Good Healthkeeping

Consultation

Q1

No, because of its underlying presumption that we know what health is. We only know what disease is, and rather assume that health is its absence. Resistance to disease is a consequence of health, but is not the same as health.

I would follow pre-war research (e.g.Pioneer Health Centre, Peckham) and define health as the faculty for creation – which means mutual creation with ones environment and circumstances. So health is ability to act, not any kind of state. It will not take a standard form that can be recognised statistically, but its consequences will be obvious to systematic observation – self-organising communities, more self-reliance, less supine behaviour.

Health is not in the first place a public phenomenon but individual, and highly variable between individuals. A healthy society springs rather easily from a bunch of healthy individuals, subject only to the constraints imposed by circumstance.

So a public health service would be one in which obstacles were removed from the development of individual human potential, so far as possible.

Q2

This is not the right question. Healthy people cope with all factors creatively, to make the best of them. The key requirement is that all influences must be enabling. Even then, any factor that is arbitrarily rigid and beyond personal manipulation deters health.

Far the most important factors are

1. good mains **drainage**,
2. clean separate mains **water supply**,
3. clean **air**, good **ventilation**
4. access to **daylight** and to **natural forms** (plants, parks, water features)
5. Quality, freshness and variety of **food**.

Agricultural policy is rarely thought of as a health matter but it is the least well covered of these vital guardians of individual and therefore public health.

Lifestyle, social and economic factors are the plasticine healthy people model. They form the concrete agenda of living, they don't determine health as such.

Genetic factors are immutable for practical purposes, but by no means determining in most cases. Only thyroid cancer, as I recall, was influenced as much as 50% by genetic predisposition, in the Karolinska Institute's study of identical twin pairs. All others were fundamentally environmental in origin.

Preventative and curative services are at present barely relevant to health at all. Looking for things before they occur is deeply unpopular, so doesn't work. Cultivating people's appetite for life works fine, however, and quickly halves demand for medical care of any sort.

Please get off the glib term "healthcare". Health cares for itself. Medical care is something entirely different, and does nothing for health as such.[i]

Q3

This whole case study is framed in an extraordinarily tendentious way.

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council.

No vaccine has ever achieved herd immunity in Britain. Yet we enjoy increasing freedom from infectious disease, in a trend that started well before vaccination was even invented. Good public health (response Q2) is responsible.
The exception is mumps infection in adults (15+). This has drastically deteriorated in the past few years, since MMR was introduced. 50,000 cases are notified per year now. This is chiefly because the mumps component of MMR lasts for only about 10 years, and is not boosted after 4 years of age. Compared with the older habit of letting children get mumps harmlessly before puberty, conveying life-long immunity thereafter, this is a disaster. No need to get into cases here but MMR is not well conceived and total reliance on it arises solely from a fault in the ICT programming of the national call/recall scheme for vaccination. It does not allow for the recording of single vaccines (M, M and R) and it clearly should.
Vaccination can never cover all the individual causes of disease, so is a fundamentally flawed strategy. The mere existence of a vaccine is not sufficient reason to make its use a public imperative.
Proper attention to food quality and maintenance of other health factors will undermine infectious (and other) diseases far better, and comprehensively.
There is a strong case for fundamental review of the place of routine mass infant vaccination.

1. Most of the diseases protected against are miniscule risks now in this country. That is not thanks to vaccination, but to good environmental health provision.
2. Protection against meningitis is best done by ensuring that skin and mucous membrane is perfectly formed, to prevent what are common germs, and harmless in the right place, getting into the wrong place.
3. Whooping cough is best prevented in small infants by isolation at home, with older children in the family vaccinated in toddlehood.
4. Commencement of any vaccination programme before 6 months of age is ill-conceived, since the infant immune system is not commissioned before that age.
5. More attention to enabling infants to remain at home at that age, breast-fed by mother effectively isolated with intimate family members, is a far better way forward.

There is no place for compulsion to accept any vaccine.

1. They are not sufficiently effective to justify such reliance.
2. Nor are they perfect. The state can never adequately compensate for the devastating consequences to the few adversely affected, and is rarely even willing to acknowledge them.
3. Once health is properly understood, it is clear that healthy individuals should never be medicated for the benefit of less-healthy individuals. The effort should be to improve the health of the less-healthy.
4. Parents carry all the responsibility for rearing their children, and the state could never take this over even if we wished it. Parents should be supported to cater for their individual children appropriately, and never railroaded into some arbitrary public timetable.

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Q4

Not framed well. The entire preoccupation of this case study is with front-line detail. Were the essentials for health (response to Q2) taken into account and enhanced, our susceptibility to all infectious disease, regardless of cause, is minimised. Panic measures on individual scourges such as those you cite become secondary – way less important.

Q5

Improve the quality of food, and obesity will readily diminish because satiety will be achieved before fullness. Satiety depends on:

1. Food tasting honestly of what it is, and what it contains. Once you have satisfied your needs, appetite falls away. Thus food should be
    a. **Whole**, as grown – not compounded of someone's left-overs …
    b. …i.e. **unrefined**
    c. **fresh**, when all its flavours are most vivid. This implies …
    d. **locally grown**, mainly in season
    e. **organic** – pesticide residues accumulate in body fat, and may be one factor in weight gain. But organic also means grown naturally, which enables better structural integrity of the crop and more vivid flavour on the table
    f. **conservatively prepared** – elaborate recipes normally camouflage tasteless ingredients.
2. Abstinence from junk food (artificially compounded from refined ingredients), which corrupts taste utterly. Small children will select from whole-foods a perfectly balanced diet, based on taste. No-one can achieve this with junk food allowed. Sugar is far more corrupting than salt, which is (we seem to forget) vital to the human organism.

Ultimately we shall have to provide a service for health alongside our existing medical treatment services. Health advice and assistance should be free to all, and intensively available to the most needy. Medical services must ultimately carry a penalty – whether as loaded taxes, or no-claims bonuses for health insurance, or proportionate direct charges for items of service. Without these, infinite medical care provision will always appear to be some kind of human right, which it clearly is not.

Q8

Another extremely tendentious question, though in referring to the NHS review of fluoridation you are fairer than most. The entire dental profession is still in denial of these results.

You might, for instance, have pointed out that in its numerical findings based on the available (poor) evidence, benefits to teeth were not very great (15.5%) and about equalled by adverse effects in the form of cosmetically significant – i.e. rather severe – fluorosis (12.5%). Fluorosis of any degree is a sure sign of disruption to the structure of teeth, and over 40% of the population exhibit fluorosis if their water is "optimally fluoridated" at 1ppm. [ii] So fluoridation does at least as much harm as good.

Fortification of foods may be accepted but admits a scandal – that we allow food ingredients to be depleted of their natural components, and have to make these up. The food-form in which they are lost is replaced by a pure chemical salt; calcium carbonate, for example, is not a legitimate food.

This response was submitted to the consultation held by the Nuffield Council on Bioethics on *Public Health: ethical issues* between May and September 2006. The views expressed are solely those of the respondent(s) and not those of the Council. Fluoridation is an excellent example of the kind of public health intervention that no state should contemplate. It reduces the freedoms of individuals to realise their potential, giving little or nothing back. One cannot choose ones water, but one can choose not to buy fluoridated toiletries. Since fluoride is the most comprehensive enzyme inhibitor we know of, regularly used to inhibit biological activity during *in vitro* research, it must be doing harm of which we are not yet aware. And since it accumulates in bone and thymus gland tissue progressively through life, we cannot be happy about any regular and significant consumption over which we have no personal control.

The recent National Diet and Nutrition Survey provides data on fluoride excretion, through analysis of 24-hour urinary collections in some 1400 randomly selected individuals. This data suggests that about 20% of the British public already consume more than the "safe intake" of fluoride promulgated by HMG. (The figure quoted in their report[iii] is erroneous, and has been taken up with the authors). Most of these people are not fluoridated, since fluoridation schemes cover only 11% of the population. Further fluoridation, without the introduction of a simple screening test available to dentists and GPs to identify high fluoride consumers, seems bound to bring unwarrantably high consumption levels in some individuals. We should not wait for "further research" but exercise prudent judgement and ethical probity **now**.

I was party to the NHS review of fluoridation and know that the evidence for social benefit from fluoride is **extremely** thin. It would not have aroused comment at all had this not been a major question raised by the commissioners of the study. Most of the very scanty evidence showed no sign of reduction by fluoride of the different caries experience of different social classes.[iv] Only in a sub-study of a small number of under-fives was any social benefit suggested[v] and this benefit was not sustained into older ages.

On the other hand, under-nourished children have been shown on the Indian sub-continent to suffer sooner from fluorotic diseases than the better-nourished. And whereas fluoridation may improve teeth marginally, better diet is capable of abolishing dental decay completely.

Fluoridation is a lazy attempt to manipulate health, with very dangerous potential consequences. We should focus all our attention on improving the general health of the victims (see response to Q2).

Q9

1. Autonomy is fundamental to health, as properly understood.
2. Free reign of autonomous health underpins spontaneous adherence to all the other principles you suggest.
3. Parents should always consider first and only the health of the child in their care.
    a. T he purpose of vaccination is to protect the child against serious infectious diseases more safely and conveniently than natural exposure would have done.
    b. No vaccine combination should raise a challenge greater than nature would have posed. At present MMR does this (by enforcing three challenges simultaneously that in nature can only arise one at a time), and is therefore fundamentally misconceived.

c. Parents should **never** be asked to vaccinate a healthy child for the benefit of another less healthy one. Paradoxically, the less-healthy child will take less well to vaccination in any case and depends ultimately on proper attention to general health factors – response to Q2.
d. No arbitrary timetable should be imposed.
    i. It is reasonable for parents who keep their children at home to postpone any vaccines until after weaning, or six months of age, whichever is later.
    ii. Vaccines are safer given when the child is well, rather than at an arbitrary pre-arranged appointment
    iii. Since many diseases are acceptable risks or very rare in this country, it is reasonable for parents to choose immunisation against some diseases rather than others. A wider range of product choice would achieve better overall uptake of vaccines that really matter.

REFERENCES
[i] Mansfield P "Twenty years' experience of a telehealth service in the UK" J Telemedicine and Telecare 2005; 11 (Suppl 2): S2:69-71
[ii] NHSCRD "A Systematic Review of Water Fluoridation" September 2000 pp 20-21, 35-41
[iii] National Diet and Nutrition Survey: Volume 3 2003 page 129
[iv] NHSCRD ibid p 30
[v] ibid p 31 figure 6.2