

A POPULATION HEALTH FRAMEWORK FOR TEACHING HEALTH LAW

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Health law can seem unruly as a field of law, and this makes teaching a survey course on the subject very challenging. A health law survey is unlike, for example, a course on contract law that can be organized around the form of a contractual agreement. Likewise, it is different from a survey of constitutional law, which can be framed by the legal document it studies, or an administrative law course, which is structured around federal or state codes of administrative procedure.

Health law does not have a defining form or code on which to base a survey course. Certainly there are major federal statutes unique to health law: Medicare, Medicaid, the Health Insurance Portability and Accountability Act (HIPAA), and—of course—the Affordable Care Act (ACA). Yet, a course based only on these federal statutes would not adequately represent the field. As I have written elsewhere:

[L]aws affecting health care delivery are so varied that they resist systematic organization. They encompass the regulation of clinical as well as business practices, covering not only licensing and medical malpractice, for example, but also network relationships between providers and insurers; financial relationships among physicians, hospitals, and ancillary providers; and bargaining relationships among providers negotiating with payors. As a result, health law spans many different legal fields, including torts, professional and insurance regulation, antitrust, tax, intellectual property, and corporate law.¹

Indeed, health law scholars fret over the field's breadth and disorganization. They refer to health law as “a chaotic, dysfunctional patchwork”² and an “incoherent mish-mash of [legal] approaches.”³

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1. Robert Gatter, *Health Care Regulation in America: Complexity, Confrontation, and Compromise*, 28 J. LEGAL MED. 593, 593 (2007) (book review).

2. M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 321 (2003).

How, then, is a teacher to create order out of what appears to be a hodgepodge of doctrines borrowed from other legal disciplines mixed with a collection of unique state and federal statutes? What do these laws have in common other than the fact that they are each applied to conduct related to health and health care delivery?

I teach health law and have tried several ways to structure a survey course to account for these questions. I have had the greatest success with a borrowed organization framed around the goals of improving the quality of health care services, expanding access to those services, controlling the costs of health insurance and health care services, and protecting individual choice within health care delivery.⁴ Yet, even these illuminating goals are merely instruments of a larger objective—achieving health. Ultimately, health law explores the role of law in improving the health of a population over which the law has jurisdiction. Paraphrasing Professor Wendy Mariner, the study of health law is the study of how the law—with its commitment to rules, procedure, and justice—adapts “to protect the value of health.”⁵

In this way, a course in health law examines the moral, political, and economic value of health as expressed and organized through law. This essay explores how a teacher might use this broad definition of health law to organize a survey course in the field, and it does so using the concept of “population health,” which is described below.⁶

Health law is often presumed as encompassing only law relating to health care delivery. In fact, health law has and should have a broader reach because “[h]ealth is about more than what happens in a doctor’s office or a hospital room.”⁷ Personal and population health are affected fundamentally by social determinants: income, education, unemployment, neighborhood safety, housing, access to healthy foods, and so on.⁸

Consider, for example, the cleanliness of drinking and bathing water. Clean water is a condition of individual and community health, a fact that—

3. Einer R. Elhauge, *Can Health Law Become a Coherent Field of Law?*, 41 WAKE FOREST L. REV. 365, 377 (2006).

4. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* (7th ed. 2013).

5. Wendy K. Mariner, *Toward an Architecture of Health Law*, 35 AM. J.L. & MED. 67, 70 (2009).

6. This essay is an application to the classroom of a theoretical framework for health law that I explore in another article. Robert Gatter, *(Population) Health Law in Theory*, 41 J. HEALTH POL., POL’Y & L. 1129, 1130 (2016). It is based upon the population health perspective developed in WENDY E. PARMET, *POPULATIONS, PUBLIC HEALTH, AND THE LAW* (2009).

7. WASHINGTON UNIV. IN ST. LOUIS & SAINT LOUIS UNIV., *FOR THE SAKE OF ALL 4* (2015), https://forthesakeofall.org/wp-content/uploads/2016/06/FSOA_report_2.pdf [https://perma.cc/H2AZ-GX5K].

8. *Social Determinants of Health*, HEALTHYPEOPLE.GOV, <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> [https://perma.cc/7WMB-L2DP].

until the water crisis in Flint, Michigan—the public took for granted. To save money, Flint’s city managers stopped buying Detroit water and began drawing and treating water from the Flint River.⁹ A combination of the river’s contamination and inadequate treatment resulted in supplying unsafe drinking water to the residents of Flint for months.¹⁰ As a consequence, lead levels rose among the children of Flint,¹¹ creating a significant risk of neurological abnormalities.¹² Health law is incomplete if it does not account for how law relates to the conditions—like clean water—for community and individual health.

Closer to home, a recently published study of health disparities among African Americans living in St. Louis, Missouri also observes that individual and population health is determined far more by factors other than medical care.¹³ “[M]edical care only accounts for about 10% of premature deaths . . . in the U.S.,” write the study’s authors.¹⁴ Even after controlling for genetic differences, “most of the contribution to premature death is made by behaviors like diet, exercise, and smoking (40%), social factors like poverty, education, and housing (15%), and exposure to physical environments that are unhealthy because of toxins, disease carrying agents, or unsafe structures (5%).”¹⁵ While it is tempting to focus on the largest number in this list, stop and appreciate the significance of the fact that poverty, education, and housing, when combined, are *one-and-a-half times* as likely to determine personal or community health than is medical care.

From examples like these, it becomes obvious that the conditions necessary for personal health include, but go far beyond, access to quality medical care and that they include attributes that affect community health. Indeed, these stories and observations reveal that individual health is nested in population health. Likewise, they teach that health care delivery is nested in a larger collection of conditions that determine the health of a population and of individual members of that population. So, by extension, health law includes not only law related to health care delivery but also law related to each of the conditions that contributes significantly to population health.

9. FLINT WATER ADVISORY TASK FORCE, FINAL REPORT 15–16 (2016), https://www.michigan.gov/documents/snyder/FWATF_FINAL_REPORT_21March2016_517805_7.pdf [<https://perma.cc/Q26H-E283>].

10. *Id.* at 16.

11. Chinaro Kennedy et al., *Blood Lead Levels Among Children Aged <6 Years — Flint, Michigan, 2013–2016*, 65 MORBIDITY & MORTALITY WEEKLY REP. 650, 650 (2016), <http://dx.doi.org/10.15585/mmwr.mm6525e1> [<https://perma.cc/K8MX-YBX8>].

12. FLINT WATER ADVISORY TASK FORCE, *supra* note 9, at 23.

13. WASHINGTON UNIV. IN ST. LOUIS & SAINT LOUIS UNIV., *supra* note 7, at 11–12.

14. *Id.* at 12.

15. *Id.*

Population health refers to “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”¹⁶ It includes two different aspects of health at once. The first phrase—“the health outcomes of a group of individuals”—refers to the average value of any particular health measure for a population.¹⁷ So, for example, the infant mortality rate in Missouri over the decade ending in 2011 was 7.3 deaths per 1000 births.¹⁸ Meanwhile, the second phrase—“the distribution of such outcomes within the group”—accounts for variation on that health measure among sub-groups within that population, revealing any health disparities.¹⁹ So, for example, the mortality rate for African American infants born in Missouri during the same decade was more than double the rate for the state population as a whole—14.9 deaths per 1000 births,²⁰ demonstrating an unfair population health burden on African Americans. In this way “population health” captures the values of both health and equity. This makes it a particularly good framework for health law,²¹ a field that began with the law’s foundation in justice and then has adapted—and continues to adapt—“to protect the value of health.”²²

I. IMPLEMENTING A POPULATION HEALTH APPROACH IN A HEALTH LAW SURVEY COURSE

I ask students starting their survey of health law to take a population health perspective on the conditions necessary for health as well as the role of law in supporting those conditions.²³ The very first exercise in the course requires students to identify what it takes for individuals and communities to be healthy.²⁴ The students’ contributions usually start relatively close to health care delivery, identifying—for example—the need for competent professional and institutional providers, insurance programs, or other means to pay for medical services when needed, and safe and effective medicines and medical

16. David Kindig & Greg Stoddart, *What Is Population Health?*, 93 AM. J. PUB. HEALTH 380, 381 (2003).

17. *Id.*

18. MISSOURI DEP’T OF HEALTH AND SENIOR SERVICES, MISSOURI HEALTH ASSESSMENT 19, <http://health.mo.gov/data/mohealthassess/pdf/assessment.pdf> [https://perma.cc/W5DR-JUZ2].

19. Kindig & Stoddart, *supra* note 16, at 381.

20. MISSOURI DEP’T OF HEALTH AND SENIOR SERVICES, *supra* note 18, at 19.

21. See PARMET, *supra* note 6 (articulating and arguing for a population health perspective to law); see also Gatter, *supra* note 6 (examining the potential for population health to provide an organizing framework for health law).

22. Mariner, *supra* note 5, at 70.

23. See PARMET, *supra* note 6 (developing, describing and applying a “population health perspective” with respect to all law).

24. In an earlier version of the exercise, I asked students to imagine that they had been appointed the minister of health for a fictitious new kingdom with the responsibility to identify and design what is needed to assure the good health of the kingdom’s population and the individuals that constitute that population.

devices. From there, students often mention the need for a safe and healthy food supply, and—in the wake of the Flint water crisis—they now identify the need for clean drinking water. On follow-up, I ask students to articulate the connection between community and individual health, on the one hand, and safe and healthy food or clean water, on the other. They respond that, without a sufficient supply of healthy food and clean water, individuals and communities cannot maintain good health; over time, their health will deteriorate as they experience the consequences of a poor diet or of unclean water. Probing further, I ask that students move into small groups and consider what other structural conditions might result in a similar deterioration of health among individuals and communities. This results in a list that often includes clean air, adequate sanitation systems, disease surveillance and prevention, safe housing, safe workplaces, safe neighborhoods, and adequate education. To this list, we add the students' original observations about safe and healthy food, clean water, safe and effective medicines and devices, health insurance, and competent professional and institutional medical providers.

In this way, a population health framework helps students appreciate health care delivery in broader perspective. The providers, medicines, and insurance plans that help restore health—while essential to individual and community health—are just part of what it takes to promote health. Starting from this perspective pays dividends at other points in a survey of health law because it provides a basis for tying important pieces of our health care delivery system back to promoting population health. For example, physician licensure, conditions for provider participation in Medicare, the Medicare shared savings program, and state and federal health insurance regulation can each be linked to promoting population health.

Critically, the population health framework also helps teach students *both* the value *and* interconnectedness of individual and community health. For example, when we cover medical confidentiality and its exceptions, I ask the class to consider the importance of confidentiality to individuals and to community health. Students respond that individuals are more likely to pursue medical care when needed if they believe that private information they share with their providers will remain private. And an individual who seeks care in a timely manner is more likely to maintain her health or have her health restored quickly and efficiently. Moreover, students connect this individual value to community health. If individuals fear that personal information they share with their physicians would not be kept confidential, they might withhold from their providers information important to their treatment, or they might avoid medical care all together. This, in turn, would undermine care that would prevent or treat a condition (e.g., a contagious disease) in one individual and thereby put at risk others who live and work with that individual.

A lesson about health law and medical privacy, in this way, also teaches students about our interconnectedness through health. Indeed, some of the

law's exceptions for medical confidentiality (e.g., mandatory disclosure to public health officials of otherwise private health information about a sexually transmissible disease) recognize that one person's ill-health can pose a significant danger to the community of which that individual is a part.

The interconnectedness of individual and population health resurfaces when we address health insurance regulation and the uninsured. I ask students to articulate why anyone should care that someone else in their community does not have health insurance. Early answers often focus on the empathy one might have for another who lacks the means to access health care services when necessary. As the discussion continues, students also identify reasons why a person—motivated only by self-interest—might prefer that others they interact with have health insurance. As a group, the uninsured are significantly more likely than publically or privately insured populations to delay or forgo needed medical care and substantially more likely not to have a usual source of care.²⁵ Those who forgo or delay needed medical care because they lack the means to pay for those services—observe students—may be more likely to transmit disease to others and to experience more sick days from school and work as compared to those who have insurance. Additionally, those who generate a bill for health care services that they cannot afford to pay often push the cost of their unpaid bill on to others. For example, in 2013, nearly 650,000 personal bankruptcies involved unpaid medical debt.²⁶ This, in turn, results in higher credit card interest rates and higher prices charged by health care providers to their larger communities of customers so as to account for lost income from uncollectable accounts.²⁷

These are just some examples of where in a health law survey course a teacher might use the population health framework to demonstrate the links between health and certain social circumstances (e.g., a lack of insurance) and between individual health and population health. Additionally, each exemplifies the role of law in promoting health by addressing social circumstances that are linked to poor health. Other examples exist. As I have observed earlier in this essay and elsewhere, population health framework can be used to understand much of what we commonly teach in health law. These include, for example, any survey of the Medicare or Medicaid programs, which serve both individual and population health by subsidizing access to health

25. *Key Facts About the Uninsured Population*, KAISER FAMILY FOUNDATION, 7 (Oct. 2014), <http://files.kff.org/attachment/key-facts-about-the-uninsured-population-fact-sheet> [<https://perma.cc/A66D-G9LR>] (reporting findings of KCMU analysis of 2014 National Health Insurance Survey).

26. Dan Mangan, *Medical Bills Are the Biggest Cause of US Bankruptcies: Study*, CNBC (June 25, 2013, 2:29 PM), <http://www.cnbc.com/id/100840148> [<https://perma.cc/GRV8-M8NS>].

27. KAISER FAMILY FOUNDATION, *MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE* 15 (Jan. 2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/01/8537-medical-debt-among-people-with-health-insurance.pdf> [<https://perma.cc/NC7M-FEDA>].

insurance for vulnerable segments of society. For a teacher who dives more deeply into Medicare payment, the Medicare Shared Savings Program²⁸ provides another opportunity to address population health:

[Under this program,] an ACO [Accountable Care Organization] promises to care for a population of at least 5,000 Medicare beneficiaries without exceeding a total cost threshold set by Medicare. In return, Medicare promises to share with an ACO any savings generated by the ACO's supplying needed care at a cost below that threshold. Medicare, however, shares these savings only if the ACO meets quality measures for the population of Medicare beneficiaries it serves. Population health is served in this program in two ways. For one thing, it promotes the health of subpopulations of Medicare beneficiaries by conditioning the payment of shared savings on meeting quality measures taken at the subpopulation level. Further, it incentivizes providers to be wise stewards of public funds that are used to assure future access to medical services for Medicare beneficiaries.²⁹

Other examples include professional and institutional licensure laws, the Emergency Medical Treatment and Labor Act (EMTALA), malpractice payment reporting to the National Practitioners Databank, state and federal regulation of private health insurance, and others.

This is not to say that each of these examples demonstrate how the law values health—both at the individual and population levels—perfectly. Nor is each of them necessarily an example of laws motivated by population health. Rather, each can be *understood* in reference to population health because each has significant effects on population health. Thus, even if a teacher critiques a particular aspect of health law for striking the wrong balance among economic efficiency, individual choice, and population health, students learn that both individual and population health are core values that should be reflected in the law.

As a core value, population health is also a common thread that binds together the four policy goals I use to help organize a health law survey course: quality, access, cost, and choice. As demonstrated above, examples of health laws that can be understood from a population health perspective can be linked to one or more of these goals, suggesting that each of these policy goals derives from the fundamental value of individual and population health.

A population health framework for teaching health law also creates opportunities for teachers to connect a course in health law to other legal topics that might not otherwise appear connected. Because individual and population health is affected so significantly by social determinants including poverty, education, housing, and non-toxic environments, a health law course can be directly connected to other areas of legal study: urban planning, fair housing,

28. 42 C.F.R. § 425.10–425.810 (2015).

29. Gatter, *supra* note 6, at 1141 (citation omitted).

environmental law, education law, food safety and food access programs, and so on. Thus, a health law survey course framed by population health is a gateway to a wide variety of topics in which the law adopts the value of population health, safety, and welfare. In short, each represents the intersection of law and fundamental human needs.

II. THE CHALLENGE OF TEACHING INDIVIDUAL CHOICE AND POPULATION HEALTH

A population health approach to teaching health law often runs counter to our impulse to understand the law from the perspective of the rights of individuals. Thus, mandatory vaccination laws appear to be a clash of public health and individual liberty rather than a policy in pursuit of population health. Those who teach health law from a population health perspective will routinely come up against the question: “How can the health of the population be reconciled with individual rights?” After all, individual choice is one of the four policy goals—along with promoting quality of, controlling costs to, and increasing access to health care—associated with health law. How does that policy goal fit within a population health framework given that the choices of an individual can be at odds with population health?

The frequency and persistence of this question can be attributed in part to the tools we use to teach health law. Case law always describes a disagreement and its resolution, and, in health law, cases often describe a clash between individual and community interests. For example, we learn about state public health powers by reading *Jacobson v. Massachusetts* in which an individual claims that his constitutional rights have been violated when he is fined by local public health officials for refusing to obtain a smallpox vaccination.³⁰ We teach about the ACA’s individual mandate using *National Federation of Independent Business v. Sebelius* and its claim that individuals who do not want to purchase health insurance cannot be forced to do so by federal legislation designed to regulate interstate commerce.³¹ *King v. Burwell* demonstrates how Congress intended federal tax credits under the ACA to be used as premium subsidies for some Americans who purchase health insurance from the federal exchange, and it does so through the arguments of several individuals who prefer that they not be forced to purchase health insurance, not even with the financial assistance of the federal government.³²

Case law is a wonderfully valuable tool for teaching health law, and I am not advocating against its use here. Instead, I suggest only that health law teachers account for the fact that case law in which individuals’ rights are

30. 197 U.S. 11, 26 (1905).

31. 132 S. Ct. 2566 (2012).

32. 135 S. Ct. 2480 (2015).

pitted against population health interests will naturally lead students to question whether individual choice can be reconciled with a population health perspective of health law. The opening exercise described above in which students identify what it takes for individuals and communities to be healthy remains a valuable touchstone to address this question.

The opportunity for individual choice rests on a foundation of population health. For individuals to engage in daily activities, to be creative and productive, to socialize with friends and family, and to participate in political governance, each requires health. And individual health is determined most significantly by aspects of population health including access to adequate health insurance, access to competent health care providers, access to safe and healthy foods, clean air and water, adequate sanitation, safe housing, and on and on. In this way, individual freedom and opportunity depend on population health. A teacher might use the story of the Flint water crisis or excerpts from population health reports showing the inequitable distribution of individual health burdens in city and state populations. These sources, when coupled with traditional case law, demonstrate that individual freedom rests on a foundation of population health.

At the same time, population health depends upon respecting individual rights. As a practical matter, there is a limit to the ability of governments, insurers, and health care providers to force individuals to act or refrain from acting in particular ways in the name of population health. Instead, population health depends largely on the cooperation of individuals, and individual cooperation depends on respecting individual rights. Consider, for example, that governments rarely rely on mass, forced quarantines to control a dangerous and contagious disease because mass quarantines are nearly impossible to enforce. To demonstrate this, a teacher, in addition to case law, might also assign descriptions of the failed quarantine in turn-of-the-century San Francisco³³ or a similarly failed mass quarantine in Monrovia, Liberia during the recent Ebola outbreak.³⁴

I also use the informed consent doctrine as an opportunity to address individual choice, cooperation, and health. As we read case law that largely vindicates the rights of individuals to choose their treatment plans based on their individual interests and the information provided to them by their physicians, there is an opportunity to nest the legal doctrine in the goal of shared decision-making between patient and physician. We discuss the likelihood that an individual will follow a treatment plan after that person leaves the hospital or physician's office if that person has participated in

33. MARILYN CHASE, *THE BARBARY PLAGUE: THE BLACK DEATH IN VICTORIAN SAN FRANCISCO* 207 (2004).

34. Mark A. Rothstein, *From SARS to Ebola: Legal and Ethical Considerations for Modern Quarantine*, 12 *IND. HEALTH L. REV.* 227, 273–74 (2015).

making the particular treatment choice in partnership with her physician. This discussion brings us to a more individualized example of the importance of cooperation and health, which helps to demonstrate that better health outcomes often result from laws that protect individual rights so as to encourage health education and cooperation.

CONCLUSION

Health law is an unruly field to survey and present to new students. Yet, health law teachers need not give in to the idea that the field is nothing but a haphazard collection of law from other fields applied to health care delivery. Rather, health is the common value, and I find the concept of population health provides a practical and illuminating framework for highlighting what makes health law unique.