An Editorial Note

Jonathan Swift once quipped that "human happiness is a perpetual state of being well deceived." The business of "human happiness" is at the heart of this issue of *Health and Society*. At the same time, the nature, extent, and consequences of a cherished deception are called into question: that the contribution of medicine to prevention of sickness, disability, and premature death must be taken at its own evaluation. Thus, there has been a gross misrepresentation of the major influences, particularly personal medical care, on past and future improvements in health. Human happiness, the argument continues, would be advanced more rapidly if we were to correct the misuse of resources and the distorted role attributed to medicine.

The arguments surrounding publication of Professor McKeown's work are from thoughtful observers, and their positions are both literate and numerate. Across the Western world, increasing attention to the nature of the deception comes not from latter-day Luddites, nor evangelistic Calvinists, nor even therapeutic nihilists. Rather, we are undoubtedly witnessing a growing disenchantment with the pursuit of unlimited progress through unlimited spending on unlimited medical care. The evidence arrayed by Professor McKeown and others is impressive, indeed. It ranges from scientific validation of our grandmothers' homilies about the evils of weed and whisky, and the benefits of work and rest, all the way to sophisticated reconstructed life tables.

Health and Society has given so much attention to this discussion because more than modifications in our nation's medical care system are at stake; national social policy is the issue. The moral imperatives of distributive justice would be irrationally invoked if, in truth, the health care service we are distributing is irrelevant or, as some would have us believe, even harmful.

The contributed commentaries on *The Role of Medicine* are intended to serve as a corrective to such gross misinterpretation. After all, Professor McKeown weighs the contribution of Asclepius against that of Hygeia; he does not pit Apollo against Dionysius.

It is perhaps the commentary from rural Wales (in singularly

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un-bardic tones) that comes closest to offering a sobering antidote to the cost-benefit-risk equation which consumes such a large share of current discussions about the health of our nation. Large cost and limited benefit are, indeed, social constructs, not medical judgments, and ultimately should be considered apart from estimations of clinical risk. Benefit transfers—whether in cash or service—are generally not "efficient," but they may have high social value even in the face of limited risk. Professor McKeown does not discuss the Janusian nature of risk, i.e., it runs two ways. However, the quotation cited on page 372 leads to an interesting speculation. What are the medical and social risks of *not* performing any given medical service?

Surprisingly, the many cogent criticisms of Professor McKeown's methodology fail to move much beyond technical assessment. Even if the data for England and Wales, or that for the United States, were plotted on a semilogarithmic scale, the thrust of the deception thesis is only marginally modified. But a point which is likely to be obscured in all of the criticisms of methodologic niceties is that in pneumonia or in unemployment, the "hard core" becomes relatively more difficult to crack. Each unit of accomplishment will extract a higher and higher economic and social cost. Nature seems to regard a zero death rate as a numerical vacuum to be abhorred.

In the absence of more refined historical data, a serious caveat must be heeded when approaching the incontrovertible downward slope of mortality, even in this century. Note that the crude data available to Professor McKeown, and the more refined data calculated by the McKinlays, fails to differentiate changing death rates along class and income lines. It may be reasonable to hypothesize, then, that those determinants of health so articulately enumerated may benefit over time first the well, the educated, the wealthy, and the urban dweller. The therapeutic measures which rank last in McKeown's aggregated population may actually have the effect of condensing the more societal benefits for those last to benefit from general improvements.

The interventions introduced in the late nineteen-sixties under the Maternal and Infant Care program in the United States were *medical measures,* and were used in such manner as to deal with the historical, social, and economic discrepancies among groups with respect to generations of deprivation. The dramatic improvements in survival among black infants which resulted from medical ser-

vices, incidentally, would only have been visible on a semilogarithmic scale. They were "marginal gains" only to the aggregate.

Perhaps in a more rational and cost-effective world, such as Gulliver never found, "human happiness" might best be pursued outside the medical market place. The evidence presented here serves to alert us; in attempting to buy the best we are clearly not getting the best buy. But the same evidence is inadequate, as the Cantabrigian sage cautions, to add reason to simplistic speculations on those greater social benefits to be gained by decreasing our expenditures on health services and shifting investments to other areas. Surely, it would be sounder *in the long run,* to invest in education, employment, income maintenance, housing, and other contributors to happiness. The evidence is probably even more convincing when one weighs the potential contributions to health between the budgets of HEW and DOD. But in our society, such shifts are not likely to occur *in the short run.*

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