

Public health, the public good, and drug policy

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Ole Rogeberg's commentary critiques what he takes to be "the public health approach" to drug policy, offering in counterpoint what he identifies as four "lessons" from drug policy reform movements. He takes as his exemplar of the public health approach a book, *Drug Policy and the Public Good* (Babor et al. 2010), which has twelve co-authors, including myself. As authors, we owe Rogeberg thanks for the compliment of being taken seriously.

Public health is a broad church within which can be found diverse tendencies. A strong strand in it has been the focus on using evidence to inform policies affecting the health of the people: Snow's identification of the Broad Street pump as the source of a London outbreak of cholera is often taken as the pioneer action of epidemiology (Tuthill, 2003). From Rogeberg's Lessons 3 and 4, it can be seen that he has no argument with that aspect of a public health orientation. Where he does seem to differ from a public health orientation is in another aspect: public health's tendency to privilege the population level over the individual level in public health policymaking. Often this has been at the expense of individual choices, liberties and interests. Taking the handle off the Broad Street pump to stem the epidemic undoubtedly inconvenienced various individuals and businesses who preferred to use the pump and indeed depended on it for their water supply; but the action was

taken for the common good, in disregard of individual preferences.

The implicit framing of Rogeberg's lessons seems to be in terms of welfare economics (Feldman & Serrano, 2006). In line with this framing, his Lesson 2 explicitly privileges the individual's "subjectively perceived benefits from use" as a basis for policies. As he acknowledges, his orientation ignores the "harms that use imposes on third parties" – what economists call "externalities" – although these have been a major element in policy debate and justifications around drug policy, and for drugs like alcohol are very considerable (Nutt et al., 2010; Laslett et al., 2010). The relative weight to be given to individual preference and to the collective good tends to be a major point of divergence between welfare economics and public health, with the latter being much more sceptical about the collective good being served by aggregated individual preferences. I agree with Rogeberg that current global drug policies give little or no positive weight to consumer preferences and subjectively perceived benefits in policymaking. In fact, the current situation is more contrary to his framing than he acknowledges: a major criterion for imposing an international prohibition on a particular substance is its "abuse potential", which has conventionally been measured by the degree of euphoria and relative preference for the drug as scored by experi-

enced drug users (Room, 2011). However, I don't think this situation is attributable to a public health orientation, but rather to the broader considerations which have determined drug policy – including factors which Rogeberg mentions such as “moral panics” and actors like Nixon and Ehrlichman. In public health, in contrast, there is a strong tradition of recognition of and determined pragmatism about human choices and behaviour, regardless of what moralists or politicians may decree. This has been manifested in such public health initiatives as sexual health clinics a century ago and the promotion of contraceptives today – and, as Rogeberg notes, in such initiatives acknowledging choices to use drugs as needle exchanges and injecting rooms.

The welfare economics frame is also evident in Rogeberg's Lesson 1, concerning the “full harms” of illegal markets. His argument that a licit market is automatically to be valued over an illicit market because the latter is less efficient, “harming society by squandering labour that could be productively employed elsewhere”, has two big problems.

(1) It depends on an assumption of full employment – that there will be alternative labour for those who would be put out of work by legalising the market. This argument does not get very far in a situation of chronic underemployment; what is the more productive employment available for an opium poppy grower in Afghanistan or a coca-leaf picker in Bolivia? Those defending the current international prohibition system have occasionally put forward arguments akin to Rogeberg's, but with a contrary framing, in terms of what are portrayed as the negative effects seen

as resulting from a legalised market – that legalisation could mean that the drug cartels could become “newly ‘enfranchised’ captains of industry”, with their political influence moving on from covert corruption to “blatant, overt lobbying”, and that cultivation could be transferred to more efficient locales in developed countries: “California might become the world center of cannabis cultivation, for example” (UNDCP, 1997:191). Though some of us were amazed that those running the system were putting forward such arguments to justify it (Room & Rosenqvist, 1999), it had to be acknowledged that the scenarios were plausible. Market efficiency can have substantial downsides, which Rogeberg's frame does not acknowledge.

(2) Related to this, Rogeberg's Lesson 1 does not mention or take into account the potential “full harms” of the competing models -- legal markets in psychoactive substances. Public health advocates, and indeed the United Nations, are presently trying to deal with the substantial global burden of “noncommunicable diseases” (NCDs), for which major risk factors are tobacco, alcohol and dietary factors such as salt, saturated fats and sugar (WHO, 2015). The patterns of use of such risk factors can all be framed in terms of “subjectively perceived benefits of use”. But such a framing ignores how the markets in these commodities have been constructed, and consumer preferences motivated, by market forces – forces which will be hard to control in legalised markets, given current trade agreements. Rogeberg criticises my statement, concerning the details of a cannabis legalisation regime, that a public health approach “should ... be aiming to hold down use, at least by soft

control measures which apply across the board without singling out specific users” (Room, 2014), as amounting to saying that “the best policy ... is the most restrictive”. However, my statement was not about the most restrictive regime -- prohibition -- but rather about the regulatory provisions for a legal market. The statement is simply an application to cannabis of the hard-won experience with such psychoactive commodities as alcohol, for which, in countries such as Norway, rates of consumption and of health and social problems have been kept down by such measures as limiting the number of sales outlets and hours of sale, keeping the price relatively high with taxes, limiting advertising – and by the state itself running part of the retail market (Room, 2000). Though cannabis is less harmful to health than alcohol, heavy use still tends to result in substantial harms, as evidenced by the fact that, even without a legal market, it is second only to alcohol as the primary drug among those coming to alcohol and drug treatment in Australia (AIHW 2014:33).

The title of *Drug Policy and the Public Good* was an explicit signal that its framing and approach is not limited to the realm of public health – as Rogeberg acknowledges. Neither the book nor Rogeberg really tackle what it would mean to expand a public health approach to encompass “justice, freedom, morality and other issues beyond the health domain” which, as DPPG noted, “have an important place in drug policy formation”. The primary reason that the “public good” was not really defined in the book is that, as acknowledged on page 6, “the authors here span a wide spectrum of policy views”. Despite our diversity of orienta-

tions, I was pleasantly surprised by how much the twelve authors of the book could agree on, when we focused on the epidemiology of use and problems and on what the research evidence showed about the effects of various policy strategies. The book is thus most useful, as Rogeberg recognises, as a collegial summary of what was known at the time of its publication about what happens, in terms of intended and unintended effects, with the implementation of particular policies.

Since there was no general agreement among the authors about what were the desirable directions and paths for future policies, the conclusions in Chapter 16 of the book represent the least common denominator of what we could agree on. The chapter is thus stronger on what does not work and on the need for more policy research than on what future policies should be. We left recommendations about general policy directions, beyond what is in Chapter 16, to other publications by one or more of us, in other venues.

More generally, I think Rogeberg is expecting too much from public health as a field. What could be described as a “public health approach” can be fitted under a variety of different drug policy regimes. Somehow Jerome Jaffe and his colleagues managed to institutionalise methadone as harm reduction in the U.S. in the precise period of the conversations between Nixon and Ehrlichman referred to by Rogeberg (Massing, 2000). In affluent societies currently, the mainline “public health approach” to alcohol differs quite considerably from the approach for tobacco and nicotine. The flag of public health is not sufficient to point the way for every society through all the issues such as justice,

freedom and morality – not to mention culture and history – which play significant roles in drug policy.

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