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List of questions

1. 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?**

Yes I agree that this definition captures much of the spirit and principles of public health in a general and succinct way however I wonder by distilling to such a concentration that the complex essence of public health is somehow missed.

The creation and the sustaining of "good health" for all including the reducing of health inequalities involve socio-economic environmental elements of both micro and macro society-(see the next question). Within the above definition there is also an inference that society collectively to produce positive conditions to improve health, this I believe this a little naïve on at least a couple of levels

- That society somehow collectively agrees to produce good health for all people- how could this happen?

- That there are no such things as anti-health forces within society e.g. tobacco companies etc

I am not sure that I can capture a definition however there are some elements that I believe need to be included

- The elements of both individuals, local communities and micro i.e. local and macro i.e. national and wider society- and be clear about this
- Health inequalities – that not everyone starts at the same starting point
- Socio- economic and environmental components of health
- Diversity including health status and disability

General Comments

"Healthy" by whose definition? Is this objective or subjective? How might this be measured? When do we know that it has been achieved or not? How much of a variable is this ?

The definition for health and healthy that has challenged many of us for years- in many cases we are using the WHO 1946 definition

> "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"

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

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The Definition has not been amended since 1948. There has been much debate about the use of the term “complete” that academics would be in a much better position to comment about then me.
A quick scan of the term healthy with the dictionary presents several definitions

1. Possessing good health.
2. Conducive to good health; healthful: *healthy air.*
3. Indicative of sound, rational thinking or frame of mind: *a healthy attitude.*
4. Sizable; considerable: *a healthy portion of potatoes; a healthy raise in salary*

Society- what do we mean by this?
The dictionary definitions include

- the aggregate of people living together in a more or less ordered community.
- a particular community of people living in a country or region, and having shared customs, laws, and organizations.

At what level does this definition work?, micro, macro- are we including the whole of Government, European , global influence? Are we including the anti-health forces here for example big business such as tobacco and food companies such as Mc Donald’s or Coca- Cola.
How is there a mechanism to make people or society healthy? There has been some action around Government and some intent to get to the “fully engaged scenario” suggested by Derek Wanless in his second report to HM Treasurer but where is collective product of that? And what about the role of the business community.

2. 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?**

It is the current main academic and public health practice view that the interactions between the following five factors are the main influences affecting public health and the root of ill health. Much has been made of individuals’ impact on their own health and lifestyle. Work undertaken by the , now defuncted, Health Development Agency suggested that nearly 70% of what determines our state of health is what they called “community health actions” and included social, environmental and economic conditions. Certainly working at a local level although we work closely with individuals and communities the biggest change in public health are those that impact on their broader life. A paradigm shift or behaviour change for many is a lot easier if the societal, economic or environmental conditions are changed e.g. sanitation and clean water, compulsory education, seat belts and the seat belt law, smoking cessation and no smoking laws

There are a couple of factors that although could be considered as a product of socio-economic society I think should be included in the influencers

- Behaviour
- Media

3. 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?**

The consultation document illustrated how often herd immunity is achieved through voluntary system. One wonders if there is an artefact around compulsory vaccinations within US and France- and it must be noted that within the US there are 17 states that do not have compulsory vaccination. A quick check will show that there is a strong movement opposing mandatory vaccination in many US States as well as France and one wonders if the overall benefit outweighs the aggravation factor. Something that can't be judged without the history.

I think that is it around the communication of risk of the disease and that of the vaccine. Perception of risk is a key driver in much of this (this links into the discussion around ways of influencing public health pg 15).

Thanks to a variety of reasons there are many people who have doubt about the relative risk of many of the vaccination when compared to the impact of the disease. This is something that is shaped and formed in individuals minds by a wide variety of influencers including health care professionals e.g. health visitors offering childhood vaccinations or primary care practices offering 'flu vaccination to the over 60s and those who are deemed to be more vulnerable to 'flu, advertising- usually DoH, media- often negative or sensational stories and peers and families- look at the low vaccination uptake of MMR in some parts of leafy London and the subsequent rise in measles. Compare this to say smallpox where people saw that the disease was frequently fatal and often disfiguring or polio where people who survived were often debilitated.

Where there is also the suggested link between vaccinations and something perceived to be far worse than the disease being prevented e.g. autism and autistic spectral disorder (ASD). There is an interesting discussion about public perceptions and views around what they see as physical ill health and mental ill health and perhaps the greater societal stigma around mental ill health than physical ill health. There is also the "guilt" factor with parents shown on national media wracked with guilt as they wonder if they had not agreed to their child being immunised would their child be free of this potentially debilitating mental health disability. I think in all this it is important to factor in that perspectives change when it is someone close to you who is affected and the greater good seems to be far less relevant.

Current evidence demonstrates that the certain childhood illnesses will kill and seriously debilitate hundreds of children a year and although there is much media interest (see above question) there is still no causal link established between vaccinations and autism or other conditions e.g. kidney disorders. The large

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[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.

majority of us with children with ASD (my son was diagnosed 4 years ago) agree with that our child's condition was in no way triggered by vaccinations received and that vaccinations were a positive contribution to our children's good health however there are a few people who feel certain that their child's condition was as a direct result of vaccination. The media plays a strong part in fanning the flames of uncertainty.

In many ways I wonder if it comes down to the balance of the complex ethical questions and the pragmatic fiscal drivers. Or put in a devils advocate way that I'm sure many people looking at the shrinking budgets and their perceptions of risk will be asking how effective is it to push for compulsory vaccinate everyone, where evidence shows that in countries who have this that uptake is in the late 80 or early 90% when in many places for most vaccinations we achieve herd immunity.

An important part of this is around communication and what messages are being delivered to both the community and the health care professionals delivering the vaccinations plus the antagonising role of the media.

- **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?**

I believe that if it was felt that the child might be seriously harmed or killed by a disease or condition that could be prevented or reduced in severity by a vaccination. However there is the complex ethical issue about who has the overall decision around life and death for children or dependants. Many parents would feel that their parental role and their "human rights" are being infringed This leads into to the decision of "who knows bests" and the hierarchy of power and influence and who has the final say. Vaccination by preventing a disease can also put people into a sense of false security. A kind of " this is not is not dangerous or frequent disease and I'm more concerned about the side effects" This is also fuelled by the media.

This may be considered comparable to the examples around blood transfusions and certain faiths.

4. 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?**

Interestingly it may be that media and films might make quarantine more acceptable than it once was. Forced quarantine should be considered in a case of an individual who has been exposed to a pathogen or is demonstrating symptoms of exposure to a pathogen that is highly virulent and has a high morbidity rate e.g. SARS or pandemic 'flu.

The balance between enforced quarantine and civil liberties is a challenge and a difficult judgement call that is likely to be made with relatively short notice- if it is a new pathogen. At present there is much work being undertaken around pandemic 'flu (something that currently of course doesn't exist) and there has been enormous press coverage, this could support this difficult process. However in the balance of good public health enforced quarantine around a pathogen that is highly contagious with a high death rate is something that is necessary. This truly is a life or death situation. While there might be some issues afterwards quarantine could ensure that there are many more people to complain about this- something that the survivors may like to consider

- **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?**

There is disease surveillance being undertaken by WHO and other agencies that informs this process and keeps the global public health fraternity informed. Pragmatically countries are much more likely to support work to prevent outbreaks of epidemics that are certain to be transmitted to their own countries.

I am not sure if I have sufficient information to respond to a question around what criteria should be used and in what circumstances

- **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?**

Quick answer yes almost certainly. Borders seem to be more concerned about contaminants of the economy e.g. contraband- goods or people, or the environment e.g. meat or food products. Could border control be in a position to monitor and control infectious disease? At the moment there is some focus on immigrants rather than holiday makers or business travellers.

The challenge is that this is around preventative measures and the measurement of effectiveness even around established infectious diseases.

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[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.

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

There is an interesting inference around the two examples around the nature of infection which might reflect the media interest around the two. HIV/AIDS is communicated through specific risk activities around sexual activities and the sharing of bodily fluids and the HIV virus survives for a short period of time outside the human body and although there have been cases where people have been prosecuted under the Offences Against the Person Act 1861 this relates to very few people compared to someone with active TB who is not taking their medication and could potential infection people who are not even known to them.

TB is spread by droplet infection and coughs and sneezes potentially could effected everyone within the spay zone it is contagious in a much more random way compared to HIV.

If there is a virulent highly infectious and life- threatening disease- with a high mortality whose main or sole mode of transmission is droplet infection then maybe mandatory testing could be considered. However there needs to be a care pathway after this testing including quarantine, treatment and rehabilitation.

5. 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?**

It is a very loaded opening statement around food. How is this justified? In some parts of society this may be the case in other parts high fat high sugar foods are being used a cheap ways to stop feeling hungry. Obesity once mainly prevalent in the poor is now starting to be one of the health challenges that is breaking down the social barriers the social gradient is flattening. And food means different things to different parts of the community including those who see obesity as a sign of prosperity and affluence and something to aspire to.

It seems generally agreed that obesity is not just about the food we eat but also the amount of physical activity we undertake. Policies need to consider both and the complex interactions that society has on food consumption and physical activity. This includes issues that have obvious direct impact on consumption such as advertising and other issues that have less obvious but still direct impact on prevalence such as community safety and the fear of crime stopping people letting children play on the streets or walk to school.

For food surely much of this is around skills development and education of society. Cooking and food preparation skills are an essential part of policies around food as well as accessibility to affordable healthy food choices. Education and planning play a part at local level as does environmental health.

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Policies need to consider the issue around access to shops that were considered by PAT13 of the Social Inclusion Unit starting to look at the issue around food deserts and how out of town supermarkets were reducing the number of local food shops. This has an impact on the sustainability of the community

There is currently debate about whether shock tactics such as those used around cigarette packages should be used around obesity. "Honey we're killing the kids" type of programmes

- **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?**

The criteria should reflect the widest possible thinking around food and how food impacts on people's life

e.g. access, affordability, cooking skills, school meals, local foods, the impacts of large supermarkets and what they sell, advertising and influencing that impact at local level on both individuals and their social, economic environments as well a regional and national policies around retailing

The criteria should reflect the widest possible thinking about physical activity.

e.g. how to societally change the attitude around taking physical activity

- **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?**

Too often policy is reduced to the responsibility of the parents and individuals and negates or at least seriously reduces the role of the food industry and the government, now this is not to say that individuals bear no responsibility however this is a societal problem and although there is a contribution from parents they are not the sole influencers around this complex issue.

At present the industry bears little responsibility for developing and selling products that are high in fat or sugar or both and hide behind the choice and parental education defence. Morgan Spurlock in his documentary Super size me demonstrated the damage that fast food has on individuals. This is not something that we should over look. Certainly after the documentary certain products were removed by Mc Donald's. Big business has, perhaps very shrewdly, linked into healthier food messages e.g. chocolate bars for sports.

Perhaps this should be something that the food industry and or Government could consider is about

- **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?**

Within the NHS there is great interest of effective and successful surgical intervention. It is clear that those trusts that are putting restrictions on people with high BMI or who are smokers are quoting evidence around complications around surgery, increased risks during and post operatively. Smokers on average seem to have 50 % more post operative complications and subsequently tend to stay as an in patient longer. So again it is the balance around risk and fiscal drivers complicated by the fact that people who are smokers or who have a high BMI are much more likely to require treatments and interventions earlier in their lives.

Confounding this can be those non smokers and those with lower BMI- many of higher socio- economic status with potentially increased articulation will potential be pushing for NHS services to be provided to people who don't "bring it on themselves"

I think that for me the answer is no it is not acceptable to make the provision of NHS service dependant on whether a person is obese or not. I do think however that people with high BMI and who are smokers need to be supported by the NHS and other agencies especially preoperatively to help them reduce their BMI or quit smoking to increase their recovery and to reduce their complications.

6. 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?**

In my view the tobacco industry and strong lobbying from the hospitality and other trades influencing, and perhaps employing, key politicians. One is also reminded of the Yes Prime Minster episode" The Smoke screen" aired in 1986 and the debate about what smokers contribute to the countries taxes

Jim Hacker: "Humphrey, we are talking about 100,000 deaths a year." Sir Humphrey: "Yes, but cigarette taxes pay for a third of the cost of the National Health Service. We are saving many more lives than we otherwise could because of those smokers who voluntary lay down their lives for their friends. Smokers are national benefactors."

- **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?**

There is the question should cigarettes be legal. They do kill a large proportion of users when they use the product as it is intended. There is no other product that manages this. The additive nature is perhaps something less important there are other products that many people could say that they are addicted to that don't cause the fatalities.

In the US there is an ongoing prosecution of the tobacco companies

- **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?**

Cigarette smoking still has a large social gradient so consideration has to be made about the societal contribution to cigarette smoking. If there were increased contributions then a portion of society who were already disadvantaged would have an additional burden and if we don't consider additional cost might we be considering rationing. It must be said that this type of approach would have an impact and provide another push for some people who want to quit to succeed however is this the way that we want to go. Should we be looking at a wider intervention that provides self esteem and confident building programmes in schools to stop children taking up smoking, should we be ensuring that we work with adults to identify why they continue to smoke and then work with them to reduce that and help them quit.

Perhaps it is here that we should ask the tobacco companies to intervene and support the 70% who profess that they want to quit to support them. However would a multi-billion industry want to take part in activity that will ultimately see their own demise?

I have great concern around the concept of deliberately or negligently increasing their chance of requiring public health resources- who is to decide what is a risk or not.

- **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?**

Not all smokers argue that they choose to smoke many say that they are addictive and they have to smoke- it's not quite the same.

The state should impose sanction on smoking where the smoke is impacting on others health and safety

The state has the right to prevent the sale of tobacco it just chooses not to exercise this right.

If the state wants to reduce the number of premature deaths and to decrease the burden on health and social care and treatment it is in their own interest to prevent children and teenagers from smoking

7. 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?

As with tobacco lobbying has played a large part plus the challenge that alcohol in small quantities does not seem to be harmful to health- although the claims about health enhancing qualities seem to be exaggerated. There is also a social role around alcohol- it was safe to drink long before water was in this country.

- **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?**

There is a cultural shift around alcohol and alcohol usage. In the last couple of decades alcohol use has been growing streadily with many parts of society drinking a lot more. Part of this is down to the increasing number of palatable and sweet drinks along side a sub culture of "lads and ladettes" and the going out and drinking lots to conform with peer expectations, part of it is about the growing number of socially acceptable places to drink alcohol e.g. wine bars and part is the increasing number of cheap alcohol, conveniently marked with alcohol content for those parts of society who want to get drunk cheaply. I think that the lessons of prohibition with the US shows that limiting alcohol is not the simple answer around alcohol consumption. Certainly as a person with a lead on sensible drinking this is something that many of us are racking our brains around this issue. It seems to be a complex issue around societal norm and risk taking within younger people and escapism or dealing with stress for many older people combined with the increased availability of affordable, palatable drinks

There is a big challenge for retailers within the licensed trade and the role that they play around alcohol consumption. It may be that some of this can be covered around licensing laws and within the community safety agenda rather than the public health agenda.

8. 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 that the reason was that choice was offered rather fluoridation happening across the whole water system. I wonder if people given for example the opportunity of choosing if iodine was added to salt would campaign so vigorously?

I'm not sure if I can answer the question about the international difference in the acceptance of fluoridation of water but I know that in places with fluoridation I have seen much better oral health within children. I have worked in disadvantaged areas with fluoridated water and more affluent places without fluoride in the water and the difference was noticeable- those poorer children had much better teeth than the affluent. One of the most awful things a dentist has

to do it to extract children's teeth. In non fluoridated areas there are many more children who have all or nearly all their milk teeth extracted something that can be reduced with fluoride

- **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?**

There are examples e.g. Clean Air Act that demonstrate that to have country wide measures there needs to be national legislation otherwise there will be areas that opt out

- **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?**

There are plenty of examples seat belt legislation, tobacco control – I think that by waving the banner of choice implies that societal we have total freedom and, of course, we don't. Or rather many of society don't. There is the governance role of Government.

9. 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?**

All of the principles have some importance within public health and contribute to the whole however all have both their strengths and weaknesses and it could be argued that by asking for a subjective response you are building additional bias into this process.

Ethics is a study on morality a philosophy on what is "right" and "wrong" if you like, looking at the fundamental principles that define values and determine moral obligation or duty. So for example within public health it is clear that autonomy, as was stated in the consultation document, is not straightforward. What about these industries "tempting" people to eat calorific food with limited nutritional value? This of course challenges the concept of society and the role that people and businesses play.

It could be suggested that within UK society that there has been a paradigm shift societally about the role of autonomy i.e people being more responsible for their own health. Certainly there are also shifts, although maybe to a lesser degree but reflecting the first shift, in all the other principles within public health. Consent and trust are in many ways a construct of these shifts.

This is, of course not new and, historically, there have been shift in the other direction. It could be suggested that these principle and the importance they play in public health increases and decreases over time influenced by a variety of

factors including national governance. So responses to this question will, in all likelihood be influenced by this and the other drivers that influence the respondents own stance on ethics.

Personally I think that the harm principle is one that needs to have more importance, as for the rest I find that my opinion varies on the issue 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?**

See above comment- and quick answer no not easily beyond harm principle being top or near the top

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

Trust is important but as for the rest then each parent will be guided by a variety of principles based on their life circumstances and experiences- surely this is part of the challenge. Autonomy may impact on the harm principle. Nearly all parents want the very best for their children today's society makes it increasingly difficult for them to be certain that they are.

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.

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.