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.

Les Dundon

List of questions

The definition of public health

Do you agree with the definition of public health introduced above ("[W]hat we, as a society, collectively do to assure the conditions for people to be healthy"[1])? If not, please explain why. What alternative definition would you propose?

I do not agree because:

Whilst this definition successfully conceptualizes public health, it is too loose. The definition of "health" has to be established first, and the scope of "people" has to be explained. As it stands, this definition of "public health" could easily include the provision of plastic surgery to improve the self image of a very small number of people. That could easily be regarded as the provision of beauty treatment at the public expense.

Further, I don't think it is useful in defining roles and responsibilities. For example, whose role is it to police advertising which promotes unhealthy lifestyles? Whose responsibility is it to ensure cost effectiveness?

Finally, I question whether the aim is to assure, rather than promote, the conditions for "people" to be healthy. Clearly, people have choice (freedom), so the latter aim is easier to achieve. Of course, the consequence of the latter option is morally more difficult to deal with; people make bad choices all the time – should they be penalized for their lack of wisdom?

I feel there should be a clear division of responsibility, separating public health from personal health. Whether personal health should be funded by the public purse, at to what extent, is a separate question. Therefore, I would propose the following definition of public health:

"What we, as a society, collectively do to assure the conditions to prevent general (epidemic) illness and to promote the choices that empower healthy lifestyles.

In this way, we usefully separate out three distinct aims:

To prevent disease, or other common ailments; by vaccination etc
To promote those choices that reduce the impact of poor health on the public purse while empowering people to lead healthier, fuller lives
To provide personal healthcare as required.

I believe that successfully promoting the choices that empower healthy lifestyles will reduce the need for personal healthcare to much lower levels.

---

1 (Institute of Medicine (1988) *The Future of the Public Health* (Washington, USA: The National Academies Press).

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.

Factors that influence public health

Do you agree that interactions between the following five factors are the main influences affecting public health: the environment, social and economic factors, lifestyle, genetic background, preventative and curative health services? If so, do you think some are more important than others? Are there other factors we should include? If so, what are they?

No, I do not agree.

I think education/information provision is the most important factor affecting public health, and that is not included! To promote healthy lifestyles, you have to get the message to where it's needed and the health service is failing to do this. If fizzy drinks manufacturers can get their message to all socio-economic groups, so can you.

I think individual attitudes towards social responsibility versus civil liberty plays a part. An obvious example being our driving habits. We know that traffic pollution is a cause of ill health, and road traffic is a major cause of injuries. But do we drive smaller cars, or choose to take fewer, slower journeys by car to reduce these hazards?

I think social exclusion, rather than "social and economic factors" is a cause of bad health. Public health reached a relative high point during WW2 because of rationing which ensured a healthy diet. People didn't have more money, they were just engaged in a way that empowered them to lead healthier lives.

By my definition of public health, genetic background is clearly not a factor and should be excluded. This is an instance of personal health being funded, rightly, by the public purse.

Prevention of infectious diseases through vaccination

Some countries[2] 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?

For childhood vaccinations, parents make decisions on behalf of their children. Are there cases where the vaccination of children against the wishes of their parents could be justified? If so, what are they?

The "Harm Principle" is an important factor in responding to this question. Articles 8,9,10 and 11 of the European Convention on Human Rights (Incorporated into the Human Rights Act 1998) take this into account. Eg article 8:

1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the **protection of health** or morals, or for the protection of the rights and freedoms of others.

The ethical issue has already been decided. Compulsory vaccinations are justifiable in some circumstances.

[2] Countries with mandatory vaccination policies include the USA and France. In these countries children must have received certain vaccines before they can start school.

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.

With regard to vaccination of children, section 31 (9 and 10) of The Children Act 1989 defines significant harm as the threshold for intervention into family life. Section 11 of The Children Act 2004 mandates the provision of services to all children with a regard to "safeguarding and promoting the welfare of children. Vaccination of children against the parents wishes may be justifiable on the grounds that not to do so would expose them to risk of significant harm. Note: both CA 1989 and CA 2004 are compliant with the UNCRC.

That said, I feel that the problem would be very much alleviated by better education of the parents.

Control of infectious disease

- Control measures for specific diseases depend on how infectious a disease is and how it is transmitted. For infections that are directly transmitted from person to person, what justification would be required to render interventions such as forced quarantine, which helped to control the outbreak of Severe Acute Respiratory Syndrome (SARS) in Asia, acceptable in countries such as the UK where such measures may be considered to infringe civil liberties? If you think such measures cannot be justified, what are the principal reasons?

- In general, the earlier that an outbreak of disease is detected, the easier it will be to control. 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?

Once again, the criteria for action can be derived from international legal agreements such as the ECHR, UNCHR and the UNCRC. Where these are incorporated, or reflected, in UK statute law the decision may be reduced to a question of proportionality.

- Travel and trade are key factors in the spread of infectious diseases. Global travel and exchange of goods are increasing rapidly. Each day, two million people travel across borders, including around one million per week between developing and developed countries. Disease-causing organisms and vectors can therefore spread quickly around the world.[3] Are new measures needed to monitor and control the spread of infectious diseases? If so, what would be promising strategies?

The SARS affair demonstrates that some types of infectious disease can be effectively controlled if the source is identified quickly and states co-operate in preventing the spread of infection across borders. Funds can then be targeted at eradication of the infection at source.

On the other hand, the avian flu problem demonstrates the limitation of this approach. Birds migrate, and you can't cull all of them.

Under which circumstances, if any, would mandatory testing for highly infectious and life-threatening diseases such as tuberculosis or HIV/AIDS be justified?

If there is clear evidence that a person may be infected with a notifiable disease, then mandatory testing is justified. For example, if a person is diagnosed as HIV positive, then their sexual history must be laid bare and their sexual partners should be tested. This is,

[3] USA National Intelligence Council (2000) *The Global Infectious Disease Threat and Its Implications for the United States – Factors affecting growth and spread: International trade and commerce,* available at: www.cia.gov/cia/reports/nie/report/nie99-17d.html, accessed on: 19 Apr 2006.

again, justified under the Human Rights Act.

Obesity

Food is closely linked with individual satisfaction and lifestyle. This means that 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 to achieve a reduction in obesity?

If average calorific intake has gone down while levels of obesity have increased, then perhaps food is not the problem. A healthy diet has a much wider effect than simple weight control and we should seek to demonstrate its benefits to general health whilst avoiding stigmatic labels. The healthy schools program is already providing anecdotal evidence in this respect. Removal of fizzy drinks machines is said to have resulted in calmer students while the replacement of fatty, salty school lunches has resulted in better energy levels in the afternoon.

While there is clear evidence about the extent and scale of obesity, there is far less clarity about what measures should be adopted by the government and other stakeholders to prevent it. In view of this uncertainty, what would be suitable criteria for developing appropriate policy?

Identifying the causes of the problem would be a good start. Prevention is better than cure, so policy aimed at reducing the causes should be considered.

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?

Parents are the primary carers and as such are obliged to ensure the health of their charges. An obese child is suffering from neglect. (Though the neglect is not willful).

The food industry could probably be persuaded to adopt labeling which empowered parents to make sensible choices for their child's diet. Eg "This bar of chocolate contains about 1/5 of your child's recommended daily calorific intake."

Schools should provide education to enable pupils to make sensible food and lifestyle choices. Encouraging physical activity would be helpful.

School food providers should not provide access to "unhealthy" food choices. Government should legislate to ensure helpful food labeling, fund ongoing information campaigns for parents, and police advertising aimed at children.

- Is it acceptable to make the provision of NHS services dependent on whether a person is obese or not (see example in Section 4.2 of Part B)? If so, what criteria should govern whether or not interventions are provided, and should similar criteria be developed for other lifestyle-related health problems that are significantly under the control of individuals?

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.

It is a mistake to assume that lifestyle is significantly under the control of individuals. Choices are usually constrained and often badly informed. I would hazard a guess that at least one member of your committee drives a silver BMW, though the colour is not their first choice. It is also unlikely that the engineering merits of the BMW actually played a part in that choice; although they will have accepted the advice of the motoring press that "rear wheel drive is best". (Engineers will dispute that.)

The same problem applies when you go to the supermarket to buy food. Do you have the time to read the labels on each item you buy? Is the label meaningful? Can you afford your first choice?

Smoking

The effects of smoking on health have been known for a very long time. Comprehensive measures by governments to prevent harm to the population are relatively recent. In your view, what are the reasons for this delayed response? Are there any lessons that can be learned from other countries, or from strategies pursued in other areas of 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?

The delayed response is probably due to public opinion. If most people smoke, then restricting their activities is not going to win an election; public opinion had to be changed first.

It would be foolish to say there are not lessons to be learned from other countries or other areas of public health. However, I have none to offer.

Public information campaigns about the health risks of smoking are ongoing. Tobacco products are clearly labelled. Significant revenue is raised from taxing the industry. Legislation prevents the sale of tobacco products to children under 16. I think the industry is, by and large, meeting its responsibilities.

Individuals will always choose to smoke (I don't, by the way). Prosecution would drive the industry underground losing the tax revenue that contributes to the cost of treatment.

- Should smokers be entitled to higher than average resources from the public healthcare system, or should they be asked for increased contributions? 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?

Smokers do pay increased contributions. If £8Bn is raised in taxes and 1/4m hospital admissions are related to smoking, that's £32,000 extra for each such admission.
I think, statistically, you are more likely to be injured in the home than taking part in adventurous sports. However, it would be easy to legislate to require insurance for such activities. That said, adventurous sports inspire us and it might not be wise to inhibit them.

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.

- Smokers argue that they choose to smoke. 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, which is known to be addictive and highly dangerous? How vigorously is it reasonable for the state to act to prevent children and teenagers from smoking?

The state has the right to impose sanctions for the protection of health. Eg to reduce the incidence of passive smoking. The state has, in the past, outlawed the sale of cocaine which was at one time available over the counter at Boots. The multi billion pound cocaine industry is now completely underground. I dispute that tobacco is highly dangerous. A pack of 20 a day is likely to do less harm than the same money spent on McDonalds burgers and fries.

The Gillick principle applies to children who choose to smoke. It is not illegal for children to smoke – it is illegal to provide tobacco products to them. The government should seek to persuade children not to smoke, enlisting the help of their parents.

Alcohol

- The effects of excessive consumption of alcohol on the health of individuals and society have been known for a very long time. It can be argued that in view of 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?

- In view of the impact of excessive consumption of alcohol on individuals and society, what are the roles and responsibilities of agents other than the government to limit consumption? Are there different responsibilities for producers and, for example, retailers? If so, which?

Smoking immediately and unconditionally affects others in the vicinity of the smoker. Alcohol is a contributory factor of antisocial behaviour, but the behaviour is driven by emotion.

Self responsibility is a principle of a free democratic society. So the agent that bears most responsibility for limiting consumption is the individual. However, people usually drink in groups and peer pressure is a useful tool in such situations. The host (landlord) of any drinking activity has the right (and responsibility) to limit the drinking behaviour of guests.

How can we place a responsibility on retailers for limiting consumption? If I organise a party at my home, I will go to the retailer and purchase sufficient alcohol for that party. Is that an indication to the retailer of a drinking problem?

Producers of alcoholic beverages label their products according to alcohol content. Recently, the industry has begun to promote the idea of sensible drinking.

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.

Supplementation of food and water

- Fortification of some foodstuffs such as flour, margarine and breakfast cereals has been accepted for some time. Why has the fluoridation of water met with more resistance? What are the reasons behind international differences in the acceptance of fluoridation of water? What criteria are there that determine acceptance?

I think there are probably three factors behind the resistance to fluoridation of water:

- We don't have a choice and resist restrictions on our freedom.
- Advertisers concentrate on oral hygiene and pearly white teeth rather than dental health. Consequently, people do not see dental health as your responsibility.
- The benefits to the individual are not seen as worthwhile.

- Which democratic instruments (for example, decision by Parliament or local authority, consultations or referenda) should be required to justify the carrying out of measures such as fluoridation?

I have no specific opinion on this save that consultation and referenda are much easier to carry out with the high bandwidth communications systems available to us now. I have a general opinion that decision making should be devolved as far as possible, so I suppose I would choose referenda.

- Achieving population benefits of fluoridation means restricting choice of individuals. Children benefit the most from fluoridation. However, as with vaccinations, adults, rather than children, are making decisions about whether or not to receive the intervention. Under what circumstances is it acceptable to restrict the choice of individuals in order to protect the health of children?

S31 (9 and 10) of the Children Act 1939 defines the circumstances in which it is acceptable to restrict the choice of individual to protect the health of children from significant harm.

Ethical issues

- In your view, is there one of the following principles that is generally more important than the others: autonomy, solidarity, fair reciprocity, harm principle, consent, trust (see Section 5 in Part B)? If so, which one and why? Are there any other important principles that need to be considered?

- Can these principles be ordered in a hierarchy of importance? If so, how would such an order relate to the five case studies (infectious diseases, obesity, smoking, alcohol, and the supplementation of food and water)? Would the order have to be redefined for each new case study? Are there particular principles that are of special importance to some case studies?

- In cases such as vaccinations or fluoridation parents decide on behalf of their children. Which ideas or principles should guide parents in their decisions?

In my view, there is a well established, standard model for ordering these principles which places the harm principle as the most important.
The principles can be ordered by relating them directly to the hierarchy of human needs. (Maslow: A theory of human motivation, 1943) In order of importance then, we have:

- Harm principle (relating to physiological needs)
- Trust (relating to the safety needs)
- Solidarity (relating to the social needs)
- Autonomy and consent (relating to the esteem needs)
- Fair reciprocity (In a negative sense, it relates to self actualisation; we often comment on how much more we could do without such high levels of taxation, but we are too philanthropic (social) to deny anyone heath care.)

You may place more emphasis on autonomy and consent, relating them to the safety need. However, I have chosen not to because the Stockholm syndrome demonstrates that to be incorrect.

This ordering allows the prediction of the publics reaction to each case. This affects our view of the five case studies in two ways. Firstly, we can order their priority: Infectious diseases (safety), Smoking(safety), Alcohol (Safety), Obesity (social), Supplementation of food and water (it's invisible). Secondly we can use the response of the public to work on such problems:

- I think the bird flu affair demonstrates our desire for the public health system to protect us from harm (infectious disease), and the debacle that came of it reduced our trust in that system.

- Peer pressure to reduce obesity, smoking and alcohol abuse is clearly a demonstration of solidarity. We tend to support those close to us who struggle with these problems while we tend to be judgmental at a distance. Ultimately, we want these people to improve; not because they are a burden but because they are people, like us.

- Fluoridation of water? A referendum would almost certainly produce a "Yes" vote. Given the choice, most people do not "cut their nose off to spite their face".

The role of the parents is to meet the needs of the child. The hierarchical nature of human needs allows the parent to weigh up the relative merits of the case accordingly, taking the child's views into account in line with his/her maturity. I think most parents do this naturally anyway. For example, most children don't want to be vaccinated – it hurts and it makes them feel unsafe. But mum lets the doctor do it anyway because she realises it protects the child's health.

Parents have no difficulty in understanding the principles of the hierarchy of needs, they watch the needs emerge in their infant in that order.

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.

The case studies have been chosen because we think that they highlight a number of important ethical tensions and conflicts between different agents, ranging from individuals to families, to NGOs, companies, healthcare professionals and the state. Other case studies could have been chosen to illustrate the same types of tensions and conflicts. We would be interested to hear if you think that there are other types of ethically relevant issues concerning public health that we should address.

I think the "sanctity of human life" needs to be addressed, but not in a religious sense.

Here are two points of law:

It is legal to abort a 24 week old, sentient, foetus – without its consent.
It is illegal to assist the suicide of a terminally ill person who is in constant pain, even if it is their expressed wish.

It seems to me that there is an element of hypocrisy here. To kill a sentient human, who does not choose to die, for the sake of expediency on the one hand and to prevent the death of a sentient human who does choose to die on the other seems irreconcilable to me.

I am not against abortion, nor am I in favour of euthanasia. However, I think there has to be more careful consideration of the effects on public opinion of these issues, and the way they are presented. At present, the media suggests that ethics committees are ducking the issue. The end result is a degradation of trust.

My own views on these issues are:

The legal limit for abortion should be reduced to a term below the point at which the foetus becomes sentient (below 20 weeks, I believe). I think health professionals in this country generally aim for termination in the first trimester anyway.

A terminally ill person, in constant pain, for whom there is no hope of cure, should be allowed (or even assisted) to die if they, and only they, so choose. I think the law could be arranged to provide immunity to the assistant in much the same way as s14 of the Sexual Offences Act, 2003 provides immunity to the sexual health professional.

Some of the questions asked with reference to a specific case study also apply to other case studies, for example whether people who accept some kind of damage to their health as part of their lifestyle, such as smokers, should be entitled to fewer resources from the public healthcare system, or be asked for increased contributions. Respondents are welcome to comment on these specific questions in a general manner.

The concept of rationing or requiring increased contributions are nonsense in the context of a publicly funded health service. I'd demand a refund!

It is against human nature to deny care to those who need it on the grounds that they cannot pay, or that they brought it no themselves. We have a long history of charity in this country, predating the NHS, providing care to those who cannot afford it and to those who have brought calamity upon themselves.

It is only the "bravery of being out of range" that allows us to even consider it. Surely, the man who tries to commit suicide by throwing himself in the river is the least deserving of our aid and yet we would leap to his aid in an instant – even against his wishes.

The solution to the NHS funding problem is not in trying to ration services or extract more money from the needy. Try reducing waste and overheads instead.