Individual Will And Social Conditions: Toward An Effective Health Maintenance Policy

By AMITAI ETZIONI

ABSTRACT: Many prominent health experts now assert that major improvements in the health of the American people must come from individual efforts to alter unhealthy personal habits and lifestyles rather than through medical services and technology. But it does not necessarily follow that a more ethical and feasible national health policy would focus primarily on exhorting Americans to mobilize their individual willpower to change to more healthful personal habits. In determining the nature of such policy, three main points are essential. First, the "health and individual responsibility" argument may overestimate the health benefits which will accrue from personal habit changes. Second, that argument tends to overlook or misconstrue the nature of societal constraints on individual will. It fails to specify the sociological conditions under which millions of individuals can change their lives significantly and the role social conditions play in maintaining unhealthy behavior and attitudes. Finally, the focus on individual decisionmaking deemphasizes the role of collective efforts, of public policy, in securing higher health standards. In essence, then, we suggest that a health policy that promotes curbing unhealthy habits and encourages healthy ones through societal action is more ethical and feasible than one focusing on "health as individual responsibility."

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AMONG THE more prominent and thoughtful experts concerned with the relationship between health and society, the following kind of consensus appears to be emerging: in the years to come, new breakthroughs in medical research, increased availability of medical services and traditional public health measures will be increasingly unable to produce the dramatic improvements in health that the public has learned to expect from them. A major revolution in public perceptions is needed: citizens of advanced industrial nations must be taught that they will achieve the greatest health gains—especially against such major killers as heart disease, cancer, stroke, and accidents—by looking to their own individual efforts. Principally, this means changing careless and unhealthy personal habits and lifestyles; stopping smoking, drinking alcohol only in moderation, and maintaining proper weight and diet, for example. Additional health habits individuals are to adopt include: regular exercise, adequate sleep (generally defined as seven to eight hours nightly); slower, more careful driving; and avoidance of “stress”—a term which encompasses a variety of consequences resulting from overwork, excessive worry, or fast living.

Dr. John H. Knowles, President of the Rockefeller Foundation and former professor at Harvard Medical School, concurs: “the next major advance in the health of the American people will result from the assumption of individual responsibility for one’s own health.”

Dr. Keith Reemtsma, of the Columbia University College of Physicians and Surgeons, sees the policy issue as one of mass education: “Today, health is largely a matter of individual choices. How should 215 million Americans be persuaded to take care of themselves?” And according to Alvin R. Tarlov, Chairman of Medicine in the University of Chicago’s Division of the Biological Sciences and the Pritzker School of Medicine, the medical profession should learn from Madison Avenue and develop techniques of “social marketing” to change such health- and self-destructive behavior as careless driving, alcohol and drug abuse, cigarette smoking, overeating, poor nutrition, avoidable stress, and lack of exercise. “One must recall the enormous effectiveness of our advertising industry,” he said in an address to the 72nd Annual Congress of Medical Education, “the billions of dollars poured into advertising annually by the industrial establishment have effectively sold ideas and goods which the people previously were unaware they wanted.”

Representative of the kind of mass education that Dr. Tarlov recommends, and illustrative of the emerging consensus on health care, was a public service advertisement issued recently by the California State Department of Health: The ad urged Californians to increase their life and health expectancy by following seven “good health practices” which included moderate drinking, good nutrition, and adequate sleep.

4. California State Department of Health, 1973–74 study by Lester Breslow, M.D., M.P.H., Dean of UCLA’s School of Health. The New York State Department of Health has also issued a public service advertisement admonishing radio listeners to devote
It should be noted that the proponents of increased individual responsibility for health care substantiate their arguments with data rather than relying solely on philosophical or moral reasoning. With respect to longevity, Dr. Knowles observes that the improvements in medical science and services achieved between 1900 and 1965 added only 2.7 additional years to the life expectancy at 65. In contrast, he cites studies by Breslow and Belloc of nearly 7,000 adults followed for five and a half years which suggested that many more years could be added to life expectancy if individuals observed the following basic health habits: (1) three meals a day at regular times and no snacking; (2) breakfast every morning; (3) moderate exercise two or three times a week; (4) adequate sleep (7 or 8 hours a night); (5) no smoking; (6) moderate weight; (7) no alcohol or only in moderation. The studies suggested that a 45-year-old man who practiced none to three of these habits had a remaining life expectancy of 21.6 years (to age 67), while one practicing six to seven of these habits had a remaining life expectancy of 33.1 years (to age 78). In other words, proper health habits could add 11 years to the average life expectancy at age 65.

Of course, in the past, medical care and public health measures have been enormously significant in adding to the numbers of people surviving to age 65. They lowered infant mortality rates and virtually eradicated such contagious diseases as diphtheria, rheumatic fever, smallpox and polio. Between 1900 and 1965, Knowles points out, these factors added 21 years to average life expectancy at birth. But as of 1977, most of the gains that occur through these methods have already been made. Though Knowles argues for a societal attack on pollution and other environmental health hazards, he accords such efforts lower priority than reform of personal habits and lifestyles.

As we see it, the argument that American society has accorded too high a priority to medical services and too low a priority to other means of improving health has some persuasiveness. It does not necessarily follow from this, however, that a more ethical and feasible national health policy would be to focus primarily on exhorting Americans to mobilize their individual will power in order to change to more healthful personal habits. Our thesis in the following pages is that sociological analysis suggests otherwise. Our ar-

gument consists of three points. First, the “health as individual responsibility” argument quite likely overestimates the magnitude, and certainly the health benefits, that will accrue from personal habit changes. Second, it tends to overlook or misconstrue the nature of the societal constraints on the individual will, and hence fails to specify the sociological conditions under which millions of individuals are able to change their lives significantly and the role social conditions have in maintaining unhealthy behavior and attitudes. Finally, the focus on individual decisionmaking deemphasizes the role of collective efforts, of public policy, in securing higher health standards. Our thesis, we suggest, defines a more ethical and feasible national health policy than the policy of “health as individual responsibility.”

THE KNOWLEDGE BASE OF SOCIAL POLICY

Our review of the relevant research suggests that proponents of greater individual responsibility tend to advocate habit changes whose causal links to specific health outcomes are well established, along with ones whose health value is much more in doubt or little known. The causal relationship of smoking to lung cancer and emphysema is well documented. Likewise, the role of excessive drinking in bringing on cirrhosis of the liver, as well as needless deaths and disabilities due to drunken violence and drunken driving, are solidly established. The significance of slower driving for auto accident prevention is also clearly documented.

In contrast, evidence regarding the ill effects of drug use, other than cigarettes and alcohol, is in many cases weak and uncertain. Hence medical, as opposed to purely moral, arguments against such drugs as marijuana, cocaine, and heroin tend to be much less compelling. (Evidence of physiological harm is particularly poor for marijuana, but not completely compelling even for heroin.)

What is most important for the majority of Americans is that the relationship between lowering the likelihood of heart disease, stroke, and other similar serious diseases and such oft-prescribed personal behavior changes as losing weight, maintaining a restricted diet to try to reduce serum cholesterol, and engaging in various forms of regular exercise is also unclear and unproved. Science recently reviewed numerous studies of the causes of the cardiovascular diseases. The studies available provide uncertain evidence either to support or reject the usefulness of weight control, proper diet, and exercise. While there is a relatively strong correlation between proper weight and low mortality and morbidity, this does not demonstrate that persons who have been overweight for years and then succeed in losing, say, 25 pounds will thereby gain the same protection as persons who have been, and remain, slim as a result of genetics, metabolism, or life-long proper nutrition and exercise.

Regarding cholesterol, comparative national rates of heart disease


have been found to correlate significantly with both serum cholesterol concentrations and with the saturated fat intake of the populations studied. Thus, the Japanese and the Finns, who eat low fat diets, have the lowest rates of both cholesterol and heart disease. However, investigations point out that since different populations have different genetic backgrounds, one is on scientifically uncertain ground in predicting that changes in diet could produce similar results for Americans. Indeed, most studies in which investigations have tried to determine whether a switch to a proper diet does decrease serum cholesterol found only modest (approximately 10 percent) reductions. And, the data did not show that coronary mortality was curtailed as a result. The Science report adds that although most researchers believe individuals who exercise decrease their chances of developing cardiovascular disease, studies have generally been unable to demonstrate such a relationship.

Perhaps the strongest argument for caution is that some of the prescribed self-help may turn out to be harmful, not merely ineffective, though we freely admit that this evidence often is as uncertain as the other. For instance, some reports suggest that jogging, especially for those not used to physical exercise, may trigger, rather than help avert, heart attacks. Pressuring people to diet may also prove harmful, because so many dieters rely heavily on special diet products, high in artificial sweeteners and other chemicals, which a growing number of experts fear may eventually prove carcinogenic. In addition, most of those who lose weight soon gain it back, and this "yo-yo" syndrome is hardly likely to be healthier, indeed may well prove to be much less healthy, than staying at a higher weight. Finally, as people find themselves repeatedly unable to do what is prescribed, their failure becomes a source of shame and guilt and self-deprecation, hardly healthy physically or mentally.

In addition, many observers have noted the growing phenomenon of the "worried well," a group whose ranks may swell as the "self-help road to health" movement catches on. According to Lewis Thomas, M.D., mass health education efforts have led to a widespread public misconception that "the body is fundamentally flawed, subject to disintegration at any moment, always on the verge of mortal disease, always in need of continual monitoring and support by health-care professionals." He goes on to say that it is not only the medical care establishment which feels these concerns; "even the proponents of good hygiene, who argue publicly in favor of regular exercise, thinness, and abstinence from cigarettes and alcohol, base their arguments on the presumed intrinsic fallibility of human health." In this atmosphere individuals tend to become overly

12. Dr. Hilde Bruche, author of several books and articles on the problems of weight and eating disorders, writes that many dieters "clamor for quick reduction" and because they are often disappointed when their high aspirations are not fulfilled, they enter into the cycles of "drastic losses and rapid regaining." "'Dieting' to such patients . . . becomes a magical tool that will bring fulfillment of impossible aspirations. Without a corrective reappraisal of their fantastically high aspirations they are bound to be disappointed and will regain the painfully lost weight." Hilde Bruche, "The Psychology of Obesity," Medical Opinion (August 1973), p. 39.
14. Ibid.
concerned about minor or nonexistent health problems, overload the medical care system, and fall prey to over-the-counter drug hypes.

At a December 1976 symposium on sleep disorders, sleep researchers agreed that one of the most common causes of insomnia is no cause at all. That is, when sleep patterns of a person complaining of insomnia are monitored in the laboratory it becomes clear that they have overestimated how long it takes them to fall asleep or how long they are awake during the night and thus underestimate their actual amount of nightly sleep. According to Dr. Sidney Cohen, psychiatrist at the University of California, insufficient sleep for one or two nights is not debilitating, contrary to what many people believe. "The major debilitating factor is related to the worry about not having slept." The sleep researchers also agreed that such "pseudo-insomnia" may result from widespread public ignorance that not all individuals require eight to nine hours of sleep a night.15

In short, to the extent that one seeks to mobilize individuals to treat themselves as a way to improve the public’s health, one clearly should limit oneself to treatments whose benefit is clearly established. Otherwise, at best, individual mobilization will lead to needless effort and, at worst, the inadvertent harm may exceed the benefits.

We now turn to our second and major theme. To urge Americans to accept individual responsibility for their health is to underestimate the role of society in creating conditions under which individuals both need to and are able to mobilize their will power and to ignore the constraints societal factors impose on the impact of individualistic efforts.

### The Technology [sic] of Will Power

Dr. Knowles writes:

Prevention of disease means forsaking the bad habits which many people enjoy—overeating, too much drinking, taking pills, staying up at night, engaging in promiscuous sex, driving too fast, and smoking cigarettes—or put another way, it means doing things which require special effort—exercising regularly, going to the dentist, practicing contraception, ensuring harmonious family life, submitting to screening examinations.16

Granted that some personal habits, such as drinking to excess and smoking, do require modification, it is far from self-evident that the most effective way to bring about large-scale behavior change is by exhorting millions of individuals to mobilize ever higher levels of will power to achieve ever greater degrees of self-control.

A taken-for-granted assumption underlying this approach is that the required behavior changes are of necessity effortful, unpleasant, or unenjoyable and thus require considerable amounts of self-denial. Because, in addition, the amount of personal effort needed is viewed as "fixed," it is taken for granted that what must be jacked up is the amount of "will power" each individual puts behind his or her health effort.

In contrast, we suggest that, rather than focusing on creating (and even more difficult, sustaining) the motivation to make difficult, unenjoyable habit changes, the emphasis should be on how to make adopting or


keeping to a healthful regimen easier to accomplish. By reducing the effort, tension, and strain needed to overcome unhealthy habits and sustain healthy ones, the same amount of will power or motivation to change would go a much longer way.

In some cases, technological shortcuts in the form of various medical interventions may prove helpful. For example, alcoholism is one of the major afflictions whose treatment has traditionally been viewed as requiring a mobilization of will power. Thus, it is generally stressed that alcoholics must be willing to admit to themselves and to others that they are alcoholic, must truly want and seek help, must recognize the seriousness of the problem, and agree to try hard not to drink again. The fact, however, is that most alcoholics who go on the wagon fall off it again. (As Mark Twain put it: It’s easy to stop smoking; I did it many times.)

The problem seems to be that while many alcoholics have some motivation to stop drinking, it is insufficient for the difficult regimen of breaking their addiction. However, should antabuse, given in small dosages (such as 0.25 grams) prove safe, it might help a significant proportion of these alcoholics because it requires much less will power to take this medication regularly than to refrain from drinking. The medication acts by causing alcohol consumption to have highly unpleasant effects. Soon after ingesting the alcohol an individual who has taken antabuse may experience a burning sensation in the face and neck, a severe headache, and often, a feeling of faintness leading to vomiting. In the words of the physician who first detected the effects, Dr. Erik Jacobsen, “The discomfort is so intense that, once experienced, it prevents an overwhelming majority of patients from further attempts to take alcohol as long as they are influenced by antabuse.”\(^{17}\) The drug has been used infrequently because when it was first administered, in high dosages, it was believed to have caused a fatality. More recent studies, however, using lower dosages, are reported safe and effective, although the use of antabuse is still far from reliably indicated on either ground.\(^{18}\) The drug serves better to illustrate an idea than as a prescription.

Similarly, unwanted pregnancies would be curbed if means of control were developed besides those requiring intervention before each intercourse (condom, diaphragm), regular intake (the Pill), or one which is anxiety-producing, difficult to reverse, and requires surgical intervention (sterilization and vasectomy). The required new procedure would be easily reversed, require one intervention until reversal was required, and involve no pain and no anxiety (the IUD used to be considered a fair approximation). With a given level of will power, such a technique would provide a means of preventing unwanted pregnancies superior to any other.

Seat belts and air bags do a thousand times more for safer driving than driver education does. We mean that literally; a study of the cost


per death averted suggests that seat belts are 1,000 times more effective than driver education.\(^\text{19}\)

All this is not to suggest that people should not “do their share,” but rather to propose that in our moral predisposition for “strong” individuals, we are overlooking the fact that the most effective way to healthier lifestyles may be not in changing people’s preferences and habits, but in recognizing their inclinations and easing their efforts with the help of science and technology.

**SOCIAL CONDITIONS AND INDIVIDUAL WILL**

Nor are the level of individual “strength” and wise conduct largely subject to self-control. They are, to a significant extent, dependent on social conditions. To illustrate the point from another area of human conduct, it has long been recognized that individuals are better able to resist government encroachment on their political and other liberties if they are members of “organic” communities, are bound together in voluntary associations, or are otherwise well integrated into the social fabric. No one is considered more vulnerable to government tyranny than an isolated, “atomized” individual. The same holds for wise versus unwise health practices. The mass society makes people vulnerable to exploitation through mass appeals, fashions, and fads. Dr. Beverly Winikoff of the Rockefeller Foundation has written:

We offer nutrition and health education at the same time that we offer barrages of commercials for soft drinks, sweet snacks, high-fat foods, cigarettes, and alcohol. We tell people to stop smoking, and we subsidize the production of tobacco. We put candy machines in our schools and cigarette machines in our offices. . . . I do not think it is appropriate to expect the public to swim upstream against powerful currents of commercial information and socioeconomic pressures.\(^\text{20}\)

It is not that those in well-integrated communities will necessarily follow wise health policies; that depends largely on what patterns their communities approve and disapprove, promote and discourage or condemn. It is a matter of what they define as wise conduct and how highly they value health versus other values, from conquest to success. True, persons who are committed to change their unhealthful habits can, to some extent, turn the impact of patterns of social and cultural communities to their advantage. For example, individuals seeking to overcome alcoholism, drug addiction, smoking, and compulsive eating tend to be more successful when they join a supportive peer group, such as Alcoholics Anonymous, Synanon, or Weight Watchers, than when they try to rely only on their own will power. Most individuals, however, find themselves unable to join such intensive group life, and even those who do must deal with the pressures of the larger society and culture, of which they are also members. A survey examining the role of environmental variables related to alcoholism concluded:

An individual who is a member of a culture in which there is both pressure to drink and culturally induced guilt and confusion regarding what kinds of drinking behavior are appropriate, is


more likely to develop trouble than will most other persons.\textsuperscript{21}

As another observer put it, there are very few alcoholics in Saudi Arabia.

In the same way, smoking has its social causes. It still carries cultural connotations of being "grown up" and "sophisticated," and starting to smoke still operates as a kind of "rite of passage" to many adolescents. This and related factors help explain why so many teenagers start smoking, although they are aware of the health risks.

Thus, while there is a significant individual element involved, a very high proportion of both the temptation to act unhealthily and the capacity to resist, or, to put it positively, to act healthily, is much less individually, than it is socially, determined.

THE SOCIETAL PROJECT

Beyond immediate peer group pressure, ethnic background and the general culture, is what we may call "America's project." Each society may be viewed as organized chiefly for one purpose, while other purposes take secondary and tertiary places. During a period of transition or disorganization, of course, no clear project may be visible. Thus, in the crusaders' day, medieval societies might be said to have seen their prime object in holy wars; traditional China had a great interest in cultural products; Athens, in public affairs. In our society, most of our time, resources, and attention are spent on production and consumption. These economic activities are the most valued and highly rewarded. A "societal project" is typically more responsive to certain of what humanist psychologist Abraham Maslow termed "basic human needs" than others. The American "work hard, play hard" consumer society is indeed so committed—if not addicted—to material and comfort needs of its members that its capacity to serve their health needs is thereby lowered.

Concretely, the societal project deeply affects all aspects of our life: work, leisure time, family life. Its impact on health—or unhealthy impact—is visible in each of them. At work, these affects are correlated with rank; thus, for those at the top, corporation leaders, advertising executives, management personnel in general, the main danger seems to be stress-related illness. "Making it" requires long hours and intense commitment as well as considerable self-discipline and competitive behavior, all of which are reported to be associated with high blood pressure and hence with a predisposition to a variety of illnesses, especially cardiovascular troubles. In the lower ranks, semiskilled, unskilled, and other members of the labor force and their families face health risks posed by the uncertainties of the production cycle. Studies suggest there is a positive, albeit complex, correlation between economic recession and infant and maternal mortality, mental hospital admissions, suicides, auto accidents, heart disease, and cardiovascular-renal disease.\textsuperscript{22}


Meanwhile, the average worker is at risk from the estimated 12,000 on-the-job deaths and 2.1 million job-related injuries that, according to the National Safety Council, occur annually. The Occupations Health and Safety Act of 1970, overwhelmingly passed by Congress, has been under attack by labor groups for failing to provide the worker with the protection promised in the legislation. A study prepared by the Department of Labor Subcommittee revealed that 96 percent of all covered employers had not experienced an inspection by the Occupational Health and Safety Administration during the Act’s first three years of existence. Although steps have been taken to provide adequate staffing for inspections and promulgation of standards, it seems that the Occupational Health and Safety Act affords inadequate protection for the problems of death and injuries on the job.

The consumer role that is central to the market economy is equally hazardous. Our leisure and recreational hours often center around use of hazardous products. The automobile is the main killer of those aged 15–24 and a major killer for all age groups. It has been predicted that 1,100 out of every 100,000 males in the United States will die from motor accidents. By the time a white male in America reaches 35, his chances of dying in a motor accident are reduced by one half. For nonwhite males, however, the chances remain high, with nearly 800 out of every 100,000 likely to die from such accidents. While it used to be widely held that it is the driver’s unwise driving which is the main cause of accidents, Ralph Nader’s book Unsafe at Any Speed and scores of studies have shown that the auto and road design are at least a major source of the problem.

Many children’s toys are hazardous. The bicycle, for example, leads the Consumer Product Safety Commission’s “Ten Most Wanted Products” list. To arrive at a product’s ranking, both frequency and severity of injuries are taken into account, with injuries to children and older people given extra weight. The traditional approach to consumer health hazards was to stress individual choice and responsibility. Caveat emptor—let the buyer beware. Moreover, the impossibility of eliminating all risk factors has long been stressed. As one popular argument goes: the only way to make certain you will never be in an auto accident is to stay at home and never go anywhere. It is assumed that each decision to consume a particular product entails an implicit balancing of risk against enjoyment.

The conclusion is that apparently the individual consumer prefers enjoyment to health. As columnist George Will puts it:

Everyone says life is “priceless,” but 75 percent of Americans do not use their cars’ safety belts (only 4 percent use the shoulder harnesses) and would not buy them if the government gave them a choice. Every politician says what Senator Henry Jackson said when he said...

24. Ibid.
26. Ibid., pp. 43–44.
endorsed a plan to spend God only knows (certainly Jackson doesn't know) how many billions of dollars on expanded government health programs: "There is nothing more precious to any of us than our health." Those obviously false words are refuted by actions, by people routinely choosing the satisfaction of appetites over the improvement of health.28

The problem, as Dr. Irvine H. Page, editor of Modern Medicine, defines it, is how "to persuade a pleasure-loving, affluent and undisciplined society to accept the necessary warnings."29

Realistically, however, the consumer frequently has no knowledge of and no means of obtaining the needed knowledge concerning the health risks of various products. There are thousands of chemical compounds used in the processing and packing of food, soft drinks and the coloring of fruits, for example, which have not been tested for toxic or carcinogenic effect. Not even if every consumer were to go shopping with a van containing a chemical lab and a trailer full of monkeys to conduct his own tests, would it be possible through such individualistic efforts alone to establish the long-run effects of old and new dyes, additives, colorings, flavor agents. Similarly, when individuals buy health foods, they cannot check whether these products are really pure or just differently packaged and as chemically dosed as the rest. These are jobs for public agencies, for which citizens pay their taxes. Often the only effective way to express our will is through collective, public efforts.

Red Dye No. 2 provides a case in point. In wide use at least since 1970, it had never been permanently approved by the United States Food and Drug Administration (FDA) due to unresolved safety questions. As a result of a review by the FDA’s National Center for Toxical Research which, near the end of 1975, concluded that there was a "statistically significant increase in a variety of malignant neoplasms [cancerous tumors] among tested rats," the dye was banned. It was only by means of a sophisticated biostatistical analysis that Red Dye No. 2 was found to be a possible cancer-causing agent.30

Moreover, a person purchasing an ice cream cone has no way of knowing whether or not it contains Red Dye No. 2 or any other dye. Typically, until the government intervenes, there has been little the citizen can do.

The consumer’s preferences and capacity to choose are also shaped by market availability. If Americans eat so much junk food, a major reason is that it is so alluringly packaged, so conveniently accessible, so temptingly ready to be eaten. It is ever-present to shoppers in supermarkets, to children in their refrigerators and school lunches—to everyone just about everywhere outside the home in fast food stands and vending machines. On the other hand, try to buy a piece of fruit in most subway, bus, or train stops.

In a similar vein, potential car buyers are saturated with appeals based on styling rather than safety. Dealers are well prepared to handle personal preferences for one color over another and such standard comfort options as a fancier exterior or a tape deck, but the individual interested in safety features, such as

airbags, will find the marketing system much less accommodating.

The point is not that the individual has no degree of freedom, no personal responsibility for his or her own health. Where the unhealthy consequences of particular behaviors are clearly documented and widely known, and where choosing the more healthful behavior does not entail an unrealistically high sacrifice such as giving up one's job, the accountability of the individual is great. Thus, if an individual persists in smoking and develops lung cancer, or refuses to wear a hard hat on a construction job and is hurt by a falling brick, the decision ultimately was his to make and he is responsible for its consequences. The main point of the preceding analysis is to stress the importance of societal factors in setting both health hazards and ill-health temptations and in shaping the ability of the individual to cope with them.

As far as health policy follows, those who call on individuals to act wisely should spend more of their time addressing themselves to the existing sources of power which shape society, be more concerned with environment, workers and consumer protection, and, more deeply, with the nature of the societal project. Individuals have a better chance of improving their health by acting publicly, as voters and members of civic pressure groups, than as consumers, or workers, or homemakers, or parents. The ability to curb unhealthy habits and to evolve healthy ones lies largely on the societal, collective level.