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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QUESTIONS ANSWERED:

Question 1 The definition of public health

ANSWER:

The consultation document is correct to note that there are lots of definitions of public health. However, in practice I am equally happy/unhappy with all the definitions I have seen proposed, which suggests that there is some other reason why we agonise over the definition. There is an on going argument over how we should define "health". Therefore a phrase such as "conditions for people to be healthy" is also problematic, as if we have a different concept of what health means in this context, we will have a different understanding of what these conditions to assure it should be. There is a difference between Public Health in the sense of "Health of the Public" and "Health of individual members of the public". Used in the first of these contexts, public health would relate to the way that Plato for example could have talked about the health of Republic. The community/society in which we live would be an end in its own right and hence would be worthy of nuturing. Individual members of the public could be described as having obligations to working towards this end and should stay as healthy as possible to make contributions to the economy etc. Government would also need to create a framework for people to interact and minimise social strife, prejudice etc. Such a view would be considered politically incorrect in liberal Western societies, certainly within Anglo-American frameworks of bioethics that heavily focus on autonomy and where it is frowned upon for governments to have a concept of the 'Good Life'. However, continental Europe and its approach to ethics places more weight on solidarity. Other cultures give even more emphasis to community values. It is important to remember that much of our social benefits, social care, public health and socialised medicine legislation arose out of war and economic strife, where the drivers were mainly to ensure that the population was healthy to work and fight during wars eg after the Crimean and Boar wars and the two World Wars. Travel medicine regulations aim to protect the population from diseases being brought into the country, not for altruistic motives out of concern for the immigrant. Within this sort of framework, the obligations of Public Health Specialists are to the wider conceptulisation of Public Health, rather to individuals within the public. However, in reality public health must work within a professional and political framework where consumerism and the rights to the individual have prima facie priority. Hence definitions of public health have tended to focus on creating legal, social and physical environments that allow the individual to exercise autononmous informed choice and consent to improve their own health according to their own concept of the 'Good Life', and perecption of 'quality-of-life'. As public health professionals this frequently maks us feel uncomfortable. Quite rightly we are concerned about inequalities in health but also inequalities in abilities to maximise their health (however they wish to define it) because of inequalities in disposable income, knowledge about determinants of health and ability to use the political, social and health care systems to their advantage. Public health professionals are also uncomfortable when one individual's or group's choices impact on the ability of others to reaslise their aspirations for

health. Such conflicts are frequently mentioned in the context of communicable disease control (including sexual health) and passive smoking. In such context, arguments may be employed to justify restricting freedom for some, so that others are not harmed. As John Stuart Mill argued in his essay "On Liberty," freedom means "doing as we like, subject to such consequences as may follow: without impediment from our fellow creatures, so long as what we do does not harm them" nor "attempt to deprive others of theirs, or impede their efforts to obtain it." Indeed human rights apparently guarenteed in the UN Declaration of Human Rights or the European Convention on Human Rights may be interfered with if it is 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 and morals, or for the protection of the rights and freedoms of others". However, I believe that there is a danger that Public Health practice can become obsessional with increasing life expectancy and improving quality of life as defined by SF36, EQ-5D or other measures of quality life, rather than engaging with the public to understand exactly what the goals of Public Health should be. I do not underestimate the difficulty of doing this, but I think at present our actions lack democratic legitimacy and sensitivity. Our effectiviness is compromised as a result.

Question 2 Factors that influence public health

ANSWER:
As I alluded to in my answer to question 1, there is a difference between Public Health inter alia "Health of the Public" and "Health of members of the public". These are the main influences affecting the health of the individual. Preventative and curative health services would normally be considered to be the least influential. Genetic may be the most important but the full role of genes is still being ellucidated. In any case genetic background is likely to interact with lifestyle and environment in determining personal risks. Similarly, social and economic factors will also interact with lifestyle and environment.

Question 4 Control of infectious disease

ANSWER:
I believe that quarantine can be justified but the threat to civil liberties must be taken seriously. The factors that would need to be considered would include: the seriousness of the disease (ie risk of death or serious complications if infected), whether treatment is available, the cost of treatment, the ability of the health care system to cope, whether voluntary 'quarantine' measures (as were used in Toronto during SARS outbreak) were effective. Mandatory testing for TB and HIV would only be justified in extreme circumstances where someone represents an unreasonable risk to others and is unwilling to receive treatment etc. In practice I can only conceive of compulsory testing for HIV where someone has been recklessly and knowingly infecting others without their 'consent'. There is already enough stigma associated with HIV, and mandatory testing may make this situation worse. There is a difference between making testing mandatory and routine however. Making HIV testing routine may reduce stigma, but significant changes in public and profesional attitudes would be required to achive this. We learnt in the middle of the 20th Century that the best way of improving the public's sexual health was to remove draconian legislation and to encourage voluntary testing for sexually transmitted

disease. Mandatory testing for HIV would be a counterproductive step. Mandatory testing for groups such as for health professionals should also be treated with caution. As any such policy should be proportionate to the actual threat to the public health, which is probably lower than most patients expect.

Question 3 Prevention of infectious diseases through vaccination

ANSWER:
I have discussed the obligations of parents to their children in my answer to other questions. Voluntary schemes are on balance to be preferred. Compulsory schemes, without public support or understanding of their justification are likely to further damage public trust in governments and public health agencies. Compulsory schemes would be justified if there are no alternatives, the diseases to be prevented are of a severity or prevalence to warrant such approaches, and hence the compulsion is proportionate to the infringement of civil liberties.

Question 5 Obesity

ANSWER:
I have discussed the roles of parents and industry in my answer to other questions. A person's access to NHS services should depend on their capacity to benefit and the opportunity costs for using the resources in other ways. Thus an obese person should not be denied or given a lower priority for treatment, just because they are obese. However, it would be legitimate to give them lower priority if there was evidence that the intervention would have lower effectiveness because of the body mass index. Similar arguments would apply for smokers being denied surgical treatments for coronary heart disease until they stopped smoking.

Question 6 Smoking

ANSWER:
The delay in response to the public health dangers to tobacco have mainly been due to economic and political factors. In my answer to question 7, I defend (to some extent) the alcohol industry from having direct obligations to the public health. I describe how I see the limits of their obligations, including an obligation to provide a wholesome product with appropriate warnings and instructions for safe use. It has been known for many years that cigarretes are not a wholesome produce and that it is very difficult if not impossible to use tobacco safely. Furthermore it has been demonstrated in courts that the tobacco industry has deliberately acted to keep this information from their customers. Thus I believe that they bear some, but not all, moral and legal obligation for smoking related disease (smokers must also accept some responsiblity for their illnesses). No, smokers are not entitled to higher than average health care resources per se, just because they are smokers. Similarly they should not be asked for increased contributions, as they are already likely to pay more money to the state via tobacco duty than they consume in healthcare. It would of course be more difficult to answer this if they were in fact being subsidised by non-smokers. The example of other groups who deliberately or negligently increase their chances of requiring NHS resources is often quoted in this context. At which point it is recognised that we all accept risks to our health in one form or another, and not just adventure sports. Trying to untangle the risks assoicated with all our lifestyle choices would be impossible eg what diet we eat, what we do in our lesiure

time, how far/fast we drive. An insurance actuary could give it a go in giving us an individualised health insurance premium, but even insurance compancies only assess for major risk factors such as gender, age, smoking, past medical history etc. It just gets impractical to accuratly assess all risks. In any case the UK public are very proud of the NHS which is based on the principle of solidarity with each receiving the care that they need free at the point of use (well in principle anyway!). Yes the State does have the right to prevent the sale of tobacco as it is addictive and dangerous. Whether it should is another matter. In my answer to question 9 I describe the importance of acting in the best interests of the child, but how it can be very difficult in deciding exactly what is the 'best' course of action versus one that is statisfactory or contrary to a child's interest. In my answer to question 9 I also refer to the importance of providing a child with an 'open future' as far is practicable. Arguably a child reaching the age of majority who is already addicted to nicotine does not have an open future and is already experiencing cardiovascular damage that may impact on life expectancy. Thus measures to protect vulnerable groups such as children are justified even if it means that is some restriction on the rights of others. Thus for example restrictions on the ability of adults to smoke to prevent children from passive smoke would be morally acceptable, provided that these restrictions on adult smoking are proportionate ie the impact on their civil liberties are not greater than the demonstratable benefits for children, co-workers and the public health more generally. If however, we allow adults to smoke, despite the known risks, then we are accepting that an autonomous adult has the right to make an informed decision to harm their health. The date when a child reaches majority, or reaches an age when they are allowed to smoke, drink alcohol, vote, have sex etc are legally defined, rather than being defined in terms of a child's maturity or ability to act as a fully autonomous individual. Indeed a person older than 16, 17 or 18 may never be fully autonomous or intermittently lack that capacity. In the same way a child below this age will have capacity to make some decisions. For example, a child of 2 is capable of making a choice between flavours of ice cream, and we are happy for them to make that choice. It is just that we wouldn't want a young child to have the responsibility of making decision about life saving health care. We do however recognise that children as young as 12 or 13 are capable of making some decisions eg about contraception, as long as an assesment is made of their capacity to understand the implications of having sex at that age and would otherwise be having unprotected sex. Thus when the State is acting to prevent children and teenagers from smoking, some account must be made of their capacity for making autonomous choice and whether any restrictions of other people's freedoms are also proportionate.

Question 7 Alcohol

ANSWER:
I agree that alcohol policy has lagged behind tobacco policy. This probably reflects a slower realisation of the true damage to the public and social health of alcohol and also the higher proportion of smokers who develop smoking related disease compared to the proportion of drinkers who experience morbidity. It is difficult to specify a responsible level of tobacco smoking, whereas it is possible to define consumption limits of alcohol that are unlikley to be harmful and indeed may even by beneficial to health. I don't think that producers and retailers have any direct reponsibilities for the public health over and above any general responsibilities that would be expected of other sectors of the economy. They have legal and moral

obligations to their customers to provide a wholesome product and to provide information about its proper and safe use. Thus there is an obligation to warn people about the dangers of excessive use. There is also a duty of care to their customers, and so they shouldn't serve alcohol to people who are drunk. Pub landlords have obligations to people who live in their neighbourhood, as good neighbours. They also have obligations to wider society not to create noise and other forms of nuisance via their contractual license agreement with the local authority. As part of this legal framework, the government could impose a quasi moral obligation on the alcohol industry to act in the public interest. As part of their public relations strategy, the alcohol industry may also want to appear as though thay respect the public health eg how they responded to pressure about the way that they advertised alcopops. However, I do not think that they have any additional moral or legal obligations. At the end of the day they are private companies with the aim of producing profits, as do the pharmaceutical industry, baked bean maufacturers, or washing machine manufacturers etc. The responsibility to improve the Public Health lies with central and local government and public health agencies. It is for them to influence the alcohol industry and their cumstomers via voluntary agreements, information campaigns, taxation policy,legislation and licensing frameworks.

Question 8 Supplementation of food and water

ANSWER:
I am the coordinator of a European project on public health ethics. As part of this project we have conducted research examining European public attitudes to various areas of public health policy. One of these policy areas was water fluoridation. While citizens in most countries opposed water fluoridation, the views were probably not that strongly held. Those countries which were more supportive tended to have a history of exposure to artificial sources of fluoride via public water supplies, uses of tablets/rinses in schools and so were more comfortable with the safety. In countries where most focus groups opposed fluoridation there were some residual concerns about health risks, but in general people didn't see the point in accepting any small risk of harm as they thought that these were not proportional to the benefits, given that children could get the benefits of stronger teeth via fluoride tooth paste. There was a recognition that some parents do not ensure that children brush their teeth. However in this case, focus group participants believed that parents should be made to do so, or schools/other agencies should ensure that children have access to fluoride via toothpaste, rinses etc. Trust is also an important factor, and the public do not trust government reassurances that anything is safe anymore. The quality of evidence in relation to water fluoridation is not high, but on balance it suggests that fluoridation is beneficial to the public health and the adverse efects are limited to fluorosis. On this basis, the decision to fluoridate could be made by any legitimate authority, subject to some form of democratic control. Thus it could be central government, local government or the NHS (acting through the authority of the government). However, given a vocal minority who oppose fluoridation, consultation would be appropriate otherwise public trust might be further eroded. However, the cost of referenda is large, and given that dental caries rates are falling, and the public health case for fluoridation is not that overwhelming, then the cost of referenda is probably not justified. The comparison between fluoridation and vaccination in this context is not a good one. Adults make decisions about childhood

vaccination and it is the child who experiences the costs/benefits. With fluoridation, the entire population is exposed to any risks (albeit very small) of water fluoridation, as the intervention is mass administered rather than via clinical consultations.

Question 9 Ethical issues

ANSWER:
I believe solidarity to be the most important. Solidarity is term that covers various concepts. For example, solidarity can be subdivided into communal solidarity where a group of people have a common interest and constitutive solidarity where people have an interest in common. Communal solidarity can be further subdivided into group solidarity and moral solidarity. The other principles listed within the consultation documents are consistent with the concept of solidarity, and would be respected in a society that operates within a solidarity framework. As I have discussed previously it is difficult for a public body to specify how a child should be brought up, because this would infer some concept of the 'Good Life' which should be imposed. In any case there are the practical difficulties of enforcing 'ideal parenting policies', and it would be impossible to check and approve every decision that a parent makes. Thus although the Children Act and other legislation/policies talk about acting in the best interests of the child, 'best interests' is a very difficult concept to define. Thus in practice it is usually left to the parents to decide what is in the best interests of the child. However, this should not be seen as a parental right to bring up their child in any way that they feel fit. Indeed it should be seen as a parental obligation rather than a right. Thus for example, within the U.N. Convention on the Rights of the Child, there is an obligation on to "… take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child". Thus, making decisions about the upbringing of a child is usually within the rights of the parents but it is their responsibility to do this within socially acceptable norms. Where there are concerns about the way that parents are discharing their parental rights/obligations, then the final arbitors of 'best interests' will lie with the court. As far as it practicable, children have a right to "an open future" (for example see writings of Joel Feinberg), and it is this criterion that should guide what should underpin decisions about the best interests of a child. Thus for example, a child needs to have the best health and social care and education that is practicable to allow him or her to reach adulthood, at which time they can utilise the physical and intellectual capacities that they have to make their own life choices, even if these are considered by others to be harmful. For example a young adult could choose to smoke. Thus for example, the Courts will typically intervene when parents refuse life saving health care interventions or refuse to send their child to school. The Courts tend to be more reluctant to intervene in parental decisions about religion or other forms of cultural education.