NUFFIELD COUNCIL ON BIOETHICS 20 YEARS

28 Bedford Square
London WC1B 3JS
Telephone 020 7681 9619
Fax 020 7637 1712
bioethics@nuffieldbioethics.org
www.nuffieldbioethics.org

15 March 2011

Public Health Consultation
Department of Health
Room G13, Wellington House
133–155 Waterloo Road
London SE1 8UG

Dear Sir / Madam

Thank you for the opportunity to comment on the Government's strategy for public health in England, *Healthy Lives: Healthy People*. My comments are drawn from the Nuffield Council on Bioethics report *Public health: ethical issues*, published in November 2009.[1]

Intervention ladder

We welcome the use in the White Paper of the Council's ladder of interventions, which shows the range of interventions available to policy makers, from the least to the most intrusive.

I would like to clarify, however, that the intervention ladder is not in itself a model or strategy for public health (as suggested in the Government's press release on the White Paper).[2] The function of the ladder is to compare alternative approaches in terms of their intrusiveness and likely acceptability. Different interventions will be appropriate depending on the problem and the context. Any intervention implies value judgements about what is or is not good for people, and requires justification. The higher the rung on the ladder, the stronger the justification has to be.

Coupled with the intervention ladder, therefore, is the Council's 'stewardship' model, which provides the main basis for designing public health programmes and justifying interventions. The core characteristics of public health programmes carried out by a stewardship-guided state can be summarised as follows.

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 appropriate housing;
- pay special attention to the health of children and other vulnerable people;
- promote health not only by providing information and advice, but also by programmes to help people 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 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;
- seek to minimise interventions that are perceived as unduly intrusive and in conflict with important personal values.

We are pleased to see many of these characteristics recognised in the White Paper. However, it would be helpful to see explicit reference to the Government's programme to reduce health inequalities in England, and how the public health strategy will link with this.

Nudging

In several places in the White Paper, the Government stresses that it will use the least intrusive approach to achieve the desired effect, focussing on enabling and guiding people's choices wherever possible. It states: "There is significant scope to use approaches that harness the latest techniques of behavioural science to do this – nudging people in the right direction rather than banning or significantly restricting their choices."

While we support applying policies that achieve the desired social goals while minimising significant limitations on individual freedom, the evaluation of public health interventions cannot always start at the bottom. Depending on the evidence, stronger measures might be required from the start.

In addition, it is important to recognise that 'nudging' is still a rung, albiet fairly low down, on the intervention ladder and will require justification. It is also important to note that non-intervention is not always to be preferred over intervention, as 'doing nothing' will often have adverse consequences for many people.

Evidence

This leads on to the important issue of evidence. The White Paper states "A culture of using the evidence to prioritise what we do and test out innovative ideas needs to be developed, while ensuring that new approaches are rigorously evaluated and that the learning is applied in practice." We agree.

In the context of public health, there are two areas where consideration of relevant research findings is especially important: first, evidence about causes of ill health; and secondly, evidence about the efficacy and effectiveness of interventions. Ideally, evidence should be based on peer-reviewed research, and not on preliminary results or unpublished reports. Selective use of evidence or 'policy-based evidence' that has been commissioned or interpreted to support existing or planned policies is unhelpful.

The role of third parties

We welcome the Government's commitment to ensuring the corporate sector recognise and act on their public health responsibilities. We believe that if there is a lack of corporate responsibility, or a 'market failure' (i.e. the corporate sector fails to deliver on its responsibilities), it is acceptable for the state to intervene where the health of the population is significantly at risk. This, combined with evidence of 'what works', was the justification for a number of recommendations on alcohol consumption and obesity by the Council. For example, in 2009 the Council recommended:

- *Businesses, including the food industry, have an ethical duty to help individuals to make healthier choices. The food and drink industries should therefore review both the composition of products that they manufacture and the way they are marketed and sold. Where the market fails to uphold its responsibility, for instance in failing to provide universal, readily understandable front-of-pack nutrition labelling or in the marketing of food more generally, regulation by the government is ethically justifiable.*

  Research by the Food Standards Agency found that a single front-of-pack labelling system that combined traffic light colour coding, high/medium/low text, and %GDA information would be most effective. However, retailers continue to use a range of different labelling schemes.

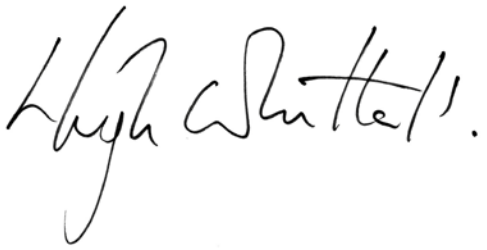
- *We recommend that evidence-based measures judged effective in the WHO-sponsored analysis* Alcohol: No ordinary commodity *are implemented by the UK Government. These include coercive strategies to manage alcohol consumption, specifically in the areas of price, marketing and availability.*

  We welcome the Government's commitment to tackle excessive alcohol consumption by, for example, banning the sale of alcohol below cost price and increasing fines for those caught selling alcohol to children. However, alcohol-related harm is still a major public health problem and further action

may be required, for example, making alcohol much less affordable by setting a minimum price per unit, as recommended by the National Institute for Health and Clinical Excellence.

Please do not hesitate to contact me if you would like to discuss any of these points further. Full details of the Council's report and recommendations are available through the Council's website at www.nuffieldbioethics.org/public-health

Yours sincerely



Hugh Whittall
Director, Nuffield Council on Bioethics

Email: hwhittall@nuffieldbioethics.org
Tel: 020 7681 9619

[1] Nuffield Council on Bioethics (2009) *Public health: ethical issues*. London: Nuffield Council on Bioethics. www.nuffieldbioethics.org/public-health
[2] Department of Health. *Public Health England – A new service to get people healthy*. 30 November 2010. http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_122249