Choosing health? First choose your philosophy

"For each of us, one of the most important things in life is our own and our family’s health." With these words, the UK Prime Minister, Tony Blair, introduced the long-awaited White Paper on public health, Choosing health: making healthy choices easier, from the Department of Health for England. The case for investment in the health of the population had already been made by the Treasury. Its Wanless Report emphasised the importance of engaging fully with the determinants of population health, not only because health is important in its own right but also because doing so will reduce future costs to the National Health Service. The White Paper represents the Department of Health’s vision of how this engagement is to be achieved.

It is important not to lose sight of the fact that this document represents a fundamental shift from short-term reactive perspectives about illness to a long-term proactive policy about health. The Government is to be applauded for this. However, at its heart, Choosing health has failed to resolve philosophical tensions that have prevented the genesis of a coherent public-health strategy. What is the balance that should be struck between state intervention and individual freedom? Choosing health cannot make up its mind.

UK governments have in the past recognised that, left to their own devices, individuals will not necessarily act in ways that maximise their health. As a consequence, the state has acted to protect individuals from their actions, demanding safer drug-packaging to make suicide more difficult, for example. It has also acted to protect individuals from the actions of others, as when it imposes speed limits on roads. The problem is to know where to draw the line because many actions by an individual will affect in some way on other people. The dilemma the Government faces is illustrated by the condemnation it receives when it is seen as failing to protect the public, as when a rail crash occurs, yet the same voices accuse it of establishing a nanny state when it seeks to act on the far greater risks from smoking or poor nutrition.

The first decision to make when developing a public-health strategy must be to decide the philosophical basis on which it is to stand. What is the present Government’s philosophy on the balance between the state and the individual? Its original Third Way seems to have slid into obscurity and the Prime Minister, when asked to describe his defining philosophy by a sympathetic Member of Parliament, was unable to answer. Elsewhere governments have asked the people. The Swedish Government engaged in a nationwide consultation that led to an explicit statement on the values that should underpin its health strategy. In England the consultation undertaken to inform the White Paper focused on specific issues rather than on underlying values; the Government’s Big Conversation, which might have looked at values, has produced few meaningful results, except to confirm that most people do not trust politicians. Thus it comes as something of a relief to find that the White Paper sets out a clear statement of the values on which policy is to be based. This approach is encapsulated in the document’s title, which manages to introduce the Government’s favourite concept, choice, twice within six words. The words choose or choice appear a further five times in the Prime Minister’s foreword, so setting the tone for the rest of the document. To avoid any misunderstanding, the Health Secretary, in his preface, emphasises that “our starting point is informed choice. People cannot be instructed to follow a healthy lifestyle in a democratic society”; although later he admits a note of caution in that “We need to strike the right balance between allowing people to decide their own actions, while not allowing those actions to unduly inconvenience or damage the health of others.”

The Department of Health thus appears to have embraced the arguments set out by John Stuart Mill in his essay On liberty in which he argued that the only justification for the state to constrain the actions of an individual were when an individual’s actions risked harming others. As long as the individual is an adult, any action that results in harm only to him or her self is not a concern to others.

Yet it was never quite as simple as Mill suggested, as people face constraints in making choices. These constraints can be environmental, involving structural, organisational, and financial barriers, as well as individual, such as psychological and informational barriers. These constraints were recognised by the Health Secretary in a lecture at the UK Faculty of Public Health on Nov 25, 2004, in which he emphasised that the driving force behind the White Paper...
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was the concept that “men and women make their own choices but do not do so in circumstances of their own choosing”. Here, far from taking Mill’s libertarian perspective set out in the foreword to the White Paper, he has borrowed from Karl Marx, who argued that “men make their own history, but not of their own free will, but under given circumstances with which they are confronted”. The implication of this dialectic suggests that extensive intervention by the state in the form of regulation and legislation will be required to modify those constraints that arise from the environment in which people live. The resulting philosophical tension between the desire to allow people to decide their own actions, and the need to recognise the power of circumstance on people’s lives, has not been resolved in the White Paper.

On the one hand, the Government is prepared to legislate to ban retailers from selling tobacco if they flout the law on underage smoking and to ban smoking in some public places. On the other hand, with food for example, the Government advocates taking the back seat, limiting state action to providing “information and practical support so that healthy choices are easier to make” by extending the “the use of the 5 a day logo to foods targeted at children”. The logic of this approach is at best opaque, and at worst defeatist and inconsistent. The approach implies that children can be expected to make informed choices about food but not about cigarettes. Furthermore the emphasis on voluntary agreements with the food industry ignores the Government’s own admission in the White Paper that the effect of such agreements with the tobacco industry “is slow” as well as research showing that voluntary regulation of the food and alcohol industry is ineffective. Yet the Government persists in its decision to “work with industry to develop voluntary action to reduce fat and sugar levels” and is waiting until 2007 to confirm that voluntary codes to regulate the promotion of food to children will not work. It is unclear why, if legislation to ban smoking is needed now, legislation on food and alcohol can wait.

A determination to rely on the provision of information to change behaviour pervades the White Paper. There are to be new national campaigns on sexual health, obesity, smoking, and alcohol. Action in these areas is certainly welcome, given the evidence that UK adolescents have some of the highest rates in western Europe of smoking, hazardous drinking, teenage pregnancy, and illicit drug use. The question is whether such campaigns will work?

The challenge is enormous. Any campaign will take place in an environment in which individuals are already bombarded with a vast array of highly sophisticated and enormously expensive marketing activities designed to encourage activities that are likely to damage health. This is recognised by the Government, which notes in the White Paper that expenditure on marketing by the food industry, much of it promoting products that are high in fat, sugar, and salt, is a hundred times greater than that spent by the Government to promote healthy eating.

But the battle to secure behavioural change will not necessarily be won by those who spend the most on bringing messages into the public domain. Successful behaviour change requires three elements. The first is that effective health-promotion messages communicate positive values associated with choosing health. The second is that such messages must take account of the complex network of factors associated with risk-taking behaviour. These include factors at the individual level (including motivation, perceived consequences from different courses of action, and values placed on those consequences), their social support networks (including the influence of families and peer groups), their local environment (eg, school ethos), and the national context (including the whole range of often subtle marketing activities, taxation, and regulation). The third element is the development of specific action plans that take account of the needs of different groups. Ensuring the successful implementation of these elements requires long-term planning of clearly thought through initiatives, supported by high-level commitment to ensuring that policy is based on rigorous evidence.

The uncertain path from the publication of research to policy implementation is widely recognised. Here the White
Paper concedes that a major problem will be the lack of evidence to inform policy. But who is going to do this research? Although an expansion of training in public health is mentioned, there is nothing on developing capacity in academic public health, an area that has suffered disproportionately in the fall-out from the most recent Research Assessment Exercise. However it is not only academic units that must engage in research; “local providers must take account of the factors that impact on the decisions people make about their health”15. Staffed primary-care trusts must be wondering how they are to do this amid the mass of competing priorities and, in many cases, large budget deficits, while anticipating the highly destabilising consequences of the National Tariff and Patient Choice initiatives.

Given the lack of an evidence base, it is imperative that new initiatives are evaluated and that the results influence service delivery. In many cases the preferred design will be the randomised trial. Yet, axiomatically, this design requires that the intervention be embedded in half of the target community (until and unless it is shown to be effective). How many primary-care trusts, under central pressure to deliver results, will be willing to wait for the evidence of long-term improvements in public health? As the experience of successive UK reforms since the late 1980s shows, the National Health Service does not provide a climate that encourages in its effort to nudge ministers towards policies that are coherent, based on evidence, resistant to vested interests, and which are actually implemented.

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We declare that we have no conflict of interest.

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Patronising monkeys

We meet again. Here we are, my friend Eric and I, putting the world to rights. First, an apology. In a previous discussion,1 we referred to our fellow primates as Homo sapiens. This is in error; some years ago, H sapiens decided to be a subspecies—H sapiens sapiens. It is difficult to make sense of this pompous conceit, but nonetheless we apologise. We apologise, in addition, on behalf of our species, Pan troglodytes (which remains proudly unsubspecied), for a regrettable outbreak of species-subspecies violence in a Ugandan National Park. Some rogue chimpanzees got intoxicated on stocks of banana beer, illegally brewed by H sapiens sapiens, and killed up to eight children.1

Inexcusable, but who is truly to blame? There is good news, of a sort. Chimpanzees have been found to be smarter than H sapiens sapiens children, at least in trying to get food out of a box.3 We do not find this observation surprising.

Chimpanzees have long been patronised by H sapiens sapiens for speaking, typing, using tools to get food out of boxes, and so forth. We have griped before about this.4 Now it is the monkey’s turn. Snoopers photographed Capuchin monkeys (Cebus albifrons) in Brazil using stones to dig up vegetable roots and eat them.2 Isn’t that just so cute? And it is the first report, ever, of a monkey using a tool to dig up roots.