

Monographs of
the Víctor Grífols 27
i Lucas Foundation

Ethics and public health

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INTRODUCTION

Far less attention has been paid to ethics from a public health perspective than from a medical perspective. The initial impetus behind the development of medical ethics came in response to the discovery of the atrocities carried out in the name of clinical experimentation in Nazi concentration camps. Subsequently, ethics extended into the field of clinical care, patient rights and, in particular, the concept of patient autonomy.

By contrast, public health has been somewhat neglected by ethics, despite the fact that health practice faces a variety of ethical challenges, including potential conflicts of interest, whether involving individuals, groups or society as a whole (what was once referred to as “the common good”).

This neglect may to a degree have been concealed by the habitual recourse to utilitarianism when it comes to establishing priorities and designing collective health interventions, but it has surely also reflected the continuing influence on the public health movement of the traditions of enlightened despotism.

However, over recent years we have seen the start of initiatives designed to make up for lost time, and to promote the application of ethics to a range of areas within public health, and the application of ethics to professional practice. While these initiatives have had little impact on the public health sphere at either an academic or a professional level in Spain, they nonetheless provide a good basis for making up some of the lost ground.

While public health activities across the board could benefit from the application of ethical considerations, we must also remain alert to the potential for abuse, such as using ethics as a pretext for infringing the very principles and values we seek to defend. In this context, the paper by Ricard Meneu has particular relevance, addressing as it does the question of the scope, the role and the limits of an ethical perspective for those working within the public health sphere. In order for this perspective to be combined with that of participants from ethics, philosophy and the law, we need to promote contact

between these different areas and to facilitate mutual understanding and the exchange of ideas. This point is drawn out by Joan Pons in his summary of the event.

We were particularly grateful for the contribution of Ildelfonso Hernández, who delivered the second paper of the seminar. Until just a few months ago he held responsibility for Public Health within the Spanish Government. His experiences and analysis are of particular relevance, giving us as they do a detailed insight into the effects of applying ethics to public health plans and programmes, including the early drafts of Spain's new public health legislation, which came into force in October 2011 and makes explicit reference to the rights and duties both of citizens and of the administration. In this context, ethical assessments are likely to acquire increasing relevance in guiding our judgements about health interventions. Hernández discusses this development with reference to the debate around the response of the health authorities to large-scale problems such as the recent flu pandemic.

The final paper, which I delivered, sought to map out a basis for the ongoing work of the participants and of those who we hope will join us in the future. I invited the ideas, contributions and suggestions of those present, and also provided a brief introduction with the aim of providing a shared language for discussing public health, the functions it performs and the activities of which it consists. In his summary, Joan Pons also stressed the need to raise awareness among those involved in education, accreditation and implementation in public health.

Andreu Segura
Coordinator

**Aspects and issues in
public health which
require a specific,
individual ethical
analysis**

Ricard Meneu

*Vice-president of the Health Services Research
Institute Foundation of Valencia*

Initial considerations

If, as I believe, the ends of men are many, and not all of them are in principle compatible with each other, then the possibility of conflict – and of tragedy – can never wholly be eliminated from human life, either personal or social.

Berlin, I. “Two Concepts of Liberty”. In Berlin, I. *Four Essays on Liberty*. Oxford: Oxford University Press, 1969.

The purpose of these pages is to help delineate the specific features of public health which may require us to adapt the usual approaches of bioethics. We need to start by recognizing the fact that we have historically been very slow to take ethical issues into account in the area of public health in general and in its practice with respect to other areas of health (bioethics) and public intervention (governance).

During the past decade there has been a desperate attempt to make up lost ground, as evidenced internationally by a profusion of academic publications designed to analyse and classify the issues at stake, together with the issuing of regulations, proposed codes of ethics and other applied documents. Inevitably, all of these documents are underpinned by a whole range of judgements, values, conceptual frameworks, preferences and beliefs – with, needless to say, some represented more heavily than others – with the result that they are not always fully compatible.

In Spain, the equivalent activity has been, to put it politely, somewhat scarce. Despite this, in an act of blind optimism, we have set ourselves the goal today of establishing “elements and criteria for the design of a programme in ethics and public health”. Given that it would be somewhat premature to set out a curriculum before clarifying its content, I have taken a cautious approach; one which, without wishing to seem pessimistic, seeks a fruitful space between the two extremes of “paralysis by analysis” and “teaching what one doesn’t know”.

To this end, the document which follows concentrates on identifying a range of contributions which may help to map out the issues raised in the title: “Aspects and issues in public health which require a specific, individual ethi-

cal analysis”. In order to reduce to a minimum interference arising from the subjective viewpoint of the compiler, this document is presented as a patchwork which brings together texts, lists and opinions from around 100 relevant sources. Differences in the analytical quality, relevance and focus of these texts means the reader must be warned of one obvious fact: that we should not confuse the map with the territory. The map is neither complete nor absolutely precise, while the territory itself cannot be captured with the perfection described in Borges’ famous short story *On Exactitude in Science*, which describes a map so detailed that it was the same size as the empire it depicted!

It should instead be approached like the directions jotted down on a scrap of paper to inform a passing visitor about (part of) the terrain through which he wishes to travel. Some features will be emphasized, many potholes and ditches will be omitted, and a few of the least appealing routes will be ignored. This may seem like a limited ambition, but it is worth considering the alternative of jumping on a “public health ethics in a nutshell” tour bus to listen to the droning of a misinformed guide.

This having been said, I should also warn the reader of the inevitable bias of any anthologist, above and beyond the question of omissions and inclusions. In the selection which follows, I have placed special emphasis on my particular concern to ensure that, before taking decisions about health – and establishing a corpus of documents contributes to such decisions – we should consult the interested parties. I also have a special interest in conflicts with the principle of autonomy, by which I mean my autonomy as a citizen, not as a health professional. And this is something I address at the end.

Some perspectives on public health and ethics

Almost a quarter of a century ago, Peter Skrabanek, the man who coined the term *skepticaemia*, made a sensible observation in the *Journal of Medical Ethics*:

It is a paradox that medical experimentation on individuals, whether patients or healthy volunteers, is now controlled by strict ethical guidelines, while no such protection exists for whole populations which are subjected to medical interventions in the name of preventive medicine or health promotion. As many such interventions are either of dubious benefit or of uncertain harm–benefit balance, such as mass screening for cancers or for risk factors associated with coronary heart disease, there is no justification for maintaining the ethical vacuum in which preventive medicine finds itself at present.

Skrabaneck, P. “Why is preventive medicine exempted from ethical constraints?” *Journal of Medical Ethics*, 16, 1990, pp. 187–190.

More recently, when concern for ethical analysis of public health was beginning to manifest itself, *The Lancet* offered a very incisive observation:

Public-health decisions commonly involve conflicting and ambiguous ethical principles. Ideas like *efficiency*, *human rights*, *cultural respect*, *equity*, and *individual choice* are commonly invoked but rarely analysed in public-health debates.

Roberts, M. J. and Reich, M. R. “Ethical analysis in public health”. *Lancet*, 359, 2002, pp. 1055–9.

Let us look at some other recent statements on this issue:

In the arena of Public Health, it would seem that to ignore ethical tensions between communal and individual interests would be *prima facie* poor professional practice, for Public Health issues are constitutively concerned with the relationship between public and private “goods”.

Hester, D. MA. “Professing public health: Practicing ethics and ethics as practice”. In Boylan, M. (Ed.). *Public health policy and ethics*. Springer Science, 2005.

Within the vast enterprise of public health, decisions about issues involving ethics have been and continue to be made on a daily basis without explicit reference to ethical principles and concepts from the formal discipline of bioethics.

Kahn, J. and Mastroianni, A. “Public health and bioethics”. In Steinbock, B. (Ed.). *The Oxford handbook of bioethics*. OUP, 2007.

Medical ethics, focused on doctor/patient relationships, is widely discussed and taught to medical students. But a comparable field of public-health ethics is not as well developed to guide public-health practitioners.

Roberts, M. J. and Reich, M. R. “Ethical analysis in public health”. *Lancet*, 359, 2002, pp. 1055–9.

It is accepted that the recommendations applied in the field of clinical care (in which the ethical principles of autonomy and non-maleficence predominate) are not generally suited to the field of public health (where the principles of justice and beneficence predominate).

Tormo Diaz, M. J. “Recensión de Coughlin, S. S., Soskolne, C. L., Goodman, K. W. Case studies in public health ethics”. American Public Health Association, Washington, DC 1997. *Rev. Esp. Salud Pública*, vol. 73, no. 1, 1999.

The American Public Health Association’s “Principles of the Ethical Practice of Public Health” (<http://www.apha.org/codeofethics/ethics.htm>) strikes me as most admirable and useful. For their intellectual quality, commitment, and energy, those responsible for filling such an important gap in public health practice deserve commendation and gratitude from all of us in this field. However, I am also struck by the total absence of public representation in the drafting and review of this document.

Lear, W. J. “Where’s the public in public health ethics?”. *Am. J. Public Health*, 93(7), 2003, p. 1033.

This well-remarked absence of the public from reflections upon the ethics of public health is all the more striking when one considers that public health is carried out in the public’s name. One of the most important documents published during recent years, the Nuffield Trust publication “Public health: ethical issues” defines the context of the debate as follows:

Public health measures raise complex questions about the relationship between the state and the individuals and organisations that are affected by its policies. They also raise questions about the duties that individuals have towards each other. A substantial body of literature in political philosophy examines these relationships of duties and entitlements.

(...) The central issue in public health is the extent to which it is acceptable for the state to establish policies that will influence population health.

“Public health: ethical issues”. *Nuffield Council on Bioethics*, 2007.

Aspects and issues in public health

Establishing the correct ethical framework for the consideration of Public Health is an issue which must be addressed before we consider the question of education. The basic options range from those who argue for the application of the framework generally adopted by bioethics to those who advocate an ethical approach which is specific to public health issues.

A number of arguments are adduced in favour of the need for a specific ethical framework, including the fact that the relationship between public health actions and the individuals who belong to the affected populations is very different from the doctor–patient relationship. From this, it is argued that mainstream bioethics is not applicable. For example, according to Upshur:

- The focus of public health is directed to populations, communities and the broader social and environmental influences of health.
- As well, there is a greater focus on prevention than on treatment or cure.
- Public health practice differs substantially from clinical practice. The context, mandate and range of activities carried out by public health practitioners encompass a wide set of considerations:
 - Most public health departments are part of state, provincial or federal governments.
 - The overarching concern for the individual patient found in clinical ethics is not neatly analogous to a concern for the health of a population.
 - As well, there is no clear analogy to the fiduciary role played by physicians.

Simply put, populations are constituted by diverse communities of heterogeneous beliefs and practices. These may at times come into conflict. Individual versus community rights and conflicts within and between communities/ are the more likely locus of ethical reflection in public health practice.

Hence, public health ethics must recognize and be able to reason through issues relating to:

- social, political and cultural contexts;
- the existence of competing values and perspectives;
- and perhaps, incommensurable world views.

Given these considerations, it is clear that the straightforward application of the principles of autonomy, beneficence, non-maleficence and justice in public health practice is problematic.

Upshur, R. E. G. “Principles for the justification of public health intervention”. *Canadian Journal of Public Health*, 93, 2, 2002, pp. 101–3.

Other arguments in favour of a specific approach stress the many distinctive features of ethical analysis in public health. For example, the Stanford Encyclopedia of Philosophy states:

There is no standard way of organizing the ethics of clinical practice, public health and biomedical science. Whichever approach is preferred, a key question remains: What distinguishes public health ethics from medical ethics? The answer lies in the distinctive nature of public health. Public health has four characteristics that provide much of the subject matter for public health ethics:

1. it is a public or collective good;
2. its promotion involves a particular focus on prevention;
3. its promotion often entails government action; and .
4. it involves an intrinsic outcome-orientation.

Faden, R. and Shebaya, S. “Public Health Ethics”. In Zalta, E. N. (Ed.). *The Stanford Encyclopedia of Philosophy*, <http://plato.stanford.edu/archives/sum2010/entries/public-health-ethics/>

Although it is less common to go from this rejection of the bioethical framework to an in-depth analysis of the implications of such a conclusion, it can certainly be argued that concern at the imposition of obligations or restrictions on healthy citizens (using the coercive powers of the state) in the name of potential aggregate improvements requires greater justification than is currently offered.

Various studies have considered some of the specific features of public health and their implications, although rarely with the aim of providing a comprehensive overview. The main aspects considered refer to the problems of an almost universal “domain of application” and a non-specific definition of *health* – often influenced by an unquestioning *imperialism* in its scope and a worrying equation of health with *welfare* – combined with the multiple meanings covered by the term *public* (or “populations”).

Below we will quickly pass over the question of the scope of public health (the “strict” or “classical” doctrine *vs.* the “broad” one embodied by the “new public health”) and we will sidestep the debate around the definition of *health*. However, it should be noted that much of the literature assumes that health is the *good* to be maximized, above any other utility or desire, equating it with *well-being* or assuming on the part of the public a desire to maximize it regardless of any utilitarian analysis of so doing.

As Rickles argues in a recent, well-regarded text on the philosophy of science:

What is considered part of the domain of applicability of public health is flexible to the point of near universal inclusivity: almost anything can be viewed as a public health issue.

Rickles, D. “Public Health”. In Gifford, F. (Ed.). *Handbook of the Philosophy of Science*. Vol. 16 (available at <http://philsci-archive.pitt.edu/5322/1/PubHealth%28Rickles%29.pdf>).

Defining and measuring “health” is not easy, as we will emphasize below, but, in addition, “public” is a complex concept with at least three dimensions that are important for our discussion of ethics.

1. Public can be used to mean the “numerical public,” i.e., the target population. (...) In measurement and analysis, the “numerical public” reflects the utilitarian view that each individual counts as one and only one. [considerations of justice]
2. Public is what we collectively do through government and public agency – we can call this “political public.” The state’s use of its police powers for public health raises important ethical questions, particularly about the justification and limits of governmental coercion and about its duty to treat all citizens equally in exercising these powers. In a liberal, pluralistic democracy, the justification of coercive policies, as well as other policies, must rest on moral reasons that the public in whose name the policies are carried out could reasonably be expected to accept.
3. Public, defined as what we do collectively in a broad sense [...] Ethical analysis on this level extends beyond the political public.

Childress, J. F.; Faden, R. R.; Gaare, R. D.; Gostin, L. O.; Kahn, J.; Bonnie, R. J.; Kass, N. E.; Mastroianni, A. C.; Moreno, J. D. and Nieburg, P. “Public Health Ethics: Mapping the Terrain”. *Journal of Law, Medicine & Ethics*, 30, 2002, pp. 169–177.

The meaning of the term *public* in pronouncements upon public health, then, is almost as varied as that of its companion, *health*. For a review of the different perspectives encompassed by a single term, see the interesting essay by Verweij and Dawson.

Verweij, M. and Dawson, A. “The meaning of “public” in “public Health”. In Dawson and Verweij (Eds.). *Ethics, prevention and public health*. OUP, 2007 (available at: <http://fds.oup.com/www.oup.co.uk/pdf/0-19-929069-5.pdf>).

Add to this the fact that:

Government public health actions present at least two types of ethical/political challenges:

- One set of challenges focuses on the scope of public health, e.g., does government have a public health duty to prevent chronic disease by addressing behavioral (sedentary lifestyle) or socioeconomic (poverty) risk factors?
- Another set of ethical challenges involves the appropriate means of public health intervention, e.g., should government outlaw risk-taking behavior such as riding a bicycle without a helmet? When is the state justified in quarantining a noncompliant patient with tuberculosis?

The state’s use of its police power, particularly in paternalistic or coercive policies, raises important ethical questions for a liberal, pluralistic democracy.

Childress, J. F. and Gaare Bernheim, R. *Public health ethics. public justification and public trust*. Bundesgesundheitsbl, Gesundheitsforsch, Gesundheitsschutz, 51, 2008, pp. 158–163.

Although there is a widely held disregard for these concerns, which questions the relevance of liberty and autonomy as concerns of the English-speaking world with little relevance to Spain, the question is very far from being of merely academic interest, going as it does to the very heart of our accepted rules for living together.

Ethical issues raised by this conflict in public health include:

- the government’s role in coercing or influencing health-related behaviour;
- the use of incentives (economic or otherwise) to promote health;

- the balance between public interventions and individual autonomy;
- the definition of a socially acceptable level of risk;
- the fair distribution of risks and benefits among the population;
- the need to provide definitive answers or recommendations on the basis of uncertain data;
- compulsory interventions (screening, testing, vaccination, etc.) administered in a way that does not follow the requirements of informed consent;
- equitable access to health care;
- reduction in health status disparities.

Petrini, C.; Gainotti, S. and Requena, P. *Personalism for public health ethics*. Ann Ist Super Sanità, 46, 2, 2010, pp. 204–9.

To summarize, ethical problems in public health are identified when individual rights and the public interest come into conflict.

Beauchamp, D. E. and Steinbock, B. “Population perspective”. In Beauchamp, D. E. and Steinbock, B. (Eds.). *New ethics for the public’s health*. New York: Oxford University Press, 1999.

A specific, individual ethical analysis

Having set out some of the arguments to the effect that some aspects of public health provide a justification for a distinctive approach which is separate from the general domain of bioethics, and before addressing – in Ildelfonso Hernández’s text – a set of case studies of “public health issues”, we will now seek to define in broad terms what “a specific, individual ethical analysis” might consist of.

A basic classification could fall into one of two categories: the insistence that bioethical principles can be applied to public health practice, with greater or lesser adaptations – which, if true, would mean there would be no need to extend this section – and attempts to extend, revise or replace the existing bioethical framework.

Together with those texts which advocate a specific approach, it should also be noted that there are the views of well-known supporters of the principlist approach, and these are presented before the attempts to refute them.

Public health ethics, like the field of public health it addresses, traditionally has focused more on practice and particular cases than on theory, with the result that some concepts, methods, and boundaries remain largely undefined.

Childress, J. F.; Faden, R. R.; Gaare, R. D.; Gostin, L. O.; Kahn, J.; Bonnie, R. J.; Kass, N. E.; Mastroianni, A. C.; Moreno, J. D. and Nieburg, P. “Public Health Ethics: Mapping the Terrain”. *Journal of Law, Medicine & Ethics*, 30, 2002, pp. 169–177.

[A]t its core, public health introduces tensions between individuals’ autonomy and the need to account for perspectives and needs of communities and populations (...) there is a fundamental tension between utilitarian approaches embodied in the collective values of public health and a principles-based approach which strongly supports the protection of individuals.”

Kahn, J. and Mastroianni, A. “Public health and bioethics”. In Steinbock, B. (Ed.). *The Oxford handbook of bioethics*. OUP, 2007.

One view of public health ethics regards the moral foundation of public health as an injunction to maximize welfare, and therefore health as a component of welfare. This view frames the core moral challenge of public health as balancing individual liberties with the advancement of good health outcomes.

An alternative view of public health ethics characterizes the fundamental problematic of public health ethics differently: what lies at the moral foundation of public health is social justice. While balancing individuals’ liberties with promoting social goods is one area of concern, it is embedded within a broader commitment to secure a sufficient level of health for all and to narrow unjust inequalities.

Faden, R. and Shebaya, S. “Public Health Ethics”. In Zalta, E. N. (Ed.). *The Stanford Encyclopedia of Philosophy*. <http://plato.stanford.edu/archives/sum2010/entries/public-health-ethics/>

Public health ethics’ has recently emerged as a specialized sub-discipline of bioethics devoted to “those ethical issues and perspectives that may be said to be distinctive to public health. apart from the perspective of clinical medicine”. [...] Ethics flows into politics too when we consider that the policies thus imposed often constrain the liberties of people in some way or other (e.g. the enforcing of seat-belt wearing; the banning of smoking in public places, etc.). Hence, though related to issues found in clinical medicine, public health throws up issues that appear to be *sui generis*.

Rickles, D. "Public Health". In Gifford, F. (Ed.). *Handbook of the Philosophy of Science*. Vol. 16 (available at <http://philsci-archive.pitt.edu/5322/1/PubHealth%28Rickles%29.pdf>)

There is one other issue we must address before we seek to apply to public health "a specific, individual ethical analysis". This is the attempt to establish the scope of application of each contribution or debate, while distinguishing between principles and practice, in a free-for-all which adds little to the quality of analysis.

In the words of Callahan: "Just as public health is broad in its scope, the range of ethical issues in the field is uncommonly wide, encompassing ethics *in* public health as well as the ethics *of* public health".

Callahan, D. and Jennings, B. "Ethics and Public Health: Forging a Strong Relationship". *Am. J. Public Health*, 92, 2002, pp. 169–176.

Or, as Gostin has argued: "A problem when defining the sphere of ethics in public health is the wide scope of public health activities." Gostin distinguishes between:

The ethics *of* public health: concerned with the ethical dimensions of professionalism and the moral trust which society places in professionals to act for the common good.

Ethics *in* public health: incorporates the ethical dimensions of the public health undertaking; the moral concern with the health of the population; the balance between collective goods and individual interests, and considerations of justice.

Ethics *for* public health: the value of healthy communities, the interests of the population, particularly the weak and the oppressed; and pragmatic methods.

Gostin, L. O. "Public health, ethics, and human rights: A tribute to the late Jonathan Mann". *J. Law Med. Ethics* 29(2), 2001, pp. 121–130.

Even if one does not agree with his use of prepositions, it seems clear that the first aspect which requires attention is the one he labels as ethics *in* the principles of public health. The focus of these principles relates to the question of *when public health action is justified*. Hence, the locus of application of these principles is restricted to a specific, but significant domain. The principles

articulated will not, for example, cover screening and prevention programs, health promotion programs or public health research.

- Harm principle (Mill).
- Least restrictive or coercive means (Siracusa).
- Reciprocity principle (Harris and Holm, 1995: 1215–17).
- Transparency principle (Habermas).

Methods, models and frameworks for ethical analysis in public health

Having sketched out the terrain, we can now consider the case for a specific ethical framework for public health, building upon some of the frameworks of those who have preceded us in this endeavour:

We seek to fill that gap by providing a method for describing and analysing the major ethical ideas invoked in discussions of public-health policy. Our approach sorts ethical arguments into three major categories, each representing a major theme in contemporary public-health discourse:

- utilitarianism, which asserts that decisions should be judged by their consequences, in particular by their effect on the sum total of individual wellbeing;
- liberalism, which is focused on rights and opportunities, on where people start, not on where they end up;
- and communitarianism, which involves visions of an appropriate social order and the virtues that will maintain such an order in a particular community.

Roberts, M. J. and Reich, M. R. "Ethical analysis in public health". *Lancet*, 359, 2002, pp. 1055–9.

Or, more widely, using the models listed by Petrini: utilitarianism, deontological theories, communitarian ethics, egalitarian theories, liberalism, contractualist theories, personalism and casuistry.

Petrini, C. "Theoretical models and operational frameworks in public health ethics". *Int. J. Environ. Res. Public Health*, 7, 2010, pp. 189–202.

In the face of conflicts between the moral considerations which we “assume” to be embodied in the objectives of public health (to produce benefits, avoid harm, maximize utility) and other moral commitments, Upshur propose five “justified conditions”: effectiveness, proportionality, necessity, least infringement and public justification:

If the public philosophy of the pluralist, liberal democracies establishes assumptions in favour of freedom, privacy, confidentiality, etc., in the selection of public health interventions, then our moral discourse with regard to public health policies, their practice, and the specific decisions must start with these assumptions.

However, these are only assumptions and, as such, may be refuted. It is therefore important to identify the conditions under which they may be refuted, what we term “justified conditions” which indicate when the assumption in question may justly be refuted.

We will identify five “justificatory conditions”:

1. effectiveness
2. proportionality
3. necessity
4. least infringement
5. public justification

These conditions are intended to help determine whether promoting public health warrants overriding such values as individual liberty or justice in particular cases.

Upshur, R. E. G. “Principles for the justification of public health intervention”. *Canadian Journal of Public Health*, 93, 2, 2002, pp. 101–3.

Recently Kass (2001) and others (Childress *et al.*, 2002) have convincingly argued that public health ethics deserves its own place within bioethics: that public health is distinct in its history and application in comparison to the dominant individual rights orientation reflected in the more established bioethics approaches based in medicine and research.

Kahn, J. and Mastroianni, A. “Public health and bioethics”. In Steinbock, B. (Ed.). *The Oxford handbook of bioethics*. OUP, 2007.

One of the authors, Kass, proposes a 6-step framework:

1. What are the public health goals of the proposed program?
2. How effective is the program in achieving its stated goals?
3. What are the known or potential burdens of the program?
4. Can burdens be minimized? Are there alternative approaches?
5. Is the program implemented fairly?
6. How can the benefits and burdens of a program be fairly balanced?

This is not a code of professional ethics, which more likely would address general norms and expectations of professional behavior and probably would be the product of a professional society. Rather, this is an analytic tool, designed to help public health professionals consider the ethics implications of proposed interventions, policy proposals, research initiatives, and programs.

Kass, N. E. “An ethics framework for public health”. *Am. J. Public Health*, 91, 2001, pp. 1776–82.

To clarify the difference between such a framework and a “professional code”, Annex 1 provides a document of this sort, the “Principles of the Ethical Practice of Public Health” of the Public Health Leadership Society.

Childress has framed a set of criteria similar to those of Kass, identifying what he calls “general moral considerations in public health ethics”. These echo the emphasis of Kass on considerations of justice, but stress the tension between respect for individual rights and the collective good.

Sometimes, in particular cases, a society cannot simultaneously realize its commitments to public health and to certain other general moral considerations, such as liberty, privacy, and confidentiality.

An important empirical, conceptual, and normative issue in public health ethics is the relationship between protecting and promoting the health of individuals and protecting and promoting public health. But suppose the primary reason for some restrictions on the liberties of individuals is to prevent harm to those whose actions are substantially voluntary and do not affect others adversely.

Coercive intervention in the name of strong paternalism would be insulting and disrespectful to individuals because it would override their voluntary

actions for their own benefit, even though their actions do not harm others. Such interventions are thus very difficult to justify in a liberal, pluralistic democracy.

Childress, J. F.; Faden, R. R.; Gaare, R. D.; Gostin, L. O.; Kahn, J.; Bonnie, R. J.; Kass, N. E.; Mastroianni, A. C.; Moreno, J. D. and Nieburg, P. "Public Health Ethics: Mapping the Terrain". *Journal of Law, Medicine & Ethics*, 30, 2002, pp. 170–8.

Within a conceptual framework for thinking about and resolving conflicts, the relevant general moral considerations include:

- producing benefits;
- avoiding, preventing, and removing harms;
- producing the maximal balance of benefits against harms and other costs (often called utility);
- distributing benefits and burdens fairly (distributive justice) and ensuring public participation including the participation of affected parties (procedural justice);
- respecting autonomous choices and actions, including liberty of action;
- protecting privacy and confidentiality;
- keeping promises and commitments;
- disclosing information as well as speaking honestly and truthfully (often grouped under transparency); and
- building and maintaining trust.

This process needs to be transparent in order to engender and sustain public trust.

Childress, J. F.; Faden, R. R.; Gaare, R. D.; Gostin, L. O.; Kahn, J.; Bonnie, R. J.; Kass, N. E.; Mastroianni, A. C.; Moreno, J. D. and Nieburg, P. "Public Health Ethics: Mapping the Terrain". *Journal of Law, Medicine & Ethics*, 30, 2002, pp. 170–8.

There are, of course, lots of other classifications and models. Häyry summarizes them in three main categories: welfare liberalism, traditional communitarianism; and radical libertarianism, as show below.

Words that define three major ethicopolitical approaches to all public activities

Welfare liberalism	Traditional communitarianism	Radical libertarianism
autonomy	integrity	liberty
non-maleficence	vulnerability	harm avoidance
beneficence	welfare	general happiness
justice	solidarity	non-violation of rights
efficiency	subsidiarity	non-intervention
privacy	modesty	individual sphere
consent	legitimacy	voluntariness
confidentiality	data sharing	control over self
safety	precaution	harm prevention or risk control
public interest	social democracy	other people's interests
transparency	administrative competence	non-interference
trust	confidence	scepticism
ownership	citizenship	contract and compensation
openness	honesty	right to ignorance
equality	respect	earned entitlement

Häyry, M. "Public health and human values". *J. Med. Ethics*, 32, 2006, pp. 519–521.

Summary, with a final consideration

Summary

After the initial delay in considering the ethical issues related to public health and its practice, the last decade has seen an explosion of analysis in this area, including guidelines, proposed codes and other practical documents.

Although the equivalent activity in Spain has been less than scant, by accessing work from other countries we can make up for this shortfall. The problem may be an obstinate one, but we must be even more obstinate than it, and I therefore believe that we can tackle the challenge which lies before us. Because our final objective is to define the basic features of “desirable” training in this area, it seems reasonable to expect that the process could be aided by organizing cross-disciplinary discussion groups which could use materials such as those presented here to reach agreement as to the basis of the best approach.

And a final consideration

I understand “biopolitics” as the way attempts have been made, since the 18th century, to rationalize the problems raised for government practice by phenomena proper to a collection of living beings constituted as a population: health, hygiene, natality, longevity, races (...) Within a social system of respect for legal subjects and the freedom of initiative of individuals, how can the phenomenon of “population” with its specific effects and problems be taken into account? In whose name and by which rules can it be governed? The debate which took place in England in the mid-19th century regarding public health legislation may serve as an example.

Foucault, M. “Naissance de la biopolitique. Résumé du cours”. *Annuaire du Collège de France*, 1979. Reproduced in *Dits et Ecrits*.

A document on the question which concerns us here (Coleman, C. H.; Bouësseau, M. C.; Reis, A. and Capronc, A. M. “How should ethics be incorporated into public health policy and practice?”. *Bull World Health Organ*, 85(7), July 2007, p. 504) refers in its introduction to the origins of “ethical

consideration in public health”, noting: “Though originating with the professions, ethical duties are of concern to society in general, and their violation – as by the doctors who conducted experiments in the Nazi prison camps – can constitute human rights as well as ethical violations.”

Inevitably, the standard story of bioethics – with its canonical tale of the Nuremberg Code (1948), the Helsinki Declaration (1964), the Belmont Report (1979), etc. – takes us back inexorably to the ghosts of the concentration camps. But, like the tiger which devoured Borges, “we are the camps”. What I mean by this is that the creation of “camps” – or at least a rudimentary form thereof – lies at the origins of public health. Participants at the meeting which gave rise to this publication had only to look around them. We were on a *lazaretto*, an island used as a maritime quarantine station for visitors to the Menorcan capital, Mahón, for a purpose which we may term isolation but which many writers on biopolitics would define as “exclusion”. In my contribution on ethics and public health I have avoided wandering through the prisons and lunatic asylums of Foucault, or through “what remains of Auschwitz” in the company of Agamben, but it is worth recalling his concept of *homo sacer*, particularly the second part, which refers to the state of exception.

I have never ceased to be surprised by the concern with criminal conduct – contrary to any (bio)ethics – in the camps, when the real problem lies in their very existence. Once they exist, what goes on in them cannot truly provoke the celebrated cry of Conrad’s *Heart of Darkness*: “The horror! The horror!” It is in their very nature to constitute a place in which, lying at once within and outside of the juridical space of the state, life is treated as a substance which lacks human form.

Obviously, this was not the case of the *lazaretti*, but they still provide a clear precedent for a space for imprisonment and the suspension of the humanity of those detained there, in the name of safeguarding the rest of humanity, or at least those living in the nearby port. In our camp, life is still treated as having a human form, but some of its predicates are relaxed for the good of the majority. Lives with rights, preferences and utilities which are “suspended” in the name of social well-being. This is the other side of the coin we

minted with our emancipatory tales of the more palatable traditions of public health.¹

I hope you will excuse my somewhat rambling diversion, but it seems to me that simply stating that the patient–doctor relationship is not the same as the relationship between public health and the individuals affected by its decision is to leave too much unsaid. The imposition of obligations or restrictions (using the coercive capacity of the state) in the name of abstract aggregate improvements requires greater justification than is provided at present. It has already been noted that, in our case, the problems of an almost universal “domain of application” and a non-specific definition of *health* – often influenced by an unquestioning *imperialism* in its scope and a worrying equation of health with *welfare* – combines with the multiple meanings covered by the term *public* (or “populations”).

I hope this makes clear the need for a more specific focus in the analysis of ethical problems which, more so than in other settings, can easily overstep the limits.

ANNEX 1

Principles of the Ethical Practice of Public Health

Version 2.2 © 2002 Public Health Leadership Society

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.
2. Public health should achieve community health in a way that respects the rights of individuals in the community.
3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.
4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.
5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.
6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community’s consent for their implementation.
7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.
8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.
9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.
10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public.

Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.

11. Public health institutions should ensure the professional competence of their employees.
12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

Notes

1. It is somewhat surprising that the Nuremberg Code, developed in the first instance as a response to the trials in that city of concentration camp doctors, states in its first point of the "Directives for Human Experimentation": "The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent." This would appear to bear little relationship to the situation of the subjects of those experiments, not because of the absence of consent, but because of the abolition of any such notion in the camps.

**Elements for
developing a set of
case studies to support
the application of
bioethics in public
health**

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Introduction

Before considering the potential applications of ethics to public health, we need to define the current scope of public health and its contents, the causes of health problems and the best solutions to them, who is involved and what actions should be taken by public health institutions and professionals.

There are various documents which can help us to identify the current scope of public health. The work of the Institute of Medicine¹ on the future of public health became a reference for health professionals. It defined the mission of public health as “what we, as a society, do collectively to assure the conditions for people to be healthy”. Based on this work, the Public Health Functions Steering Committee (PHFSC) defined the ten essential public health services in the United States, and these have influenced similar proposals in Europe.^{2,3} These essential services are shown in Annex 1, together with the actions performed by Spain’s Department of Health, Social Policy and Equality in this sphere.

In Europe, the documents drawn up by the countries which have held the presidency of the European Union illustrate the range of visions of public health.^{4,5,6,7,8} We have gradually recognized the need to take into account the effects of government policy on people’s health, and the need to establish effective mechanisms for taking action across sectors (the health component of all policies). We have also recognized the effect of inequality and the lack of social cohesion on populational health. In 2010, the Spanish presidency promoted the European Union’s commitment to reducing social health inequality and a vision of public health based on the social determinants of health. In broad terms, we can say that our vision of public health tends to ascribe responsibility for health to the individuals considered, and is based on an epidemiology of risk factors which associates individual behaviours and factors with disease. According to this view, society’s efforts to improve health are based on actions aimed at getting individuals to modify their behaviour in order to make it healthier.

Another vision tends to attribute health to a set of determinants which range from policy at the macro-level to the individual behaviours mentioned

above. In this case, society’s response needs to address a whole set of health determinants, from the structural (political and socioeconomic context, inequality, etc.) to the individual, giving priority to policies which promote a healthy environment. These visions are not mutually exclusive and, depending on the particular problem, the place and the time, one approach or the other may be emphasized, although it is also true that there are vested interests which stress individual actions. It is worth noting that the effectiveness of strictly individual actions has been questioned by research, when such actions are not accompanied by environmental modifications. Indeed, current public health ethical frameworks stress the need for public health actions to create the conditions for a healthy life.

If we take an overview of these different visions, with the aim of specifying the scope for describing examples from public health in which the application of ethical principles could be useful, then it is important to note that the recently passed Spanish General Public Health Act⁹ modifies the 2003 legislation on the Consistency and Quality of the National Health System and sets out the public health provisions to be pursued in Spain. It identifies the following actions:

- Information and vigilance in public health, and epidemiology alert and rapid response systems for public health emergencies.
- Defending the aims and objectives of public health, through a combination of individual and social actions designed to achieve political commitments, support for health policies, social acceptance and support for specific health objectives or programmes.
- Health promotion through multisectoral and cross-disciplinary programmes.
- The prevention of disease, disability and injury.
- Health protection, preventing the negative impact of different aspects of the environment on health and well-being.
- The protection and promotion of environmental health.
- The protection and promotion of food security.

- The protection and promotion of occupational health.
- The evaluation of health impacts.
- Monitoring and control of potential health threats deriving from the import, export or transfer of goods, and from international passenger travel.
- The prevention and early detection of rare diseases, and support for patients and their families.

As a result of this legislation, the Spanish legal system recognizes that public health goes beyond actions rooted in health monitoring, protection and promotion and the prevention of disease, to include defending the aims and objectives of public health and evaluating the health impact of other policies. These actions were already included in the competencies of public health professionals listed by the Spanish Society for Public Health and Health Administration and the Spanish Epidemiology Society.¹⁰ This act also requires, in article 3, that all public health actions are implemented in accordance with general principles (box 1), including in particular the issues of safety, evaluation, equity and health in all policies.

The legal system, then, has extended the range of public health actions and also provides a set of general principles for public health actions which have some similarities to the ethical criteria set out in ethical frameworks for public health. It should also be noted that the way in which the general principles are listed assumes a broad vision of public health which includes reducing social inequality and influencing public policy as a whole.

Box 1

General principles of public health in Spain's General Health Legislation

CHAPTER II

General principles of public health

Article 3. The general principles of public health action

Both public and private bodies, in their public health activities and actions which affect collective health, will be subject to the following principles:

1. **Principle of equality.** Policies, plans and programmes which have an impact on the health of the population must promote the reduction of social inequalities in health and should incorporate actions to affect social determinants, including specific objectives. Equality will be considered in all public reports which have a significant impact on public health. Similarly, actions in the area of public health will incorporate a gender perspective and will pay specific attention to the needs of people with disabilities.
2. **Principle of health in all policies.** Public health actions will take into account non-health policies which influence the health of the population, promoting those which favour healthy environments and discouraging, where possible, those which pose a threat to health. In addition, public policies which affect health will evaluate this effect and will seek to reconcile their objectives with the protection and improvement of health.
3. **Principle of relevance.** Public health actions will be commensurate to the scale of the health problems they seek to correct, justifying their necessity on the basis of principles of proportionality, efficiency and sustainability.
4. **Principle of precaution.** The existence of clear evidence of a possible serious impact on the health of the population, even where there is scientific uncertainty regarding the nature of the risk, will determine the suspension, prohibition or restriction of the activity.
5. **Principle of evaluation.** Public health actions should be assessed on the basis of their implementation and outcomes, at intervals appropriate to the action being monitored.
6. **Transparency principle.** Public health actions must be transparent. Information about them must be clear, simple and comprehensible for the general public.
7. **Principle of integration.** Public health actions must be organized and implemented as part of an integrated approach to the health system.
8. **Principle of safety.** Public health actions should only be implemented after first assessing their safety in health terms.

When identifying and describing specific cases in which it may be appropriate to apply ethics to public health, we may wish to:

1. Distinguish between different ethical perspectives (the ethics of public health professionals; ethics in the theory and practice of public health; ethics in public health advocacy).
2. List cases according to types of public health intervention or service and basic principles of action.
3. List cases according to who performs the intervention (government, other public bodies, private institutions, community organizations, scientific organizations, etc.).

Each option has advantages and drawbacks, and they may all contribute to the goal of ensuring that our set of case studies is an exhaustive one. For example, one might follow option 2 but complement it with option 3 in order to identify all the stakeholders involved.

The types of action to be described include, as a minimum, the following:

- Good governance in public health.
- Public health regulations and individual liberties.
- Public health monitoring and information systems.
- Public health communication.
- Health education.
- Preventive interventions: immunization, screening and treatment.
- Public health emergencies.
- Public health research.

Stakeholders include the following:

- Health organizations and other public bodies related to public health, and associated centres.
- Community groups, of patients or others.
- Universities.
- Agencies for the assessment of policies, interventions and technologies.
- Professional and scientific associations.

- Accreditation bodies and related.
- Private bodies with an interest in health or whose operation affects public health.
- Scientific journals in health and related areas.
- Research agencies and bodies.

When describing those situations where ethics is applicable, I have drawn on some of the generally available public health ethics frameworks, in particular those of the Public Health Leadership Society,¹¹ the framework proposed by the Nuffield Council on Bioethics¹² and the Kass criteria.¹³

Elements for developing a set of case studies to support the application of bioethics in public health

Below I have described a series of cases, taking as my starting point the following elements: the scope and types of public health action; the current vision of this field; the generally accepted and regulated principles of action; the different stakeholders involved; and the frameworks and criteria described for the application of ethics to public health. The aim of this description is to examine whether these elements provide an adequate basis for developing such a set of case studies. The case studies described are based on real situations in which it was difficult to arrive at final decisions, but which provide a good basis for analysing ethical principles in practice and extending the conclusions to similar situations. The description follows the order of the different types of action.

Application of ethics to good governance in public health

Issues of good governance are common to all government departments, because the questions of independence and transparency, conflicts of interest

and accountability apply to all government actions. However, it is arguable that in the health sphere there are situations which require particular attention,¹⁴ because when we talk about good governance here we want to extend it to all stakeholders in public health governance, understood as sustainable social and institutional development which, by promoting a healthy balance between the state, civil society, and the market economy, tends to maximize the health of the population. Among the public health situations which give rise to doubts or conflicts, we can mention: establishing the public agenda in population health issues; alliances between public bodies and different stakeholders in public health; and the establishment of public health recommendations by the health authorities or others.

The process by which the public policy agenda in health matters is configured is a key issue, influencing social debate and determining priorities. For example, when new technology appears, such as anti-pneumococcal vaccine or new scientific evidence of the effectiveness of early lung cancer detection, a range of stakeholders position themselves to ensure that this technology takes its place on the political agenda and to guarantee that it is covered by public health provision. To do this, they use a range of strategies to influence the general public through the media, to communicate directly with health professionals, or to co-opt politicians and decision-makers by attending events of a more or less scientific nature which help to raise awareness of the benefits of the new technology. This situation is not clearly addressed by ethical frameworks for public health, which tend to restrict themselves to the analysis of specific actions or programmes. In my opinion, the participation or otherwise of the health authorities in events relating to new technology should be subject to careful analysis, because the establishment of action priorities and the health policy agenda is a key issue and one which is influenced by the presence of health authorities at events of this type. Their presence at certain events may distract them from attending to other more important health problems, in addition to which it often exposes them to those parties with an interest in health decisions who already enjoy most power and influence. At the same time, if the participants in such events do not have clear, publicly available policies to prevent conflicts of interest, or hold interests in other areas which are contrary to public

health objectives, this may undermine the confidence of the population in the health authorities.

The agenda of health decision-makers and politicians must ensure fair participation across society. This balance is not something which can be achieved passively, because some sectors of society are able to use the lobbying process to achieve greater access to political power and thus have a greater capacity to influence the decision-making process. To promote the participation of the community as a whole, as recommended in the Public Health Leadership Society or in order to pay particular attention to the health of vulnerable groups, as proposed by the Nuffield Council on Bioethics, health decision-makers must establish active participation mechanisms and pay particular attention to their own and their department's agenda, including the application of ethical principles.

By the same token, it is important to analyse the alliances the health authorities build with different sectors to improve the health of the population. During the course of the last parliament in Spain, we had the case of a company offering the Department of Health, Social Policy and Equality a significant amount of space on one of its products – up to a third of the visible surface – to include flu prevention messages in the context of the 2009 pandemic. During discussions, it became clear that the only thing required in return (but this was non-negotiable) was that the logo of the Department should appear next to the warning message. Some of this company's products – together with similar products of other companies – have been linked in the scientific literature with excess weight and obesity, and the company has also been accused of attempting to exercise undue influence by sponsoring medical organizations and exploiting loopholes in the system of self-regulation to advertise its products on children's TV.^{15, 16, 17} At the same time, the company has also been involved in positive health initiatives in disadvantaged areas.¹⁸ The question to resolve is the following: Should the Department of Health ally itself with a company to take preventive action, and use its logo to do so, when some of the actions and products of this company could be considered to be contrary to the aims of public health? In this case, it was decided not to go

ahead with the collaboration, because it was felt that using the logo would indirectly have implied that certain products were healthy when the opposite was the case. It was also felt that such an initiative would compromise future work between the Department and similar companies and might undermine trust in the health authorities. However, the Department (under a different Minister) has recently signed a public agreement with alcoholic drinks manufacturers,¹⁹ when the Framework for alcohol policy in the WHO European Region – published in Spanish by the Department – advises against this:²⁰

“In addition to the key players and stakeholders in public health, the drinks industry and associated businesses and organizations have a primary role in ensuring that the production, distribution, promotion and selling of alcoholic beverages meet the highest possible standards of business ethics. Public health policies concerning alcohol need to be formulated by public health interests, without interference from commercial interests. Involvement of the drinks industry and associated businesses and organizations in youth education or youth activities is subject to question because their support, direct or indirect, could be seen as an attempt to gain credibility with a youth audience.”

In addition, the Department has signed the agreement despite the fact that the industry has repeatedly failed to comply with the first objective of the agreement:

“To avoid any communication, information, publicity or commercial promotion which relates the consumption of alcoholic drinks with social or sexual success, with improved physical performance, or which encourages the consumption of alcohol by minors, or offers a negative image of abstinence or moderation. Likewise, any advertising or information which stresses the high alcohol content of a drink as a positive quality should be avoided.”

In the three public health ethics frameworks mentioned above, perhaps the only criterion applicable here is the recommendation of the Public Health Leadership Society regarding the need for public health institutions to establish partnerships which increase public confidence and the effectiveness of institutions. Confidence in the health authorities is indispensable for good

governance in public health, and nothing should be done which endangers this. The issue of how and with whom to establish partnerships is an increasingly difficult one. The company concerned has been involved in initiatives supported by the United Nations and many large corporations take actions in cooperation with international institutions to contribute to the achievement of the Millennium Development Goals.

There is a progressive process by which international government institutions, including the World Health Organization, are replacing public funding from national sources with funds from large corporations. This tends to compromise the agenda of such institutions, conditioning the establishment of priorities, modifying the vision of how to achieve better health and well-being, and influencing politicians by circumscribing what is and is not acceptable. We have no procedural framework for examining the balance between the risks and benefits of such partnerships, and public health therefore needs to consider this question on the basis of analysis of similar situations.

Drawing up recommendations on public health and identifying official voices in health information material affects public trust in the health authorities and the health system in general. There are a lot of different actors in this area, and it is usual for health authorities to request the help of experts and scientific bodies to establish prevention or health promotion recommendations. Conflict generally arises with regard to preventive interventions which involve technology and associated economic interests. Until the publication of Spain's general public health legislation, there were no explicit provisions regarding the need to address conflicts of interest involving the different stakeholders in public health. Before then, it was possible – and indeed happened – that people with clear conflicts of interest joined expert groups which established recommendations on the introduction of a vaccine or preventive medicine. It has become increasingly difficult to find health settings which are free of the intervention of private companies, whose activities range from training to scientific research. Conflicts of interest in the medical setting have been discussed in detail elsewhere;²¹ what I am interested in here is to identify specific public health issues which require attention

and, in particular, the process of establishing which technology or intervention to evaluate and on what basis recommendations are made.

The pressures noted above condition the work of expert groups in recommending, for example, the use of vaccines or screening processes with marginal gains for the health of the population, while ignoring recommendations for the implementation of preventive or health promotion interventions, such as the prevention of injury in the elderly and in children, where no business stands to profit but there may be greater benefits for the health of the population. This imbalance occurs despite the fact that the majority of the institutions and experts which perform evaluations are public, giving rise to the paradox that the needs and priorities of private entities effectively enjoy public funding. Scientific bodies could make a significant contribution in this area by establishing mechanisms to guarantee the independence and impartiality of their recommendations. The steps taken by the Spanish Society for Epidemiology and the publication of a document establishing guidelines to ensure independence and transparency by the Spanish Society for Public Health and Health Administration²² may serve as examples.

Other actors, from research agencies to universities, as providers of experts, or evaluation agencies, could participate in this process of improving transparency and independence. There is a lot of work still to be done, because even agencies which have made some progress towards achieving transparency and independence and have regulations in this area, such as the European health agencies, have had problems. For example, the European Parliament criticized the management of the European Medicines Agency during 2009 in a unanimous report which stated that it is, “unacceptable that the agency does not apply the relevant standards for resolving conflicts of interest in an effective manner, as a result of which there is no guarantee whatsoever that drug evaluation is performed by independent experts”. It also considers it to be “unacceptable” that the agency does not establish “principles and guidance with regard to independence and confidentiality applicable to the Board of Management and committee members, and to experts and agency staff”.

Public health regulations and individual liberties

Protecting health, the basic aim of public health, depends on the formulation of standards and ensuring that these are implemented through a variety of control systems. Legislation is, therefore, one of the foundation stones of public health and the site of a constant struggle to reconcile the collective good with individual freedoms. Living as members of a society means that our options are limited by the need to consider how are choices affect others. The idea of interdependence is thus central to populational and community initiatives and, as a result, to public health. However, interdependence cannot serve as a pretext for passing abusive legislation which is excessively interventionist, and nor can freedom offer an alibi for inaction when the state should use its power to protect the health of the population. In the search for a fair balance, ethics can provide solutions.

The process of developing legal standards for public health inevitably throws up issues which may contribute to the process of developing a set of case studies. The decision as to whether or not to pass any particular piece of legislation is crucial because one of the issues at stake is the health of the population. The process of participating in and influencing the development of health standards may also give rise to issues which would be clarified by analysis from an ethical perspective. The content of legislation, whether health legislation which directly affects the fundamental rights of the individual (isolation, quarantine, etc.) or not specifically related to health but with implications for public health (traffic), tends to be the focus of most debate in this area. If we begin by considering legislative action or inaction, the first thing to do is to analyse whether any given law (or the scope thereof) is necessary. This is the case with Spain’s recent legislation on passive smoking. Once it had been decided in principle to legislate, it was necessary to decide upon the scope: that is, in addition to ridding public spaces of exposure to tobacco smoke, whether it was necessary to add any action not directly related to the principal purpose of the law, such as guaranteeing the right of catering workers to a healthy working environment and that of minors not

to be involuntarily exposed to smoke. Other additional measures considered, some of which were included in the legislation, were a prohibition on smoking in schools and health centres, the possibility of banning smoking inside private vehicles when they contain children, and banning smoking in play parks. The decision as to whether or not to include each of these options involved a consideration of the equilibrium mentioned above. In these cases, both the Nuffield framework²³ and the Kass proposal²⁴ are useful, because they include criteria such as: that regulation should promote healthy environments, the need to minimize interventions perceived as being too intrusive or troublesome, and the need to pay special attention to children and other vulnerable groups.

However, legislative inaction is rarely the focus of attention. For example, in Spain there is no health regulation on the use of pesticides in residential settings: that is, in towns, parks, schools, etc. Environmental exposure underlies a third of cancers, and it would therefore seem appropriate to limit any exposure to risk. At the same time, Spain has no legislation on the prevention of physical risks in swimming pools, despite the fact that they are a frequent cause of injury, although in this case it should be noted that legislation was under preparation with respect to technical health criteria for swimming pool air and water quality and safety, with the aim of protecting the health of swimming pool users from potential physical, chemical or microbiological risks derived from their use. These examples, and the decision to pass the anti-smoking legislation, underline the fact that, where there are known risks to public health which could be avoided through legislation, any decision as to whether or not to take action involves conflicts and these conflicts may raise issues which can be considered from the perspective of public health ethics.

This decision-making process – which tends to remain hidden – involves a number of stakeholders. The principal responsibility is that of the authorities, within which there are tensions as to whether or not it is appropriate to act. On the one hand, there is the pressure on all governments to legislate in order to be seen to be taking action, while on the other there is the attraction of taking the path of least resistance. The administration, even if it is aware

of the problem, may not act because the issue is not the subject of public debate, hoping thereby to reduce its exposure to criticism. What is more, this legislative inaction tends to be encouraged by private bodies whose interests run contrary to the health of the population, and which enjoy impressive organizational capacities and wield influence either directly or through third parties, adopting at times the guise of civil society groups.

At the same time, there is the influence of those favourable to public health, such as scientific organizations. They are less well organized and wield less influence; although they have imagination and critical capacity, they tend towards the diagnosis of problems rather than the assessment of proposals. In fact, it is unusual for scientific societies to draw up a list of essential actions for improving the health of the population, and even less so for such a list to include specific legislative proposals.

When drafting health regulations, a key question is the level of effective democracy in processes of public participation. We need to examine decisions about who plays a formal part in the draft process and who participates informally, together with the degree of transparency in the process of modifying regulations, from the original proposal or first draft through to the final version. Although this question is not specific to public health, when applied in this field it may have unique features given that one of the values at play is the health of the population as a whole, and that in the representation process the interests of some sectors are represented more effectively than others. The situation is as follows: when health protection regulations are drafted (food safety, quality of bathing or drinking water, chemical products, etc.) there is a tension between private or corporate interests which prefer less regulation and, therefore, seek a lower level of protection (for example, fewer requirements for control of the use of chemical substances, lower penalties, less explicit food labelling, etc.) and protecting the health of the population. This tension reveals a clear imbalance against public health, because although steps are taken to encourage the participation of civil society organizations, corporate interests have permeated and promote many platforms and stakeholder associations, making them into their mouthpieces. Beyond the formal processes of modifying legislation, actors are involved

at every level, with the result that different sectors of Government, influenced by particular actors, may propose modifications which, at times, occur during the final stages when there is no longer an opportunity to respond (for regulations where Parliamentary approval is unnecessary), when the level of transparency and accountability is diluted, and when the outcome is determined by the hierarchy of power or skill of certain experienced actors. For legislation which is subject to Parliamentary approval, it is important to remember that members of parliament are also exposed to these imbalances in favour of interests contrary to public health as a result of the effect of lobbying. To sum up, we need to examine whether decisions regarding the participation of the population in legislative activity on public health issues which directly affect them are commensurate with the requirement of democratic justice. The ethics of public health includes this criterion, and its application requires that the administration ensures that participatory processes actually enable it to be applied, by reviewing the quantity and quality of the bodies and organizations regularly involved in this process, and assessing how representative they are.

With respect to the content of legislation, and in order to identify a set of case studies, it may be helpful to order these according to the level of intervention in the individual sphere. Firstly, there are those which affect the fundamental rights to preserve public health, and this is the area which requires the greatest level of ethical analysis. This sphere includes laws containing specific public health measures which provide, for example, for the isolation of an individual suffering from a contagious disease which is a threat to the community. These cases are similar to those which arise in clinical care settings and which bioethics is well equipped to resolve. And bioethics is similarly well equipped for the analysis of laws which impose obligations on health professionals. During the drafting of Spain's general public health legislation, various participants raised the possibility of imposing upon health professionals an obligation to achieve higher vaccination rates, given the difficulty of increasing these by other means. Some drafts even included an article providing for obligatory vaccination or, alternatively, informing patients of the immune status of the health professionals attending to them. Both options were finally rejected because the issue had not been debated in sufficient

detail. Regardless of whether this issue is addressed at the legislative level or not, analysing it from an ethical perspective could be useful.

It is also worth considering other laws which affect individual behaviour or impose the adoption of changes in the private sphere without affecting fundamental rights. The anti-smoking law and its scope – private spaces or public open-air spaces, where the value being protected is not directly the health of others but rather, indirectly, public health through pedagogic action – are a clear example of this type of legislation. A law imposing the provision in private homes of devices to prevent injury to the young or the elderly would be innovative and could give rise to conflicts. It is important to stress here that, with regard to health protection, when innovative legislation is established gradually and incorporated in areas unrelated to health (for example, building codes, safety, consumer or environmental regulations etc.) it is accepted more readily than when direct action is required of citizens. That is, if the injury prevention devices are included little by little in manufacturing standards (carpets, floors, furniture, etc.) they are more easily accepted by the population and give rise to less discussion about interference in individual liberties. By the same token, when it comes to food legislation, it is more acceptable for the population (but not for the industry) to regulate the contents of foods than to restrict their sale in certain places. This reveals alternative courses of action for public health when we consider the role of regulations in health protection.

Regulation which affects public health also includes health and safety standards which do not directly affect the individual sphere, even if they may interfere with private interests. These are food standards relating to labelling and safety, water safety and quality standards, environmental standards, etc. The dilemma in these cases is the result of a conflict between the health of the population and the interests of individuals or companies. And the values which, from an ethical perspective, are threatened tend to be those related to effective public participation and the processes which ensure the quality of our democracy.

Finally, an aspect of public health regulation which is not exclusive to it but which deserves attention from an ethical perspective is its content with regard

to ensuring compliance and the identification of responsibilities. There are a worrying number of legal regulations which are not implemented and which do not guarantee the rights they supposedly enshrine, simply because they do not include provisions on accountability and the identification of those responsible for their implementation. The process of drafting Spain's general public health legislation is an example of this, because all of the guarantees established in the early drafts gradually disappeared, to leave scarcely a trace in the final bill. The ethical frameworks for public health described above address this question, at least with regard to the effectiveness of the interventions to be made, in assessing whether adequate means are provided to ensure this effectiveness. Public health legislation defines the powers and duties of the state with regard to health, and in the same way that it specifies the procedures for exercising these state powers to protect health, it must also clearly establish responsibilities and methods for accountability. As a result, just as the ethical perspective is essential when examining the limits of the power which the state is entitled to exercise in order to protect the health of the population, so too ethics may analyse the scope of the obligations which must be assumed in order for public health aims to be achieved.

Public health monitoring and information systems

Public health monitoring and information systems have an essential role to play in performing essential public health functions. In fact, the criteria and recommendations contained in the ethical frameworks for public health make it clear that we need to identify the fundamental health problems of the population, their causes and distribution, in order both to initiate and then to evaluate interventions. Some basic principles of public health – such as safety, fairness, and the analysis of costs and benefits – are not possible without suitable information.

In the clinical sphere, nobody would question the need for an accurate diagnosis prior to embarking upon treatment, or the need to perform tests to

monitor its effect. In public health, however, interventions are typically embarked upon without the existence of the information systems which would permit their evaluation. It is paradoxical that we accept that any health professional needs to perform individual tests to check on the effect of treating an individual patient, while in contrast it is common for us to perform preventive interventions, such as screening hundreds of thousands of people for cancer, without having in place the information systems which would allow us to adequately evaluate the results. The requirement for evaluation in public health is not just an academic detail. It is indispensable because, in public health, the context modifies the effectiveness of interventions to a greater degree than in the clinical setting, and this means that we must have a detailed understanding of the real effect of an intervention upon a given population in comparison with a reference population. Even if, for example, an early detection programme or health education campaign has a given impact in Scandinavian populations, it may be that this effectiveness is different in the Spanish social and health context. Spain's current public health legislation includes the principle of evaluation. However, the article which stipulated that no populational health intervention should be implemented without there also being a monitoring system in place was removed during the final drafting stage before it was submitted to Parliament.

It seems clear that, from an ethical perspective, we need to consider whether the information available is sufficient to justify any public health initiative. The typical cases which arise relate to the following questions. Should screening for colon cancer be conducted in the absence of a cancer register? Is it appropriate to administer primary prevention medicines to population groups characterized by their risk profile without any possibility of identifying the effectiveness of such action? Should we take health education initiatives without there being any way of knowing whether these have brought about the desired modifications to behaviour? These sorts of question are not generally raised explicitly (or even implicitly) in daily practice, and many public health initiatives are taken in the absence of an adequate information system. It is sometimes argued that the importance of a given problem and the demonstrated effectiveness (in other settings) of the intervention, mean there should be no delay in implementing it in order to improve the health

of the population. This is the case with the early detection of colon cancer, which is being gradually introduced across Spain. However, this argument about not delaying the benefits is also invoked when there are doubts as to the effectiveness of a given intervention, with the result that early detection initiatives are usually implemented even when there is insufficient evidence as to their capacity to deliver benefits in terms of the health of the population. Assuming that action should be taken even where there are doubts sidesteps the fact that any preventive action may also cause harm. The requirement for safety and the need for evaluation oblige us to consider this question very carefully. It is true that the lack of information or of adequate monitoring systems should not serve as a pretext for inaction, but it is also the case that we must strike a balance, and here ethical frameworks may be helpful.

Another less obvious question regarding public health monitoring decisions relates to the proportionality of resource use. Out of inertia, we tend to accept public health monitoring systems regardless of whether or not the resources allocated to monitoring each health problem or its causes are commensurate to the scale of these problems among the population as a whole. When taking decisions about monitoring, situations such as the following may arise. We know that chemical contamination constitutes a threat to public health in today's society, and there is growing agreement that it would make sense to introduce a monitoring system based on biological samples to identify levels of internal contamination. However, inertia means that we continue to concentrate our monitoring efforts on health problems which are not necessarily the most important. Because timescales when caring for the population as a whole are very different from the timescales of individual patient care, this does not seem to be the correct way to approach decisions.

How to measure social behaviour and which indicators should be the focus of political attention are issues which have been reviewed by Stiglitz, Sen and Fitoussi,²⁵ in a report prompted by recognition of the limitations of GDP data as a measurement of economic and social well-being, an endeavour which goes beyond the scope of this text. However, even if we restrict ourselves to the realm of public health services, from an ethical perspective we must ask

why some marginal health issues are monitored and other, more important ones, are not.

Bioethics has considered in detail the threat that monitoring and information systems may pose to individual privacy. And this analysis has informed the development of legislation on the confidentiality of health information so that, in general terms, this is adequately protected by the law. Notwithstanding, we still face the problem of balancing the need for populational health information in order to plan appropriate action, on the one hand, with the need to protect privacy which may at times obstruct epidemiological research, on the other. In these cases, in addition to technical solutions, it may be necessary to analyse the costs and benefits of given vigilance actions and information systems. An aspect which receives less consideration is the risk of the stigmatization of groups, for example when monitoring systems associate certain disease or risks with membership of a particular group (socioeconomic status, physical characteristics, sexual orientation, etc.), and this is an issue which must be taken into account when identifying a set of case studies.

Another perspective from which to consider monitoring and information systems in identifying a set of case studies is the access the population has to any information generated. If it is not possible to access information about health risks in a manner which is simple and clear, this may undermine the right to autonomy. When analysing examples, we must distinguish between information about environmental health risks, information regarding risks resulting from public health actions, and risks deriving from the actions of the care services in relation to medical devices, services, centres, hospitals, etc.

In the first instance, the questions which arise and which might benefit from ethical analysis are related to the paternalism of health authorities, as a result of which they do not reveal certain levels of risk, either because they lie below recommended thresholds or because the authorities claim that to do so would generate unnecessary alarm. Not so long ago, there was resistance to providing information about air pollution in cities for fear of creating panic, but this information is now widely available without any panic occurring. Howe-

ver, there is not always a consensus as to which information should be available, and still less so as to whether this information should be immediately accessible. The type of conflict to study would include the following. Should citizens be aware of the level of heavy metals contained in the fish they buy – or other contaminants in any other food – by accessing the results of public health laboratories? Should water quality analysis reports be available to the general public? Should the public be informed of daily hospital admissions predicted as a result of pollution exceeding healthy limits? Should the results of water analysis at bathing beaches be accessible to the public?

If we are talking about threats to health arising from public health interventions, the usual questions relate to information about adverse effects and other results of the preventive effort to achieve a beneficial effect. These questions are more or less the following. Should candidates for early detection be informed of the full range of potential outcomes and the preventive effort required to obtain success? (I am referring to expressing results in a form which facilitates an informed choice, by identifying the number of people who would need to be screened in order to prevent a single death, the number of false positives for each 100 individuals, the number of biopsies or other interventions required; the number of unnecessary surgical operations, etc.: that is, not just the benefits but the risks as well.)²⁶ Should detailed information about the adverse effects of vaccination be included when parents are asked for authorization? The position of some public health practitioners is that offering clear, detailed information would deter the public from preventive action, thereby depriving them of the associated benefits. To date, the information offered has been far from complete, and represents an infringement of our autonomy.

Along similar lines, we need to consider the information provided to the users of health services about how these operate. There is resistance to informing about the success and failure of care services, the frequency of adverse events, the results of quality audits or other indicators which could be used to order services and centres by the quality and safety of the services they provide. Just as occurs with population screening, the tendency is towards inaction rather than transparency, and it is worth stopping to consider what light ethics may throw upon this.

Public health communication

There is a wide range of participants in public health communication, including not just the media and the health authorities but also health professionals and their organizations, researchers and research centres, scientific journals, companies and well-known individuals who lend their image to health-related campaigns.

There is evidence that some companies have put pressure on the media to influence health communications: for example, by reducing their advertising in health sections. On other occasions, health information appears to have been directly funded by a company with direct interests in a healthy (or even an unhealthy!) product. These are issues which involve both ethics and journalistic standards. However, given the influence of the media on the public's perception of health and healthcare, the processes by which the health information agenda is established would also benefit from analysis from the perspective of public health ethics.

With regard to the other actors, the questions which usually arise are the following. Is it acceptable for a scientific society to publicly recommend preventive actions involving the products of a company from which it receives funding? Might it be more acceptable for it to only promote vaccination even if it received funding for this purpose from the pharmaceutical industry? Should researchers, scientific journals or research institutions take care, when writing press releases, not to exaggerate the practical implications of any discoveries reported? Should companies be free to raise public awareness of health problems for which their products do not modify the course of the illness? A recent example of this in Spain is the information campaign “Alzheimer's: it's better to know”, despite the fact that this is a disease where there is no evidence that early diagnosis is effective. Is it appropriate for companies to “convert” discomforts into illnesses in order to sell new drugs and encourage their inclusion in public healthcare provision?

With respect to the health authorities, communication should be treated in the same way as any other public health action, and be subject to the same scrutiny and the same ethical framework. This is also relevant to communi-

cation in crisis situations, where the risks of incorrect procedures are greater. The recent swine flu pandemic was the motive for a whole range of criticisms regarding the ethical failings of health institutions at all levels, and of vaccine manufacturers. Ethical analysis from a public health perspective is essential, but some of the issues which arise are not so much issues of public health communication as issues of good governance: transparency and independence in public health.²⁷ Another issue which should be reviewed is the participation of the health authorities in communication actions which have an apparently laudable objective but which also entail the risk of appearing to endorse products and companies which could have a negative effect on public health. We have already discussed some examples with reference to good governance. Others might include whether a “keep yourself refreshed” campaign at the start of the summer, to raise awareness of the need to stay hydrated during heat waves, presented by an association of soft drinks manufacturers, should be given official endorsement? As discussed above, the endorsement of any communication activity with the presence or logo of the Department of Health should be questioned and subject to ethical analysis.

Health education

The attraction of health education is that it is considered not only necessary and beneficial, but free of risks; so much so that, for some, it is in principle deemed to be preferable to other strategies. However, it is not an innocent action, because in addition to the potential for paternalism, health education may entail manipulation, social stigmatization of target populations and, at times, increased inequalities. Health education is usually more popular among those who view health as a private issue which does not depend on the state and which, as a result, tends to attribute health to freely chosen individual actions. Leaving aside for a moment the accuracy or otherwise of this view, health education interventions should occur within the framework of actions which enable the satisfaction of some of the recommendations or criteria of the ethical frameworks for public health described earlier. I refer,

for example, to the recommendation that public health programmes should seek to improve the social and physical environment, by ensuring that health options are easily accessible, and that they should seek to reduce health inequalities. In drawing up a set of case studies, I would identify the following questions when considering health education actions designed to modify behaviour. Are education initiatives supported by actions to facilitate the adoption of the behaviour being promoted? Is it sufficient to educate people in healthy behaviours when the policies which affect the environment and condition healthy choices go in the opposite direction? Is it possible to build health education alliances with organizations some of whose activities may be contrary to the aims of public health? Is it right to run health education campaigns which do not include a focus on justice to ensure that the focus is on those with the greatest need? A key issue in health education is the difficulty of evaluating outcomes in health terms, and the scant commitment to doing so. The popularity of this approach to public health leads to there being multiple participants in health education, whether real or supposed, without any evaluation procedure being planned, in contravention of any framework of public health ethics.

Other public health actions

In addition to the types of action identified above, public health also covers preventive interventions, public health emergencies, and public health research. With the exception of research, these types of action are already covered by the ethical analysis set out earlier, and I do not believe that further consideration would add much. For example, screening has been the object of both direct and indirect consideration in the context of good governance, legislation, monitoring and communication. The same might be said of public health emergencies. Perhaps, with regard to vaccination it is worth remembering that unresolved questions remain as to whether vaccines should be voluntary, as became apparent when the Regional Government of Andalusia went to court to enforce the vaccination of children in the context of an outbreak of measles in Granada.

Applied public health research, the aim of which is to deliver improvements to the health of the population, may have implications for decisions about public health at every level. However, it is common for project design and the presentation of results to bear little relation to what would actually be useful for the implementation of public health measures. For example, it is not uncommon for researchers to use relative measures of risk instead of absolute ones, making it difficult to identify the magnitudes in population terms and, therefore, to apply them in programmes. It is also common for research groups not to anticipate the mechanisms required to communicate their results to the relevant authorities. It could be argued that this is the responsibility of the authorities themselves, but much of this research is publicly funded and it seems reasonable that mechanisms should be established to return the investment to society.

An agenda for ethics and public health in Spain

Analysis of the elements involved in creating a set of case studies for the application of bioethics to public health, and the identification of possible examples, reveal both the potential benefits of such an approach and the urgency of encouraging initiatives to develop and apply an ethics of public health. It is not a question of replicating either in part or in full the available work, whether from bioethics or frameworks and recommendations about ethics and public health. Rather, what is required ranges from the training of professionals and the generation of knowledge to the formulation of recommendations for good governance in public health, and involves not just the health authorities but all the other stakeholders we have mentioned, too. Achieving this involvement requires the participation of key stakeholders. It requires, for example, that scientific societies involve professional associations and other bodies in the development and application of the ethics of public health. This involves influencing public administrations to incorporate some recommendations of good governance into their practice and their rules of operation. The process of developing regulations which derive from Spain's general

public health legislation is an excellent opportunity. The work which remains to be done is hard, but the potential benefits for the governance of public health and the health of the population mean it is worthwhile.

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**Elements and criteria
for the design of a
programme in ethics
and public health
(an agenda)**

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This article includes some considerations regarding activities to promote ethics in the public health sphere, offered as a starting point for analysis and discussion. Many of the proposals are based on the editorial by James Thomas published in the *Journal of Public Health Management Practice*, titled “An agenda for public health ethics”.¹

The specific features of applying ethical considerations to public health are the focus of the first working session at today’s event, while the second session focuses on a specific set of case studies identifying situations and problems which could benefit from this ethical perspective. Both contributions must be taken into account when considering the contents of a working programme on public health ethics to be developed by the institutions in which health professionals and ethicists work.

Justification

The need for a strategy which helps promote the application of ethical considerations in the public health sphere is clear from the two presentations we have already read.² The question is whether we need to design a programme, or at least some of the basic elements of a plan or programme of action, with the aim of promoting and consolidating the ethical perspective as a contribution to the design, implementation and evaluation of public health interventions, and whether we are in a position to do so.

Among the arguments which would justify promoting the application of ethics in the public health sphere are the following:

- The importance of the ethical perspective in the design, implementation and evaluation of public health interventions affecting populations and communities.
- The collective dimension of public health interventions, the need for collective health promotion and protection interventions, and the consequences of collective interventions.

- The specific nature of this collective dimension of responsibility for health, and the freedom to adopt health measures which entail restrictions for others.
- The need to include, together with the “principles of bioethics” (beneficence, justice and autonomy) and perhaps others such as the precautionary principle and the principle of accountability, more utilitarian or outcomes-based approaches.

However, to date very little attention has been dedicated to these questions, either from a public health or an ethical perspective, as a result of which it would seem advisable to carry out preliminary investigations in the spheres of ethics and of bioethics in order to identify what the preferences of health professionals are.

We need to discuss whether the effort of developing an explicit programme is worthwhile and, if it is, to identify what the priorities and objectives of such a programme should be, together with the roles of professional organizations, academia and the authorities.

Aims and objectives

The aim is to promote the involvement of individuals and groups in the design, implementation and evaluation of collective health measures, in order to facilitate ownership of individual and collective ownership of health decisions at the social level.

Effective promotion of this involvement is a matter for society as a whole. Professional and scientific organizations and bodies may play the role of catalyst, stimulating reflection and debate, and generating contributions which help society to take decisions in a democratic, legitimate manner. The social role of professional bodies is to ensure that their members exercise their profession correctly, and the contributions of such bodies should therefore consist of conclusions rather than proposals.

It is also necessary to consider whether we should formulate specific objectives which would involve professional and scientific organizations, founda-

tions and the health professionals involved here. It is still unclear whether it is worthwhile formulating objectives which would then be put to others.

Whom should we address?

In the first place, the general public, so that cultural institutions and organs of social communication would be spaces in which to consider the importance of ethical considerations within the public health sphere, stimulating dissemination and discussion. So too should the institutions of legislative power, where legal decisions are taken which have the potential to affect group health but which also affect the freedom and responsibility of citizens. And, of course, it also involves the executive in the spheres of public administration which, directly or indirectly, implement public health interventions. In this context, postgraduate education and continuing professional development have a particular role to play.

Secondly, it involves health professionals responsible for collective health: professional associations and other bodies, scientific societies, universities and colleges.

Finally, it also includes those non-health professionals who may be involved in processes related to health: urban planners, lawyers etc.

The general public could be the permanent target of cultural initiatives designed to implement and promote ethical consideration of public health, particularly questions of a more cultural nature such as, for example, the rationality of health expectations; the limitations of health systems; the justice of resource distribution, etc. With respect to drawing upon issues and situations with a health angle, we should consider both the potential and limitations of the role of professional organizations and their members. The experience of the most recent disputes could be enlightening: the flu pandemic, human papillomavirus (HPV) vaccine, etc.

In any case, it would seem to be better to focus efforts on analysing the opportunities for developing an applied ethics of public health in a training

and professional context, during both undergraduate and postgraduate education, as an element of continuous professional development, and as a focus of scientific and professional interest.

Issues considered in the presentation

As Thomas reminds us:

“Academic ethicists, on the other hand, are notorious for avoiding concrete or prescriptive answers. Moreover, they are too seldom involved in the situations that give rise to the ethical concerns. So, for example, very few academic ethicists have worked in a county or state health department. If they had, they would know that public health practitioners are eminently practical. They need to know what to do right now, and they need to know the action is both effective and equitable.” And he goes on: “We need more public health practitioners with formal graduate training in ethics. Although the slowly growing number of ethics faculty positions in schools of public health is a welcome development, they are seldom filled by people who have had experience in a health department ... In contrast, many medical ethicists are trained in medicine and some continue to practice medicine while also studying and teaching ethics. There are a few articles and books on unethical events in the history of public health, but the topic remains relatively unexplored.”

“Not infrequently, stories of the past reveal human or institutional tendencies that we need to correct or restrain in the present and future. In addition, there are some ethical questions that need to be addressed with empirical research. For example, what are the best ways to gather input from a community when planning a public health policy?”

“We are all born or enculturated with a sense of right and wrong. This intuition gives us a leg up in thinking about ethics, but it can also make us regard training in ethics as unnecessary. As anyone who has created or implemented policies for a community knows, treating the variety of interest groups equitably can be an immensely difficult challenge. Others who have walked this road before have developed principles and tools, but one needs to actually study and practice them in order to apply them well. We must ensure that each practitioner of public health is trained in the ethics skills relevant to his or her responsibilities.”

“We are most likely to act ethically when ethics is woven into the fabric of our lives and work. We are least likely to act ethically when we have to stop what we were doing and pick up a new task that feels like busy-work or a barrier to accomplishing our purpose. I hold out hope that people will actually look forward to ethical decision-making in the practice of public health because it gives them an opportunity to interact with others over topics they care about deeply.”

“Choosing among several options for action – each of them flawed – can lead to paralysis. One goal important to remember is that we are not looking for the “right” answer but one that is morally defensible. When we make a tough decision, are we able to say with sound ethical reasoning why we made the decision we did? It is also important to remember that our goal is not an ethics bureaucracy or even an ethics scholarship. Our goal is health with justice and justice through health. Our deliberations on ethics are worth nothing if they do not move us toward this goal.”

Following Callahan and Jennings,³ the areas of public health activity most susceptible to ethical considerations are those which are related to the promotion and protection of collective health, risk reduction, research, and avoidable and unfair health inequalities. According to these, the questions to consider would be:

- Public health leaders should promote discussion of ethics and public health.
- The editors of public health and bioethics journals should prioritize rigorous, high quality work relating to the application of ethics in public health.
- It would be useful to compile case studies and examples for use as teaching material and as a basis for discussion, analysis and learning.
- Questions regarding ethics should be formally included in the definition of research projects, with the aim of considering both the ethical implications of actions, and ethics itself.
- Public health schools should give more importance to ethics and should therefore increase the requirements with regard to accreditation procedures.

- We should encourage the inclusion of ethical considerations in continuing professional development programmes by the employers of public health professionals.
- Agencies, centres and public health services should promote (invite experts, encourage development) and provide facilities for (time and resources) meetings on ethics in professional practice.
- Ethicists should focus on public health, treating it as a subject of analysis and developing ways of bringing an ethical perspective to bear on public health.

This should be addressed to: 1) Academics, including educational institutions, scientific and professional organizations such as SESPAS (Spanish Society for Public Health and Health Administration) and foundations such as the Víctor Grífols i Lucas Foundation; 2) institutions, health centres, services and programmes involved in public health; 3) social and administrative bodies with an impact on public health, such as town planning, traffic, etc. and 4) citizens’ institutions in general.

In these contexts, the proposals are:

- Promoting ethical reflection in any of the forums in which public health professionals participate, particularly those regarding professional practice, continuing professional development, and postgraduate education.
- Situations which occur in professional practice and, above all, those which make it into the mass media, should be used as an opportunity for developing and disseminating ethical considerations.
- We need to organize formal learning activities, by including courses on public health ethics within broader qualifications; by discussing case studies in postgraduate education; and by providing continuing professional development to the public health profession.

References

1. Thomas, J. C. “An agenda for Public Health Ethics”. *J. Public Health Management Practice*, 14, 2008, pp. 329–31.
2. Ricard Meneu argues that, in the current circumstances, the aim of creating a working programme is premature, given the scarce attention which has been paid to this issue to date. In this case, rather than proposing a programme of activities which looks outward to other health professionals, perhaps we need to start by consolidating and expanding our own knowledge of this area. Whichever option is chosen, an agenda would appear to be necessary.
3. Callahan, D. and Jennings, B. “Ethics and Public Health: forging a strong relationship”. *A. J. Public Health*, 92, 2002, pp. 169–76.

Summary

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The event “Ethics and public health” held on 22 and 23 September 2011 consisted of three sessions, each of which included the opportunity for participants to discuss the issues raised.

First session. Aspects and issues in public health which require a specific, individual ethical analysis

Speaker: Ricard Meneu

There is no doubt, according to the speakers and other participants, that bioethics has been a latecomer to public health, something which is even more the case in Spain, and that a stronger bioethical presence would have made a constructive contribution to recent debates (anti-smoking legislation, human papillomavirus vaccine). What is the reason for this delay or, rather, the scant concern of public health professionals for the ethical issues which are so closely linked to their practice? It is beyond question that bioethics has made great progress in the doctor–patient relationship, whether in a clinical or research setting. By contrast, its influence in the public health sphere would appear to be less, despite the fact that this is an old debate in the English-speaking world. It is as if public health interventions (through public health programmes) were not subject to the same requirements (an explicit reference to ethical principles) as clinical or research interventions.

This fact can be understood in part because, in public health, any intervention is aimed at the population as a whole. But is this sufficient to explain the exceptional status of public health? Public health, as the most political branch of medicine, is where there is scope for the greatest conflict between individual and collective rights. At any time, there may be a need for a greater or lesser degree of coercion. It is no surprise that the Spanish legislation on special measures in public health ((3/1986, 14 April) is the shortest piece of basic legislation on the Spanish statute book. Given its political nature, with the state at the centre, both Bentham’s panopticon (which was applied not only to prisons but also to schools, hospitals, quarantine stations, etc.) and Foucault’s biopolitics (the public health departments are the state) feature strongly.

Among the participants, divided almost equally between medical professionals (public health practitioners and clinicians) and teachers of bioethics (moral and legal philosophy), all of whom have an interest in the ethics of

human behaviour, there was agreement as to the need to clarify language, an essential step if we are to make common progress. However, this proved no easy task and took up most of the first part of the session. What is the specific scope of public health, its core and complementary aspects? Almost everything can be seen as a public health issue, and even more so if one considers that public health involves areas which are not (administratively) part of the health remit, but which influence it nonetheless. This multisectoral nature is one of the defining features of public health. We should not be surprised that, as the general public health act wished to specify, the health impact of all public policies should be examined.

However, health itself is an evasive concept, and definitions of it (WHO, Jordi Gol) fail to resolve the issue, confusing well-being with health, ignoring the fact that there may be “healthy” ways of being sick, and ignoring the social determinants of health and illness. What is health? A state, a capacity, an instrument for achieving other goals, a construct? Like ethics, where it is easier to say what is wrong than to define what is right, perhaps it is best to seek to clarify concepts by starting from a negative, the concept of illness. Although this makes for a better classification, it also tends to be ever-increasing (some “illnesses” are removed – homosexuality – but many others are added: one need only glance at the Diagnostic and Statistical Manual of Mental Disorders or DSM of the American Psychiatric Association). And at any rate the result is far from comprehensive and there is very far from being a consensus as to its contents. We must accept, then, a degree of vagueness in our objective, health, and seek instead to specify the scope of public health.

There is no doubt that, since the 19th century (and even before) many competencies have been included within the scope of public health (quality of drinking water, epidemic control measures, waste disposal, food, etc.), but if there is a defining characteristic of public health activities, it is that they occur within the context of three main objectives: protection (health), prevention (illness) and promotion (health). But these do not mark out an exclusive territory, as is made clear by food issues (the competency of both the Department of Agriculture and the Department of Health) or of drug addiction (the Ministry of the Interior and the Department of Health).

Nobody would ask who is responsible for dealing with a potential cholera epidemic (the remit of the Department of Health) but who is responsible for

correcting the social inequalities which have such a large influence on mortality? This is clearly a political issue, but unless data is analysed and causal relations are shown, it may be nothing more than rhetoric.

Bioethics is not just a question of the aim (do we need to prevent this?) but also, especially, of the means (how do we prevent it?). This took the debate down another path, where the focus was on the basis of bioethics.

Collective protection, the aim of public health, is a value which we must preserve and promote, ensuring that we balance our ethical perspective with other considerations in order to avoid extremes. How far is it legitimate to seek to influence the behaviour of individuals? What methods are legitimate for this sort of action? There is no question that, in democratic societies, such action may be legitimate, but this fact should not be used as a pretext for obviating the need for moral justification. The vision of the English-speaking countries, which has become so influential in today's world, privileges individual rights above public intervention, and reduces the role of the state to the least amount of interference with the life of ordinary citizens. The current period, following this trend, has seen continued growth of individual rights, at the expense of the public and the collective. This reflects the predominance of the individual as sovereign consumer.

As a result, public health interventions are framed within a programme (organized intervention) designed to benefit the community, but individual beneficiaries are anonymous while most individuals will obtain little benefit at all (Rose's prevention paradox). Not only is there this paradox, but also another, perhaps less easy to pin down, which is the accentuation of risky behaviour (for example, driving more dangerously) as a result of feeling individually protected (wearing a seatbelt). This is what is known as moral hazard.

Comfortable, high-income countries appear to embody a general trend towards the non-acceptance of risks. The media have a decisive influence, which ultimately conditions the political response. Something must be done, no matter what, and no matter whether the expenditure of resources is out of all proportion to the potential benefits or risks, which are uncertain or simply unknown. We hardly have to look far to recall cases (mad cow disease, flu pandemic) which were the reason for multiple, high-cost interventions, in particular the opportunity cost of the sacrifices which were made to prevent

a cost which was subsequently revealed to be of far lesser magnitude than had originally been predicted.

However, the worst political and social repercussions tend to arise in response to inaction in the face of potential disaster. The example of the Italian seismologists who underestimated the risk of the Abruzzo earthquake is just one of the most recent. To act or not to act: both have their consequences and their risks.

All ethical theories are based on principles, even if there is a tendency to simplify these in practice. Such theories can help to ensure that decisions, choices and behaviours are consistent, without necessarily providing solutions. A set of case studies, by contrast, takes a bottom-up approach to problems, working more on the basis of implicit principles through a process of analogy. The Belmont report, we must remember, argues for a combination of different perspectives: the perspective of principles and of case studies, the individual perspective, the environment, and the values which interact and come into conflict.

Some of the principles or values which arose repeatedly in the discussion and which appear to be particularly closely linked to the public health sphere are:

- *Transparency.* This means that there can be no "state secrets" in public health, and that we should not conceal knowledge from the public of the information available regarding risks and the potential consequences of alternative courses of action, with all the uncertainties these entail. However, no politician will agree to appear in public talking of uncertainties and the unknown.
- *Participation.* It can be argued that political representation acts at this level, but in many cases action is guided by the resolutions of expert committees where citizens or the groups at whom the intervention is addressed are scarcely represented. We can talk about paternalism, the knowledge of the expert acting in good faith and for the benefit of all, the difficulty non-experts have in understanding not just technical terminology but also estimates and probabilities (lack of numerical comprehension). These panels or committees of experts should include representatives of the general public or of the groups at whom the intervention under consideration is aimed. Of course, it is far from easy to make these issues accessible, but there must be deliberation

(an essential part of the bioethical process) to (gradually) arrive at a consensus between participants which would facilitate both the implementation of actions and the acceptance of risks. And it goes without saying that in controversial interventions the inclusion of different perspectives and the view of those at whom the intervention is directed become an essential element.

With regard to the issue of proportionality, there must be acceptance of the interference which public health measures may represent for the population as a whole. In this case, it is worthwhile to review the document “Public Health: ethical issues” (<http://www.nuffieldbioethics.org/sites/default/files/Public%20health%20-%20ethical%20issues.pdf>) published by the Nuffield Council of Bioethics and which the speaker strongly recommended. In this respect, where before the tendency was to talk of coercion or intrusion upon individual liberties, the document, which incorporates many of the elements addressed in the debate, proposes grading the level of intrusion of the authorities in defence of the public good (the health of the population) in accordance with the principle of proportionality, so that the greater the restriction on freedoms, the higher the level of justification must be.

Second session. Elements for developing a set of case studies to support the application of bioethics in public health

Speaker: Ildefonso Hernández

Ildefonso Hernández began by considering the complexity of regulation in everyday areas such as alcohol, smoking, food and the so-called obesity epidemic in high income countries. The risks at the level of health and benefits at other levels (tax revenue) are difficult to weigh up, and the different stakeholders do not have the same strength or wield the same degree of influence. Although in the United States the role of lobbies and interest groups is in some ways more transparent, the problems remain the same. In the United States, for example, with regard to the control of contagious infections such as sexually transmitted diseases (STD), you may receive a call from the CDC (Center for Disease Control) informing you that your most recent sexual contact has a STD, and advising you of what you should do.

It is a feature of societies governed by the rule of law that policies are articulated through legislation and other regulatory procedures. Public health is no exception to this rule, which in many cases is articulated through the structures of the European Union. A law which is not enforced is void. And by the same token, it is severely weakened if there are no guarantees and mechanisms to ensure that it is monitored, and to assess its impact. The current trend for shrinking the role of the state makes it increasingly difficult, if not impossible, to perform these monitoring and assessment activities.

To this we must add the fact that the scales by which we judge the reliability of scientific evidence, give pride of place to controlled, random trials and meta-analysis of these. But in public health there are few experimental studies: although there are plenty for breast cancer screening programmes, even these have failed to resolve our key concerns, while for other widely implemented screening processes, such as the use of PSA to identify prostate cancer, there is far less evidence. Instead, public health tends to rely on observational studies (control cases, cohorts), and these should not be ignored, given that, for both ethical and scientific reasons, these are the only study designs which are practicable.

Public communication by politicians and health managers, in a situation of potential pandemic, as we saw in the case of swine flu (H1N1), is often problematic. A few unfortunate phrases issued by the health authorities (remember mad cow disease, or the rapeseed oil scandal in Spain in the 1980s) remain engraved in the collective memory. What information is provided and the manner of the information process are vital. Not all the details of public health analysis are made public. When a description of individual causes of death appears on the front page, it causes alarm; when silence is maintained, then it is possible that even more fear will be created by the belief that important information is being concealed. We should not be surprised that conspiracy theories are so fashionable. Inaction and a lack of transparency are not good companions in these situations. But transparency is not just about providing information; this must also be comprehensible. It is true that, in some cases, transparency may be harmful, but in the context of public health it must remain a higher value. Not only does it help to increase the level of public understanding, but it is also essential to providing the full

range of input so that individuals can make informed choices. It is undeniable, however, that, to give just one example, there is still a tendency to conceal or downplay adverse effects (false positives and negatives, anxiety associated with results, radiation, etc.) of breast cancer screening.

Spain's general public health legislation seeks to address the problem of conflicts by requiring all parties to declare them. Scientific organizations, associations of patients and their families, and interest groups often end up receiving support from the industry (medicines, health products, food, etc.). As a result, those who make the most noise receive the most attention, regardless of the quality of their arguments. It can be depressing but ultimately there is a certain logic to suspecting any company or multinational which proposes a public health campaign (or requests public support). The speaker explained how the Spanish system, following the American tradition, has been permeated by lobbies, which directly influence the health commission of the Spanish Parliament, gaining access to the politicians who make legislation.

Health education is another key element of public health. We are all aware of the role of social determinants (education, income) and how inequalities affect health. To focus entirely on individual conditions (obesity, exclusive individual responsibility for bad choices) and ignore social determinants is to completely miss the point. The only effect is to stigmatize the most disadvantaged, whose capacity for choice is (very) limited.

One may isolate oneself from the social and economic context, but it is an illusion to pretend that many of the interventions and programmes designed with the aim of preventing illness and injury are not mechanisms for the transfer of resources from the old to the young, from the poor to the rich, from the sick to the healthy. Nor should we ignore the economic motivations underlying the provision of health care and of many public health measures. Not for nothing did Cochrane argue that the impact of the NHS should be assessed by comparing working days lost through illness with working days lost due to strikes.

Public health emergencies and how they are managed continue to loom large in the eyes of the media. This issue connected with the previous day's proceedings: from quarantine and other restrictions on mobility introduced in the

14th century at the time of the Black Death, through the modern-day equivalent of such restrictions in the face of the SARS pandemic ((2002–2003), to the call from the mayor of Barcelona for special public health measures in response to asthma epidemics as a result of inhaling soya dust from grain silo unloading in the harbour.

This role is an increasingly important one for international bodies such as the WHO, whether they are deemed successful (early identification of the causal agent of SARS) or not (handling of swine flu [H1N1]). In the face of global problems (pandemics), the role of international forums and committees of experts is fundamental when it comes to analysing the problems and debating what measures to take. However, such forums and committees, however much technical expertise their members may have, also tend to operate from a narrow perspective, ignoring other issues (psychological, sociological, communicative) which lie beyond the scope of the pathogenic agent and its mechanism of transmission. And to this is added the tendency of the general public to respond to the implementation of preventive measures with growing panic. It is no coincidence that doctors were among the least likely to seek vaccination from the feared flu pandemic.

Third session. Elements and criteria for the design of a programme in ethics and public health (an agenda)

Speaker: Andreu Segura

The final session focused on the discussion of various proposals for bioethics to form an integral part of the theory and practice of public health. Bioethical aspects should be included in continuing professional development and postgraduate education, and need to be taken on board by professional organizations and scientific bodies.

To achieve this, we need to perform the difficult job of raising awareness among the different groups involved, from setting up groups to establishing forums and producing publications with the aim of ensuring that this debate about ethics and public health is open and fruitful. We need to define an agenda and develop a range of activities to this end, including the content of educational courses, a set of case studies, and a list of key works in this area.

Report

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The meeting was organized by the Spanish Society for Public Health and Health Administration (SESPAS) and the Víctor Grífols i Lucas Foundation, with the aim of “promoting ongoing collaboration between public health professionals and ethicists, in order to identify the issues which would benefit from shared debate and consideration, and to establish a programme of activities in the spheres of undergraduate and postgraduate education and continuing professional development, in the practice of public health and the health system, in society, and in our culture in general”.

There were three speakers and three sessions. The first was Ricard Meneu (Valencia), who considered aspects and issues in public health which require a specific, individual ethical analysis. The second was Ildefonso Hernández (Alicante), who considered practical examples where public health would benefit from the application of bioethics. And the third was Andreu Segura (Barcelona, president of SESPAS), who considered the criteria which would form the basis of a programme of activities in ethics in the context of public health education and practice.

Including the speakers, there were 19 invited participants: philosophers, lawyers, experts in bioethics, doctors and the president of the Víctor Grífols i Lucas Foundation, Victòria Camps (Barcelona). The doctors included three with training and/or practical experience in primary care (Pablo Simón, from Granada, Rogelio Altisent, from Zaragoza, and myself).

The event operated on a seminar format, with ongoing, lively, rigorous discussion. The first session reviewed the most important publications on ethics and public health from around the world, highlighting issues specific to public health and how to address them. In my definition of *public health* I defended a vision of it as a health system which offers services to groups and populations, operating through institutions with a legal mandate to meet objectives regarding health prevention (of disease), promotion (health improvement) and protection (the establishment of laws, rules and regulations). Of course, public health activities involve many other spheres, such as education, doctors’ surgeries or traffic regulation, but that is “public health through other policies, institutions and activities”.

In any case, it is important to bear in mind that health services are offered to inhabitants, not only to citizens (a more restrictive concept). There are relatively few national programmes of public health activities: antenatal diagnostic programmes; diagnosis of metabolic disorders, neonatal screening, vaccines and breast cancer. At the same time, the field of public health is dynamic, and some activities are transferred to other professionals once basic problems have been resolved: for example, sewage treatment or housing standards.

There was a detailed discussion of the state’s coercive capacity to impose public health standards and, at times, to subject individual rights to the pursuit of the common good. In the United States, individual liberty is understood in a different way than in Europe, as can be seen by the tolerance of firearm possession in the United States, and this individualism has an influence both on bioethics in general and on the way it is applied to public health in particular.

Public health activities need powerful justifications, as they involve interfering with people’s choices and personal lives (restrictions on freedom in order to achieve benefits for the population).

Naturally, the question of risk arose: of the personal and collective acceptance of risks and of the proportionality of public intervention to modify risk (and how this is assessed).

There was debate about the principles of bioethics (autonomy, non-maleficence, beneficence and justice) and their adaptation to public health, with general acceptance of the precautionary principle (without allowing it to go too far) and of reasonable transparency (which facilitates decision-making).

Rose’s paradox was explored (actions which offer little benefit to individuals may offer great benefits to the group), something which provides a justification for considering group benefits when deciding upon interventions, an approach which in turn may give rise to accusations of “well-meaning manipulation”. And, inversely, that which is of great benefit for the group may be catastrophic for the individual (for example, encephalitis due to measles vaccination).

Often, public health problems are related to individual health services, either for better (advice against smoking) or for worse (adverse effects or complications of medical treatment). It is important to bear in mind that any health activity (whether individual or collective) may cause harm, and that the basic principle should be *primum non nocere*.

The second session built on the debate which had preceded it to address more practical issues, such as good governance, regulations, health monitoring, communication, health education, prevention, emergencies and research. It considered, for example, the “world” of vaccines, including the experience of the swine flu pandemic¹ (Ildefonso Hernández was director of Public Health at the Department of Health at the time) and, in passing, the “anti-vaccination” movement, the absurd proposal that autism is related to the MMR vaccine, and the similarly absurd demand for proof of causality when vaccines cause harm.²

Another topic of discussion was obesity, and I insisted on its political origins: the politics of geographic and urban development; employment policies and the location of industries and services; the promotion of private transport and other issues (the aim is to convert obesity into a medical problem, without assessing the impact of food, of the basic act of eating, on what it means to be a human being, with millions of years of evolution under conditions of near-permanent hunger).

And in this regard I also argued for the fallacy of the notion of “lifestyles”, as if we were free to choose, when in reality they are “living conditions” which are more or less imposed upon us (so that we may then become victims or guilty parties).

Inevitably, the questions of smoking and alcohol came up, together with the ethical problems raised by their management from a public health perspective. And the example of the Basque Country, with its proposals for “good governance” in public health, was considered.³

There was discussion of the funding of public health campaigns by companies and industries with an interest in promoting unhealthy practices. In this respect, the problem of the disparity between the influence on the public

health agenda of powerful interests and the far lesser influence of affected groups or populations was considered.

With respect to the process of developing rules, laws and regulations, mention was made of the practice of “not provoking antibodies” or of avoiding reactions which might harm political or personal interests. As a result, legislation is not always ethical or even logical. The problem may be aggravated if, with the predominance of neoliberal ideas (of the right or far-right) the state and the public sector “shrink” yet further, reducing the power of public health and the ability to defend the health of groups and populations. The aim should be that rules should become codes of conduct for both health professionals and members of society as a whole. Unfortunately, in many cases publishing rules, laws and regulations appears to exhaust the political energy, and nothing is done to ensure that these are mirrored in practice.

In screening programmes, such as for breast cancer, few realise that information is “commandeered”, leading to the overestimation of benefits. In practice (to take the example of the region of Castilla y León) the breast cancer screening programme leads to earlier diagnosis of 1 in 7 indolent breast cancers, and delays 1 in 9 aggressive breast cancers.⁴ In no case does it reduce mortality in the screened population, possibly due to the mortality associated with overdiagnosis and overtreatment (chemo and radiation therapy). In this regard, there was a very interesting debate about communication and propaganda, and how the two concepts are often mixed, particularly during public health crises in the “mass formation media” (not “information”, in the words of Agustín García Calvo).⁵

Participants insisted on a responsible transparency, one which respects both individuals and groups, does not commandeer information and, at the same time, is not an exercise in obscenity or imbecility. What matters is not the freedom to know but rather equality of opportunities to choose. In any event, “not to do” is as much of a decision as “to do”, and what we “don’t do”, others will do out of their own interests, a fact which poses profound ethical problems.

Participants noted the limitations and relative ineffectiveness of health education, in comparison to formal education (both compulsory and beyond).

In a perceptive comment, regarding the need to “know”, it was noted that some doctors treat Bayes theorem almost as if it were magic; in other words, it is used all the time, without people necessarily knowing how it works.

The radical opinion was expressed that ethical problems arise in association with all public health interventions. In other words, public health decisions are always the expression of explicit or implicit values, in which ethical conflicts are resolved (often without recognizing them).

The session ended with the ethical problems raised by research (and its absence) in public health, the problems of external validity, the challenge of moving from efficacy to effectiveness, and excesses of commission rather than omission.

The third session reflected on the need for ethics, despite a feeling among many health professionals of “What’s the point? If I’m already doing a good job ...” However, some public health interventions can be very harmful, and good intentions are not enough. Among other questions, participants discussed: 1) developing a section of SESPAS dedicated to ethics and public health; 2) producing a text on training (for both students and professionals) and ethics in public health (an assignment taken up by Rogelio Altisent, who agreed to produce a first draft); 3) promoting discussion of the literature on ethics and public health in clinical and health management;⁶ 4) maintaining the work of the group by online collaboration; and 5) promoting the description of case studies in ethics and public health (I offered my services to Ildefonso Hernández to describe the response to the swine flu pandemic in 2009 and this offer was accepted, so there is one text in preparation). In summary, it was an excellent event which it is to be hoped will provide a good starting point for the job of ensuring that ethics becomes integral to public health.

References

1. With respect to virus A/California/7/2009/H1N1, the author’s opinions are summarized in the video of the conference held at the Faculty of Medicine of Oviedo, on November 2010, as part of a workshop on “Science and Marketing”, de Farmacriticxs (medical students) and NoGracias (health professionals who promote “healthy” relations with industry). Available at <http://timefortruth.es/general/juan-gervas-la-vacuna-de-la-gripe-no-sirve-para-nada/> (consulted on 15 December 2011).
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List of participants

Coordinator

- Andreu Segura, Director of Public Health at the Institute for Health Studies (IES) and president of the Spanish Society for Public Health and Health Administration (SESPAS).

Speakers

- Ricard Meneu, Vice-president of the Health Services Research Institute Foundation in Valencia.
- Ildefonso Hernández, Professor of Preventive Medicine and Public Health at Miguel Hernández University.

Invited specialists

- Macario Alemany, Professor of Legal Philosophy at the University of Alicante.
- Rogelio Altisent, Coordinator of the Bioethics Research Group at the Aragonese Institute for Health Sciences.
- Emili Balaguer, Professor at the Department of Public Health, History of Science and Gynaecology at the Miguel Hernández University.
- Josep M.^a Busquets, Member of the Bioethics Committee of Catalonia.
- Marc Antoni Broggi, Surgeon and President of the Bioethics Committee of Catalonia.
- Victòria Camps, President of the Víctor Grífols i Lucas Foundation.
- Maria Casado, Director of the Bioethics and Law Observatory at the University of Barcelona.
- Juan Gérvas, Doctor and Honorary Professor of Public Health at the Autonomous University of Madrid.

- Joan Pons, Scientific Advisor to the Agency for Information, Evaluation and Quality in Health.
- Àngel Puyol, Director of the Department of Philosophy at the Autonomous University of Barcelona.
- Isabel Rio Sánchez, Researcher at the National Centre for Epidemiology (CNE), at the Carlos III Institute for Health.
- Bernabé Robles, Neurologist and Master in Bioethics.
- Begoña Román, Professor of Ethics at the University of Barcelona.
- Màrius Morlans, Doctor and President of the Ethics Committee of the Vall d'Hebron University Hospital, Barcelona.
- Núria Terribas, Director of the Borja Institute for Bioethics.
- Pablo Simón, Professor of the Department of Citizenship and Ethics at the Andalusian School of Public Health.

Publications

Bioethics monographs:

27. *Ethics and public health*
26. *The three ages of medicine and the doctor-patient relationship*
25. *Ethics: an essential element of scientific and medical communication*
24. *Maleficence in prevention programmes*
23. *Ethics and clinical research*
22. *Consent by representation*
21. *Ethics in care services for people with severe mental disability*
20. *Ethical challenges of e-health*
19. *The person as the subject of medicine*
18. *Waiting lists: can we improve them?*
17. *Individual Good and Common Good in Bioethics*
16. *Autonomy and Dependency in Old Age*
15. *Informed consent and cultural diversity*
14. *Addressing the problem of patient competency*
13. *Health information and the active participation of users*
12. *The management of nursing care*
11. *Los fines de la medicina* (Spanish translation of *The goals of medicine*)
10. *Corresponsabilidad empresarial en el desarrollo sostenible* (Corporate responsibility in sustainable development)
9. *Ethics and sedation at the close of life*
8. *The rational use of medication. Ethical aspects*

7. *The management of medical errors*
6. *The ethics of medical communication*
5. *Practical problems of informed consent*
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