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.

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General Comments

My main misgiving about this document as a whole is that it seems to assume an ahistorical, non-institutional, non-quantitative, centralized and top down approach in Public Health. The definition of Public Health that is cited from the American Institute of Medicine — 'what we as a society collectively do to assure the conditions for people to be healthy' — is not problematic. However, the first terms of reference of the working party refers to the issues arising 'when designing measures to improve the public health'. This form of words assumes that there are 'designers' — an elite group who know in advance what is good for the public — and that the only need is to work out ('design') the instruments to achieve chosen goals.

The implicit model offered is inconsistent with reasonable interpretations of why health has improved in recent times.
Take, for example, the reasons for the improvement of adult health in the second half of the 20th century in high-income countries such as the United States, the United Kingdom, other European countries and Australasia. When one looks at, for example, the reduction of mortality attributable to smoking which has been the biggest single contributor to the decline in adult male mortality in England, it is clear that there has been a complex cumulative institutional process that has produced this very favourable outcome. A key component at an early stage was state support for medical research which led to the first English language reports of the association of smoking with lung cancer. During the 50s and 60s there are multiple press accounts of findings on the association of smoking and various adverse health effects. This press coverage was amplified by deliberate efforts of the organised medical profession which led to the publication of the College of Physicians report in 1962 and this, in turn, precipitated the Surgeon General's report in 1964 …. and so on. It is quite a bit later before we get large scale organized anti-smoking programmes. (There is actually a reference to this sequence in the text.)

Likewise when we look at the perhaps most successful anti-smoking programme in today's world, that in California, it clearly has a complex and decentralized history including the multiple clean air ordnances passed by local governments in California starting with that in Berkeley in 1977, then culminating in a state-wide referendum in 1989 and the implementation of the formal programme during the 90s etc.

If we look at, say, sudden infant death in the UK there is a complex evolution of expert opinion on the best way of putting babies to sleep which turns out retrospectively to have been mistaken through the 60s and 70s. Then there is a change of professional opinion, first in the Netherlands then in the UK and then in the United States in response to findings from research studies in the Netherlands, New Zealand and elsewhere. The UK Health Department's response is <u>not</u> a leading factor in this situation. It was only really precipitated into action in 1991 by the growth of agitation through the mass media and so on.

So, in this context to see the central state as the initiator ('designer') of well-understood programmes that will help the public is not concordant with history. On the other hand it's not discordant with history to see the crucial role played by the central state creating circumstances that help in 'collectively assur[ing] the conditions for people to be healthy'…. Or, put another way, of helping to enhance society's 'problem solving capacity' in health matters. This has included, for example, assuring the appropriate infrastructure for public health activity, assuring support for medical and public health research and assuring support for public health surveillance. It is all of these things that really creates the circumstances whereby society can 'collectively assure the conditions for people to be healthy'.

Quality of Public Health Surveillance and Assessment

A related issue arising from the former points is that the way that analyses of the avoidable causes of ill health in the population are conducted and presented raises ethical issues in itself. Such activities should be conducted with honesty, transparency and rigor. Because there are typically substantial associated uncertainty with such assessments it is also important that this uncertainty is accurately conveyed in such assessments.

An example where existing practice need to be substantially improved **is in the formulation and presentation of 'attribution claims' — claims**, that is, **that so much ill health is due to this or that exposure, eg to alcohol or obesity** etc. All **such claims rest** explicitly or implicitly **on a comparison with an alternative** of distribution of the exposure of interest. That is to say, one can only make sense of a claim that the existing distribution of alcohol consumption is causing a given quantum of ill health by knowing what it is being compared with ie the alternative or counterfactual distribution of exposure. It is important that this counterfactual be explicitly stated.

If the alternative is zero consumption then this must be stated because achieving zero consumption of alcohol is never likely to be an objective of public policy. This being so, the quanta of ill health attributed to alcohol using this counterfactual does not actually tell us how much of the ill health attributable to alcohol might be preventable by shifting distributions of exposure to *feasible* alternatives.

On page 31 of the existing text there are some very poorly specified claims about the ill effects of alcohol attributing deaths, for example, to 'alcohol misuse' without defining it. This should not be regarded as acceptable in this kind of document or in any document intended to guide public discussion on public health policy.

Some more specific comments

References to state institutions

There is reference in the document to the government but actually both the central and local government play important roles in public health and the implication of the frequent reference to the government, meaning the central government, is to leave a strong impression in favour of a centralized approach. I think this is inappropriate.

Part 3, page 13 'Factors that influence public health'

The list of categories offered here seem very unsatisfactory. How it is that, for example, the category 'social and economic factors' does not also include lifestyle is very unclear because lifestyle itself is a social phenomenon as is implied by the component style and as is historically the case in its first usage by Max Weber.

A more fundamental difficulty with the discussion on pages 13 to 15 is that whilst they might provide some insight on cross-sectional distributions of health levels between social strata it provides almost no insight into how societal factors have influenced the evolution of health levels in the population as a whole. It seems rather important that any discussion of the value of different approaches to protecting and improving health should rest on some coherent understanding how big gains in health have been achieved in the last half century.

For example, a historical/institutionist interpretation of health transformations and their causes might throw different light onto the optimal approach for responding to the rise of obesity. We might consider, for example, that an important requirement is to establish a framework within which society can learn how well it is progressing in achieving the containment of this problem.

An important role for the state in this context is help find means to fill in the important information gaps in relation to time trends in the determinants of obesity. For example, energy expenditure is very difficult to measure and self-reports have low validity. It therefore becomes rapidly important to substantially expand the resources devoted to objective measures of energy expenditure in the population and to repeat these over time. This would enable a much clearer process of collective learning about how the underlying determinants were changing… and so on.