedical progress and the health care infrastructure,

\begin{itemize}
\item \textsuperscript{369} See Weiss, supra note 305, at 372.
\item \textsuperscript{370} See Paul Starr, \textit{The Social Transformation of Medicine} 335 (1983).
\end{itemize}
private entities clearly do not include them among their costs of producing health care services. We can, therefore, think of them as social goods. Our claim is that managed care organizations should, as a matter of conscience, internalize the positive externalities resulting from the nation’s collective investment in health and implement policies that provide the principal investors in the health care system (taxpayers) with an adequate return on this investment.371 One way for managed care to do this is to add a community health component to their mission.372

Prior to World War I, only a trickle of federal research dollars had been devoted to medical research, mostly for the study of infectious diseases, but in the post-war period federal spending on a wide range of biomedical treatment-oriented research exploded. Such public funding stimulated the development of a host of biomedical advances including the discovery of antibiotics and vaccines, such as penicillin and streptomycin. Notably, the success of the 1954 Salk polio vaccine trials fueled political and social support for the NIH and biomedical science: “The magic of science and money had worked.”373

Taxpayers have further invested in health by providing subsidies for medical school expansion, physician residency programs through Medicare,374 and the construction of hospital, long-term care and ambulatory care facilities under the Hill-Burton Hospital Act.375 Further, taxpayers have invested directly in health care through government sponsored Medicaid and Medicare programs, as well as through their own individual contributions to health plans and payment of insurance.

371. Jonathan Showstack expresses concern that managed care systems are using these publicly financed assets to make substantial profits. Moreover, he argues that because managed care plans are responsible for enrolled populations, the principal investors in the health care infrastructure, taxpayers, have a right to expect a return on these investments in the form of better community health. Therefore, “managed care systems should add a population perspective to their missions and programs.” Jonathan Showstack, Nicole Lurie, Sheila Leatherman, Elliott Fisher & Thomas Inui, Health of the Public: The Private-sector Challenge, 276 JAMA 1071, 1071 (1996).

372. Under this perspective, a socially responsible managed care system would have the following attributes: (1) Enrolls a representative segment of the general population living in the system’s geographic service area; (2) Identifies and acts on opportunities for community health improvement; (3) Participates in community-wide data networking and sharing; (4) Publishes information regarding its financial performance and contributions to the community; (5) Includes the community, broadly defined, in the governance and advisory structures of the system; (6) Participates in health professions education programs; (7) Collaborates meaningfully with other members the public health infrastructure; and (8) Publicly advocates for community health promotion and disease prevention policies. See Angus et al., supra note 201, at 1077-83.

373. STARR, supra note 370, at 347.


premiums. And, as we discussed in Part VII, taxpayers have provided loans, incentives and financial assistance to further the development of managed care through the Health Maintenance Organization Act of 1973. Less directly, but just as important, the tax exemption granted to nonprofit hospitals has been a continuing and massive subsidy, and, increasingly, managed care systems are integrating such non-profit facilities into for-profit health care networks.

Considerations of this sort demonstrate shortcomings in the prevailing view that shareholder enrichment is managed care’s sole social responsibility. If political communities form for the communal provision of security and welfare, and if publicly-funded medical research and development is an expression of this concern, the community, then, is also a stakeholder. We do not challenge the legitimacy of for-profit enterprises supplying health care, nor do we argue, literally, that all stakeholders, taxpayers and shareholders, are entitled to a monetary return on their respective investment. Instead, our point is that investor-owned managed care firms can view health care as a profit-making industry, but this perspective should be balanced with a concern for the community and a recognition of its investment in medical research and development.

Of course, society subsidizes other private industries such as airlines through support for airports and air traffic control, and farmers through subsidies and federally-supported research. Indeed, the activist, liberal state subsidizes numerous public goods that are used as factors of production by for-profit firms. As a general matter, the government actively regulates these industries in the public interest. Subsidization and regulation of airlines, for instance, ensures the coordination of airline transportation, but equally important, protects collective goals and aspirations for airline safety. Cass Sunstein argues that the protection of such aspirations is a “vindication of democracy.”

376 See generally Barry R. Furrow, Enterprise Liability and Health Care Reform: Managing Care and Managing Risk, 39 St. Louis Univ. L. Rev. 79, 85 (1994). Professor Furrow argues that the concept of tax exemption for non-profit hospitals is dubious “as the health care enterprise has mutated from charity to revenue maximizer.” See also, e.g., M. Gregg Bloche, Health Policy Below the Waterline: Medical Care and the Charitable Exemption, 80 Minn. L. Rev. 299 (1995).


379 See, e.g., 7 U.S.C.A. § 3152 (grants and fellowships for food and agricultural sciences education); 7 U.S.C.A. § 1471(a) (emergency livestock assistance); 7 U.S.C.A. § 1444 (cotton price support); 7 U.S.C.A. § 1446 (support for nonbasic agricultural commodities such as dairy products).

380 Sunstein, supra note 2, at 3.
Governmental initiatives in health are different. Public aspirations for health protection and promotion through government regulation have been largely unmet, while, at the same time, for-profit health plans exploit government subsidies for their own gain. Under ERISA, for example, plaintiffs have no remedy, state or federal, for improper denial of care and other acts of malfeasance by managed care plans and ERISA has evolved into a “shield of immunity.” Thus, with few substantive federal and state regulations reflecting public aspirations for quality health care, the case for social responsibility of for-profit health care plans is more compelling.

B. ACCOUNTABILITY

To those with a sense of medical history, it will seem puzzling to suggest that managed care organizations should be held accountable to consumers and payers for public health promotion and community benefit. True, public health promotion has never been a recognized component of biomedical ethics, especially for physicians; but in this section, we examine the changes in the physician/patient relationship under managed care and conclude that managed care organizations, rather than physicians, are the locus of accountability for the welfare of subscribers. By extension, we show that the idea of accountability necessarily leads to duties of beneficence that involve public health promotion. Further, we suggest that consumer reliance on managed care organizations to “manage care” presents a duty of fidelity that obligates health plans to take all feasible steps to prevent unnecessary illness among enrollees.

Accountability has become a principal focus of health policy and, indeed, much of the debate about managed care concerns the issue of what constitutes the appropriate form of accountability. Accountability figured prominently in President Clinton’s Health Security Act and advocates of managed competition renamed managed care organizations “Accountable Health Plans.” Medical ethicists such as Emanuel & Emanuel define accountability as involving the procedures and processes by which individuals are responsible for a set of activities and for

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explaining or answering for their actions.384 Public health promotion and community benefit are among the recognized domains of accountability in health care.385

In modern health care practice, patients are not, arguably, treated by doctors but cared for under organized systems of care that arrange for the facilities and physicians through which their members receive care. These systems promise cost-effective quality services to large populations and, typically, agree to provide comprehensive health care services to an enrolled membership for a fixed per capita fee. Further, these organizations make allocational decisions, such as the types of services that will be provided and decide which domains should be primary, preventive care or disease treatment. And, as we have demonstrated, employers and other payers are increasingly holding managed care plans, not individual physicians, responsible for health outcomes. In the modern environment, then, these considerations situate the health plan as the locus of accountability for health promotion and the welfare of enrolled populations.

We can derive a duty of beneficence from this idea of accountability. Beneficence refers to an action done for the benefit of others and typically demands more than the principle of nonmaleficence; agents must take active steps to help others, not merely refrain from harmful acts.386 As usually formulated, however, beneficence is applied to individuals, particularly in trusting relationships, such as physician/patient, and as a general matter is not applied to populations.387 Nevertheless, the principles of beneficence apply in the managed care context because subscribers look to the organization, rather than individual physicians, as the entity responsible for care. It is well documented that the managed care plan must, because of competition, compel the physician to act as its agent, and physicians are obligated to take into account interests other than those of their patients. As stewards of scarce capitated resources, physicians have responsibilities to other patients, physicians in their practice group, and toward the health care plans to which their patients

385. Emanuel & Emanuel describe the domains of accountability: “professional competence, legal and ethical conduct, financial performance, adequacy of access, public health promotion, and community benefit.” Id. at 230.
387. See id. at 263-71.
belong.\textsuperscript{388} Considerations of this sort suggest that if the duty of beneficence is to retain any meaning, it must be extended to the organization since the evolution and expansion of managed care has challenged the traditional patient-centered medical ethics.

To provide positive benefits to all subscribers, as beneficence requires, managed care organizations must develop a population-based perspective. Enrollees clearly benefit from healthier communities and, therefore, the duty to do good and promote patient welfare should include a community component. Consider, for example, a traditional physician-patient relationship in which the patient arrives at the physician’s office with symptoms of a communicable disease such as tuberculosis. Beneficence requires the physician, among other things, to conform to the standard of care in diagnosing the disease, providing treatment and notifying the local board of health. Ensuring the health of the patient is the primary concern.

The same ethical principle of beneficence should operate when managed care organizations assume responsibility for the health of enrolled populations. Managed care organizations typically possess automated systems that distribute patient records within the extended system of medical treatment, case management, and financial review, which enable the organization to identify clusters of disease or injury which pose a risk for other members of the enrolled population. If numerous patients have been treated for tuberculosis, then the managed care organization is on notice that there is a risk of tuberculosis infection in the community which could jeopardize the health of individuals relying on it for health care. Whether the organization undertakes community-wide public health measures is a function of whether it is driven by the goal of maximizing institutional profits or is motivated by the goal of assuring the well-being of its population. Thus, we claim that managed care organizations are ethically obligated to, at a minimum, cooperate with public health officials in identifying, monitoring and preventing health threats within the community to ensure the well-being of the enrolled population.

Another ethical basis for managed care organizations to promote public health is consumer reliance on managed care organizations to “manage” care. The duty of fidelity obligates the organization to act in good faith to keep vows and promises, fulfill agreements and maintain

\textsuperscript{388} See Paul Clay Sorum, \textit{Ethical Decision Making in Managed Care}, 156 ARCHIVES INTERNAL MED. 2041, 2041 (1996).
In the face of a public health threat, a health plan member has the right to expect that the organization is taking affirmative steps to protect her health. Consumer reliance on the plan to manage care necessarily must include the promotion of public health measures to prevent unnecessary illness among their enrollees, maintain their satisfaction and retain their loyalty. Thus, to meet public expectations, managed care organizations must assume more meaningful community roles. Further, from a consequentialist perspective, activities that maximize benefits and minimize burdens are preferred; and we have demonstrated that prevention and population-based activities are arguably more important in reducing morbidity and mortality of individuals and populations than medical interventions and the treatment of existing disease. Considerations of this sort suggest that managing the health of enrollees should involve the value of achieving more favorable health outcomes for the greatest number of people. If we take the fundamental importance of health seriously, how, then, could it be said that managed care’s duties are limited to classical medical treatment, but not to community well-being?

In sum, while managed care is assuredly entitled to satisfy shareholder demand to maximize profits, it must do so consistent with societal aspirations for disease prevention and health promotion. The perceived prerogative of managed care to exploit publicly-funded biomedical research and the health care infrastructure are limited by the claims of the public to healthy communities. Further, managed care’s responsibility for enrolled populations provides an ethical obligation to engage vigorously in community health activities. Such activities should be highly cost-effective in the long-run because the population remains healthier and uses fewer services. Achieving a just balance between stakeholder claims represents an enduring challenge and must be a part of a vigorous and expanded democratic discussion about the health of the nation.

CONCLUSION

Health and longevity are substantially affected by environmental, behavioral, and socioeconomic factors that pose direct threats to health or that affect exposure to risk. Nevertheless, public health interventions, although crucial to reducing premature morbidity and mortality, have suffered from a political culture that has under-funded public health and

389. See BEAUCHAMP & CHILDRESS, supra note 386, at 430.
under-appreciated the overarching importance of health in increasing human happiness and prosperity. More fundamentally, this Article has demonstrated how public health is structurally deficient. The private sector, particularly managed care organizations, are in a better position than government to monitor and ensure community health because these organizations are more closely associated with people and their health and, therefore, can more readily observe and influence personal choices, obtain information on rates of illness and injury from specific causes, and identify health risks in the community. Thus, no matter how much we as a society invest in government public health, private sector managed care is critical in improving the health of the nation.

While it is widely recognized that the health promotion and disease prevention objectives of public health are becoming increasingly important to managed care as a way of ensuring healthier present and potential enrollees, this Article has asserted that managed care has few incentives to engage in community public health activities. Manifestly, everyone gains value from prevention and healthy communities, but an understanding of managed care’s economic incentives suggests a conflict between short-term profit maximization objectives and the goal of health maximization for present and potential enrollees. In this regard, we have shown that a rational plan manager would likely prefer to free ride on those public health services provided by other health plans or government, rather than directly provide services. This is because new prevention initiatives may depress current earnings with the hope of improved future earnings that may not be realized if enrollees switch health care plans.

The void between managed care’s promise for community health, on the one hand, and economic reality, on the other, leads us to conclude that government must make a deliberative effort to correct the market failure in the supply of public health goods. As we have shown, theories of community and democracy, the Constitution and public health history, and practice all point to government as the entity responsible for the protection and assurance of health. Yet, the deterioration of the public health infrastructure combined with the growth in managed care and its population-based orientation suggest that a purely governmental model of public health is anachronistic. Mindful of this, we argue that government can exercise its responsibility for public health as a facilitator, regulator, funder or a force for intervening to reduce public health threats. The basic power or obligation of government to protect and preserve the health of populations legitimizes government efforts to change the incentive
structure, or reorder private preferences to involve managed care in public health maximization.

To accomplish this, we first advocate delegating concrete public health services under some instances to managed care—personal medical and clinical prevention services. This is not to say that health departments should completely avoid the compelling pressures to provide medical services to the poor and uninsured; rather, we argue, government must reduce the direct provision of these services to fulfill its broader community obligations. We have demonstrated that substantial system savings can result from contracting out personal and clinical health services to managed care. Further, managed care can supplement public health’s provision of other services—surveillance, health promotion, counseling services and education. Most health departments lack the personnel, laboratories, and information systems to identify and respond effectively to the great variety of health risks facing populations. At the same time, many managed care organizations are developing the capacity to identify clusters of diseases and injuries within the enrolled population and, through investigation, find out what caused them. This information is critical for public health policy development and community health assessment. Further, managed care can assist in the early detection and control of emerging microbial threats through data collection and analysis because, assuming health plans are routinely reporting to health departments on community status, such clusters would be brought to the attention of public health officials before there is a widespread epidemic. Finally, managed care can greatly assist in health promotion, education, and counseling by delivering health messages and counseling services to their enrolled populations or sharing the cost of community wide health messages and providing education and counseling services that benefit the entire community.

These public health services are principal candidates for privatization for two reasons. First, managed care’s expertise and resources suggest that substantial value can be added by the private sector in these areas. Public health agencies are not necessarily optimally effective when providing medical and clinical services and, therefore, eliminating duplicative staffs and facilities would allocate resources more rationally. Further, managed care organizations frequently possess economies of scale and economies of scope that result in more cost-effective production of services. Second, unlike other public health functions such as policy development, regulation, licensing and compulsory treatment, privatized public health, as
we have proposed it, avoids the legal and constitutional obstacles arising from a delegation of regulatory or judicial authority.

As a general proposition, public health maximization requires managed care plans to recognize their social responsibility to invest in community health, which would allow the public health system to perform essential functions other than providing personal medical services. Evidence suggests that managed care systems operating in mature markets are more predisposed to supplying community health services. Considerations of this sort suggest that government can promote community health indirectly by allowing mergers and consolidations in local areas, and repealing laws such as prohibitions on the corporate practice of medicine that impede the formation of local managed care systems. Further, government, as a purchaser of health care, can require plans receiving Medicaid and Medicare funds to provide community benefits. Government should also provide financial incentives and act as a facilitator to encourage managed care plans to engage in important public health functions such as laboratory-based surveillance and the sharing of proprietary information, which plans cannot do unilaterally.

In dealing with these issues, it is especially important to evaluate rigorously the fashionable anti-market sentiments that associate the involvement of managed care plans in public health with the destruction of the links between public health, the communitarian ethic and social justice. It is our vision that government will be responsive to the community by assuring that managed care performs its services with high quality and respect for human dignity. If privatization, as we have defined it, is approached in these terms, it emerges not as a crazy-quilt of public health commodities that are supplied by an impersonal market, but as a series of well-conceived delegations with integrity and coherence of their own. Further, cooperation can better promote the communal vision of what a health community should be if, as we suggest, cooperation with the private sector will allow local public health officials to devote time and resources to fulfill those unmet needs for which the community demands a response.

Finally, regardless of one’s views about managed care, this system of health care finance and delivery is rapidly increasing in the United States and, undoubtedly, will be with us in some form long into the foreseeable future. We have attempted to demonstrate that this development presents promising opportunities for improving the health of the nation if we as a society provide the proper incentives and capitalize on the opportunities to exploit managed care’s financial and ethical stake in healthier communities. The initial challenge in this endeavor, we believe, is to
initiate a national discourse in which community health is included in the matrix of accountability and consumer rights concerns that must be developed and maintained for managed care.