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.

Professor Theresa Marteau

The following comments are prompted by the Consultation Paper, providing specific responses to just a couple of the questions raised. The main point to make is that an analysis of the ethics of public health, a laudable aim, should be build upon a similarly sophisticated analysis of human behaviour, grounded in psychological theory. I hope some of the points below illustrate the importance of this, although these comments do not provide the detailed analysis of behaviour which could greatly strengthen the final report.

Factors that influence public health

Few would disagree that the health of the public is influenced by a combination of environmental, social and economic factors, lifestyle, genetic background and health services. Disagreement is evident, however, regarding the importance attributed to each of these in: (a) explaining the health of the public; and (b) improving the health of the public.

Conceptualising behaviour

The approach taken to improving public health depends, in part, upon how individuals' behaviour is conceptualised, a necessary prelude to considering the philosophical principles to guide public health interventions.

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Behaviour in health contexts is often conceptualised in policy and contemporary psychology as reflecting individual choice. Choice is a problematic term, as outlined below.

time perspective

The majority of smokers want to quit. The majority of those who are overweight want not to be so. Yet for most people these so-called choices are not realised. Choice in preventive health contexts usually reflects a tension between long term and immediate desires (Connor & Sparks, 2001). Behaviour in all domains is controlled more strongly by its immediate rather than its longer term consequences (Baum, 2005). The environments of affluent societies make short term desires easier to realise and longer term desires more difficult (Ovner, 2005). Individuals also vary in the extent to which they are motivated to achieved future goals with those who are more socially deprived being less motivated by future goals and more motivated by immediate goals (D'Alessio et al, 2003; Crockett et al, submitted). The social patterning of time orientation combined with an environment that makes short term desires or goals easier to achieve contributes to health inequalities.

engineering environments

Altering the environment to make choices that reflect longer term desires easier to realise has the potential to improve the health of the public far more than interventions aimed at providing information aimed at influencing choice. It could also reduce health inequalities given the evidence that the behaviour of those who are more socially deprived is more influenced by short as opposed to longer term desires. Such change requires major interventions involving for example redesigning cities (as was done in Seattle) to make walking and cycling preferred means of transport.

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responsibilities of governments

In the context of promoting healthy behaviours there is a need to consider whether governments are constraining or facilitating autonomy by legislating to prohibit behaviours such as smoking in public places or taxing heavily high fat foods. Taking the definition of an informed choice as one that reflects an individuals' values (Marteau et al, 2001) it could be argued that government intervention will, on average, facilitate more choices that reflect core values (such as being healthy) and hence could be seen as facilitating and not constraining autonomy for most people.

f*ree will, responsibility and restricting health services*

If behaviour is conceptualised as reflecting free will, this leads to an assumption that those who do not change their behaviour have chosen not to do so. Ideas of free will and responsibility are tied. Invoking responsibility means deciding whether to apply consequences to an act. So for example, if we consider a smoker responsible for their smoking, we may judge that she should be denied treatment for smoking related diseases. An alternative is to consider this behaviour as a result of a "reinforcement trap" in which smoking is reinforced in the short term (by nicotine) but punished in the longer term (by morbidity and premature mortality) while cessation is punished in the short term (by withdrawal symptoms) but rewarded in the longer term (by health). This conceptualisation leads to the design of interventions designed to overcome this trap as opposed to punishments such as withdrawal of services. This conceptualisation also does not see the individual as free but rather as responsive more to short-term reinforcement than long-term reinforcement.

Conceptualising behaviour and choices as constrained and reinforced by the environment provides a model of behaviour that avoids blame and punishment. Within such a model allocating health care on the basis of behaviour is inappropriate. An alternative model is to allocate health care on the basis of cost-effectiveness. If treatments are not cost- effective in those who abuse alcohol, are obese or who smoke, than such treatments should not be provided. Interventions could however be offered to allow such individuals the opportunity to change their behaviour so that the treatments could become cost-effective for them.

Lay conceptualisations of behaviour

Perceiving policies as restricting free choice leads to accusations of "A Nanny State". This rests upon a libertarian view of free will, namely the idea that choice is free of past events. Such a view, while psychologically implausible, is common and represents a major challenge to those charged with improving public health through the most effective means namely through policies that will lead to environmental change that provide immediate reinforcement of healthy behaviour.

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15th September 2006

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