2. Batistella, R. M. Rationalization of Health Services. Int. J. Health Serv. 331-348, Aug., 1972.
3. Tetelman, A. Public Hospitals—Critical or Recovering? Health Serv. Rep. 88:295-304, 1973.
4. Newhouse, J. P., Phelps, C. E., and Schwarz, W. B. Policy Options and the Impact of National Health Insurance. N. Engl. J. Med. 290:1345-1359, 1974.
5. Health Maintenance Organizations: A Policy Paper. Am. J. Public Health 61:2528-2536, 1971.
6. Bailey, R. M. Economics of Scale in Medical Practice. In Empirical Studies in Health Economics, edited by Klarman, H. E., pp. 255-273. Johns Hopkins Press, Baltimore, 1970.
7. Warren, B. S., and Sydenstricker, E. Health Insurance, the Medical Profession and the Public Health. Public Health Rep. Vol. 34, No. 16, 1919, quoted in Public Health Rep. 90:77, 1975.
8. A National Program for Personal Health Services. Am. J. Public Health 61:191, 1971.

PUBLIC HEALTH: ALIEN ETHIC IN A STRANGE LAND?

For the past several decades this country has attempted to attack its massive and growing alcohol problems by answering a simple question: why are some people unable to control their drinking? The clear assumption of this question is that avoiding alcohol problems is a behavioral ability, skill, or capacity and that the alcoholic "fails" as a drinker because he lacks these behavioral capacities. Despite the logical confusion and the many myths that arise when we treat drinking in an individual idiom of abilities, power, and capacities,[1, 2] many alcoholism experts persist in seeing this failure as a disease condition predisposed by psychological, genetic, social, or cultural factors.[3-5]

There is another and strikingly different theory of alcohol problems—the alcohol control approach.[6, 7] This approach argues that the primary factors contributing to alcohol problems are inadequate legal, social, and cultural controls over the availability and use of alcohol. This public health viewpoint argues that protection of the community from rising alcohol problems is not primarily achieved by strengthening individual abilities or capacities to use alcohol correctly, but rather by imposing community and societal rules that are designed to limit and control the use of alcohol and to minimize problems for the largest feasible group.

A growing body of scientific research tends to bear out this public health thesis. A group of scientists at the Addiction Research Foundation in Canada have demonstrated persuasively that it is the low overall or per capita consumption of alcohol in society (and by implication the factors that influence this low consumption, such as the rules governing the use of alcohol) that produces low rates of such major alcohol problems as cirrhosis.[6, 8, 9]

The Canadians have gathered data that show this clear relationship: in countries where the per capita consumption of alcohol is high, alcohol-related cirrhosis rates are high. In countries where the per capita consumption of alcohol is lower, the rates of alcohol-related cirrhosis are lower. Further, as the per capita consumption of alcohol goes up, so does the rate of heavy or damaging drinking. Many other experts have confirmed these findings.[10-13]

The implication of these findings for public health policy for alcohol would be the development of policies at all levels of government to reduce the per capita consumption of alcohol through more adequate public and private controls over the manufacturing, marketing, advertising, and consumption of alcohol. (Recently a leading Finnish authority—Kettil Bruun—has even called for international controls.[14]) The thrust of these policies—both official and private—would need to be conservative and should frankly discourage the use of alcohol. The overall goal would be to encourage high rates of minimal use of alcohol so as to encourage low rates of excessive use of alcohol. The most crucial and controversial implication of these findings is that all who manufacture, distribute, market, sell, and consume the substance of alcohol would be subject to fair and just controls over this substance in order to minimize problems. It goes without saying that these policies would be obligatory and involuntary, since controls imply burdens that are more than a given individual might voluntarily choose to bear.

The public health approach for alcohol controls contrasts sharply with the current policy of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) for alcohol problems. The NIAAA has absolutely no policy for alcohol controls. Instead the NIAAA has focused almost exclusively on developing treatment resources and launching a voluntary campaign to teach people "how to drink responsibly." This emphasis on training people "how to drink" is a logical consequence of the confusion that occurs when drinking problems are conceptualized as a behavioral failure.

The interesting question, however, is why the public health movement and public health leaders in the U.S. (with the notable exception of Milton Terris[15, 16]) are not calling for more stringent controls over alcohol in this country. Prohibition is undoubtedly one reason, despite the fact that alcohol controls in no way entail prohibitionism. Also, it may be that many in public health are simply unaware of this accumulating research. I believe, however, that the major reason for the silence of public health in the U.S. on this and related issues lies in another direction.

The public health movement—at least ideally—is based on the ethical claim that preventable death and disability ought to be minimized. This ethical claim has roots in the tradition of social justice and entails a commitment to prevention, collective action, and—most importantly—acceptance of the principle that minimizing death and disability necessitates the fair sharing of the burdens of prevention. In practical terms this means that majorities and powerful producer groups must (and ought to) accept the burdens of controls over hazardous or essential substances or conditions so as to maximally protect the public's health.

Public health's roots in the tradition of social justice

differ sharply from the dominant tradition of market justice found in this country. Market justice implies that people are entitled only to those substantive ends such as status, wealth, and happiness which they have acquired by fair rules or procedures, e.g., by their own abilities, efforts, or capacities. Market justice emphasizes individual responsibility, minimal collective action, and freedom from collective obligations except to respect other persons' fundamental rights.

While we have as a society compromised pure market justice in many ways to protect the public's health, we are far from realizing the public health principle that all—even powerful producer groups and vested interests—must share the burdens of minimizing preventable death and disability. For example, while we have taken steps to achieve more equity in the provision of health services, the medical care industry is far from accepting the notion that its services and structures ought be arranged so as to maximally protect the entire public. On the contrary, the success of medical science on many fronts is constantly used to buttress the central (and illusory) claim that "technological shortcuts"[17] will enable us to minimize death and disability while avoiding the burdens of collective action.

Thus public health's philosophy of collective obligation seems hopelessly unpopular—an alien ethic in a strange land. In the face of this perceived opposition, public health has sought accommodation with the prevailing ethical paradigm. The most visible signs of this accommodation are public health's increasing preoccupation with explaining (rather than controlling) public health problems, with medical care issues, and with behavioral explanations for health problems[15] that tend to conceal the need for collective action by "blaming the victim."[18]

I believe, however, that public health has overestimated the hopelessness of its position. It is clear that powerful vested interests stand ready to oppose systematic implementation of public health measures. But many others outside the public health movement, such as Ralph Nader, have demonstrated that it is possible to mobilize sufficient public support to overcome this opposition and to begin to make our workplaces, our modes of transportation, and the commodities we consume or use safer.

I believe that public support can be developed for more fair and just controls over the hazards of this world—including alcohol. I only hope that public health will soon recognize that by failing to challenge the application of the ethic of individual responsibility to health protection (and indeed by accommodating itself to this ethic), it has forfeited a leadership position in developing effective public health policy. What public health needs most of all is a return to its historic role as a broad social movement advocating full protection of the public's health and the courageous insistence that all persons and groups—including the most powerful and the most numerous—subordinate their private interests to the public goal of minimizing death and disability.

Dan E. Beauchamp, PhD
Assistant Professor
Department of Health Administration
School of Public Health
University of North Carolina at Chapel Hill
Chapel Hill, NC

REFERENCES

1. Beauchamp, D. The Alcohol Alibi: Blaming Alcoholics. Society 12:12-17, 1975.
2. Beauchamp, D. Alcholism As Blaming the Alcoholic, Int. J. Addict. 11:1, 1976.
3. Plaut, T. F. A. Alcohol Problems: A Report to the Nation. Report of the Cooperative Commission on the Study of Alcoholism. Oxford University Press, New York, 1967.
4. Keller, M. Alcoholism: Nature and Extent of the Problem. Ann. Am. Acad. Polit. Soc. Sci. 315:1-11, 1958.
5. Bacon, S. Alcoholics Do Not Drink. Ann. Am. Acad. Polit. Soc. Sci. 315:55-64, 1958.
6. deLint, J. The Prevention of Alcoholism. Prev. Med. 3:24-35, 1974.
7. Alcohol Control Policy and Public Health: Report on a Working Group. The Drinking and Drug Practices Surveyor 9, August 1974.
8. deLint, J., and Schmidt, W. Consumption Averages and Alcoholism Prevalence. Br. J. Addict. 66:97-107, 1971.
9. Schmidt, W., and deLint, J. Estimating the Prevalence of Alcoholism from Alcohol Consumption and Mortality Data. Q. J. Stud. Alcohol 31:957-964, 1970.
10. Terris, M. Epidemiology of Cirrhosis of the Liver. Am. J. Public Health 58:5-12, 1968.
11. Whitehead, P. C., and Harvey, C. Explaining Alcoholism. J. Health Soc. Behav. 15:57-65, 1974.
12. Makela, K. The Case of the Personnel Strike in the Stores of the Finnish Alcohol Monopoly. Presented at the 20th International Institute on the Prevention and Treatment of Alcoholism, Manchester, England, June, 1974.
13. Ledermann, S. Can One Reduce Alcoholism Without Changing Total Alcohol Consumption . . . ? Proceedings of the 27th International Congress on Alcohol and Alcoholism, Frankfort-am-Main, September 6-12, 1964.
14. Bruun, K. International Alcohol Politics—International Measures. Presented to the 21st International Institute on the Prevention and Treatment of Alcoholism, Helsinki, June 11, 1975.
15. Terris, M. A Social Policy for Health. Am. J. Public Health 58:5-12, 1968.
16. Terris, M. Breaking the Barriers to Prevention. Presented to The Annual Health Conference, New York Academy of Medicine, April 26, 1974.
17. Etzioni, A., and Remp, R. Technological "Shortcuts" to Social Change. Science 175:31-38, 1972.
18. Ryan, W. Blaming the Victim. Vintage Books, New York, 1971.