Public health: an ethical imperative?

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The Nuffield Council on Bioethics

- Established in 1991
- Independent body that examines ethical questions raised by advances in biology and medicine
- Contributes to policy making and stimulates debate
- 21 publications e.g. animal research, premature babies, genetic screening, pharmacogenetics
The report

- Ethical and policy framework
- Four case studies:
  - Infectious disease
  - Obesity
  - Alcohol and smoking
  - Fluoridation of water
Ethics in medicine and healthcare

Beauchamp & Childress (1979):

The ‘four principles of bioethics’

• Autonomy
• Justice
• Beneficence
• Non-maleficence
Public health concerns

• Determinants of disease are manifold

• It is not about ‘treating’ or ‘leaving’ individuals

• Importance of prevention

• Examples: Now:
  – Clean water
  – Sanitation
  – Seatbelts

• Now:
  - Heart disease
  - Liver and kidney
  - Infectious disease
The “nanny state”?  

- Individual freedom versus promotion of public health  
- JS Mill (1859) “On Liberty”  
  - Protect individual autonomy  
  - Justifications for state intervention:  
    - Prevent harm to others  
    - Care of the vulnerable  
    - Educate  
    - Provide public services
Beyond Mill: further considerations

- Consent
- Inequalities
- Promoting health
Whose job is it to ensure that we lead a healthy life?

Public health:
“The science and art of preventing disease, prolonging life and promoting health through the organised efforts of society”

• Individuals?
• Government?
• Industry?
• Others?
Public health and lifestyle choice?

Factors influencing ‘choices’

• Genetics
• Socioeconomics
• Businesses
• Government planning
• Access to health services
The Stewardship State

Aims to:
• Reduce the risks of ill health people impose on others
• Provide environmental conditions for good health
• Educate and inform
• Protect vulnerable groups
• Provide access to medical services
• Reduce inequalities

Whilst:
• Avoiding coercion
• Minimising intrusion into people’s lives
• Ensuring consent
### The intervention ladder

<table>
<thead>
<tr>
<th>Intervention</th>
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<tbody>
<tr>
<td>Eliminate choice</td>
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<tr>
<td>Restrict choice</td>
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<tr>
<td>Guide choice by disincentives</td>
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<td>Guide choice by incentives</td>
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<td>Guide choice by changing the default policy</td>
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<tr>
<td>Enable choice</td>
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<tr>
<td>Provide information</td>
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<tr>
<td>Do nothing</td>
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Applying the intervention ladder

- Proportionality
- Effectiveness
- Evidence
Case study: infectious disease
Background

Globally:

- infections cause over a fifth of all deaths
- a million children die each year from diseases preventable through vaccination

In the UK, infectious diseases account for:

- over 10% of deaths
- one in three GP consultations

New infectious diseases: one per year
Prevention through vaccination

• Three broad approaches to vaccination policy:
  – voluntary
  – incentivised
  – quasi-mandatory

Conclusions:
  – No justification for moving beyond voluntary system in UK for childhood vaccination
Surveillance

• Population surveillance using anonymised data
  – Conclusion: acceptable for predicting trends

• Notifiable disease surveillance using identifying data
  – Conclusion: acceptable for avoiding harm to others if invasion of privacy is minimised
Surveillance

• Global surveillance of infectious diseases is vital
• Problems if countries do not have capacity or do not cooperate
• Conclusions:
  – UK should enhance surveillance capacities of developing countries
  – WHO should explore virus isolates as ‘public good’
  – WHO should impress social responsibilities on pharmaceutical companies
Control

- Quarantine and isolation are at the top of the intervention ladder
- Conclusion: ethical justification involves weighing the harm principle with consent and avoiding intrusive interventions
Case study: obesity
Background

• Obese = BMI $\geq 30$
• Risk factor for range of chronic diseases
• 30,000 deaths a year in England are attributable to obesity
• 24% of women and 22% of men were obese in 2009 – trebled since 1980s
• Childhood obesity increased from 11% in 1995 to 15% in 2009
Causes of obesity

Highly complex causes:
• Food high in fat and sugar is cheaper and more available
• Eating out more
• Food is lower in protein
• Bigger portions
• Advertising
• Changes to transport patterns
• More lifts, escalators
• Reduction in manual jobs
• Labour-saving devices

Need ethical framework to determine intervention
Protecting children

• Obesity in children is a particular concern
• Schools are part of the bigger picture
• Conclusions:
  – Schools should encourage a more positive culture towards food, cooking and physical activity
  – Weighing young children is crucial but reduce risk of stigmatisation
  – Develop criteria for intervening in the home
Role of industry

• Consumer choices are influenced by availability and marketing
• The food industry has an ethical duty to help individuals to make healthier choices

• Conclusions:
  – Food industry should adopt the most effective labelling scheme, and if it does not, there is justification for legislation
Role of Government

• Energy expenditure levels have decreased

• Measures to increase expenditure:
  – segregating walking and cycling routes from heavy traffic
  – car-free zones in city centre
  – maintaining playgrounds

• Conclusion:
  – town planners and architects should be trained to encourage people to be active through design of buildings and spaces
Case study: alcohol and tobacco
Background: tobacco

- Alcohol and tobacco raise similar ethical issues, both legal, addictive harmful to users and others
- In 2009, 21% of adults were smokers, down from 39% in 1980.
- In 2009, 5% of 11-15 year olds were regular smokers.
- Smoking associated with 18% of all deaths in adults in 2010
- Smoking ban in 2007: welcomed
Background: alcohol

- There were 7,000 alcohol-related deaths in 2008, an increase of 24% since 2001.
- 16m people in the UK were classified as ‘hazardous drinkers’ in 2007
- Alcohol causes high level of harm to others: drink driving, accidents, violence
- Yet legislation on drinking has not been introduced as it has for smoking
Role of Government

• Government’s alcohol strategy has in the past focused on education campaigns and voluntary labelling.

• A new strategy is expected in 2012 – Government has indicated support for stronger interventions such as minimum pricing.

• We recommended:
  – Government should introduce more stringent measures to tackle drinking e.g. increasing tax, restricting hours of sale
  – Analysis of longer opening hours needed.
Protecting children

• Adverse effects of drinking and smoking on children is concerning

• Conclusions:
  – Banning smoking in the home would be very difficult to enforce
  – Intervention might be acceptable if child at very high risk of harm
  – Alcohol and tobacco industries should take more responsibility for preventing harm to child health
Conclusions

• Many major health issues cannot be adequately addressed through medical treatment models
• The preventative approach of public health is vital
• Claims of ‘nanny statism’ can be challenged
• An ethical justification for public health interventions can be made
• Indeed, evidence-based, proportionate interventions could be seen as an ethical imperative