# Nuffield Council on Bioethics

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Christine Salmon Percival
The Clerk
Science and Technology Committee
House of Lords
London SW1A 0PW

Dear Christine

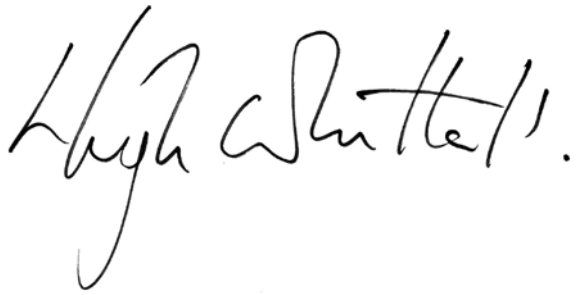
I am writing in response to your call for evidence on behaviour change, in particular the ethical considerations.

Following a two-year inquiry, the Nuffield Council on Bioethics published a report in 2007 on the ethics of public health, which can be downloaded at: www.nuffieldbioethics.org/public-health.

The report was prepared by a Working Party that was chaired by Lord Krebs and included members with expertise in health economics, law, philosophy, public health policy, health promotion and social science. To inform discussions, the group held a public consultation and met with representatives from relevant organisations.

I hope that this is a helpful contribution to the inquiry. Please let us know if we can be of further assistance.

Yours sincerely



Hugh Whittall
**Director**



NUFFIELD COUNCIL ON BIOETHICS

## *Ethical considerations*

*When is it appropriate for the state to intervene to influence the behaviour of members of the public and how does this differ from when it is appropriate for the commercial or voluntary sector to intervene? In particular, when should this be done by outright prohibition and when by measures to encourage behaviour change? Are some methods of producing behaviour change unacceptable? Which and why?*

1 Chapter 2 of the Council's report *Public health: ethical issues* reviews the role of the state in public health and then outlines a framework for a public health policy, based on a classical liberal conception of the state's role. While this framework is suitable to address some of the principal issues arising in the context of public health, it also has certain limitations. We therefore propose a revised and extended version of the initial framework, which we call the **stewardship model**.

2 The report concludes that the state has a duty to help everyone lead a healthy life and reduce inequalities in health. Our 'stewardship model' sets out guiding principles for making decisions about public health policies.

***The stewardship model***

Concerning goals, public health programmes should:

- aim to reduce the risks of ill health that people might impose on each other;
- aim to reduce causes of ill health by regulations that ensure environmental conditions that sustain good health, such as the provision of clean air and water, safe food and decent housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also with programmes to help people to overcome addictions and other unhealthy behaviours;
- aim to ensure that it is easy for people to lead a healthy life, for example by providing convenient and safe opportunities for exercise;
- ensure that people have appropriate access to medical services; and
- aim to reduce unfair health inequalities.

In terms of constraints, such programmes should:

- not attempt to coerce adults to lead healthy lives;
- minimise interventions that are introduced without the individual consent of those affected, or without procedural justice arrangements (such as democratic decision-making procedures) which provide adequate mandate; and seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values [para 2.44]

3 The stewardship model and the principles that underpin it do not provide a fixed set of rules, but elaborate factors to be taken into account when developing policy (paragraphs 2.44, 2.52, 8.3–8.12).

**Role of third parties**

4 Although the state should be guided in its public health policies by the concept of stewardship, this does not absolve other parties, in particular the corporate sector, from their responsibilities. We discuss the concept of corporate social responsibility, and note that while companies may have different motivations for pursuing social responsibility strategies, they increasingly recognise that they have obligations beyond simply complying with relevant laws and regulations. If industry fails to meet these obligations and the health of the population is significantly at risk, the market fails to act responsibly. In such cases, we argue, it is acceptable for the state to intervene (paragraphs 2.47–2.50, 5.26, 5.16–5.25, 6.18–6.31, 8.24).

**Proportionality**

5 The 'precautionary principle' is often invoked where there is some evidence of a serious threat to health, safety or the environment. The precise meaning of the principle has been the subject of much debate and it would be wrong to see it as a simple rule. This is why we prefer the term precautionary *approach*, rather than precautionary *principle* (paragraphs 3.15–3.16).

6 A Communication by the European Commission on the matter helpfully suggests that five main elements can be distinguished: (a) scientific assessment of risk, acknowledging uncertainties and updated in light of new evidence; (b) fairness and consistency; (c) consideration of costs and benefits of actions; (d) transparency; and (e) proportionality.

7 Whether an intervention is proportionate depends largely on: whether the public health objectives are sufficiently important to warrant particular laws, policies or interventions; how likely the intervention is to achieve certain ends; and whether the means chosen are the least intrusive and costly whilst still achieving their aims (paragraphs 3.16–3.19). The concept of proportionality is closely linked to what we call the 'intervention ladder'.

**The intervention ladder**

8 Our 'intervention ladder' (attached) is a method of thinking about the acceptability and justification of different public health policies. In general, the higher the rung on the ladder at which the policy maker intervenes, the stronger the justification and the stronger the evidence has to be. A more intrusive policy initiative is likely to be publicly acceptable only if there is a clear indication that it will produce the desired effect, and that this can be weighed favourably against any loss of liberty that may result [para 3.37].

***The intervention ladder***

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| ***Eliminate choice***. Regulate in such a way as to entirely eliminate choice, for example through compulsory isolation of patients with infectious diseases. |
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| ***Restrict choice.*** Regulate in such a way as to restrict the options available to people with the aim of protecting them, for example removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants. |
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| ***Guide choice through disincentives.*** Fiscal and other disincentives can be put in place to influence people not to pursue certain activities, for example through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces. |
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| ***Guide choices through incentives.*** Regulations can be offered that guide choices by fiscal and other incentives, for example offering tax-breaks for the purchase of bicycles that are used as a means of travelling to work. |
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| ***Guide choices through changing the default policy.*** For example, in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an option available). |
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| ***Enable choice.*** Enable individuals to change their behaviours, for example by offering participation in a NHS 'stop smoking' programme, building cycle lanes, or providing free fruit in schools. |
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| ***Provide information.*** Inform and educate the public, for example as part of campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day. |
| |
| ***Do nothing*** *or simply monitor the current situation* |