

The importance of public-health ethics

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Whose responsibility is health? Is it purely a matter of individual choice or do governments have a role to play? What about others, such as businesses, employers and health professionals: do they also have responsibilities? Discussions of these issues in the media reveal a whole spectrum of views. These vary from considering any curbing of our freedom to do as we please as infringements by the pernicious “nanny state”, to crying “someone should do something” to tackle public-health problems such as obesity, excessive drinking or smoking.

The central ethical dilemma, therefore, in public health, is to balance respect for individual freedom and liberty with the responsibility of governments to provide their citizens with some degree of protection in relation to health. Nowadays, few would argue with governments’ role in ensuring that certain basic services, such as clean air and water, are provided. Measures that were previously hotly contested and seen as “nanny state interference”, such as pasteurization of milk and fortification of white bread, are no longer contentious.

But in the 21st century in developed countries, many of the major questions of public-health policy relate to so-called “lifestyle factors” that influence the risks of major killers such as heart disease and cancer. Here people often refer to “lifestyle choices”, but the notion of “choice” can be troublesome, as choices are often constrained by the actions of others, such as industry and government, and by socioeconomic, environmental and genetic factors. Therefore, the ethical justification for government intervention to promote public health deserves close scrutiny.

In traditional bioethics, much emphasis is placed on the freedom of the individual. However, in public-health policy, some measures might constitute minor infringements of a person’s freedom but bring about significant benefit for a large number of people, hence the

need to balance freedoms with community benefits.

In November 2007, the Nuffield Council on Bioethics published a report *Public health: ethical issues*,¹ based on the findings of a working party that I chaired. The report tackles these very issues and sets out a model for public-health ethics which we call the “stewardship model”. The term stewardship in this context has previously been used by WHO² and the King’s Fund.³ In our considerably expanded version, we provide a framework that specifies the responsibilities that liberal governments have in terms of addressing the needs of the population as a whole. Our stewardship model recognizes that governments should not coerce people or restrict their freedom unnecessarily. It also stresses that governments have a responsibility to provide the conditions under which people can lead healthy lives. In addition to protecting its citizens from harm caused by others, the “stewardship state” has a particular responsibility for reducing health inequalities and protecting the health of vulnerable groups such as children.

One of the ways in which the somewhat abstract philosophical model is translated into policy is by applying what we call the “intervention ladder”. This is a tool that enables one to rank public-health measures according to their coerciveness or intrusiveness. The higher up the ladder an intervention ranks, the stronger the need for justification and sound evidence for implementation. An example of a measure at the top of the ladder is that of compulsory quarantine or isolation in the event of an outbreak of infectious disease; both clearly involve a significant infringement of liberty. We suggest that these measures may be ethically justified where the harm to others can be significantly reduced.

Public-health ethics are also an important consideration at an international level. One area we consider is that of the activities of tobacco companies

in developing countries and the concept of corporate social responsibility. It is well established that tobacco is a highly harmful product. In many developed countries, companies adhere to harm reduction strategies, such as bans on advertising and restricting the availability of tobacco to children. If tobacco companies are serious about their responsibilities, they will universalize such practices in all areas in which they operate.

The international context also matters in the case of infectious disease, since infections do not respect national borders. Furthermore, countries differ in their capacities to monitor and respond to outbreaks. The Nuffield Council’s Working Party argued that the stewardship model can also be applied at the global level. In this context it means that developed countries have obligations to assist developing ones, for example in terms of enhancing surveillance capacity. At the same time, developing countries have obligations to cooperate with international surveillance and control efforts, although clearly the terms of cooperation require close scrutiny. In the report, we discuss Indonesia’s recent refusal to share influenza virus isolates with the WHO-sponsored surveillance system.¹

In conclusion, public-health ethics is important for three main reasons: (i) the fundamental issues raised in public health over the role of governments; (ii) the shortcomings of existing models in bioethics for dealing with such issues; and (iii) the global relevance of health and public health that makes these issues so pertinent. ■

References

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