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Fiona Reynolds

"What we, as a society, collectively do to assure the conditions for people to be healthy." Do you agree with this definition?

This supports my view that public health is the responsibility of all – whether professionally or in our daily lives. This extends from ensuring the provision of services (health, environmental, etc) to taking personal responsibility for disposal of our own litter. Public health measures are usually seen as a top-down imposition of rules and regulations (whether benevolent as a curb on the activities of industry or restrictive on individuals) and this statement suggests the possibility of a bottom-up approach.

Factors that influence public health:

Do you agree that interactions between the five factors are the main influences affecting public health: environment, social and economic factors, lifestyle, genetic background, preventative and curative factors?

The interaction between the environment, political, social and economic factors, 'lifestyle' behaviours, genetic background and preventative factors are the main influences on public health.

Public health, in its 'purest' form, is more focused on prevention rather than curing symptoms. Curative services have a very important role to play in the health of the nation, but for the majority of conditions that form the largest burden on public health, there is no cure – often only management and palliative care. It could be stated that the impact curative services have is that they are more likely to receive funding than measures aimed at improving the public health.

'Lifestyle' behaviours are generated from the social and economic environment in which we live, and these in turn are often determined by the political climate of the country. Political decisions also impact upon the wider environment and unless this term is included as a definition of 'social factors' it is surprising to see it excluded here. The term 'lifestyle' implies choice. While it may be the most appropriate of words to convey simply the meaning of "individual behaviours and actions", it is a misleading term to be used in public health. It ignores the issue that for many people (the socially excluded and those in socioeconomic groups IV and V) there is no choice because of the area they live in, their access to transport, the home they can afford, 'leisure time' and other priorities (caring for family members, getting the children to school, work).

Genetic background is an important factor to consider, *if* the interaction with the environment is taken into account. There are few conditions caused by a single genetic variation – the majority of the key public health diseases (CHD, diabetes, obesity, etc) are linked to a combination of influences.

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Prevention of infectious disease through vaccination

Some countries have a compulsory rather than voluntary system of vaccination. On what basis can such policies be justified to achieve herd immunity? Should they be introduced in the UK?

It depends on the disease to a large extent. Vaccination is usually offered because the disease is very infectious and/or its effects are serious. So there *may* be an obligation for the State to make vaccination compulsory on the Benthamite principle of doing the 'greater good for the greater number of people'. However this contradicts any commitment to autonomy of the individual.

Uptake of vaccination for children is variable and can be an emotive issue, particularly regarding MMR. Any attempt to legislate, making this compulsory, would be deeply unpopular; which is paradoxical when considering the complaints received by Health Protection Units about the cancellation of the schools BCG programme. So, legislation guided by public views would be inappropriate, mainly thanks to information received (from the media) being distorted.

This is a difficult issue as very few people want to be ill and most would profess to be willing to take steps to reduce their risk of becoming ill. However, the past successes of vaccination programmes in the UK seems to have actually undermined their future success.

Making vaccination compulsory very much depends on public perceptions and memories of the diseases in question. (For example measles is viewed as just resulting in a few spots while tuberculosis is viewed almost as a deadly and virulent plague). However, on the grounds that public health services have a duty to the public health, i.e. the greater good, compulsory vaccination would seem to be a logical progression.

Are there cases where vaccination of children against their parents' wishes could be justified?

Deciding to take action against parental wishes is a simpler issue when dealing with a treatment for an illness or condition. Vaccination essentially means protecting a child from something that may never happen – especially against diseases where vaccination programmes have been successful. Parental concerns about potential side-effects are entirely understandable. No parent wishes to harm their child by not taking action, but equally they don't want their action to harm their child.

It could be argued that the health service needs to view children as individuals in their own right, with human rights to the provision of health care, rather than as their parents' "possessions". This argument only stands for as long as children's vaccinations are provided for free. This stance would also impact on the clients' right to recourse. If there were adverse effects from a vaccination the health provider would be in an unenviable situation having vaccinated a child against its parents' wishes. In addition as parents have a duty of care, to impose vaccination would be to completely disregard autonomy and undermine trust with health services. It would also be another example of 'top-down' public health.

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Control of infectious disease

For infections that are directly transmitted from person to person, what justification would be required to render interventions such as forced quarantine acceptable in the UK where such measures may be considered to infringe civil liberties?

It could be argued again that the issue here is the greater good, but it depends on what the infection is and how it is transmitted. It could also be argued that quarantine could be enforced only for infections spread by droplets (coughing and sneezing). However, even some of these diseases (e.g. tuberculosis) may require prolonged exposure. Again forced quarantine would 'ride slipshod' over personal autonomy, but what about an individual's personal responsibility to others, society and the public health? If an individual has a contagious infection and does not comply with treatment maybe then it would be appropriate to enforce quarantine. While it is an individual's choice to accept or not accept treatment, their choice has to have limits when it impinges on another person's right to health.

What would be suitable criteria to determine in what circumstances, and to what extent, the state should provide more resources to develop methods of preventing outbreaks of serious epidemics in other countries?

It seems to me that the problem currently isn't the amount of resources provided but the way in which they are used. It seems never ending levels of administration impede the progress and effective use of these resources.

Are new measures needed to monitor and control the spread of infectious diseases?

The surveillance system in the UK is an effective means of passive surveillance. What could improve this would be regular training updates so that clinicians recognise symptoms, e.g. many doctors over-report the occurrence of measles and use the surveillance system as a means of confirming diagnosis. It would also be appropriate to offer training on how to make notifications so that speed is ensured.

Would mandatory testing for highly infectious and life-threatening diseases such as TB or HIV/AIDS be justified?

The information from mandatory testing could be used for service development; to evaluate any public health and health promotion initiatives; and to assess any growing need. However, to some extent this is already possible with current practices. Mandatory testing should also be introduced when there is an infrastructure to cope with demand for testing and most importantly demand for treatment.

With regards to HIV/AIDS, mandatory testing could send out a signal that it is "ok to have unprotected sex unless your partner tells you that they are HIV positive". Mandatory testing could remove the personal responsibility to protect oneself. How would mandatory testing improve public health? Would it involve notifying services and the public of an individual's positive status? Would it provide the evidence to demand funding for more treatment and targeted prevention work? It may be highly problematic – adding to the stigma and discrimination of people who have such conditions.

Yes, these conditions are infectious and life-threatening, but the transmission of them can be curtailed by individuals taking responsibility for their own actions – i.e. practising safer

sex. There is a risk that this message of personal responsibility could be lost within mandatory testing.

Obesity

Any strategy that seeks to change people's behaviour is likely to be perceived as particularly intrusive. How should this sensitivity be considered in devising policies that seek a reduction in obesity?

Overall, it appears that there has been an abdication of personal responsibility. If State (government or National Health Service) attempts to tackle the problem it is criticised as generating a nanny state. If it does nothing, it is criticised for not helping the population.

What would be suitable criteria for developing appropriate policy?

An approach to tackling behaviour is to attempt to change the structures that surround our daily lives. Public transport is expensive and private services means that in many areas no thought has gone into the planning of routes that are quick and convenient – i.e. instead of being based on a hub and spoke model, bus routes should cross areas rather than being restricted to the main routes in and out of a city centre. Planning of city centres is a key to changing behaviour – out of town shopping centres rely on people having cars to reach them. In addition, the way food is priced is another area to be tackled – if a packet of biscuits costs 25p and one apple in the corner shop costs 25p, which product are people going to buy?

What are the appropriate roles and obligations of parents, the food industry, schools, school-food providers and the government in tackling the problem of childhood obesity?

The role of people caring for children (i.e. all of the above) is to ensure the food they eat is healthy and nutritious. There does however seem to be a problem around educating people about what good food is – and most importantly the preparation and cooking of it, namely that it can be quick and easy. Cookery / domestic science / home economics are viewed as subjects for children not likely to 'do well' academically and as a result cooking is not taken seriously. There needs to be a move from treating this subject as suitable for those who 'won't be going to university'.

The food industry and government also have roles to play – banning the targeting of junk food adverts at children; reducing the sugar and salt content in food and examining pricing policies (e.g. biscuits compared with fruit).

Is it acceptable to make the provision of NHS services dependent on whether a person is obese or not?

It really depends on what particular service the person requires. Many surgical procedures require people to lose weight, for safety reasons, before it can go ahead. In the case of IVF treatment for infertility, weight is associated with an inability to have children so losing weight for this treatment is another example of where provision should be dependent on obesity.

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Smoking

Comprehensive measures by governments to prevent harm to the population are relatively recent. What are the reasons for this delayed response?

The delays could be attributed to the control the government has allowed tobacco companies to have. If government receives any of its funding from such interest groups, it is unlikely that it will be swift to introduce such messages. Progress is being made but at a slow pace for a government allegedly committed to public health.

What are the responsibilities of companies that make or sell products containing hazardous substances, such as nicotine, that can be addictive? Should they be prosecuted for damaging public health or required to contribute to costs for treatments?

While tobacco remains legal the manufacturers cannot be prosecuted. Despite excellent advertising campaigns from the tobacco industry, the decision to smoke (without consideration to passive smoking here) is still an individual responsibility. The same argument stands for any manufacturer selling potentially addictive substances – alcohol, sugar, caffeine and chocolate.

Should smokers be entitled to higher than average resources from the public healthcare system? Would similar charges be justified for other groups of people who deliberately or negligently increase their chances of requiring public health resources, such as people engaging in adventure sports?

On reading this question I assume “public health resources” to refer to the public’s health resources such as the NHS treatment services to deal with ensuing problems (rather than public health resources aimed at prevention) and will answer the question using this interpretation.

If smokers are to be targeted in such a way, then it may be necessary to widen such a remit. People who drive to work, rather than walking are deliberately making a choice not to exercise. Anyone who does walk to work is choosing to breathe in the fumes produced by all of the motor vehicles on the roads. An athlete pushes their heart to work to its utmost capacity on most days – could this be described as unnecessary exertion, as we no longer have to run in such a way for survival? At the same time, people who do smoke or who participate in extreme sports are often charged higher life-insurance premiums. Could this be viewed as justification for bringing this form of market to healthcare?

In my opinion, no. So-called ‘lifestyle choices’ such as smoking are not a true choice for many people. Smoking is more common among people of lower-socioeconomic groups where there is greater deprivation and is often a form of ‘release’ from stress. To penalise these groups would be adding to the burden of health inequalities. These are the groups who carry the greatest burden of ill health.

What rights does the state have to impose sanctions to prevent them from smoking? Does the state have the right to prevent the sale of tobacco? How vigorously is it reasonable for the state to act to prevent children and teenagers from smoking?

“If tobacco is as harmful as they say it is, the government would ban it,” was a comment I heard recently. When tobacco is labelled as harmful, it is possible that any efforts to police its sale to children are viewed as half-hearted. There is no sign of commitment from the government – i.e. ‘do as I say not as I do’.

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Alcohol

It can be argued that in view if the significant harm to individuals and society, comprehensive measures by governments to prevent harm are lagging behind those for tobacco. In your view, what are the reasons for this?

The alcohol lobby and breweries who provide financial support to government have not yet fallen out of favour. This is certainly a common perception. It links into views that spirits – traditionally the beverage of ministers – rarely receive as many tax increases as beer and lager – the drink of the masses. It seems that there are many in authority who do not view alcohol as a drug and do not countenance restrictions.

Again, there is a feeling of 'do as I say, not as I do'.

There is an issue around personal responsibility. However, there seems to be little support for personal responsibility – reduction of 'happy hours'. I do think that the extended opening hours is a good thing and while behaviour shift may take many years, work has to start somewhere.

Supplementation of food and water

Why has the fluoridation of water met with resistance?

It seems to depend on people's experience of previous fluoridation. Individuals living in areas where previously there was fluoridation report that their older siblings have 'better' teeth than they do – fewer fillings and whiter teeth. Others seem to be concerned about possible dangers in drinking what they view as medicated water.

Which democratic instruments should be required to justify the carrying out of measures such as fluoridation?

In my view, there is a lot of discussion from government about how they are opening up the public's ability and access to participate in democratic processes, e.g. 'The Big Conversation'. However, this approach doesn't really allow people to make decisions. Why not hold a series of referenda across the country? In some areas there is greater support for processes such as fluoridation and in these areas the water authorities could take action even if there is not national support. Yes, this would require more work and there is a chance that people could vote against public health measures where there is robust evidence. However, it is important to inform the public of the different issues so that they can make the choice.

Under what circumstances is it acceptable to restrict the choice of individuals in order to protect the health of children?

If the individual's choice is detrimental to the health of the child, who is another individual, then there is an argument for restricting this person's choice. An easy example is where the individual chooses to abuse a child – agencies should remove the child from this person. However, as a parent, our society tells us that they are responsible for the wellbeing of the child and if a parent is reluctant to allow vaccination because of fears of

harm, then it is more difficult to impose restrictions. Their actions may be counter to state / government / health service requirements but their intention is to act in the child's best interests.

If we restrict the choice of individuals in order to protect the health of children in every instance, then as a society we risk absolving all individuals of all responsibility and autonomy. There is already a struggle in sex and relationships education as many parents want schools to teach a subject they themselves are uncomfortable discussing but object to the content taught by the schools. Who has a responsibility for the child's health? The parents – even if their actions are contrary to public health ethos, they usually act in their child's best interests.

Ethical issues

Which of the following is generally more important than the others: autonomy, solidarity, fair reciprocity, harm principles, consent and trust?

All are equally important. There is no hierarchy. They need to be abided by to allow balance in public health actions.