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A matter of moral perspective

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Abstract. In the USA, treatment for alcohol and drug problems is provided in both the public and private sectors. But because there is no universal health insurance scheme, access to treatment is severely limited.

This unfortunate situation may be a consequence of an historically influential moral perspective on poverty and illness. An alternative perspective is urged.

In a free society the relationship between public and private health care might be relatively straightforward. The public sector, under government leadership, would provide a broad base of care and would act as the insurer of last resort, making treatment services available to those who could not afford them on a private basis. The private sector, guided by the 'invisible hand' of market forces, would provide additional or alternative services for those who could afford them. While this model seems to hold for Britain at the present time, it does not hold for either Canada or the USA.

In Canada the federal and provincial governments provide universal health insurance which covers treatment for alcohol and drug problems, but have systematically discouraged the development of a private health care sector. In the USA there are both public and private sectors of health care, each of which makes some provision for the treatment of alcohol and drug problems, but there is no insurer of last resort. It is estimated that more than 30 million Americans—a population equivalent in size to more than the entire population of Canada—have no health insurance at all. A much greater number who are insured are either not covered for alcohol and drug problems or for psychiatric problems, or else have sharply restricted coverage.

Thus, while in Britain treatment for alcohol and drug problems seems to be both a right and a privilege, in Canada it seems to be largely a right, and in the USA largely a privilege. Why these differences should exist between countries that in many respects are quite similar is puzzling. It may be, however, that the position of the USA arises from a dominant moral perspective that has tended to inform public policy here to an unusual degree.

Many of the groups that founded this country, such as the Puritans, the Quakers, and others, had strong religious and moral convictions and came here to give them their full expression. Among these moral perspectives was that of John Calvin (1509-64), whose theology dealt extensively with salvation as the consequence of predestined divine election. A corollary often derived from this basic tenet was that the elect might be known through their worldly attributes, particularly health and wealth.

The converse of this corollary was that the poor and the sick were not likely to be among the elect. Through further elaboration, poverty and illness came to signify moral inferiority. If the poor and the ill are morally inferior, there exists no obligation to help them. With some notable exceptions, the USA seems to feel no such obligation. National health insurance, for example, is unlikely to be enacted in the foreseeable future, and perhaps not at all. There is no constituency for it. As some recent commentators have observed, "Whatever we might like to believe about ourselves, we do not have as high a sense of responsibility for each other as do our British and Canadian neighbors".¹

Alcohol and drug problems seem especially likely to fall within the purview of this moral perspective. With respect to alcohol problems, consider the chilling 1822 statement of Justin Edwards, a Massachusetts minister and a founder of the American temperance movement: "Keep the temperate people temperate; the drunkards will soon die, and the land be free".² Consider that a 'new puritanism' is perceived to be abroad in the land.³ Consider the sluggish and inadequate federal response to AIDS,⁴ a problem afflicting especially intravenous drug abusers, as well as other whose behavior renders them morally suspect. And consider the persistent emphasis on punishment in the current national drug strategy.

What is being urged is not that health care and other problems be considered outside of a moral perspective. That is neither possible nor desirable. But there are alternative moral perspectives. Con-

sider a moral perspective of that radical thinker, the central figure of the Christian faith, on (among other matters) ministering to the sick: "Inasmuch as ye have not done it unto one of the least of these my brethren, ye have not done it unto me".⁵ Were the USA to adopt *that* moral perspective, universal health insurance would be enacted tomorrow.

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Warlingham and Minnesota compared

From Dr Max Glatt (London, UK)

Abstract. The Minnesota Model approach used by private units during the past decade has come in for criticism because of various negative aspects. On the other hand it obviously also has many positive features. There are many similarities between the Minnesota approach and that of the NHS from the 1960s onwards, based largely on the 1952 Warlingham Park Hospital model. It should be possible to provide both NHS and private units which cut out the criticized aspects of the Minnesota Model whilst retaining its positive features. Community (out-patient) facilities should play a prominent part in all such units.

The past decade has witnessed a gradual phasing out of NHS units and a marked growth of private units. If Dr Curson is right, it seems that private units now also find themselves in difficulties and

that "some of the in-patient Units . . . may be forced to close".

By and large the recently arrived private units work on what has come to be called the 'Minnesota Model' which, as the Editorial points out, has been criticized from various quarters, particularly because of the fact that in the 'Minnesota Model' the therapy is in the main carried out by counsellors who predominantly are recovered (or, as AA calls them, 'recovering') alcoholics. Their principal advantage is their own drinking experience which helps them to identify with the patients. However many of them have little training in understanding and coping with emotional and social problems possibly underlying their alcohol abuse and there may be problems, as described by Blume,¹ such as "competition and conflict with professionals . . . over-compensation for lack of training and . . . over-identification". Because these counsellors have usually recovered by and are therefore imbued with the Minnesota treatment, there often is the risk, as quoted in the Editorial, of "dogmatism, inflexibility and intolerance", heavy and often very aggressive 'confrontation' with patients, with any deviation from the counsellor's views interpreted as being 'in denial'. Little opportunity is given for open and critical discussion, so that many patients may find it easier to comply (namely agreeing on the surface, but remaining unconvinced). However in all fairness often these counsellors are themselves aware of such risks.

The 'Minnesota Model' has many positive points and in practice it apparently works with many patients. As I have witnessed over the past 10 years of working in Minnesota units, in spite of my often very critical view of certain of their methods, many patients find them very acceptable even if their claimed success rates have never been substantiated by scientific research. When the 'Minnesota Model' arrived in this country in 1980, there were about 35 NHS units in operation, based largely on the Warlingham Park Hospital (1952) programme.² There were many similarities between the 'Minnesota Model' and the NHS units, although there were distinct differences:

(1) In the Minnesota Model the main role is played by counsellors. Although most NHS units also made use of recovered ex-patients to assist in-patients and for the after-care programme, the treatment was mainly carried out by a multi-disciplinary 'professional' staff.

(2) The NHS units used an eclectic method

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