

## Public Health as Social Justice

Dan E. Beauchamp

Anthony Downs<sup>1</sup> has observed that our most intractable public problems have two significant characteristics. First, they occur to a relative minority of our population (even though that minority may number millions of people). Second, they result in significant part from arrangements that are providing substantial benefits or advantages to a majority or to a powerful minority of citizens. Thus solving or minimizing these problems requires painful losses, the restructuring of society and the acceptance of new burdens by the most powerful and the most numerous on behalf of the least powerful or the least numerous. As Downs notes, this bleak reality has resulted in recent years in cycles of public attention to such problems as poverty, racial discrimination, poor housing, unemployment or the abandonment of the aged; however, this attention and interest rapidly wane when it becomes clear that solving these problems requires painful costs that the dominant interests in society are unwilling to pay. Our public ethics do not seem to fit our public problems.

It is not sufficiently appreciated that these same bleak realities plague attempts to protect the public's health. Automobile-related injury and death; tobacco, alcohol and other drug damage; the perils of the workplace; environmental pollution; the inequitable and ineffective

distribution of medical care services; the hazards of biomedicine—all of these threats inflict death and disability on a minority of our society at any given time. Further, minimizing or even significantly reducing the death and disability from these perils entails that the majority or powerful minorities accept new burdens or relinquish existing privileges that they presently enjoy. Typically, these new burdens or restrictions involve more stringent controls over these and other hazards of the world.

This somber reality suggests that our fundamental attention in public health policy and prevention should not be directed toward a search for new technology, but rather toward breaking existing ethical and political barriers to minimizing death and disability. This is not to say that technology will never again help avoid painful social and political adjustments.<sup>2</sup> Nonetheless, only the technological Pollyannas will ignore the mounting evidence that the critical barriers to protecting the public against death and disability are not the barriers to technological progress—indeed the evidence is that it is often technology itself that is our own worst enemy. The critical barrier to dramatic reductions in death and disability is a social ethic that unfairly protects the most numerous or the most powerful from the burdens of prevention.

This is the issue of justice. In the broadest sense, justice means that each person in society ought to receive his due and that the burdens and benefits of society should be fairly and equitably distributed.<sup>3</sup> But what criteria should be followed in allocating burdens and benefits: Merit, equality or need?<sup>4</sup> What end or goal in life should receive our highest priority: Life, liberty or the pursuit of happiness? The answer

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to these questions can be found in our prevailing theories or models of justice. These models of justice, roughly speaking, form the foundation of our politics and public policy in general, and our health policy (including our prevention policy) specifically. Here I am speaking of politics not as partisan politics but rather the more ancient and venerable meaning of the political as the search for the common good and the just society.

These models of justice furnish a symbolic framework or blueprint with which to think about and react to the problems of the public, providing the basic rules to classify and categorize problems of society as to whether they necessitate public and collective protection, or whether individual responsibility should prevail. These models function as a sort of map or guide to the common world of members of society, making visible some conditions in society as public issues and concerns, and hiding, obscuring or concealing other conditions that might otherwise emerge as public issues or problems were a different map or model of justice in hand.

In the case of health, these models of justice form the basis for thinking about and reacting to the problems of disability and premature death in society. Thus, if public health policy requires that the majority or a powerful minority accept their fair share of the burdens of protecting a relative minority threatened with death or disability, we need to ask if our prevailing model of justice contemplates and legitimates such sacrifices.

### **Market-Justice**

The dominant model of justice in the American experience has been market-justice.<sup>5</sup> Under the norms of market-justice people are entitled only to those valued ends such as status, income, happiness, etc., that they have acquired by fair rules of entitlement, e.g., by their own individual efforts, actions or abilities. 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 pub-

lic's health, we are far from recognizing the principle that death and disability are collective problems and that all persons are entitled to health protection. Society does not recognize a general obligation to protect the individual against disease and injury. While society does prohibit individuals from causing direct harm to others, and has in many instances regulated clear public health hazards, the norm of market-justice is still dominant and the primary duty to avert disease and injury still rests with the individual. The individual is ultimately alone in his or her struggle against death.

### *Barriers to Protection*

This individual isolation creates a powerful barrier to the goal of protecting all human life by magnifying the power of death, granting to death an almost supernatural reality.<sup>6</sup> Death has throughout history presented a basic problem to humankind,<sup>7</sup> but even in an advanced society with enormous biomedical technology, the individualism of market-justice tends to retain and exaggerate pessimistic and fatalistic attitudes toward death and injury. This fatalism leads to a sense of powerlessness, to the acceptance of risk as an essential element of life, to resignation in the face of calamity, and to a weakening of collective impulses to confront the problems of premature death and disability.

Perhaps the most direct way in which market-justice undermines our resolve to preserve and protect human life lies in the primary freedom this ethic extends to all individuals and groups to act with minimal obligations to protect the common good.<sup>8</sup> Despite the fact that this rule of self-interest predictably fails to protect adequately the safety of our workplaces, our modes of transportation, the physical environment, the commodities we consume, or the equitable and effective distribution of medical care, these failures have resulted so far in only half-hearted attempts at regulation and control. This response is explained in large part by the powerful sway market-justice holds over our imagination, granting fundamental freedom to all individuals to be left alone—even if the "individuals" in question are giant producer groups with enormous capacities to create great public harm through sheer inadvertence. Efforts for truly

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effective controls over these perils must constantly struggle against a prevailing ethical paradigm that defines as threats to fundamental freedoms attempts to assure that all groups—even powerful producer groups—accept their fair share of the burdens of prevention.

Market-justice is also the source of another major barrier to public health measures to minimize death and disability—the category of voluntary behavior. Market-justice forces a basic distinction between the harm caused by a factory polluting the atmosphere and the harm caused by the cigarette or alcohol industries, because in the latter case those that are harmed are perceived as engaged in “voluntary” behavior.<sup>9</sup> It is the radical individualism inherent in the market model that encourages attention to the individual’s behavior and inattention to the social preconditions of that behavior. In the case of smoking, these preconditions include a powerful cigarette industry and accompanying social and cultural forces encouraging the practice of smoking. These social forces include norms sanctioning smoking as well as all forms of media, advertising, literature, movies, folklore, etc. Since the smoker is free in some ultimate sense to not smoke, the norms of market-justice force the conclusion that the individual voluntarily “chooses” to smoke; and we are prevented from taking strong collective action against the powerful structures encouraging this so-called voluntary behavior.

Yet another way in which the market ethic obstructs the possibilities for minimizing death and disability, and alibis the need for structural change, is through explanations for death and disability that “blame the victim.”<sup>10</sup> Victim-blaming misdefines structural and collective problems of the entire society as individual problems, seeing these problems as caused by the behavioral failures or deficiencies of the victims. These behavioral explanations for public problems tend to protect the larger society and powerful interests from the burdens of collective action, and instead encourage attempts to change the “faulty” behavior of victims.

Market-justice is perhaps the major cause for our over-investment and over-confidence in curative medical services. It is not obvious that the rise of medical science and the physician, taken alone, should become fundamental obsta-

cles to collective action to prevent death and injury. But the prejudice found in market-justice against collective action perverts these scientific advances into an unrealistic hope for “technological shortcuts”<sup>11</sup> to painful social change. Moreover, the great emphasis placed on individual achievement in market-justice has further diverted attention and interest away from primary prevention and collective action by dramatizing the role of the solitary physician-scientist, picturing him as our primary weapon and first line of defense against the threat of death and injury.

The prestige of medical care encouraged by market-justice prevents large-scale research to determine whether, in fact, our medical care technology actually brings about the result desired—a significant reduction in the damage and losses suffered from disease and injury. The model conceals questions about our pervasive use of drugs, our intense specialization, and our seemingly boundless commitment to biomedical technology. Instead, the market model of justice encourages us to see problems as due primarily to the failure of individual doctors and the quality of their care, rather than to recognize the possibility of failure from the structure of medical care itself.<sup>12</sup> Consequently, we seek to remedy problems by trying to change individual doctors through appeals to their ethical sensibilities, or by reshaping their education, or by creating new financial incentives.

#### *Government Health Policy*

The vast expansion of government in health policy over the past decades might seem to signal the demise of the market ethic for health. But it is important to remember that the preponderance of our public policy for health continues to define health care as a consumption good to be allocated primarily by private decisions and markets, and only interferes with this market with public policy to subsidize, supplement or extend the market system when private decisions result in sufficient imperfections or inequities to be of public concern. Medicare and Medicaid are examples. Other examples include subsidizing or stimulating the private sector through public support for research, education of professionals, limited areawide plan-

ning, and the construction of facilities. Even national health insurance is largely a public financing mechanism to subsidize private markets in the hope that curative health services will be more equitably distributed. None of these policies is likely to bring dramatic reductions in rates of death and disability.

Our current efforts to reform the so-called health system are little more than the use of public authority to perpetuate essentially private mechanisms for allocating curative health services. These reforms are paraded as evidence that the system is capable of functioning equitably. But, as Barthes<sup>13</sup> points out (in a different context), reform measures may merely serve to "inoculate" the larger society against the suspicion that it is the model itself (in our case, market-justice) that is at fault. In fact, the constant reform efforts designed to "save the system" may better be viewed as an attempt to expand the hegemony of the key actors in the present system—especially the medical care complex. As McKnight says, the medical care complex may need the hot air of reform if its ballooning empire is to continue to inflate.<sup>14</sup>

#### *Public Health Measures*

I have saved for last an important class of health policies—public health measures to protect the environment, the workplace, or the commodities we purchase and consume. Are these not signs that the American society is willing to accept collective action in the face of clear public health hazards?

I do not wish to minimize the importance of these advances to protect the public in many domains. But these separate reforms, taken alone, should be cautiously received. This is because each reform effort is perceived as an isolated exception to the norm of market-justice; the norm itself still stands. Consequently, the predictable career of such measures is to see enthusiasm for enforcement peak and wane. These public health measures are clear signs of hope. But as long as these actions are seen as merely minor exceptions to the rule of individual responsibility, the goals of public health will remain beyond our reach. What is required is for the public to see that protecting the public's health takes us beyond the norms of market-

justice categorically, and necessitates a completely new health ethic.

I return to my original point: Market-justice is the primary roadblock to dramatic reductions in preventable injury and death. More than this, market-justice is a pervasive ideology protecting the most powerful or the most numerous from the burdens of collective action. If this be true, the central goal of public health should be ethical in nature: The challenging of market-justice as fatally deficient in protecting the health of the public. Further, public health should advocate a "counter-ethic" for protecting the public's health, one articulated in a different tradition of justice and one designed to give the highest priority to minimizing death and disability and to the protection of all human life against the hazards of this world.

#### *Social Justice*

The fundamental critique of market-justice found in the Western liberal tradition is social justice. Under social justice all persons are entitled equally to key ends such as health protection or minimum standards of income. Further, unless collective burdens are accepted, powerful forces of environment, heredity or social structure will preclude a fair distribution of these ends.<sup>15-17</sup> While many forces influenced the development of public health, the historic dream of public health that preventable death and disability ought to be minimized is a dream of social justice.<sup>18</sup> Yet these egalitarian and social justice implications of the public health vision are either still not widely recognized or are conveniently ignored.

Seeing the public health vision as ultimately rooted in an egalitarian tradition that conflicts directly with the norms of market-justice is often glossed over and obscured by referring to public health as a general strategy to control the "environment." For example, Canada's "New Perspectives on the Health of Canadians,"<sup>19</sup> correctly notes that major reductions in death and disability cannot be expected from curative health services. Future progress will have to result from alterations in the "environment" and "lifestyle." But if we substitute the words "market-justice" for environment or lifestyle, "New Perspectives" becomes a very radical document indeed.

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Ideally, then, the public health ethic<sup>20</sup> is not simply an alternative to the market ethic for health—it is a fundamental critique of that ethic as it unjustly protects powerful interests from the burdens of prevention and as that ethic serves to legitimate a mindless and extravagant faith in the efficacy of medical care. In other words, the public health ethic is a *counter-ethic* to market-justice and the ethics of individualism as these are applied to the health problems of the public.

This view of public health is admittedly not widely accepted. Indeed, in recent times the mission of public health has been viewed by many as limited to that minority of health problems that cannot be solved by the market provision of medical care services and that necessitate organized community action.<sup>21</sup> It is interesting to speculate why many in the public health profession have come to accept this narrow view of public health—a view that is obviously influenced and shaped by the market model as it attempts to limit the burdens placed on powerful groups.<sup>22</sup>

Nonetheless, the broader view of public health set out here is logically and ethically justified if one accepts the vision of public health as being the protection of all human life. The central task of public health, then, is to complete its unfinished revolution: The elaboration of a health ethic adequate to protect and preserve all human life. This new ethic has several key implications which are referred to here as “principles”<sup>23</sup>: 1) Controlling the hazards of this world, 2) to prevent death and disability, 3) through organized collective action, 4) shared equally by all except where unequal burdens result in increased protection of everyone’s health and especially potential victims of death and disability.

These ethical principles are not new to public health. To the contrary, making the ethical foundations of public health visible only serves to highlight the social justice influences at work behind pre-existing principles.

#### *Controlling the Hazards*

A key principle of the public health ethic is the focus on the identification and control of the hazards of this world rather than a focus on the

behavioral defects of those individuals damaged by these hazards. Against this principle it is often argued that today the causes of death and disability are multiple and frequently behavioral in origin.<sup>24</sup> Further, since it is usually only a minority of the public that fails to protect itself against most known hazards, additional controls over these perilous sources would not seem to be effective or just. We should look instead for the behavioral origins of most public health problems,<sup>25</sup> asking why some people expose themselves to known hazards or perils, or act in an unsafe or careless manner.

Public health should—at least ideally—be suspicious of behavioral paradigms for viewing public health problems since they tend to “blame the victim” and unfairly protect majorities and powerful interests from the burdens of prevention.<sup>26</sup> It is clear that behavioral models of public health problems are rooted in the tradition of market-justice, where the emphasis is upon individual ability and capacity, and individual success and failure.

Public health, ideally, should not be concerned with explaining the successes and failures of differing individuals (dispositional explanations)<sup>27</sup> in controlling the hazards of this world. Rather these failures should be seen as signs of still weak and ineffective controls or limits over those conditions, commodities, services, products or practices that are either hazardous for the health and safety of members of the public, or that are vital to protect the public’s health.

#### *Prevention*

Like the other principles of public health, prevention is a logical consequence of the ethical goal of minimizing the numbers of persons suffering death and disability. The only known way to minimize these adverse events is to prevent the occurrence of damaging exchanges or exposures in the first place, or to seek to minimize damage when exposures cannot be controlled.

Prevention, then, is that set of priority rules for restructuring existing market rules in order to maximally protect the public. These rules seek to create policies and obligations to replace the norm of market-justice, where the latter permits specific conditions, commodities, services,

products, activities or practices to pose a direct threat or hazard to the health and safety of members of the public, or where the market norm fails to allocate effectively and equitably those services (such as medical care) that are necessary to attend to disease at hand.

Thus, the familiar public health options:<sup>28</sup>

- 1 Creating rules to minimize exposure of the public to hazards (kinetic, chemical, ionizing, biological, etc.) so as to reduce the rates of hazardous exchanges.
- 2 Creating rules to strengthen the public against damage in the event damaging exchanges occur anyway, where such techniques (fluoridation, seat-belts, immunization) are feasible.
- 3 Creating rules to organize treatment resources in the community so as to minimize damage that does occur since we can rarely prevent all damage.

### *Collective Action*

Another principle of the public health ethic is that the control of hazards cannot be achieved through voluntary mechanisms but must be undertaken by governmental or non-governmental agencies through planned, organized and collective action that is obligatory or non-voluntary in nature. This is for two reasons.

The first is because market or voluntary action is typically inadequate for providing what are called public goods.<sup>29</sup> Public goods are those public policies (national defense, police and fire protection, or the protection of all persons against preventable death and disability) that are universal in their impacts and effects, affecting everyone equally. These kinds of goods cannot easily be withheld from those individuals in the community who choose not to support these services (this is typically called the "free rider" problem). Also, individual holdouts might plausibly reason that their small contribution might not prevent the public good from being offered.

The second reason why self-regarding individuals might refuse to voluntarily pay the costs of such public goods as public health policies is because these policies frequently require burdens that self-interest or self-protection might see as too stringent. For example, the mini-

mization of rates of alcoholism in a community clearly seems to require norms or controls over the substance of alcohol that limit the use of this substance to levels that are far below what would be safe for individual drinkers.<sup>30</sup>

With these temptations for individual non-compliance, justice demands assurance that all persons share equally the costs of collective action through obligatory and sanctioned social and public policy.

### *Fair-Sharing of the Burdens*

A final principle of the public health ethic is that all persons are equally responsible for sharing the burdens—as well as the benefits—of protection against death and disability, except where unequal burdens result in greater protection for every person and especially potential victims of death and disability.<sup>31</sup> In practice this means that policies to control the hazards of a given substance, service or commodity fall unequally (but still fairly) on those involved in the production, provision or consumption of the service, commodity or substance. The clear implication of this principle is that the automotive industry, the tobacco industry, the coal industry and the medical care industry—to mention only a few key groups—have an unequal responsibility to bear the costs of reducing death and disability since their actions have far greater impact than those of individual citizens.

### **Doing Justice: Building a New Public Health**

I have attempted to show the broad implications of a public health commitment to protect and preserve human life, setting out tentatively the logical consequences of that commitment in the form of some general principles. We need, however, to go beyond these broad principles and ask more specifically: What implications does this model have for doing public health and the public health profession?

The central implication of the view set out here is that doing public health should not be narrowly conceived as an instrumental or technical activity. Public health should be a way of doing justice, a way of asserting the value and priority of all human life. The primary aim of all public health activity should be the elaboration and adoption of a new ethical model or

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paradigm for protecting the public's health. This new ethical paradigm will necessitate a heightened consciousness of the manifold forces threatening human life, and will require thinking about and reacting to the problems of disability and premature death as primarily collective problems of the entire society.

### *Right-to-Health*

What concrete steps can public health take to accomplish this dramatic shift? Perhaps the most important step that public health might take to overturn the application of market-justice to the category of health protection would be to centrally challenge the absence of a right to health. Historically, the way in which inequality in American society has been confronted is by asserting the need for additional rights beyond basic political freedoms. (By a right to health, I do not mean anything so limited as the current assertion of a right to payment for medical care services.) Public health should immediately lay plans for a national campaign for a new public entitlement—the right to full and equal protection for all persons against preventable disease and disability.

This new public commitment needs more than merely organizational and symbolic expression; ultimately, it needs fundamental statutory and perhaps even constitutional protection. I can think of nothing more helpful to the goal of challenging the application of market-justice to the domain of health than to see public health enter into a protracted and lengthy struggle to secure a Right-to-Health Amendment.<sup>32</sup> This campaign would in and of itself signal the failure of market-justice to protect the health of all the public. Once secured, this legislation could serve as the basic counterpoise to our numerous and countless policies sanctioning unreflecting growth, uncontrolled technology or unrelenting individualism. Such an amendment could enable public health in all of its activity to constantly, relentlessly, stubbornly, militantly confront and resist all efforts to dishonor the integrity of human life in the name of progress, convenience, security and prosperity, as well as assist public health in challenging the dubious stretching of the principle of personal freedom to protect every corner of social life.<sup>33</sup>

A second step on the path to a fundamental paradigm change is the work of constructing collective definitions of public health problems.<sup>34</sup> Creating and disseminating collective definitions of the problems of death and disability would clearly communicate that the origins of these fates plainly lie beyond merely individual factors (but, as always, some individual factors cannot be totally ignored), and are to be found in structural features of the society such as the rules that govern exposure to the hazards of this world. These new collective descriptions, as they create more accurate explanations of public health problems, would in and of themselves expose the weakness of the norm of individual responsibility and point to the need for collective solutions.

These new definitions of public health problems are especially needed to challenge the ultimately arbitrary distinction between voluntary and involuntary hazards, especially since the former category (recently termed "lifestyle") looms so large in terms of death and disease.<sup>35</sup> Under the current definition of the situation, more stringent controls over involuntary risks are acceptable (if still strenuously resisted by producer groups), while controls over voluntary risks (smoking, alcohol, recreational risks) are viewed as infringements of basic personal rights and freedoms.

These new definitions would reveal the collective and structural aspects of what are termed voluntary risks, challenging attempts to narrowly and persuasively limit public attention to the behavior of the smoker or the drinker, and exposing pervasive myths that "blame the victim."<sup>36</sup> These collective definitions and descriptions would focus attention on the industry behind these activities, asking whether powerful producer groups and supporting cultural and social norms are not primary factors encouraging individuals to accept unreasonable risks to life and limb, and whether these groups or norms constitute aggressive collective structures threatening human life.

A case in point: Under the present definition of the situation, alcoholism is mostly defined in individual terms, mainly in terms of the attributes of those persons who are "unable" to control their drinking. But I have shown elsewhere that this argument is both conceptually

and empirically erroneous. Alcohol problems are collective problems that require more adequate controls over this important hazard.<sup>37</sup>

This is not to say that there are no important issues of liberty and freedom in these areas. It is rather to say that viewing the use of, for example, alcohol or cigarettes by millions of American adults as "voluntary" behavior, and somehow fundamentally different from other public health hazards, impoverishes the public health approach, tending (as Terris has suggested)<sup>38</sup> to divorce the behavior of the individual from its social base.

In building these collective redefinitions of health problems, however, public health must take care to do more than merely shed light on specific public health problems. The central problems remain the injustice of a market ethic that unfairly protects majorities and powerful interests from their fair share of the burdens of prevention, and of convincing the public that the task of protecting the public's health lies categorically beyond the norms of market-justice. This means that the function of each different redefinition of a specific problem must be to raise the common and recurrent issue of justice by exposing the aggressive and powerful structures implicated in all instances of preventable death and disability, and further to point to the necessity for collective measures to confront and resist these structures.

### *Political Struggle*

Doing public health involves more than merely elaborating a new social ethic; doing public health involves the political process and the challenging of some very important and powerful interests in society. The public health model involves at its very center the commitment to a very controversial ethic—the radical commitment to protect and preserve human life. To realize and make visible this commitment means challenging the embedded and structured values—as well as sheer political power—of dominant interests. These interests will not yield their influence without struggle.

This political struggle for a *truly* public health policy crucially involves bringing the medical care complex under the control of a new public health ethic. The medical care industry, like

other powerful groups, must bear its fair share of the burdens of minimizing death and disability. Of all the perils presently confronting the public health community, there is none greater than that of gradually limiting and diminishing its mission to that of public medical care. I am deeply concerned that national health insurance—and here I have the Kennedy plan in mind—will become a vehicle to be used by what Alford has labelled the "corporate rationalizers"<sup>39</sup> to further finance, extend, solidify and entrench the power of the medical care complex. The nation's leading medical care issue is not to expand the medical care service market; the central issue is to control a powerful and expansionist medical care industry. Challenging medical dominance could go a long way toward reclaiming health as a public concern and an issue of social justice.

Challenging these centers of power in order to incarnate the priority of human life requires not only a new ethic but a supporting base of power. I believe that while professional prestige is an important attribute in the modern day public policy process, public health is ultimately better understood as a broad social movement. There is simply no way that we can hope to capture public health under a defining set of competences, skills and professional backgrounds. The political potential of public health goes beyond professionalism; at its very heart is advocacy of an explosive and radical ethic. Doing public health should be a ubiquitous, pervasive, common and routine activity accomplished in every public and private agency, at every level of government, among all peoples, and at every moment of our common history. Health policy is most decidedly not the sole preserve of physicians, schools of public health, health educators, consumer groups or any other special interest group; rather it is a fundamental concern of all human activity and a distinguishing sign of a just community. By stressing the pervasive character of public health and the problems of death and disability, the foundation for a broad social movement can be established.

At the same time, public health should always hold in mind that this power struggle is meant to be not only instrumental but also dialectical, informative and symbolic. The point of the struggle is not merely to assure that producer



interests accept their fair share of the costs of minimizing death and disability, but also—and once again—to reveal through the process of confrontation and challenge the structured and collective nature of the problems of death and disability and the urgency for more adequate structures to protect all human life.

I also believe that the realism inherent in the public health ethic dictates that the foundation of all public health policy should be primarily (but not exclusively) national in locus. I simply disagree with the current tendency, rooted in misguided pluralism and market metaphors, to build from the bottom up. This current drift will, in my opinion, simply provide the medical care industry and its acolytes (to cite only one powerful group) with the tools necessary to further elaborate and extend its hegemony. Confronting organizations, interests, ideologies and alliances that are national and even international in scope with such limited resources seems hopelessly sentimental. We must always remember that the forces opposed to full protection of the public's health are fundamental and powerful, deeply rooted in our national character. We are unlikely to successfully oppose these forces with appeals or strategies more appropriate for an earlier and more provincial time.

Finally, the public health movement must cease being defensive about the wisdom or the necessity of collective action. One of the most interesting aspects of market-justice—and particularly its ideological thrusts—is that it makes collective or governmental activity seem unwise if not dangerous. Such rhetoric predictably ignores the influence of private power over the health and safety of every individual. Public health need not be oblivious to the very real concerns about a proliferating bureaucracy in the emergent welfare state. In point of fact, however, the preventive thrust of public health transcends the notion of the welfare or service state and its most recent variant, the human services society. Much as the ideals of service and welfare are improvements over the simple working of market-justice, the service society frequently functions to spread the costs of public problems among the entire public while permitting the interests, industries, or professions

who might remedy or prevent many of these problems to operate with expanding power and autonomy.

### Conclusion

The central thesis of this article is that public health is ultimately and essentially an ethical enterprise committed to the notion that all persons are entitled to protection against the hazards of this world and to the minimization of death and disability in society. I have tried to make the implications of this ethical vision manifest, especially as the public health ethic challenges and confronts the norms of market-justice.

I do not see these goals of public health as hopelessly unrealistic nor destructive of fundamental liberties. Public health may be an "alien ethic in a strange land."<sup>40</sup> Yet, if anything, the public health ethic is more faithful to the traditions of Judeo-Christian ethics than is market-justice.

The image of public health that I have drawn here does raise legitimate questions about what it is to be a professional; and legitimate questions about reasonable limits to restrictions on human liberty. These questions must be addressed more thoroughly than I have done here. Nonetheless, we must never pass over the chaos of preventable disease and disability in our society by simply celebrating the benefits of our prosperity and abundance, or our technological advances. What are these benefits worth if they have been purchased at the price of human lives?

Nothing written here should be construed as a per se attack on the market system. I have, rather, surfaced the moral and ethical norms of that system and argued that, whatever other benefits might accrue from those norms, they are woefully inadequate to assure full and equal protection of all human life.

The adoption of a new public health ethic and a new public health policy must and should occur within the context of a democratic polity. I agree with Terris<sup>41</sup> that the central task of the public health movement is to persuade society to accept these measures.

Finally, it is a peculiarity of the word freedom that its meaning has become so distorted

and stretched as to lend itself as a defense against nearly every attempt to extend equal health protection to all persons. This is the ultimate irony. The idea of liberty should mean, above all else, the liberation of society from the injustice of preventable disability and early death. Instead, the concept of freedom has become a defense and protection of powerful vested interests, and the central issue is viewed as a choice between freedom on the one hand,

and health and safety on the other. I am confident that ultimately the public will come to see that extending life and health to all persons will require some diminution of personal choices, but that such restrictions are not only fair and do not constitute abridgement of fundamental liberties, they are a basic sign and imprint of a just society and a guarantee of that most basic of all freedom—protection against man's most ancient foe.

### References and Notes

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- Some might object strenuously to the marriage of the two terms "market" and "justice." One theory of the market holds that it is a blind hand that rewards without regard to merit or individual effort. For this point of view, see: Friedman, M. *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962); and Hayek, F. *The Constitution of Liberty* (Chicago: University of Chicago Press, 1960). But Irving Kristol, in his "When Virtue Loses All Her Loveliness," [*The Public Interest* 21:3-15 (1970)], argues that this is a minority view; most accept the marriage of the market ideal and the merits of individual effort and performance. I agree with this point of view—which is to say I see the dominant model of justice in America as a merger of the notions of meritarian and market norms.
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- For excellent discussions of the notion of market "externalities," see: Hardin, G. *Exploring New Ethics for Survival* (Baltimore, Md.: Penguin Books, 1972); Mishan, E. *The Costs of Economic Growth* (New York: Praeger, 1967); and Kapp, W. *Social Costs of Business Enterprise*, 2d ed. (New York: Asia Publishing House, 1964).
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- I am aware that I am passing too quickly over a very complex subject: The formative influences for public health. I am simply asserting that the dream of eliminating or minimizing preventable death and disability involves a radical commitment to the protection and preservation of human life and that this vision ultimately belongs to the tradition of social justice. Further, one can clearly find social justice influences in the classics of the public health literature. For example, see: Smith, S. *The City That Was* (Metuchen, N.J.: Scarecrow Reprint Corporation, 1973); and Winslow, C.-E.A. *The Life of Hermann Biggs, Physician and Statesman of the Public Health* (Philadelphia: Lea and Febiger, 1929).

There are several reasons why public health has seldom been treated as standing in the tradition of social justice. Public health usually entails public or collective goods (such as clean air and water supplies) where the question of distributive shares seems not important. However, for collective goods and in the case of death and disability, the key distributive questions are the numbers or rates of persons who suffer these fates, that no group or individual be unfairly or

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ial be unfairly or

- arbitrarily excluded from protection, and that the burdens of collective policies be fairly distributed. Writers in the tradition of social justice (such as Rawls) do not pay sufficient attention to the social justice implications of public or collective goods. This helps explain in part why many in the public health movement seldom saw themselves as involved in a drive for social justice—their work was defined as protection for the entire community (and often the entire community, rather than a minority, seem threatened in the age of acute infectious epidemics or in the drive for sanitary reform). Further, while there was opposition to even these reforms, the question of distributing the burdens of collective action did not arise so acutely as it does in the present period.
- 19 Government of Canada. *A New Perspective on the Health of Canadians* (Ottawa, Ontario, Canada: Ministry of National Health and Welfare, 1974).
  - 20 By the "public health ethic" I mean several things: The assignment of the highest priority to the preservation of human life, the assurance that this protection is extended maximally (consistent with maintaining basic political liberties: See Rawls, *op. cit.*, and note 33), that no person or group should be arbitrarily excluded, and finally that all persons ought accept these burdens of preserving life as just.
  - 21 Two examples of this point: A standard text in health administration, John Hanlon's *Public Health Administration and Practice* (St. Louis, Missouri: C. V. Mosby, 1974), does reference very broad definitions of public health but quickly settles down to discussing public health in terms of those various programs designed to deal with market failures or inadequacies. Nowhere does Hanlon seem to view the concept of public health as an ethical concept standing as a fundamental critique of the existing measures to protect human life. Second, a recent proposed policy statement on prevention for adoption by the American Public Health Association (*The Nation's Health*, October 1975), does give a very high priority to prevention but contains within it a major concession to the norm of market-justice—the category of voluntary or self-imposed risks and the treatment of this category as distinctively different from other public health hazards.
  - 22 Beauchamp, D. "Public Health: Alien Ethic in a Strange Land?" *American Journal of Public Health* 65:1338-1339 (December 1975).
  - 23 I hasten to add that I am not arguing that there are exactly four principles of the public health ethic. Actually, the four offered here can be easily collapsed to two—controls over the hazards of this world and the fair sharing of the burdens of these controls. However, the reason for expanding these two key principles is to draw out the character of the public health ethic as a counter-ethic or counter-paradigm to the market model, and to demonstrate that the public health ethic focuses on different aspects of the world, asserts different priorities and imposes different obligations than the market ethic.
  - 24 Brotman and Suffet, *op. cit.*
  - 25 Sade, R. "Medical Care As A Right: A Refutation," *The New England Journal of Medicine* 285:1288-1292 (1971).
  - 26 Ryan, *op. cit.* See also: Terris, M. "A Social Policy for Health," *American Journal of Public Health* 58: 5-12 (1968).
  - 27 See Brown, R. *Explanation in Social Science* (Chicago: Aldine, 1963) for an excellent discussion of the limitations of dispositional explanations in social science. Also, see Beauchamp, D. "Alcoholism as Blaming the Alcoholic," *op. cit.*, for a further discussion of the pitfalls of dispositional explanations in the specific area of alcohol policy.
  - 28 For excellent discussions of the strategies of public health, see: Haddon, W., Jr. "Energy Damage and the Ten Countermeasure Strategies," *The Journal of Trauma* 13:321-331 (1973); Haddon, W., Jr. "The Changing Approach to the Epidemiology, Prevention, and Amelioration of Trauma," *American Journal of Public Health* 58:1431-1438 (1968); and Terris, M. "Breaking the Barriers to Prevention," paper presented to the Annual Health Conference, New York Academy of Medicine, April 26, 1974.
  - 29 Olson, M. *The Logic of Collective Action* (Cambridge: Harvard University Press, 1965).
  - 30 Beauchamp, D. "Federal Alcohol Policy: Captive to an Industry and a Myth," *Christian Century* 92:788-791 (1975).
  - 31 This principle is similar to Rawls' "difference principle." See Rawls, *op. cit.*
  - 32 I must confess a certain ambivalence about the term "right to health." This expression is not only confused with a right to payment for medical care services, it suffers the further limitation of not conveying the full intent of the public health ethic which, at least as I see it, is to give the highest priority to life and to assure collective rules and arrangements that embody and incarnate that priority. The term "right to health" could easily be construed as something far less ambitious than these goals.
  - 33 I am not unaware that I have not begun to clarify the issue of just how far a society can go in protecting life and limb without jeopardizing political liberty. I agree with Rawls, *op. cit.*, as to the priority of liberty. However, I tend to think of liberty in terms of specific constitutional guarantees (freedom of speech, religion, due process, etc.) rather than in the more extensive sense of a positive freedom to act as one chooses except where one's actions bring harm to others. Also, shedding light on this issue of the conflict between liberty and the protection of the public's health would help shed light on just what "minimizing" death and disability specifically entails. I am satisfied at this point however that the public health ethic would move us much further toward protecting all of the public's health, without relinquishing those basic liberties and freedoms that are the attributes of a just political community and without which the very notion of social justice itself would be in jeopardy.
  - 34 Friedmann, J. *Retracking America: A Theory of Transactive Planning* (Garden City, New York: Doubleday Anchor Books, 1973).
  - 35 See: *A New Perspective on the Health of Canadians*, *op. cit.*
  - 36 Destroying these "myths" could be a major task of public health activity. See Ryan, *op. cit.*, for the best discussion of "victim-blaming" myths. See Beauchamp, "The Alcohol Alibi," *op. cit.*, for a foray against the "myth" of alcoholism. I am using myth here in the specific sense: The confusion and false definitions that arise when we discuss a public problem in an individual idiom. For a good discussion of the

- concept of myths in general, see Ryle, G. *The Concept of Mind* (New York: Barnes and Noble, 1949).
- 37 Beauchamp, "The Alcohol Alibi," *op. cit.*
- 38 Terris, "A Social Policy For Health," *op. cit.*
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