# WHAT IS PUBLIC ABOUT PUBLIC HEALTH?

by Dan E. Beauchamp

**Prologue:** *The phrase "public health," for professionals who work in the field as well as others, is an ill-defined label for a disparate number of activities. Perhaps the only common denominator connecting this amalgam is that in one way or another they affect people. Prof. Dan Beauchamp of the University of North Carolina's School of Public Health shares the unease at the lack of definition of public health, even after twelve years in the field. Beauchamp, a political scientist (Ph.D., Johns Hopkins University) and a visiting professor this year at the University of Michigan, believes that public health is fundamentally about community and about shared values of life, health, and security. But Beauchamp argues that in fashioning public health around collective concepts—and paying homage to the American penchant for individual freedom—important public health opportunities are lost. Take, for example, as does Beauchamp, matters of life-style. An alarmingly large proportion of modern disease and untimely death stems from unhealthy patterns of living, the kinds of food and drink we consume, driving without seatbelts, and smoking. Public health does not call for legislation requiring individuals to jog three miles a day or get eight hours of sleep, nor does it deny individual responsibility for health. Public health, says Beauchamp, aims only to affirm and to implement communal responsibility for the protection and promotion of health of the public in the collective sense. By insisting that individual responsibility coexist with collective rules to protect the common good, Beauchamp argues, we can save tens of thousands of lives and limit disease.*

About seven years ago, the late Dr. John Knowles, president of the Rockefeller Foundation and former director of Massachusetts General Hospital, appeared on the *Today* show promoting his book, *Doing Better and Feeling Worse.*[1] Knowles talked about the crisis in the health care system. Medicine, he said, was increasingly specialized, impersonal, and technocratic, and hospital costs were soaring out of control. He added that medicine has much less to do with health than healthy environments and healthy lifestyles.

The interviewer asked what the public could do. Knowles replied that the public should take more individual responsibility for health. I will never forget what he said next: The first step, he said, is for the citizen to find his local health department and get some pamphlets on healthy living.

Today, the crisis in health care and policy that Knowles described is far worse than it was when his book appeared. Knowles and the other contributors to the book had much of value to say about ending the crisis. But Knowles' advice—*find* your local health department—reveals a great deal about the way Americans approach public problems, especially public health problems. We often come up with very silly individual solutions to very serious public problems; recall President Ford's attempt to make war on inflation, armed with campaign buttons (Whip Inflation Now).

For most Americans, the term public health conjures up the picture of a local health department office located downtown, filled with poor people. I suspect that some, maybe all of us, secretly wonder how relevant state and local health departments are to the nation's health problems. And yet, today's serious health concerns are a public matter, not simply a matter of individual responsibility. It involves great danger—a great opportunity for the field of public health.

Despite the negativism of the current administration, the consumer, worker, and environmental protection movements are permanently on the political agenda. Every night the network news features public health issues: acid rain, pesticides, toxic waste dumps, chemical spills, automobile recalls, hospital costs, artificial hearts, the dangers of smoking, and the medical fallout of nuclear war.

The health care challenge of the 1980s encompasses sharply rising hospital costs; the safety of our environment, consumer marketplace, and worksites; the daily "meattake" of our highways; and unhealthy lifestyles. Yet the Health Care Financing Administration, the National Highway Safety Administration, the Occupational Safety and Health Administration, the Environmental Protection Agency, and the Consumer Product Safety Commission are all located outside the Public Health Service. Only the Health Care Financing Administration, the agency administering Medicare and Medicaid, remains within the Department of Health and Human Services.

Some may argue, and perhaps they would be right, that we are witnessing the end of public health. But unless we renew our understanding of what we mean by public health, unless we ask what is "public" about public health, we may as a society be the victims of major changes that few foresee—or would want if they could foresee.

## Public Health And Community

A good short definition of public health is "the protection and improvement of community health by organized community effort."[2] This emphasis on "community" is crucial. The emphasis in public health on common measures to protect the health and safety of the community makes public health measures "collective goods." Collective goods are goods whose provision or consumption is shared by members of the public.[3] Collective goods differ from commodities provided by markets or consumed by individuals.

The primary function of government is to provide such collective goods as armies, highways, lighthouses, pollution abatement, social security, and police protection. Almost all collective goods could, in theory, be provided through markets, at least to some extent; for example, all roads could be private and paid for by tolls. But collective goods are matters of common provision because they characterize and express the values of the political community. The economist Peter Steiner argues:

> the most compelling examples of collective . . . goods appear to be national defense, law and order, and public health. What is their particular appeal? Is it that they are collective consumption goods? So is television. The appeal is not in the specific planes, rockets, soldiers, policemen, vaccines, or nurses that are their elements, for each of these can be readily provided as private goods to private users, but rather in the fact that [collective goods] are part of and condition the environment of society.[4]

Police protection privately operated does not offer the protection of police provided communally and publicly, not only because the private provision of private services is predictably less effective and inefficient, but also because the public provision of police services symbolizes and strengthens the basic community commitment to the protection of life and limb of all its citizens. Similarly, collective protections employing organized community approaches can be dramatically more effective than private measures in altering the health status of the community and can, if properly designed and justified, strengthen common ties through the sharing of common benefits and the bearing of common sacrifices.

Public health is, as Jean Forster argues, fundamentally about community, and about the shared values of life, health, and security.[5] All societies

everywhere undertake communal measures for security and welfare of their members. As Michael Walzer puts it: "If we did not provide for one another, if we recognized no distinction between members and strangers, we would have no reason to form political communities. Political community for the sake of provision; provision for the sake of community."[6]

The provision of collective goods requires a central role for government. As Nannerl Henry argues: "Collective goods cannot and will not be provided without [government] to give an authoritative coordination of effort and to allocate costs for public goods and enforce payment, since there is no direct connection between enjoying benefits and paying costs in the case of such goods."[7]

In addition to the market and collective spheres, individuals have a private or personal sphere. Hannah Arendt observes that, "Throughout his life man moves constantly in two different orders of existence: he moves within what is his *own*, and he also moves in a sphere that is *common* to him and his fellowmen. The 'public good,' the concerns of the citizen, is indeed the common good because it is localized in the *world* which we have in common *without owning it.*"[8]

Public health clearly encompasses the public world, including the private market. But the private sphere is problematic for public health. In the interest of health and safety, public health measures sometimes intrude into this private sphere, but respect for individual privacy and autonomy imposes certain limits on the pursuit of even valid health and safety objectives. For example, we put fluoride in the water supply for the public's dental health, but we would not think of requiring individuals to take a fluoride tablet every day. Likewise, although everyone might enjoy better health if, for example, he or she took a brisk walk or ran every day, a law requiring each individual to engage in such exercise is unthinkable. These direct intrusions would not only be inefficient, they would put bureaucrats at the elbow of every citizen. On the other hand, motorcycle helmet laws were initially challenged as intrusions into the private realm. But these intrusions have been held constitutional in almost all jurisdictions.

## The Constitution And Public Health

In the United States, the idea of a compact for security or safety was a particularly prominent feature of that blend of republican and social contract thinking that shaped our Constitution. The purpose of the state's police power is to protect the health and safety of its citizens, to implement the social covenant for safety and mutual aid. One of the leading constitutional cases involving public health, dating from the turn of the century, is *Jacobson vs. Massachusetts,* which involves compulsory vaccination in Cambridge, Massachusetts, and cites, in defense of the alleged

invasion of individual rights, a line from the Massachusetts state constitution:

> In the Constitution of Massachusetts adopted in 1780 it was laid down as a fundamental principle of the social compact that the whole people covenants with each citizen, and each citizen with the whole people, that all shall be governed by certain laws for the "common good," and that government is instituted "for the common good, for the protection, safety, prosperity, and happiness of the people, and not for the profit, honor, or private interests of any one man, family, or class of men." The good and welfare of the commonwealth, of which the legislature is primarily the judge, is the basis on which the police power rests in Massachusetts.[9]

In the 1877 case of *Munn vs. Illinois*, the U.S. Supreme Court affirmed the right of the state of Illinois to regulate the rates of Chicago grain elevators because "property does become clothed with a public interest when used in a manner to make it of public consequence, and affect the community at large."[10]

The existence of a public realm that is the domain of public health is clearly behind the famous definition of public health found in Lemuel Shattuck's *Report of the Sanitary Commission of the State of Massachusetts, 1850*: "The condition of perfect *public health* requires such laws and regulations, as will secure to man associated in society, the same sanitary enjoyments that he would have as an isolated individual; and as will protect him from injury from any influences connected with his locality, his dwelling-house, his occupation, or those of his associates, or neighbors, or from any other social causes. It is under the control of public authority, and public administration, and life and health may be saved or lost, and they are actually saved or lost, as this authority is wisely or unwisely exercised."[11]

This view of political association blends social contract and republican thought with Judeo-Christian notions of covenant. It ascribes to the individual private interests and rights that political association is designed to protect; it also defines the individual as part of a political community that, despite diversity and pluralism, is more than the sum of private interests. As a member of that community, the citizen is subject to laws and regulations designed to advance the interests of all—the common good.

## Medicine And Community

According to the conventional wisdom, the greatest challenge to health policy today is controlling health care costs, an undertaking that has little to do with public health. Controlling costs is, in this perspective, the

business of the Office of Management and Budget and agencies like the Health Care Financing Administration. This analysis is counterproductive. Public health is not a specific set of organizations; public health is a kind of social good and an aspect of life in a community. The current crisis in health care costs has developed largely because of the failure to take into account the role of medicine in providing for the common good and the habit of viewing medicine as a commodity.

Medicine today is still perceived primarily as a private good. In the private sphere, the principle is "nothing is too good for the individual patient." In the market sphere, the principle is "nothing is too good for doctors, hospitals, and the insurance industry." The minimal government regulation of medicine tends to reaffirm the principles of the market. To help the poor, the government provides more money. The government helps the middle class with generous reimbursement schemes and tax incentives. This medical money plus fee-for-service expands the medical market and intensifies medical inflation. The lack of effective planning at any level leaves each community and hospital pitted against each other in competition for the best physicians and the latest in unproven medical technology. No government entity has taken responsibility for determining how much medicine we as a community and society need and can afford. As a result, Medicaid costs are a nightmare for every state budget officer. Health care costs as a percent of Gross National Product (GNP) have grown from 4.4 percent (1950), to 5.3 percent (1960), to 6 percent (1966), to 7.6 percent (1970), to over 10 percent in 1982. The rate projected for 1990—roughly 11 percent—seems improbably low given past trends.[12]

The welfare programs of the 1960s and 1970s have contributed to this crisis. Most liberal theories of social policy contain what Brian Barry calls the standard liberal fallacy: What is good for the individual privately must be good for the community.[13] The principle that nothing is too good for the individual patient, coupled with the uncertainty surrounding therapeutic choices, locks physician, patient, and hospital into a private logic that ultimately threatens the common health by producing an overmedicalized society. When doctors are at all unsure, the overwhelming pressure is to order more X-rays, more CAT scans or other diagnostic procedures, to try the new drug—to "do something."

## The Competition Strategy

Some recent proposals would eliminate fee-for-service, encourage doctors to join groups and to compete for patients, and eliminate tax subsidies for most "first-dollar" insurance coverage.[14] The goal of these proposals is to force medical customers to look for cheaper options in health care. This strategy raises numerous questions. Why should doc-

tors abandon solo practice and join groups? Why should such groups compete on the basis of price? Firms in American society compete on many grounds (price, product quality, advertising), and still prices rise steadily. Why should we not expect doctors to reach private agreements on price increases each year even in a more "competitive" market?[15]

The hospital industry is already competitive. Hospitals compete for the best doctors and the latest expensive medical gadgets. Promoting further competition may accelerate expansion of an already rapidly growing corporate hospital chain industry, replacing local community hospitals with for-profit organizations. This development may strengthen the trend toward "two-class" medicine in this country, with public hospitals and health departments providing bargain-basement medicine while corporate hospital chains offer first-class medicine for the rest of the population. Perhaps our greatest concern ought to be that competition strategy ignores the basic issues: Do we wish to determine how much medical care we need and can afford as a community? And do we wish to make medical care in some way a matter of common provision—a common possession and benefit—not only to guarantee the benefits of medical care to all the people, but also to express and strengthen the people's sense of community?

A corporate or market-financed system of medicine erodes the sense of common citizenship and the meaning of community rather than affirming it. By reinforcing the view that medicine is a commodity like other commodities, we risk the further deterioration of the sense of common citizenship and shared values that is essential to the functioning of any political community in the long run. Widespread public cynicism about government and its officials may spring less from a fundamental distrust of government than from resentment at the lack of such public goods as health care and more aggressive health and safety policies, which taxation and the other burdens of citizenship ought to procure.

The competition strategy pits large organizations against unorganized consumers. Instead, why not organize consumers through government and let them use their collective power to purchase the medical care they want and need at a cost they can afford? The central element of any successful policy must be a "top down" limit on national expenditures for medicine, hospital construction, and new, unproven technology. Canada and England, which have such central choice processes, have held their expenditures for health far below our own as percentages of GNP.[16] Only by "going public" and establishing some form of common provision of medical care services will we break the pattern of privatism that contributes so much to medical inflation. What is more, by going public we can strengthen our sense of political community; stop the corporate take over of medicine; retain the tradition of local, voluntary hospitals with strong community roots; stop the threat posed by proprietary and not-for-profit chains competing for profitable patients, thus threatening the very exist-

ence of public and voluntary hospitals. This prospect should appeal to the dominant voluntary sector of the hospital industry which is unlikely to relish the idea of joining the list of such chain industries in the United States as fast foods and motels. Wider choice among types of practice also should appeal to doctors who might not want to work for a corporation.

## Life-style And Community[17]

An alarmingly large proportion of modern disease and untimely death stems from unhealthy patterns of living—for example, eating certain kinds of food and drink, smoking, driving without seatbelts, and the like. Education to encourage people to live more wisely is needed and permitted, but what is the proper scope and justification of legal compulsion in self-regarding risks?

Public health does not call for legislation requiring individuals to run three miles every day, to sleep eight hours or to reduce their daily caloric intake. Nor does public health deny individual responsibility for health. Public health aims only to affirm and to implement communal responsibility for the protection and promotion of the health of the public in the collective sphere. By insisting that individual responsibility coexist with collective rules to protect the common good, we can save tens of thousands of lives and limit disease.

Drunk driving is a case in point. The current Mothers Against Drunk Drivers (MADD) campaign seeks to punish the drunk driver. This campaign seeks less to limit self-imposed risks than to limit the harms imposed by a small group on others. But both alcohol use and highway safety policy have broader implications for the community.

The consumption of alcohol is at an all-time high since the early nineteenth century.[18] Americans currently consume 2.8 gallons of absolute alcohol annually. Consumption of alcohol rose by one-third during the 1960s. The recessions of the 1970s slowed this growth somewhat, but the consumption of beer continues to rise sharply. A major reason for this growth in drinking is our current tax policy regarding alcohol. The federal excise tax on alcohol was set during the Korean War and has never been raised. Both federal and state governments use a flat tax that does not rise with inflation. Today, the federal tax is roughly one-third of what it was in 1953, as a percentage of the cost of the average bottle.[19] The states tax alcohol in the same way; only sales taxes on alcohol keep pace with inflation. As a result, the price for alcohol in the United States actually has fallen relative to the prices of other goods, such as milk and bread. Distilled spirits today cost roughly half what they cost relative to the price of other commodities several decades ago. By ignoring the impact of excise taxation on the relative price for alcohol, the United States is, in effect, cutting the price of alcohol.

A number of studies, including a recent report of the National Academy of Sciences, have confirmed the relationships of price, availability, and disposable income with rising alcohol consumption and with alcohol-related problems such as cirrhosis and highway accidents due to drinking.[20] Cook estimates if Congress were to double the federal excise tax on alcohol, as it recently did the excise tax on tobacco, the cirrhosis rate would fall by as much as 20 percent in the long run.[21] In England, for example, where excise taxes on alcohol are high, the highest rates of cirrhosis are found in the upper classes; in the United States, cirrhosis is most common in the lower classes.[22]

Teenagers and college-age adults are a significant fraction of drunk driving casualties. Largely because of our tax policies, the price of a six-pack of beer is competitive with the price of a six-pack of soft drinks. The beer industry aggressively promotes beer consumption on college campuses. Alcohol is sold in convenience stores designed to serve the traveling (and often underage) motorist.

Millions drink and drive, but very few of them are involved in serious crashes that cause death or dismemberment. In most locales in the United States, drunk drivers' risk of detection by the police is one in two thousand.[23] Individual odds low enough to encourage widespread "gambling" lead to dreadful consequences for the community—25,000 deaths in which alcohol plays a strong contributing role. General highway safety measures such as passive restraints in automobiles would be among the most effective protections against drunk driving (for the drunk and his victims). Passive air-bag restraints would save 6,000 to 9,000 lives each year, according to the National Safety Council.[24] We cannot say how many, but some of the lives saved would be potential victims of drunk drivers or the drunks themselves. This estimate assumes full implementation of a legal requirement for such restraints—which would take at least ten years. The National Highway Traffic Safety Administration's attempt to rescind the mandatory passive restraint policy indirectly "blames the victim" by denying collective obligations for those who drive without belts and is a serious blow to efforts to reduce drunk driving casualties.

Protecting the community from the effects of private individuals' use of alcohol, tobacco, handguns, automobiles, motorcycles, and so forth—means regulating the public and common world that controls the marketplace; it should not raise the specter of Big Brother—direct and close supervision of the individual's daily life by the state. Public health does not deny the importance of individual responsibility, especially for health. But individual responsibility should be the governing principle of the private sphere. In the collective sphere, the sphere of welfare, security, and community, industry and individuals must submit to reasonable restrictions to protect and promote the health and safety of the public.

In focusing attention on lifestyle commodities, I do not mean to give

them more importance than environmental or workplace hazards. But if we as a community are unwilling to protect ourselves from harm caused by lifestyle commodities, which are largely consumed by individuals for recreational purposes, we risk an unbalanced emphasis on regulating environmental and workplace hazards, threatening jobs and the economic health of basic industries. This is not a plea for reducing environmental protections or workers' safety, it is a plea for more balance in our prevention policy. Instituting common protections against the leading lifestyle risks of the consumer marketplace—smoking, alcohol, automobiles—through taxation and regulations like mandatory passive restraints for automobiles would make manifest our common commitment to health and safety throughout the collective sphere.

## Conclusion

Not long after World War II, Shirley Jackson wrote a short story, "The Lottery."[25] In the story, the inhabitants of a small town gather one day each spring for a lottery on the courthouse lawn. The holding of the lottery is traditional and obligatory. All of the people in the town either come or have someone draw for them in their absence. At the appointed time an official brings out a black box. Everyone draws a slip of paper. One by one the winners are announced. Suddenly, everyone is aware of the identity of the loser. As the loser protests that the drawing was not fair, each member of the community picks up a stone from a large pile of rocks on the courthouse lawn. The winners, one by one, then as a group, stone the loser to death.

Jackson's story is a parable about community and the betrayal of communal solidarity against death. The current administration has enshrined individual responsibility for health and safety as its Johnny-one-note health policy, attacking public health in the name of regulatory relief. The gutting of the EPA and OSHA and the National Highway Traffic Safety Administration's abandonment of the passive restraint requirement for automobiles will cost thousands of American lives each year.

Attacks on public health also impose another cost on our society, one more difficult to measure but just as significant. It weakens our already fragile sense of community and common citizenship, a bond that desperately needs strengthening and renewal. The historic mission of public health in this country has always been to advocate the protection of life and limb as a primary community value. Public health must continue to represent, as it has in the past, communal responsibility for the community's health and safety.

Public health must always be mindful of individual rights to privacy and autonomy, and advocate entry into the private sphere only in an emergency. But from where we are, we have a long way to go before we

approach the boundaries of the private sphere. Meanwhile, we must ceaselessly urge society into new territory, to rediscover the communal solidarity against untimely death and serious disability that is the basic principle of public health.

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NOTES

1. John Knowles, ed., *Doing Better and Feeling Worse* (New York: Norton, 1976).
2. U.S. Congress, House Committee on Interstate and Foreign Commerce, Subcommittee on Health Environment, *A Discursive Dictionary of Health Care*, 94th Cong., 2d session, (Washington, D.C.: U.S. Government Printing Office, 1976).
3. The best recent discussion of the concept of collective goods is by M. Olson, Jr., *The Logic of Collective Action* (Cambridge, Mass.: Harvard University Press, 1965). See also Nannerl Henry, "Political Obligation and Collective Goods," in *Political and Legal Obligation*, ed. J. Roland Pennock and John W. Chapman (New York: Atherton, 1970): 263-89.
4. Peter Steiner, *Public Expenditure Budgeting* (Washington, D.C.: Brookings Institution, 1969), 15.
5. Jean Forster, "A Communitarian Ethical Model for Public Health Interventions: An Alternative to Individual Behavior Change Strategies," *Journal of Public Health Policy* 3 (1982):150-63.
6. Michael Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, 1983), 64.
7. Henry, "Political Obligation and Collective Goods," 288.
8. Hannah Arendt, "Public Rights and Private Interests," in *Small Comforts for Hard Times: Humanists on Public Policy*, ed. Michael Mooney and Florian Stuber (New York: Columbia University Press, 1977), 104.
9. 197 U.S. 11 (1905).
10. *Munn v. Illinois*, 94 U.S. 113 (1877).
11. Lemuel Shattuck, *Report of the Sanitary Commission of Massachusetts, 1850* (Cambridge, Mass.: Harvard University Press, 1948), l-2.
12. See M. Freeland and C. A. Schendler, "National Health Expenditures: Short-Term Outlook and Long-Term Projections," *Health Care Financing Review* (Winter 1981): 97-138.
13. Brian Barry, *The Liberal Theory of Justice* (Oxford: Claredon Press, 1973), 118.
14. See Alain C. Enthoven, "The Competition Strategy," *The New England Journal of Medicine* 304 (1980): 109-12.
15. There are many critiques of the competition strategy. See especially Bruce Vladeck, "The Market vs. Regulation," *Milbank Memorial Quarterly* 59 (1981): 209-23; M. Rushefsky, "A Critique of Market Reform in Health Care: The Consumer-Choice Health Plan," *Journal of Health Politics, Policy, and Law* 5 (1981): 720-41; and M. Roemer, "Market Failure and Health Care Policy," *Journal of Public Health Policy* 3 (1982): 419-31.
16. See M. Taylor "The Canadian Health System in Transition," *Journal of Public Health Policy* 2 (1981): 177-87. Taylor indicates that Canada devotes roughly 7 percent of its GNP to health care. England spends 5.6 percent of its GNP on medical care. See J. Kinnaird, "The British National Health Service: Retrospect and Prospect," *Journal of Public Health Policy* 2 (1981): 397.
17. I employ the standard term "life-style risks," for purposes of clarity, although I object to the term because of its implicit denial of the social foundation of most individual choices. For an excellent discussion of governmental limits to life-style risks that differs from that in this paper, see D. Wikler, "Persuasion and Coercion for Health: Ethical Issues in Government Efforts to Change LifeStyles," in *Politics and Health Care*, ed. J. B. McKinlay, (Cambridge, Mass.: MIT Press, 1981), 1-36.

18. The data on alcohol consumption and taxation in this section of the paper are drawn from M. Moore and D. Gerstein, eds., *Alcohol and Public Policy: Beyond the Shadow of Prohibition* (Washington, D.C.: National Academy Press, 1982); Dan E. Beauchamp, *Beyond Alcoholism: Alcohol and Public Health Policy* (Philadelphia: Temple University Press, 1981).
19. See P. Cook "The Effect of Liquor Taxes on Drinking, Cirrhosis, and Auto Accidents," in *Alcohol and Public Policy,* ed. Moore and Gerstein, 256.
20. See Moore and Gerstein, eds., *Alcohol and Public Policy.*
21. See Philip Cook, "Alcohol Taxation: Prevention, Distribution and Revenue Effects," Paper presented to Conference on Alcohol and Public Policy, National Academy of Sciences, Washington, D.C., May 20, 1983, 7. Based on P. Cook and G. Tauchen, "The Effect of Liquor Taxes on Heavy Drinking," *Bell Journal of Economics* 13 (1982): 379-90.
22. See M. Terris, "Epidemiology of Cirrhosis of the Liver: National Mortality Data," *American Journal of Public Health* 66 (1967): 2076-88.
23. See D. Reed, "Reducing the Costs of Drinking and Driving," in *Alcohol and Public Policy,* ed. Moore and Gerstein, 348.
24. National Safety Council, *Accident Facts* (Chicago: National Safety Council, 1981), 53.
25. "The Lottery," which originally appeared in *The New Yorker* in 1948, has been reprinted in a number of collections of Shirley Jackson's short stories issued since 1950.