Chapter 2

An ethical framework

An ethical framework

Introduction: an ethical framework for policy

2.1 A great deal of bioethical literature focuses on the way the individual can be protected in the medical context, for example in relation to research. Public health programmes, by contrast, extend beyond the clinical context and focus on the population level, affecting the lives of the whole population, or large subgroups of the population. Many of these measures focus on prevention and may have implications for those who would not consider themselves to be ill. As a result they raise issues about the responsibilities and authority of the state and other agents whose policies and actions shape or affect people's lives. Much depends on the kind of intervention, the situation of those most directly affected by it, and the seriousness of the risks involved by implementing, or not implementing, a certain programme. Our aim in this chapter is to develop an ethical framework that identifies the most important values to guide public policy in this area. There is a complex network of interests, rights and ideals to consider, and it is not possible to prescribe a mechanistic formula that would dictate how these values should be applied. However, we aim to show how our ethical framework provides a coherent approach to the difficult issues raised by public health policies.

2.2 We begin by briefly reviewing the role of the state and then sketching an initial framework for a public health policy, based on a classical liberal conception of the state's role. Although this framework is suitable to address some of the principal issues arising in the context of public health, it also has certain limitations. We therefore propose a revised and extended version of the initial framework, which we call the stewardship model. This model is developed further in the next chapter on policy and it is then assessed in light of the issues raised by the case studies in Chapters 4–7. In Chapter 8 we return to this framework and draw some overarching conclusions.

The state and the citizen

Libertarians versus collectivists

2.3 A question that is fundamental to our inquiry is the relationship between the state's authority and the position of individual people and intermediate bodies such as institutions, schools and companies that are governed by its rules.[1] This issue is central to political philosophy, and attracts a wide range of points of view. We present here an overview of salient ethical theories that seek to describe the state–individual relationship. We locate these theories along a spectrum ranging from those that give priority to the individual, to those that prioritise the collective interests of the population as a whole.

2.4 At one end of the spectrum is the libertarian perspective, which affirms what are classically regarded as the 'natural' rights of man: life, liberty and property. The authority of the state in these rights is limited to ensuring that members of the population are able to enjoy these rights without interference from others. This radically individualist point of view allows only a minimal state. Apart from the ability to defend itself from external aggression, the state's legitimate activities comprise only: political institutions which provide authoritative statements of individual rights; judicial institutions which determine when these rights have been violated; and penal institutions to punish those who are found to have committed such violations. Beyond these institutions the libertarian state does not see the promotion of the welfare of its population as its proper role; so it provides little support for the establishment

[1] Clearly, the laws of a state affect not only people individually, but also other agents, such as charitable organisations or commercial companies. We address the role of companies in paragraphs 2.47–2.50.

of public health programmes, except for those that are essential in a practical way to the enjoyment of the rights it recognises.

2.5 At the other end of the spectrum there is what can be called a collectivist point of view. There are several forms, and we focus here on utilitarian and social contract approaches.[2]

2.6 In utilitarian traditions the primary aim is to maximise utility by focusing on achieving the greatest possible collective benefit. This means that actions or rules are generally measured by the degree to which they reduce pain and suffering, and promote overall happiness, well-being, or what might be called 'good health'. Hence, in the context of public health, when choosing between several competing interventions or programmes, states and policy makers ought to opt for those that are likely to produce the greatest aggregate benefit. For example, in the case of an epidemic, a utilitarian approach would usually favour isolation and quarantining, whereas such measures would be likely to lead to considerable tensions in the libertarian framework sketched above. As this example illustrates, one of the reasons why utilitarian approaches are controversial is that, in principle, they may allow the welfare or interests of some people to be 'sacrificed' if this were to lead to an increase in overall welfare.

2.7 An alternative collectivist approach is found in social contract theory. Here, the state's authority is based on the collective will of a community (for example, as expressed in a democratic vote) to live together as an enduring nation state. The rights of individual citizens are dependent upon this shared will of their community, and not antecedent to it. On this view, these rights do not constitute a limit to the state's authority to intervene in the lives of its citizens; instead the state's authority is properly exercised in that it realises the collective will of the community. This position will typically favour measures to promote the welfare of its citizens, including public goods and services of all kinds.

The liberal state

2.8 There are, of course, a range of positions in between these two ends of the spectrum. These intermediate positions hold that although it is the state's business to uphold and defend certain fundamental individual rights,[3] it is also the state's responsibility to care for the welfare of all citizens. These welfare considerations may include ensuring that all have a fair opportunity to make a decent life for themselves, and that efforts are made to level out unfair inequalities affecting disadvantaged groups or individuals.

2.9 Positions of this kind are thought of as liberal, and they place emphasis on equality between citizens, both in the personal and political spheres of life. The liberal agrees with the libertarian that the protection of individual freedoms constrains the state's authority. Nonetheless, the liberal rejects the libertarian thesis that legitimate state power is restricted to protection of these freedoms, and agrees with the social contract version of collectivism that the state's power may rightly be used to advance the welfare of its citizens. The liberal will generally reject the utilitarian claim that it is acceptable, without further argument, to pursue beneficial interventions, even if these significantly affect the liberty of some individuals. Thus, for the liberal state, some interventions to promote the interests of the population may be acceptable without providing further justification (such as ensuring opportunities for health for the

[2] We recognise that there are other theoretical frameworks that are collectivist (such as social democracy, which may be based on religious and ethical ideas), and that neither utilitarianism nor social contract theory by necessity has to lead to collectivism.

[3] Most notably those central to the life of a free citizen who shapes their own life in accordance with their own values and plays a part in democratic public affairs.

disadvantaged and vulnerable), whereas other interventions require explicit justification, or may simply not be acceptable at all.[4]

Autonomy

2.10 The liberal's emphasis on the importance of the individual's ability to determine the course of their own life reflects the value of personal autonomy. It is important to recognise that autonomy is not just a 'negative' freedom from interference. Literally, autonomy means 'self-governance'. Its realisation requires, among other things, knowledge of the possibilities available, and the basic capabilities necessary to take advantage of them. Thus the liberal state attaches great importance to the universal provision of education. It is content to put in place policies that make education mandatory, while recognising that this infringement of individual freedom may not be acceptable to some libertarians. These infringements are seen as justifiable as they enable people to develop basic capacities that allow them to make full use of the opportunities available in a society that values equality of opportunity. Recognising autonomy requires, in addition to universal provision of education, other policies that enable individuals to make their own way in the world and pursue their own personal goals. While the state cannot guarantee this, a liberal state will seek to promote it through policies aimed, for example, at minimising ill health, since this is an important obstacle to the achievement of independence and personal autonomy.

Health as a value

2.11 A reasonable level of health is generally regarded to be an essential ingredient of a good life. The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[5] Although this may be too wide-ranging, as hardly anyone might be considered fully healthy under the definition,[6] WHO's concept does illustrate that assessments of well-being can include value-judgements. This means there may be disagreement about the justification of specific policies. States should therefore be cautious about imposing paradigms of health on those who might reject them, especially where it might entail some intrusion into their personal life. In view of this, liberal states will typically see it as their responsibility to provide frameworks that reduce the risks its citizens pose to each other's health, but also to promote the health of those, such as children, who cannot take full responsibility for themselves.

2.12 Most modern Western states are liberal under this classification, and the question is how far it is proper for the state to introduce programmes that interfere to different degrees (see paragraphs 1.3, 3.37–3.38) in the lives of its population, in order to reduce the risks to the health of all or some of them. This illustrates the tension inherent in the liberal state, as a political community that seeks both to protect personal autonomy and promote the welfare of all people.[7]

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[4] The relationship between the liberal state and the libertarian and collectivist framework could also be clarified by focusing on the rights of individual people. Collectivists might argue that rights provide a constraint upon society through the codification of the collective will into human rights declarations, which then limit the choices that governments can make. In this sense, the collective will of society is exercised at two levels: first, by establishing a level of agreed fundamental principles in the form of rights which cannot be breached without special procedures such as constitutional change; and secondly, through democratic government and processes which assess current opinion on what is desirable. These principles are not limited to negative constraints on state power; they could also make obligatory some state intervention.

[5] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p.100) and entered into force on 7 April 1948.

[6] See also: Saracci R (1997) The World Health Organization needs to reconsider its definition of health *Br Med J* **314**: 1409.

[7] Note that there is no necessary exclusivity between either respecting individual autonomy or promoting the welfare of all. In many cases measures aimed at protecting autonomy may well lead to an increase in overall welfare at the same time. However, public health also gives rise to a range of competing scenarios, as we explore in Chapters 4–7.

A liberal proposal

Mill's harm principle

2.13 One way to start thinking about resolving the tension between the promotion of public health and the protection of individual freedoms is provided by the famous 'harm principle' advanced by John Stuart Mill in his essay *On Liberty*:

> "The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil, in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. Over himself, over his own body and mind, the individual is sovereign."[8]

Public health and the harm principle

2.14 To introduce Mill's principle in this way is not to suggest that it provides a satisfactory answer to all the questions that arise in the context of public health. Nor does it commit us to the wider theoretical framework in which it was set out, or to claim that harm to third parties is always a sufficient legitimisation of coercion.[9] Rather, we use it to illustrate that, even in an approach that seeks to ensure the greatest possible degree of individual liberty and the least possible degree of state interference, there is a core principle according to which coercive, liberty-infringing state intervention is acceptable: where the purpose is to prevent harm to others.[10] Throughout this Report, we refer to this version of the harm principle as the *classical harm principle*.

2.15 Several of Mill's observations are often overlooked, and we will use these to establish an initial framework for public health ethics that extends beyond merely preventing harms to others. We note, first, his comments about the type of people to which his principle applies; secondly, the type of goods that should be promoted by society; thirdly, his observations about means other than coercion that could be used to suggest behaviour change to people; and fourthly, his emphasis on individual liberty.

[8] Mill JS (1859) On liberty, in *On Liberty and Other Essays* (1989) Collini S (Editor) (Cambridge: Cambridge University Press), p.13.

[9] Therefore, harm to others is in most cases a necessary, but not by itself a sufficient, reason for coercive intervention. For example, there may be cases in which harm to others is caused, but it is preferable not to intervene in coercive ways, as the costs of intervention, whether these are financial or social, are too high. Considerations about proportionality will therefore usually become relevant in determining how to proceed in cases of harm to others, see paragraphs 3.17–3.18 and the discussion in Chapters 4–7.

[10] The assessment of what should count as harm, and to what extent a given harm should justify infringing liberties is however not always straightforward. See, for example, Feinberg J (1984) *Harm to Others* (Oxford: Oxford University Press). We provide examples of cases in which the classical harm principle is relevant in the Chapters 4–7.

Care of the vulnerable

2.16 Mill stated that his principle was to apply only to "human beings in the maturity of their faculties", and he goes on to say:

> "We are not speaking of children, or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others, must be protected against their own actions as well as against external injury."[11]

So Mill recognises that the state can rightfully intervene to protect children,[12] and other similar vulnerable people who require protection, from, for example, damaging their own health.

Public services

2.17 Secondly, Mill makes it clear that his defence of individual liberty is founded on his commitment to advancing 'utility', which can be understood as general welfare. Hence his principle is to be interpreted to allow the state to support "joint work necessary to the interest of society",[13] including, for example, the provision of clean water and regulations that limit working hours.[14] In the context of public health policy this provision is especially important as such policy is often directed at public goods and services.

Educating the public

2.18 The third point is Mill's view on the importance of educating and informing people so that they can make up their own minds about important questions concerning both the public affairs of the state, and their own personal decisions as to how to lead their lives. Hence, although Mill's discussion of the harm principle shows that he would strongly oppose public health programmes which simply aim to coerce people to lead healthy lives, he would be likely to support programmes which seek to "advise, instruct and persuade"[15] them so that they can make informed decisions about, for example, what to eat and how to exercise.

Protecting individuality

2.19 Finally, it is important to bear in mind the central theme in Mill's essay, the fundamental importance of what he calls 'individuality': the exercise of freedom in the construction of one's personal life. This value implies that interventions in personal life, even when they are intended to reduce health risks to others, carry a significant ethical cost. So far as it can be managed, the less intrusive and directive an intervention can be, the better (see paragraphs 3.37–3.38).

An initial liberal framework

2.20 In light of these points it is possible to construct an initial ethical framework for public health programmes. In this framework, such programmes have certain goals and constraints.[16]

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose upon each other;

[11] Mill JS (1859) On liberty, in *On Liberty and Other Essays* (1989) Collini S (Editor) (Cambridge: Cambridge University Press), p.13.

[12] The quote may also raise the question of whether it is useful to think of homogeneous classes such as children who, categorically, differ in their ability to make judgements from "human beings in the maturity of their faculties". The important point here is that the reasoning behind the harm principle does not mean that groups with less developed capacities should be neglected.

[13] Mill JS (1859) On liberty, in *On Liberty and Other Essays* (1989) Collini S (Editor) (Cambridge: Cambridge University Press), p.14.

[14] *Ibid*. p.95.

[15] *Ibid*. p.94.

[16] The different goals and constraints should not be understood as being ranked in a hierarchical order.

- pay special attention to the health of children and other vulnerable people;
- aim to reduce ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing; and
- aim to make it easy for people to lead healthy lives by the provision of advice and information.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives; and
- seek to minimise interventions that affect important areas of personal life.

2.21 This provides a coherent starting point for a framework for policy, although there are potential conflicts between some of the goals and constraints, for example, between the duty to care for children and the aim of minimising interventions in personal life. However, apart from such internal problems that are likely to occur in any framework to some extent, is this framework really satisfactory? Critics may feel that despite the acknowledgement here of the importance of public goods and services, this framework remains too strongly committed to individual autonomy. So we turn to consider some ways in which this criticism might be addressed.

Broadening the debate

Individual consent and its limitations

2.22 The liberal's stress on the importance of individual autonomy implies that the concept of consent plays a key role. Much of the bioethical discussion of the past two decades or so has sought to establish autonomy and consent as the cornerstones of biomedical ethics. However, we noted above that many of the issues raised by public health differ from those usually addressed in bioethics. The question of what weight consent can carry in public health, and when it is, and is not, required is a case in point as its relevance and usefulness is often overestimated in this context.

2.23 The core notion underlying the concept of consent that currently features in the bioethical literature and much healthcare law and policy can be traced back to the 1947 Nuremberg Trials of German physicians,[17] and it was later incorporated into the *Declaration of Helsinki* of the World Medical Association (WMA), and other ethical codes and laws. These codes thus established consent as a powerful and indispensable condition: any intervention that may expose someone to significant risk is morally unacceptable unless the person concerned agrees to being exposed to the risks, and, in legal terms, waives the corresponding rights.[18] Within the clinical context, the feasibility of consent, the degree to which it is, or should be, informed, genuine, specific or explicit, and the general conditions required for it to be ethically acceptable, have continued to be the subject of intense debate.[19]

[17] The court proceedings were initiated because physicians and researchers in Nazi Germany systematically forced concentration camp prisoners and others to take part in medical experiments. Almost all of the experiments were exceptionally cruel and harmful, and few of those involved survived them. To prevent any repetition of such abuses, Directives for Human Experimentation in the form of the *Nuremberg Code* were produced. The Code sought to ensure the absence of force, coercion or duress in the research context and began by stating unambiguously that "The voluntary consent of the human subject is absolutely essential". (See: *Directives for Human Experimentation – Nuremberg Code*, available at: http://ohsr.od.nih.gov/guidelines/nuremberg.html.)

[18] This is so, irrespective of whether the intervention is aimed at benefiting the person concerned, for example, by performing invasive medical treatment, or whether it is aimed primarily at benefiting a third party, for example where someone is involved in a medical research study.

[19] See: Beyleveld D and Brownsword R (2007) *Consent in the Law* (Oxford: Hart); Manson N and O'Neill O (2007) *Rethinking Informed Consent in Bioethics* (Cambridge: Cambridge University Press); Nuffield Council on Bioethics (1995) *Human Tissue: Ethical and legal issues* (London: Nuffield Council on Bioethics).

2.24 The concept of consent is rightly at the centre of clinical medicine. Although some of the issues addressed in the sphere of public health concern medical interventions, such as vaccinations, many others, such as the provision of health-conducive environments, occupational health and safety regulations or measures aimed at preventing excessive consumption of tobacco and alcohol, do not. The question is therefore to what extent consent is morally relevant in these areas.[20] Public health interventions may interfere to different degrees with people's choices or liberties. For example, in the case of quarantine and isolation the degree of intrusion is considerable, but restricting the movement of people suspected of having a severe infectious disease, whether or not they agree with it, can be justified on the basis of the classical harm principle. Many other interventions do not concern this degree of intrusion, and it is important to recognise the difference between consent requirements that are relevant in the context of clinical medicine and research, and those for infringements of people's choices or liberties in the non-clinical context of public health. Often, requiring each person to consent individually to non-intrusive public health measures is almost impossible and certainly impractical. More importantly, the possible harms and restriction of liberties that are entailed by a range of public health measures may not be severe. The essential point is that a greater, more explicit justification is needed for the state to interfere in a situation where individual consent would otherwise be required due to the considerable health or other risks involved. In contrast, such justification may not be needed where an interference merely limits certain choices.

2.25 Therefore, although in the case of potentially harmful medical interventions individual consent is required to authorise the implementation of the procedure, a 'procedural justice' approach that uses conventional democratic decision-making processes may be sufficient to authorise measures where there are no substantial health risks. Key elements of such an approach, which has also been described under the concept of 'accountability for reasonableness',[21] are: transparency of decision-making processes (in terms of the evidence, reasons and rationales cited in favour of an intervention that reduces some choice of individuals or otherwise inconveniences them); a focus on rationales that those affected recognise as being helpful in meeting health needs fairly; and involvement of individuals and stakeholder groups in decision-making processes, with opportunities to challenge interventions in preparation and in practice.[22]

2.26 The implication of this discussion for our initial framework (paragraph 2.20) is therefore that it needs to be expanded, as the constraint that concerns minimising interventions affecting "important areas of personal life", if strictly interpreted, could be too far-reaching, making impossible a range of important public health measures.

Health inequalities

2.27 Two of the key positive goals of public health programmes in the initial liberal framework are a reduction in the causes of ill health, and the provision of facilities that make it easy for

[20] Especially as an argument might be made that certain measures should not be implemented unless all those who would be affected consent to them.

[21] Daniels N and Sabin J (1997) Limits to health care: fair procedures, democratic deliberation, and the legitimacy problem for insurers *Philosophy and Public Affairs* **26**: 303–50; Daniels N (2000) Accountability for reasonableness *Br Med J* **321**: 1300–1.

[22] In Chapter 7, for the example of fluoridation of water, we discuss how procedural justice arrangements may be appropriate to justify certain liberty-infringing policies, even if they do not meet with everyone's individual approval. Another important example, considered in Chapter 4, concerns the use of patients' healthcare data for public health surveillance and research. Although some might argue that this should not be done without individual consent, it can also be argued that arrangements such as anonymising data can ensure that values such as privacy or confidentiality are protected, without jeopardising epidemiological research and public health policy that depends on having access to data from a sufficient number of people; see paragraphs 4.37–4.39).

people to lead healthy lives. In devising such programmes it is important to avoid a 'one size fits all' approach, as particular groups of people may differ in their health status, have varying health needs and respond differently to particular programmes. The uneven burden of ill health among different groups raises not only practical issues, but also the question of whether public health programmes should seek to reduce health inequalities. In Chapter 1 we answered this in the affirmative (paragraph 1.11), and noted that we viewed the reduction of health inequalities as central to any public health programme. Here, we clarify our reasoning behind this, which leads to a further important revision to the initial liberal framework. First, we consider in what sense inequalities in health might differ from other kinds of inequality. Next, we turn to a range of more detailed issues raised by seeking to reduce health inequalities: what kinds of inequality should be reduced? Between which kinds of group are we concerned about inequalities? And what strategies are the most appropriate, ethically, to promote equality?

Health inequalities versus income inequalities

2.28 Many liberal societies accept that there are inequalities, for example, in income, so why should inequalities in health be less acceptable?[23] Those defending the special status of health inequalities make an argument along the following lines. Inequalities in wealth are acceptable within a liberal framework only in cases where higher financial rewards for the best off have the implication that their performance contributes to improving the situation of the worst off (for example because of a resulting increase in welfare through the availability of cheaper goods and services for all).[24] Additionally, inequalities in income concern a good that has primarily instrumental value: more money enables people to do more. By contrast, health has both an instrumental value, and an intrinsic value. Good health is an instrumental prerequisite to do things because it concerns people's normal functioning and capabilities. However, health is also constitutive of people's overall well-being and, in a more direct sense, affects their quality of life. In other words, good health is central to making use of opportunities that are available in societies, and policies that do not provide people with fair and equal starting positions in the pursuit of such opportunities must be judged unjust. Formulated positively, "the moral function of [public health programmes] must be to help guarantee fair equality of opportunity".[25] Since fair equality of opportunity approaches[26] are central to the kind of democratic states we considered above (paragraph 2.9), it is clear that 'eliminating or reducing unfair health inequalities' is a feature that needs to be added explicitly to our initial list of positive goals of public health programmes.

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[23] See Daniels (1985) *Just Health Care* (Cambridge: Cambridge University Press); Anand S (2004) The concern for equity in health, in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press), pp.15–20; Sen A (2004) Why health equity?, in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press), pp.21–34.

[24] See Rawls J (1971) *A Theory of Justice* (Cambridge, Massachusetts: Harvard University Press).

[25] Daniels N (1985) *Just Health Care* (Cambridge: Cambridge University Press). Note that, by extending Rawls' 'justice as fairness', Daniels initially presented such a framework in relation to the more narrowly defined context of healthcare only. However, more recently he revised the approach and used Rawls' principle of fair equality of opportunity to address the wider range of determinants of health: see Daniels N, Kennedy B and Kawachi I (2004) Health and inequality, or, why justice is good for our health, in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press), pp.63–92; see also Anand S (2004) The concern for equity in health, in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press), pp.15–20; Sen A (2004) Why health equity?, in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press), pp. 21–34.

[26] Note that Daniels emphasises the distinction between two different types of equality of opportunity: in a *negative* version it "requires only that society refrains from imposing certain barriers to equal opportunity, such as … racial or sexual quotas on hiring". In the positive version, it consists of correcting "all the influences which interfere with equality of opportunity … [through measures such as] compensatory education programs, … or 'affirmative action' hiring procedures. This positive

Equality of what?

2.29 However, important questions remain about what exactly is required to 'reduce unfair health inequalities' and 'promote health of people equally'. Two principal strategies, which are not mutually exclusive, are:

- *Equality of health outcomes*. It could be argued that equality is achieved only where objectively measurable data such as life expectancy, body mass index (BMI) or blood pressure are the same among the groups or individuals under comparison.[27] One of the practical advantages of outcome-focused approaches is that, in principle, it is possible to measure degrees of equality in a relatively straightforward manner.[28]
- *Equality of opportunity and access (to health services and health-conducive environments)*. An alternative approach is to focus on equality of access. By this, one might include access both to health services and to health-conducive environments, such as cycle paths, parks, sports facilities, or safe working and living environments. In practice, many equality-of-outcome approaches are likely to give some weight to access issues.[29] One problem of access-based approaches is that people may have different capacities to make use of the provisions of access. Consequently, although access may be equal, outcomes may not.[30]

Equality among whom? Inequalities of status

2.30 As well as the 'equality of what?' dimension, two further questions need to be asked. The first is 'equality among whom?'. Health outcomes often differ across sub-groups of a given population. In seeking to create equality among these groups, one may focus on a range of different criteria that include age, gender, socio-economic status, racial or ethnic background, disability and geographical location. Analysing inequalities of status between such groups allows us, first, to identify those groups that suffer, or are at particular risk of suffering, poor health. Secondly, it allows us to focus on those inequalities that are

conception is called *fair* equality of opportunity." Instead of an exhaustive discussion of the justification of *fair* equality of opportunity, Daniels notes that for his purposes it is sufficient to settle for a weaker, conditional, claim, and that healthcare institutions and, by our extension, public health programmes (see previous footnote) "should be governed by a principle of fair equal opportunity provided two conditions obtain: (1) an acceptable general theory of justice includes a principle which requires basic institutions of society to guarantee fair equality of opportunity, and (2) the fair equality of opportunity principle acts as a constraint on permissible economic inequalities" (Daniels (1985) *Just Health Care* (Cambridge: Cambridge University Press)). Because these conditions are met by the kinds of state we considered here, Daniels' qualification applies equally in our case, and we do not use the term 'equality of opportunity' (or fair opportunity) to mean an uncompensated form of meritocracy, where equality is exhausted in simply ensuring equal access to key positions in society (without regard to the different chances people have in making use of these opportunities).

[27] Note that such an approach might commit one to hold that, for example, differences in life expectancy between men and women should be compensated for. However, the primary point of outcome-focused approaches in public health is to identify those outcomes that are modified by factors that are regarded as unfair and that can be changed through appropriate policy.

[28] The collection of data on life expectancy, BMI or blood pressure is straightforward in the sense that the measures make no controversial methodological assumptions. However, measures such as disability-adjusted life years (DALYs), proposed to capture, among other things, the quantity of ill health among particular groups, are more problematic, see Brock DW (2004) Ethical issues in the use of cost effectiveness analysis for the prioritisation of health care resources, pp.201–24; Kamm FM (2004) Deciding whom to help, health-adjusted life years, pp.225–42; Broome J (2004) The value of living longer, pp.243–60; Anand S and Hanson K (2004) Disability-adjusted life years: a critical review, pp.183–200, all in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press).

[29] Although the argument from equality of access can also be made independently.

[30] Within both options, a sub-set of equality issues arises. Firstly, the infrastructure put in place to ensure access can differ in quality in different regions, for example, because of political priorities. Secondly, the services and environments used to realise equality of outcome or access can be divided into those that could directly extend or save lives, and others that merely improve quality of life (Daniels N (1985) *Just Health Care* (Cambridge: Cambridge University Press)). Hence, an argument could be made that some services or outcomes are more important, and more central to equality, than others. Consequently health equality might be said to exist as long as there is access to a 'decent minimum', such as, for example, a health service that is free at the point of need. Equality might, on the other hand, require a far more extensive scenario, where all citizens (or those residing in a state) have equal access to equally health-conducive work or living environments. We therefore need to ask: "equality of access to what degree of which health-conducive services or environments?".

particularly unjust and thus inequitable.[31] For example, certain poorer health outcomes associated with living in big cities may be considered less unjust than say, differences in health outcomes between different ethnic groups.

Ways of reducing inequalities

2.31 Lastly, the question arises of 'how should inequalities be reduced?'. There are several different strategies that might be pursued. In principle, it would be possible to achieve equality either by lifting the level of welfare or opportunities of those who are worst off to the level of those who enjoy the highest standards, or by lowering the welfare of those at the top. Regarding the latter option, in order to avoid the problem of the 'levelling down objection' to egalitarian approaches that seek to even out inequalities,[32] some commentators have set out a prioritarian strategy: instead of relative health status one should focus on the absolute position of the worst off and raise it.[33] Such an approach may have different consequences in practice, and the implications need to monitored closely.[34]

2.32 Clearly, "health equality has many aspects, and is best seen as a multidimensional concept".[35] We do not seek here to prioritise particular health outcomes. Nor do we attempt to specify inequalities that are more unacceptable in some groups rather than others. However, the framework should provide a useful reference tool for establishing whether or not inequalities exist, and if so, in what sense health outcomes or opportunities are distributed unevenly, whether this distribution is unfair,[36] and if so, how it should be corrected.

Changing habits and the limits of information-only approaches

2.33 As noted earlier (paragraphs 2.10, 2.18), public education and information have a key role in the liberal framework, since they are non-coercive ways of bringing about improvements in health. Their success is dependent upon the ability to motivate people to change their attitude, and ultimately their behaviour, by information that they find persuasive. However, sustainable behaviour change is a major challenge even for those who have changed their attitude, and would like to act differently. It is even more difficult for those who are only partly persuaded. The latter group may additionally find requests for behaviour change, even if provided only in the form of information, a nuisance. The limited success of information strategies is illustrated by the example of seatbelts (see also Box 8.1). Although people were exhorted to wear seatbelts through information campaigns, the outcome was

[31] Equality considerations come into play where inequalities of a certain kind raise issues of justice and fairness. Inequality is therefore generally not particularly relevant in cases such as differences in life expectancy between men and women.

[32] Parfit D (2000) Equality or priority? in *The ideal of equality*, Clayton M and Williams A (Editors) (Basingstoke: Macmillan), pp.81–125; Dahlgren G and Whitehead M (2006) *Levelling up (part 1): A discussion paper on European strategies for tackling social inequities in health* (Copenhagen: WHO, Regional Office for Europe).

[33] Arneson R (2002) Egalitarianism, in *Stanford Encyclopedia of Philosophy*, available at: http://plato.stanford.edu/entries/egalitarianism/.

[34] There are three principal conceptual ways in which such a strategy might work in practice. In the best case, it will bring the lowest level at par with the highest (whether this is the highest attainable in principle, or the highest level feasible in certain given circumstances occurring in a state). However, sometimes, those who are better off may also benefit from the intervention that was initiated with the aim of benefiting the least well off. Therefore, in the second case, although the lowest group benefits and improves, groups enjoying higher levels may move up as well, to what may be a lesser, an equal, or even a greater degree, thereby reducing inequalities only moderately, or perhaps maintaining or even increasing them. In the third case, although the aim may be to lift the lowest levels, they may actually remain the same or decrease in relation to all other levels, perhaps because certain interventions or initiatives have not been taken up at all by the intended groups.

[35] Sen A (2004) Why health equity?, in *Public Health, Ethics, and Equity*, Anand S, Peter F and Sen A (Editors) (Oxford: Oxford University Press), pp.21–34.

[36] See footnote 34. Note also that an assessment of the fairness of the distribution of outcomes or opportunities must not be limited to comparing simply the levels of the best and worst off. Such an approach may ignore the possibility that often a gradient approach may be required which also considers the various levels between the best and worst position, since here, too, inequalities may be unfair and require responses in policy. From a policy perspective another issue to be considered is whether the overall curve of health distribution can be shifted most effectively by focusing on improving the situation of those at the lowest levels, or by focusing on particular groups who are slightly better off but still considerably worse than those enjoying the highest levels.

only achieved, with use becoming nearly universal, when it was made a legal requirement. As this illustrates, strategies that focus overly on the 'negative constraints' of the liberal framework may prove less effective than the liberal might hope. This is not to say that it should not be pursued in the first instance, but rather that when such an approach fails, a more invasive public policy may be needed, especially if it is to significantly reduce health inequalities (see paragraphs 3.18, 3.37–3.38).[37]

Adding a social dimension

The value of community

2.34 The discussions about consent, health inequalities and changing habits indicate that the initial liberal framework proposed above (paragraph 2.20) is too individualistic. An ethical framework for public health needs to include values that bring the framework closer to social contract theory (paragraph 2.7). What is required is a value that expresses the way that we each benefit simply from being members of a society in which the health needs of others are addressed. There is no settled term for this value: some speak of 'fraternity', others of 'solidarity'. We prefer the term 'community', which is the value of belonging to a society in which each person's welfare, and that of the whole community, matters to everyone. This value is central in the justification of both the goal of reducing health inequalities (paragraphs 2.27–2.28) and the limitation on individual consent when it obstructs important general benefits. Public health often depends on universal programmes which need to be endorsed collectively if they are to be successfully implemented. Although the initial liberal framework supports the promotion of public goods and services, it presents these primarily as ways of promoting individual welfare. Hence, it does not adequately express the shared commitment to collective ends, which is a key ingredient in public support for programmes aimed at securing goods that are essentially collective.

Paternalism

2.35 The initial liberal framework therefore needs to be revised, to make it less individualistic, and accommodate better the value of the community. Does this mean that we need to advocate paternalism, usually understood as the "interference of a state or an individual with another person, against their will, and justified by a claim that the person interfered with will be better off or protected from harm"?[38] We suggest that it does not.

2.36 Ideally, coercive policies should not be implemented without political *mandate* or *authorisation*. Lack of such legitimisation would render the interventions incompatible with the democratic nature of modern liberal states. They would also be undesirable from a more technical public health perspective, as opposition to the measures is likely to be strong, especially in personal areas such as food or sexual behaviour. The justification and feasibility of public health policies therefore depends heavily on their having a mandate. At the same time, there may be questions about which policies adequately address people's will, desire, individuality or autonomy, and how conflicts should be resolved where there is a mismatch. Are only those policies acceptable that people agree with entirely? For example, many individuals have a strong desire to eat, drink and smoke. However, the structure of desires is

[37] Public acceptance of the health-outcome-focused approach that made the wearing of seat belts mandatory can be explained by the fact that this is a relatively minor restriction of people's liberty, and there is an obvious benefit in terms of diminished risk of personal injury. The situation is different, for example, in the case of the wearing of cycle helmets by cyclists: despite the diminished risk of personal injury after an accident, a requirement to wear a helmet would be a nuisance and not cost-free, see also Box 8.1.

[38] Dworkin R (2002) Paternalism, in *Stanford Encyclopedia of Philosophy*, available at: http://plato.stanford.edu/entries/paternalism/.

complex, and individuals may have desires at a higher level,[39] to the effect that, actually, they would overall prefer to lose weight, stop smoking or drink less alcohol. In the case of smoking, raising taxes is an effective way of reducing consumption (see Chapter 6). Although such a policy may be against the 'will' or first-order desires, of many smokers, it is not clear that imposing taxes is necessarily an unacceptable form of paternalism. Indeed, in seeking to establish an environment where it is easy for people to be healthy, it may be an acceptable response to higher-order desires.[40]

2.37 Some suggest that, to reconcile the importance of individuality with the obligations of the state to guide us towards prudent behaviour, we should consider modified versions of paternalism.[41] For example, with regard to pension arrangements, a libertarian might argue that whether or not people wish to make contributions should be up to them, and that no-one should be forced to accept regular deductions from their income. A paternalist, on the other hand, might argue the opposite and view compulsory deductions as justified, because they concern important future needs. 'Libertarian paternalism' would suggest that the baseline option of policies should express value judgements about what is good for one's life, although individuals should be able to opt out at relative ease and low cost.[42] So, in the case of pensions, deductions should be made, but where people decide that they would prefer to make alternative arrangements, they should be free to do so. Another example closer to the sphere of public health that is considered by the proponents of this approach is to reorganise food at a buffet in such a way that the most healthy option is most likely to be chosen.[43]

2.38 Among the ideas underlying this approach is the recognition that environments in which people make choices are not value free. Whatever form an environment takes, it is likely to make certain behaviours easier than others. Additionally, different people may have different capacities in benefiting from specific environments. Strictly speaking, the libertarian's emphasis on individual choice can only be fair if all people have the same abilities and capacities to make decisions – where they do not, those who are less capable, or have less opportunity to compare and assess different options, are at a disadvantage. Often, people with less time or capacity will therefore just accept the default policy – the 'normal practice'. We acknowledge the difficulties associated with behaviour change (see paragraphs 2.33, 3.20, 5.11, 5.35, 6.9), and the framework set out in this Report emphasises that, in principle, it is acceptable for the state to bring about policies that have a clear aim of

[39] Frankfurt H (1971) Freedom of will and the concept of person *J Philos* **68**: 5–20.

[40] The principal problem with paternalism is thus that it may impose a value, without mandate against people's will. However, as the example shows, the will-test is often complicated by the complex structure of human desire, and it is questionable therefore whether such policies should be seen as paternalistic.

[41] Broadly, an advocate of *soft* paternalism would see state interference as justified if it helped determine whether the person interfered with is acting truly voluntarily and knowledgeably (a *hard* paternalist might argue that there can be occasions where interference is acceptable, even if the conditions of voluntariness and knowledge are satisfied). A distinction between *weak* and *strong* paternalism concerns peoples' assessments of achieving certain ends. Weak paternalism states that interference may be acceptable if people are mistaken about the fact that certain means will achieve desired ends. Strong paternalism argues that some ends people chose may be wrong in themselves, and that state intervention is acceptable to prevent people from achieving those ends. See: Dworkin R (2002) Paternalism, in *Stanford Encyclopedia of Philosophy*, available at: http://plato.stanford.edu/entries/paternalism/.

[42] Sunstein C R and Thaler R H (2003) Libertarian paternalism is not an oxymoron *University of Chicago Law Review* **70**: 1159–1202.

[43] Sunstein C R and Thaler R H (2003) Libertarian paternalism *American Economic Review* **93**: 175–9. Note that Sunstein and Thaler do not apply their approach directly to the context of public health. Transposing the principle to a somewhat fictitious example, a possible extension might be to permit free and ubiquitous sale only of cigarettes that are non-addictive and do not cause harm to health (such as certain herbal cigarettes), but permit, for example, sale of the currently marketed cigarettes only through channels such as mail ordering or similar, where more effort needs to be put into pursuing the less healthy option. The point is that, in principle, an approach such as libertarian paternalism might be developed to address a range of public health problems; however, as we discuss below, we do not think such an attempt would be useful for our purpose here, mainly because in some occasions the possibility of opting out is too risky and not helpful in reducing health inequalities (paragraph 2.40).

furthering some social good, such as reducing health inequalities. So, should we subscribe to a version of 'libertarian paternalism' as a basis of our revised liberal framework?

2.39 Although full-blown paternalism would be an inappropriate basis because it is insufficiently sensitive to the need for a mandate, libertarian paternalism is not suitable as it may allow too much choice, and it might also absolve the state from some important responsibilities. For example, in the UK, the state collects mandatory contributions to the NHS from all taxpayers as part of the taxes levied. In this way, the state establishes an important default option of having access to healthcare, ideally free at the point of need. This arrangement forms an important part of public health efforts more generally. While some perceive this as an unjustified act of paternalism, we are not persuaded that the language of paternalism is useful here, as it would be wrong to view a system such as the NHS as a policy that constitutes "interference of a state or an individual with another person, against their will"[44] (see paragraph 2.35). Some people might prefer to opt out of the NHS, but it is far from clear that many, the majority, or everybody would prefer to do so. So, the question is whether respect for the wishes of a particular group (or possibly even one single person) should be sufficient to counter arrangements that benefit a larger group of people, and, importantly, where these benefits can only be sustainably achieved through collective efforts.

2.40 Therefore, although paternalism goes too far, libertarian paternalism does not go far enough. Below, in what we call the stewardship model, we set out a proposal that we consider appropriate to capture the best of both approaches, and suitable to underpin a revised version of our initial liberal framework (paragraph 2.20).

A revised liberal framework: the stewardship model

2.41 The concept of stewardship means that liberal states have responsibilities to look after important needs of people both individually and collectively. Therefore, they are stewards both to individual people, taking account of different needs arising from factors such as age, gender, ethnic background or socio-economic status, and to the population as whole, including both citizens of the state, and those that do not have citizen status, but fall under its jurisdiction.[45] In our view, the notion of stewardship gives expression to the obligation on states to seek to provide conditions that allow people to be healthy, especially in relation to reducing health inequalities.[46]

2.42 The state needs to take a more active role in promoting the health of the public than was envisaged in our initial liberal framework (see paragraph 2.20). In addition to the goals specified therein, public policies should actively promote health, for example, by providing appropriate access to medical services, establishing programmes to help people combat addictions, and supporting the conditions under which people enjoy good health, such as through the provision of opportunities for exercise. Equally, concern for the needs of the population as a whole means that very demanding interpretations of individual consent as an expression of individuality and autonomy should be viewed with caution. Instead,

[44] Dworkin R (2002) Paternalism, in *Stanford Encyclopedia of Philosophy*, available at: http://plato.stanford.edu/entries/paternalism/.

[45] See World Health Organization (2000) *World Health Report 2000* (Geneva, Switzerland: WHO): "Stewardship is the overarching function that determines the success or failure of all other functions of the health system. It places the responsibility back on government and calls for the strengthening of ministries of health. However, it does not call for necessarily a hierarchical and controlling role of government but more of that of overseeing and steering of the health system. It calls for vision, setting of regulations and implementing them, and the capacity to assess and monitor performance over time. A strong stewardship should in fact permit a more efficient use of the private sector to meet the needs of the health system." See also Jochelson K (2005) *Nanny or Steward? The role of government in public health* (London: King's Fund).

[46] The maintenance of a service such as the NHS is one way of exercising this responsibility.

democratic, transparent decision-making procedures can often ensure an appropriate balancing of the interest of individuals and those of society (see paragraph 2.25).

2.43 The difference between paternalism and our stewardship model is that the latter is less likely to support highly coercive universal measures. Instead, the stewardship model is more sensitive to the need to respect individuality, by seeking the least intrusive way of achieving policy goals, taking into account also the criteria of effectiveness and proportionality (see paragraphs 3.18, 3.37–3.38). The stewardship approach is also more sensitive than paternalism to the concept of mandate, and the need for policies to be adequately justified. It recognises the importance of open and transparent participatory processes as a necessary condition for public health policy making, but it is also clear that these are not sufficient by themselves. Stewardship is not exercised simply by following the public vote, especially where issues involve complex scientific evidence. Under the stewardship model, public health policy should be compatible with the views of the public, and the government should create conditions that allow the public to scrutinise and judge the appropriateness of proposed polices.

2.44 The result of this discussion is a revised framework for public health, which we call the *stewardship model*. The model still incorporates the classical harm principle (paragraphs 2.13–2.14), which is a central part of the approach and which usually provides the strongest justification for public health interventions. Several important issues in public health can be addressed by reference to the classical harm principle alone. However, there is also a range of cases where the classical harm principle is of limited use, and this is where the stewardship model as a whole provides a particularly suitable reference framework. Revising the initial liberal framework, then, we summarise below the core characteristics that public health programmes carried out by a stewardship-guided state should have.

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;
- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also with programmes to help people to overcome addictions and other unhealthy behaviours;
- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensure that people have appropriate access to medical services; and
- aim to reduce unfair health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate; and
- seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values.

These positive goals and negative constraints are not listed in any hierarchical order. The implementation of these principles may, of course, lead to conflicting policies. However, in each particular case, it should be possible to resolve these conflicts by applying those policies or strategies that achieve the desired social goals while minimising significant limitations on individual freedom (see paragraphs 3.37–3.38).

Discouragement and assistance

2.45 The revised position above remains opposed to coercive interventions whose aim is simply to force people to be healthy. In this way, it respects Mill's anti-paternalist injunction that, "his own good, either physical or moral, is not a sufficient warrant" for the state to impose an intervention to make a person healthier.[47] However, whereas our initial liberal framework (paragraph 2.20) merely encouraged programmes to 'advise, instruct and persuade' people with addictions and other potentially unhealthy habits, the revised stewardship framework (paragraphs 2.41–2.44) encourages the provision of services through which risks are minimised and people are helped to change their behaviour.

Third parties

2.46 So far, the discussion has been directed at the way in which the state can legitimately introduce effective public health programmes in the light of the ethical relationship between the state and those under its jurisdiction. However, various third parties also have a role in the delivery of public health. These may be medical institutions, charities, businesses, local authorities, schools and so on. Where publicly funded, these institutions can be thought of as agents of the state and thus share the obligation to implement public health policies. On the other hand, many are not publicly funded, and may have agendas and particular goals of their own – such as charities that work with those whose health is damaged by addictions, and whose motivation may include particular cultural, religious or other values. This does not necessarily mean that their role is inconsistent with the ethical framework for public policy. Nor does it mean that they have no obligation to reflect on their role in public health.

Business

2.47 Corporate agents that are independent of government but whose activities affect public health include businesses such as food, drink, tobacco, water and pharmaceutical companies, owners of pubs and restaurants, and others whose products and services can either contribute to public health problems or help to alleviate them. There are two principal ways in which one might approach the responsibilities of corporate agents.

2.48 First, the view could be taken that, as long as companies adhere to the law, and fulfil their primary function, which usually is to satisfy their customers or shareholders, they have discharged their duties. Certainly, many companies operate in this way.[48]

2.49 An alternative view would be to argue that as actors within the public sphere, corporate agents have more extensive responsibilities, both towards their employees and the society within which they operate. Recent years have seen a significant rise in corporate social responsibility initiatives, and many large companies publish annually the results of their corporate social responsibility activities alongside their financial reports. The extent to which such initiatives are driven by marketing strategies rather than genuine social concern is difficult to assess. The emergence of corporate social responsibility is noteworthy nonetheless: if it is not driven by companies actively reflecting on their social responsibilities it seems more than likely that consumer expectations have played an active role and created a new kind of 'ethical' demand.[49]

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[47] Mill JS (1859) On liberty, in *On Liberty and Other Essays* (1989) Collini S (Editor), (Cambridge: Cambridge University Press), p.13.

[48] Friedman M (1970) The social responsibility of business is to increase its profits *New York Times Magazine* 13 September.

[49] A recent Report by the Department for Constitutional Affairs views growing demand for corporate social responsibility as one of the principal drivers of the future of citizenship, suggesting that businesses will increasingly be expected to fulfil civic duties and contribute to the public good; Department for Constitutional Affairs (2007) *The Future of Citizenship*, available at: http://www.dca.gov.uk/elections/pdfs/future-of-citizenship.pdf.

2.50 For our discussion, two points follow. First, in the same way that we would not judge the ethical acceptability of actions of individuals by merely assessing whether or not they have broken the law, it is reasonable to argue that commercial companies have responsibilities beyond merely complying with legal and regulatory requirements. Secondly, although most liberal states strive to ensure a free market, there are numerous cases where the state intervenes to protect important goods, such as the health of workers, the environment, or the health of consumers, for example by banning certain types of ingredient. We commented earlier that such measures are part of the stewardship function of the state. However, if corporate social responsibility were taken seriously, some of these interventions might not be necessary. Furthermore, regulation need not always be to the detriment of industry, but can be a driver of innovation. Recent trends have shown that the potential of health-orientated products is far from exhausted.[50] This potential can be explored proactively through initiatives by the industry, or reactively, where the industry responds to regulation. We emphasised in Chapter 1 that there is a complex web of responsibility for public health, by highlighting the importance of 'organised efforts of society' in preventing disease, prolonging life and promoting health (paragraph 1.6). Genuine corporate social responsibility clearly has a role to play in this respect. Likewise, if there is lack of corporate responsibility, or a 'market failure', it is acceptable for the state to intervene, where the health of the population is significantly at risk.

Summary

2.51 We set out in this chapter an initial liberal framework and explained its relationship to libertarian and collectivist conceptions of the state. Starting with a discussion of the 'classical harm principle', we identified several further principles that are important in considering public health issues. We recognised the importance of reducing health inequalities and noted that in seeking to reduce inequalities a range of different dimensions need to be considered, as there may be different types of inequality (outcome versus opportunity), different ways of reducing them (egalitarian and prioritarian strategies) and different groups between which inequalities may exist. In the discussion about consent we clarified the notions of individual consent and procedural justice arrangements, emphasising that it would be wrong to seek to address public health issues by reference to individual consent only.

2.52 With reflections about other principles, the considerations of health inequalities and consent illustrated that our initial liberal framework needed to be revised. We therefore presented a framework for public health policy with further goals and constraints, which we called the stewardship model. The revised framework was nevertheless incomplete, and we made some further observations, in particular on the role of corporate agents in the complex web of stakeholders whose actions determine public health. We also recognise that there are other values that might be brought into the discussion. We need, therefore, to keep our discussion open-ended at this stage, and we will return to it in Chapter 8, after the discussion of policy process and practice in Chapter 3, and the four case studies of Chapters 4–7. Next, we consider how some of the themes emerging from this chapter feature in policy and practice.

[50] Unwin J (2006) A responsibility for health – the role of business in determining what we eat, in *Whose Responsibility? The role of business in delivering social and environmental change* (London: Smith Institute), pp.16–23.