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Dr Steve Parlour

QUESTIONS ANSWERED:

Question 1 The definition of public health

ANSWER:
I would suggest that the definition should be "what we, as a society, collectively do to assure the conditions that enable people to be healthy" in order to remove the possibility of compulsion. Whilst it may seem obvious that everyone wants to be healthy, diet and activity are balanced against health and injury risks that need to be weighed on an individual basis. Potholers and lovers of cream cakes will resent interference in a risk they feel worthwhile.

Question 2 Factors that influence public health

ANSWER:
The weighting of the five factors requires medical knowledge which I do not possess.

Question 4 Control of infectious disease

ANSWER:
I have not studied this topic to the same extent as other questions and would not like to lessen the authoritative opinion of those by offering an opinion on all.

Question 3 Prevention of infectious diseases through vaccination

ANSWER:
I have not studied this topic to the same extent as other questions and would not like to lessen the authoritative opinion of those by offering an opinion on all.

Question 5 Obesity

ANSWER:
The prevalence of obesity in lower socio-economic groups can lead to policy measures tainted by cultural judgement. It is assumed that people in this group are less able to make sensible decisions and need to be coerced into making the right ones or their choices restricted to officially sanctioned alternatives. Although rationing of health services is bound to happen with finite resources, overt policies that prioritise – or withhold – treatment on the basis of previous or probable future behaviour begins an argument that has no bounds and is inevitably tinged with cultural judgment. Sporting activity also leads to sporting injuries. If treatment is rationed on the basis of self neglect or recklessness, then Accident and Emergency triage will penalise sport: the opposite of what is intended to lessen obesity. Is a heart condition due to overweight or is it hereditary? What of sexually transmitted diseases? A can of worms seems to be an appropriate metaphor.

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Question 6 Smoking

ANSWER:
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Question 7 Alcohol

ANSWER:
Early legislation of alcohol was enacted due to concerns over sobriety: not individual harm. The regulation of its sale through licensed publicans and specific premises is a result of this and has served its purpose well. Large drinking establishments, where the publican is off premises and the bar staffed by casual labour, is a distinct challenge to the discipline of the English 'pub'. Elsewhere in Europe, more relaxed licensing hours may be the cause of less drunkenness as individuals take responsibility for their own actions rather than have a third party ring a bell to tell them when to stop drinking. The behaviour of drunken Britons abroad is evidence of this lack of responsibility and cannot surely be genetic as many would have us believe. Resistance to the recent relaxation of licensing hours assumed that the British are different to our European neighbours and need to be regulated as we are naturally without self-control. The reason that governments' alcohol legislation lags that of smoking is a matter of numbers. Paternalistic legislation is not enacted by a state wishing to act as nanny but is, increasingly, an echo of public opinion. If the majority wish regulation against an unpopular minority, it will happen. It will not happen the other way round and alcohol is still popular.

Question 8 Supplementation of food and water

ANSWER:
An appendix to my PhD thesis dealt with fluoridation of water supplies and found that uncertainty around legal liability has held this back for forty years. The problem of poor dental health in children may be better addressed by dealing with the scarcity of national health dentists and, as of this year, the abolition of the concept of having your own national health dentist. Mass fluoridation is a much cheaper alternative, particularly as it is alleged that it turns an industrial waste product into a saleable commodity. Your question asks when it is acceptable to restrict the choice of individuals in order to protect the health of children. It is the choice of individual parents to neglect their child's dental health that needs to be confronted – not the individuals' right to not ingest that which they would rather not. No argument in favour of fluoridation has claimed that children with a decent diet who brush their

teeth with fluoride toothpaste and visit the dentist regularly would benefit from the proposal: only those who do not. A central argument in my thesis – shared by John Stuart Mill and others – is that the more paternalistic regulation that is imposed, the less individuals are prepared to take on responsibility for their own actions or inactions. Irresponsible parentage is encouraged by increased state intervention. I am sending an extract from my aforementioned thesis appendix by Email to Julia Trusler as suggested in her Email of 22 August 2006. (JT: appendix now added).

Question 9 Ethical issues

ANSWER:
Mill contends that individuals that take risks are essential to the development of society and should not be prevented or discouraged because the possible burden of that risk may be carried by others. The problem addressed in this study on vaccinations would not exist if people in the past had not taken great risks with themselves or others in the development of medical science. Everest would remain unconquered if risks were regulated against and America undiscovered. I believe that the harm principle should be the primary consideration in forming public policy as the danger of relieving individuals of the ability and necessity of making their own decisions is too great and not easily reversed. The remaining principles are all relevant and not exclusive but one. Just as it is right for all to contribute to a health service on an ability to pay, regardless of whether or not they make use of it, so it would be wrong to restrict treatment or apply surcharges to those judged to have not taken good care. The fair reciprocity principle seems to go against the NHS ethos in condemning those more likely to be injured or fall ill. Are we really saying that a coal miner – who chooses his job freely – should pay more as a free rider due to an expectation of illness whilst his office bound employer should pay less? This constitutes a very brief summary of my views and, as you may gather, I have a wealth of material pertaining to paternalistic legislation as it relates to public health and road safety. I am currently working on a proposal for a book based on my PhD thesis which deals with such regulation and would be happy to discuss these issues in greater detail if you wish.

Appendix to consultation response: Dr Steve Parlour

Water Fluoridation

Soon after the compulsory motorcycle helmet empowerment entered primary legislation in 1962, controversy began regarding proposals to add sodium fluoride to public water supplies. Fluoride has been shown to protect children's teeth from tooth decay by strengthening the enamel if taken from a very early age. Adding fluoride to the water supply was seen as the best way of ensuring that all children receive a minimum dosage but was objected to on a number of counts summarised later. On the 10 December 1962, it was announced that the government was to approve regulations made under section 28 of the National Health Service Act in order to allow local health authorities to request water suppliers to add fluoride to public water supplies. Many of the arguments are similar to those employed in the case studies and have a familiar ring to them. The main difference however is the controversy's endurance: the debate continues to this day with little change to the weight on either side.

The reason why this has not been satisfactorily resolved is due to the nature of the instrument itself. The case studies in this thesis are all road traffic regulations enforced by the police and created by statutory instrument under powers invested by primary legislation. With fluoridation however, the regulation enables the minister to oblige water companies to add fluoride to water supplies when requested to do so by the local health authority at the health authority's expense, although more recently local councils have been introduced into the chain to add a democratic element. Most water undertakings have let it be known, before a request is made, that they will refuse to comply without being granted indemnity against proceedings: indemnity has been the stumbling block from 1962 until the present.

Because these regulations are in the hands of the minister, parliamentary scrutiny has been limited to the occasional adjournment debate. Like the seat belt debate, much of the discussion revolved around the implementation of fluoridation in other countries and disputes over whether or not they were successful.

The arguments in favour of fluoridation were that it was proven to reduce the levels of tooth decay in children where high levels of fluoride occur naturally and could be shown to have the same effect when levels were increased artificially. The cost of adding sodium fluoride to water supplies was easily cost effective due to savings in dental treatment. Adjusting fluoride levels up to one part per million is only enhancing that which occurs naturally in water and is still less than levels naturally occurring in some areas of the country.

Against fluoridation was the claim that fluoride was responsible for a condition known as fluorosis – a point accepted but not considered serious enough by the proponents – which causes a mottling of the teeth that some medical experts believe to be an indication of the condition of the bones in the rest of the body: a valuable 'window' into parts otherwise unseen. Apart from bone damage, other claims of the effects of fluoridation are impairment of the immune system, the brain and central nervous system.[1] The benefit only falls on children under twelve years old that have a poor diet or do not clean their teeth regularly. The overwhelming mass of the added fluoride will be drunk by adults, used in industrial processes, flushing toilets, baths and watering gardens: the effect this will have on the environment has not been sufficiently researched. The overriding concern is that if anyone is concerned over the possible adverse effects, there is no possibility of opting out of mass medication although opting out is a principle accepted in immunisation programmes.

In addition to these regularly used arguments I should like to draw attention to the following.

- Because something is naturally present in water does not mean it is harmless and, because it exists in higher dosages in some places, it does not justify raising the level elsewhere.
- Where tooth decay occurs as a result of a poor diet, then surely the correct course of action would be to rectify the cause rather than conceal it by treating one of the symptoms.[2]
- As tea grows best in fluoride rich soil, an average cup of tea may contain anything from 1.4 to 4.3 parts per million of fluoride (Watts M, p17); this would put heavy tea drinkers well over an acceptable level of fluoride intake. This fact must cast some doubt over the assumed transferability of results from the USA where tea drinking is not as predominant as in the UK.

The first adjournment debate on the subject, called by Dr J Dickson Mabon, accused the government of dragging its feet on fluoridation and called upon them to introduce the addition of fluoride to water supplies nationwide without delay (HC debs 26/11/62 167-178). The USA introduced fluoridation to many areas in 1945 which was investigated by a British delegation in 1955 concluding that dental health had benefited without detrimental effects in other parts of the body and recommended trials in the UK. These were carried out in Watford, Kilmarnock and

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[1] The medical evidence for these claims is summarised by Mark Watts in *Health Alert: Fluoride* (London, Channel 4 Television, 1997) pp12-16.

[2] Similar considerations are being given to the proposed addition of folic acid to flour in order to benefit unborn children when ingested by their mothers. Vitamin B deficiency, a particular problem in the elderly, is masked by folic acid which, if added to flour, cannot be avoided.

Anglesey and lasted for five years. It was the reported success of those trials that prompted Mabon's impatience with the government.

Perhaps in response to this enthusiasm for fluoridation, Joyce Butler secured an adjournment debate for the 6 March 1963 to draw attention to the objections to it. As well as the arguments against, she quoted from a letter sent by the minister to the Water Companies Association in which he offers indemnity. "In the event of court proceedings he will indemnify both the local authority concerned and the water undertakers." (HC debs 6/3/63 607). Butler points out that "This is very serious, because this promise of indemnity goes far beyond anything the Minister has powers to perform." (HC debs 6/3/63 607) although the Water Companies Association seem to interpret that letter as an offer rather than a promise of indemnity (Modern Record Centre, Warwick University MSS.407 Annual Reports).

The Water Companies Association did not have any objections to fluoridation as long as it had local support and indemnity would be provided by the government. This was not universal however and they deplored the actions of Woking and District Water Company in placing a notice in the local newspaper (Modern Record Centre, Warwick University MSS.407 minutes). The notice declared that it was not the duty of Woking and District Water Company to provide 90% of the population with chemically treated water that is of little or no benefit to them. They contentiously pointed out that thalidomide was used for five and a half years before its effects were known (*Surrey Advertiser and County Times* 2/3/1963).

The Ministry of Health published a pamphlet entitled 'Fluoridation' in April 1963 which led to an adjournment debate by Sir Cyril Black during which he, point by point, disputed all that was contained within (HC debs 17/7/1963 683-694). He claimed that the pamphlet was biased in favour of fluoridation and that all the examples of successful fluoridation were not successes at all. When called upon to explain why the government would deliberately mislead, he suggested that they had made a mistake and it would be best if they admitted that mistake and changed policy (HC debs 17/7/1963 687). It has been shown in this thesis that parliamentarians and civil servants are most unlikely to admit to mistakes and, given that the outcome of this policy will not have effect, either positive or negative, for several decades, the tendency must be to continue with the mistake. It has not however been pursued too vigorously. Fluoridation still only occurs over a small proportion of Britain and the refusal of water companies to fluoridate without indemnity still remains.

> However, we are mindful of customers' views and before fluoridating the supply, we would want full indemnity from the government as well as assurances from customers that they want this measure. (Nigel Smetham of Southern Water 1999)[3]

> Since 1985, nearly half of all health authorities in England have requested water companies to introduce water fluoridation. None of these requests has been accepted (Gisela Stuart HC debs 29/1/2001 152).

The second of these quotations, by the Under-Secretary of State for Health, is drawn from an adjournment debate called by Bill Etherington. A study commissioned by the Department of Health was carried out by Professor Sheldon of York University (referred to as the York review) into the effectiveness of fluoridation and any adverse effects. Etherington used the Adjournment debate to illuminate the differences between the York review and press releases issued by the Department, the British Dental Association (BDA) and the British Fluoridation Society (BFS). Sheldon himself had written to the Department expressing his concern that the review had been misrepresented. A list of claims made by the Department, BDA and BFS in support of fluoridation was compared by Etherington to the actual and contrasting conclusions of the York review.

The addition of fluoride to water supplies is not to benefit everyone: it is not even to benefit all children. Fluoridation is to help protect the teeth of those children under ten who have a sugar rich diet, do not clean their teeth regularly with fluoride toothpaste and do not visit dentists regularly. Gisela Stuart confirms this.

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[3] Quoted in *New Insight* Oct 99 p21d.

> We also have very good evidence that significant inequalities remain throughout the population. Children from deprived communities, for example, including some black and minority ethnic communities, are less likely to visit a dentist regularly (HC debs 29/1/2001 151)

It seems that the diet, lack of oral hygiene and dental care are the causes of the problem that the government attempts to solve by mass medication rather than attacking the problems themselves. Another proposal was to issue parents with fluoride tablets which, as well as being a low cost alternative, allows opting out by those who object.

> But this would entail a daily administration in regular doses throughout childhood, involving a degree of perseverance which, I suggest, we could expect few parents to maintain. (Bernard Braine HC debs 6/3/1963 613,4)

Both of these responses are condescending and, whilst having some element of truth, do not necessarily justify mass medication on the grounds that people do not have the sense to take care of themselves.

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