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Public policies, law and bioethics: a framework for producing public health policy across the European Union

EXECUTIVE SUMMARY

EuroPHEN

(European Public Health Ethics Network)

www.europhen.net

Funded by the European Commission, DG Research, under FP5,
Quality of Life Programme

QLG6-CT-2002-02320
€1.854m

01 March 2003 – 31 August 2006

Abstract

Unlike the duties of clinicians to patients, professional standards for ethical practice are not well defined in public health. This is mainly due to public health practice having to reconcile tensions between public and private interest(s). This involves at times being paternalistic, while recognising the importance of privacy and autonomy, and at the same time balancing the interests of some against those of others. The Public Health specialist operates at the macro level, frequently having to infer the wishes and needs of individuals that make up a population and may have to make decisions where the interests of people conflict. This is problematic when devising policy for small populations; however, it becomes even more difficult when there is responsibility for many communities or nation states. Under the Treaty on European Union, the European Commission was given a competence in public health. Different cultures will give different moral weight to protecting individual interests versus action for collective benefit. However, even subtle differences in moral preferences may cause problems in deriving public health policy within the European Union. Understanding the extent to which different communities perceive issues such as social cohesion by facilitating cultural dialogues will be vital if European institutions are to work towards new forms of citizenship.

The aim of EuroPHEN was to derive a framework for producing common approaches to public health policy across Europe. Little work has been done on integrating ethical analysis with empirical research, especially on trade-offs between private and public interests. The disciplines of philosophy and public policy have been weakly connected. Much of the thinking on public health ethics has hitherto been conducted in the United States of America, and an ethical framework for public health within Europe would need to reflect the greater respect for values such as solidarity and integrity which are more highly valued in Europe. Towards this aim EuroPHEN compared the organisation of public health structures and public policy responses to selected public health problems in Member States to examine how public policy in different countries weighs competing claims of private and public interest. Ethical analysis was performed of tensions between the private and public interest in the context of various ethical theories, principles and traditions. During autumn 2003, 96 focus groups were held across 16 European Union Member States exploring public attitudes and values to public versus private interests. The groups were constructed to allow examination of differences in attitudes between countries and demographic groups (age, gender, smoking status, educational level and parental and marital status). Focus group participants discussed issues such as attitudes to community; funding of public services; rights and responsibilities of citizens; rules and regulations; compulsory car seat belts; policies to reduce tobacco consumption; Not-In-My-Back-Yard arguments; banning of smacking of children; legalising cannabis and parental choice with regards to immunisation. This project proposes a preliminary framework and stresses that a European policy of Public Health will have to adopt a complex, pluralistic and dynamic goal structure, capable of accommodating variations in what specific goals should be prioritised in the specific socio-economic settings of individual countries.

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Executive Summary

Background

Definition of Public Health

In 1952 the WHO proposed a definition of public health which encapsulated a wide variety of state activities such as preventing epidemics, increasing sanitation, safeguarding food and water as well as monitoring the health status of the population. As Public Health has evolved in recent years the WHO's definition has been criticised, particularly on the basis that it fails to capture the breadth and aims of public health action which extend beyond improving health *per se.* A number of alternative definitions have been proposed based on the shift away from viewing health simply as an absence of illness or prolonging life towards viewing health in terms of wellbeing.

While traditional Public Health emphasised the role of the state and public organisations more recent definitions seek to emphasise collective responsibility for health and a concern for the underlying socio-economic and wider determinants of health. In this regard Public Health is concerned with issues of equity in the distribution of health in a population and the creation of societal conditions to allow healthy choices to be made if desired. This involves the organised efforts and informed choices of society, organisations, public and private, communities and individuals. As a result Public Health is now viewed as *"the science and art of preventing disease, prolonging life and promoting health through organised efforts of society"*. Public health practice is characterised by: its emphasis on collective responsibility for health and the prime role of the state in protecting and promoting the public's health; a focus on whole populations; an emphasis on prevention, especially the population strategy for primary prevention; a concern for the underlying socio-economic determinants of health and disease, as well as the more proximal risk factors; a partnership with the populations served.

Tensions between private and public interest

Public health practice has to reconcile tensions between public and private interest, at times being paternalistic, while recognising the importance of privacy and autonomy, and at the same time balancing the interests of some against those of others, and/or society as a whole. In practice, one or more tensions may arise between private and public interest within the development and practice of public policy. For example what the individual thinks is in his or her best interests may:

- Be contrary to what others think is in the individual's best interests. Such policies would be paternalistic. Children are a special case where parents and others may have conflicting views of the child's best interests;
- Conflict with the best interests of one or more other identifiable individuals. Here public policy has an adjudication role and may consider desert and duties of care;
- Conflict with general societal interest i.e. interests of one or more individuals who are not identifiable or yet to be born. For example, arguments of justice might require a maximisation of return from scarce societal resources.

The duties of clinicians to patients are well established. In contrast, professional standards for ethical practice are not well defined in public health, because a public health specialist operates at the macro level, in some cases far removed from the context of health care, and frequently has to infer the wishes and needs of individuals that make up a population and may have to make decisions where the interests of people conflict. This is problematic when devising policy for small populations; however, it becomes even more difficult when there is responsibility for many communities or nation states.

Rationale

Under the Treaty on European Union, the European Commission was given a competence in public health. Different cultures will give different moral weight to protecting individual interests versus action for collective benefit. There is likely to be scope for variance with expansion of the European Union. However, even subtle differences in moral preferences may cause problems in deriving public health policy within the European Union. Understanding the extent to which different communities perceive issues such as social cohesion by facilitating cultural dialogues will be vital if European institutions are to work towards new forms of citizenship.

Normative Ethics

The central question of moral philosophy, is *how should one live? Normative ethics* provides substantive proposals as to how live, how to act, what sort of person one should be. In particular, it attempts to provide a moral framework governing these principles, in terms of what is right and wrong and in turn to specify associated rights and duties etc.. Since such basic moral principles will probably be stated in more general terms, it may not be clear as what should be done in a particular case, especially in morally complex situations. This is more likely within a normative framework derived from several fundamental principles which conflict or appear to conflict. It may even be difficult to assess how one fundamental principle should be applied in a particularly controversial issue. *Applied ethics* is therefore the branch of moral philosophy that seeks to apply the general principles of *normative ethics* to such complex problems.

The EuroPHEN project is primarily concerned with *normative ethics*. It is *applied* in the sense of application to the field of Public Health. But it aims to ask address the question *How should one practice as a Public Health Professional?* (as opposed to *how should one live?*). There will be associated *normative* questions such as *What are the priorities for Public Health? How should policy be derived? Who should be involved? How should policy be implemented?* There is a continuum, into more *applied* situations in relation to specific public health policy areas, which EuroPHEN also explored. However, the focus of EuroPHEN was to address *normative* issues.

The rival *normative* theories explored within EuroPHEN address how people *ought* to act, morally speaking. They are not claims about how people *do* act. EuroPHEN has explored how public policy makers *act* by describing the legislation and policies that and how citizens respond to these specific policies. However, it is important to be clear about the distinction between *what ought to be* and *what is*. A claim about how people/professionals *ought to act* should not be mistaken for a description of how people/professionals *actually act.* The importance of this distinction is that it is not possible to disprove an assertion as to what *ought* to be done in a particular circumstance just by producing evidence demonstrating that people/professionals *do not act* in this way. It is also important to distinguish substantive moral claims of *normative* ethics with mere descriptions of the moral beliefs or ethical codes of some group or organisation. These codes may have legal or quasi legal standing, for example in regulating professional behaviour. However, there is a distinction between how a particular body *thinks* its members should act, as opposed to how they *really* should act. It is also necessary to distinguish to moral from the legal. Just because the law permits or even requires that we act in a certain way, does not mean that such an act or omission is morally valid.

Aim

To derive a framework for producing common approaches to public health policy across the European Union by examining concepts of European and universal ethical standards by conducting work in three areas, namely public health policy and practice; ethical analysis; and empirical research on public attitudes.

Methodology

Three main strains of analysis were carried out within EuroPHEN.

Ethical analysis was performed of tensions between the private and public interest in the context of various ethical theories, principles and traditions including Liberalism, Social Justice, Kantism, Utilitarism, and Communitarianism. Little work has been done on integrating ethical analysis with empirical research, especially on trade-offs between private and public interests. The disciplines of philosophy and public policy have been weakly connected. Much of the thinking on public health ethics has hitherto been conducted in the United States of America, and an ethical framework for public health within Europe would need to reflect the greater respect for values such as solidarity and integrity which are more highly valued in Europe.

The project systematically compared the organisation of public health structures and public policy responses to selected public health problems in Member States. Our analysis provided insight into how public policy in different countries weighs competing claims of private and public interest, and also grounded the qualitative explorations of the public attitudes to these policies. A number of policies were analysed in greater detail to provide background for the qualitative analysis.

A qualitative analysis was conducted to explore public attitudes and values to public versus private interests for a number of topics including attitudes to community; funding of public services; rights and responsibilities of citizens; rules and regulations; compulsory car seat belts; policies to reduce tobacco consumption; Not-In-My-Back-Yard arguments; banning of smacking of children; legalising cannabis and parental choice with regards to immunisation. 96 focus groups were carried out across 16 European Union Member States (two locations in each country). Focus groups are particularly effective in highlighting both arguments used and the social and cultural context for individual believes as well as raising questions and perspectives that may not naturally occur during other qualitative methodologies. In this regard it was felt that while focus groups do not measure strength of options held, they would be particularly useful for establishing shared frames of reference and meaning. The groups were segregated according to gender; age (20-30 or 45-60 years); marital status; parental status; standard or further education; smoking status. The focus groups were tape-recorded, transcribed, and translated into English and the transcripts were then analysed and coded manually. Particular attention was paid to the reason(s) used to by participants to justify their decisions.

Some elements of the work packages of EuroPHEN could have been conducted at a national level, but there are a number of reasons why the project should have been conducted at a European level. For example, the challenge of developing a framework for public health ethics is common to all Member States, and economy of scale and effort will allow them all to benefit from the involvement of ethics and public health experts from across Europe. Research conducted at a European level is more likely to provide information to Member States on the views of all their ethnic communities of European origin.

Implication of Codes of Clinical Ethics for Public Health

Formal and informal professional medical codes of ethics exist in most countries. These ethical standards have tended to concentrate on the morality of interactions between individuals, such as doctor and patient and give limited or no attention to the macro level ethical issues nor the tension between private and public interest.

Many European Codes of conduct require that clinicians make the care of their patient their first concern. Such a requirement has limited meaning in a clinical context where doctors have many patients, and not all can be their *first concern*. At a population level such an edict has even less meaning, although there could be an obligation on a public health professional to make the care of the population for which they are responsible their first concern.

It is important to note that *community* is not a homogenous whole and to recognise that there are different cultures and disenfranchised members within the community. A community is made up of overlapping groups that can have special interests. The health of the population is the aggregation of the health of individuals even though there may be something more that is observed when people come together. Communities are in flux and always changing.

One of the most obvious ways that a clinician must demonstrate respect is in the context of privacy and consent. For clinicians this concerns the privacy of the individual patient and in general doctors must not disclose information to any person without the consent of the patient, unless ordered to do so by a Court or Tribunal. In the case of public health the issue becomes more problematic and disclosure of information maybe necessary to protect the interests of the patient, the welfare of society or of another individual or patient.

Public health institutions should respect the confidentiality of information that can bring harm to an individual or community if made public. All data and information should be respected as confidential, but as at an individual patient level, there may be circumstances when public interest requires that confidentiality should be broken. In such circumstances care must be taken to restrict the breach of confidence to ensure that there really is a genuine public interest requirement and that only the minimum amount of information is disclosed to appropriate third parties, who are also aware of their obligations.

In general consent must be given by the individual before giving any treatment or care, and competency is an important element of informed consent. The requirement to obtain consent before a health professional gives any treatment or care has become a norm within the clinical institution, however with regard to public health it is impossible to inform every member of a community of a public health decision, let alone obtain each person's consent in a meaningful way. Differences would also be expected with regard to the type of consent mechanisms which different communities will expect. The need to consult and obtain consent is of less importance if public health policies are developed with and owned by the community.

Within a public health setting communicating with populations is much more difficult than listening and talking to a single patient. As such a number of factors must be recognised. Population communication strategies need to be comprehensive to meet the very different needs of all members of the population. Public consultations need to be sophisticated to ensure that the views of as many people as possible in the population are listened to, not just those more skilled in lobbying or in more powerful positions. The means of obtaining this input should be grounded in the needs of the public, embedded within the community itself. Sometimes the process needs to be proactive, sometimes reactive however the methodology regarding the consultancy process must be clear and tailored to the needs of the issue. Particular attention should be paid to identifying disenfranchised members of society. It should be made clear that the process of informing the public about their rights and responsibilities as a citizen is a process that is lifelong, starting with school education.

Clinical professional codes tend to stress the need to respect diversity and not discriminate regarding patients or colleagues on the basis of a range of items (personal beliefs, religion, nationality, race, political affiliation, gender, ethnicity, age, socio-economic grouping or patient disability). At the level of public health policy, certain of these items which are connected to health may be the basis for positive discrimination (age, socio-economic group, patient disability).

Public health ethical codes could contain a requirement to treat people with respect and consideration for dignity, privacy etc at a population level. Respect for dignity and integrity should not be seen as implying that a public health professional must do everything that an individual or even what the majority of a population may want. Rather their interests should be considered along with the interests of other individuals and groups in the population.

The general medical codes make reference to the importance of maintaining and enhancing confidence between physicians and patient, emphasising the duty to maintain a good standard of practice and care. A critical feature of this that the public health professional should be self-reflective as to their own personal beliefs to insure that as far as practicable these should not prejudice decision making. Public health policy should be implemented in a transparent manner that facilitates accountability, including the provision of all information and evidence used to inform the decision making process.

In regard to public health there is a possibility that *conflicts of interests* will be seen to undermining public trust. There should be trust in a public health professional to protect and promote the well-being of the population as a whole. However, this trust has been eroded by various public health scares and scandals, e.g. Bovine Spongiform Encephalopathy (BSE)/ new variant Creutzfeldt-Jakob Disease (CJD), and the combined measles, mumps and rubella (MMR) vaccination.

Public health professionals are continually managing risk, and hence it is appropriate to expect them to identify and minimise risks for a population, just as clinicians are required to minimise risk to patients and clients. However it is impossible to reduce all risk, and the risk for some may increase, in the same way that the interests of a few individuals may be impaired by policy that is in the general societal interest.

The various European clinical codes emphasise the needs of the individual patients over that of the cost of treatment. For a public health professional, prioritisation and resource allocation decisions are a daily reality. Within public health practice it is impossible to avoid making choices between people. At a population level discrimination is required when making prioritisation decisions based on capacity to benefit, cost-effectiveness etc. Sometimes public health professionals become involved in making decisions, when they must discriminate between the interests of individuals, e.g. in communicable disease control. However, the important ethical issue is that this discrimination is fair and equitable. Similarly situated individuals should have equal access to health care services. Where one individual or group has greater capacity to benefit or more people may benefit because an intervention is more cost-effective compared to another, then it is just, indeed arguably ethically required, to make such choices.

Philosophical Theories

Liberalism

The question *what implications does liberalism have to public health policies?* entails different answers depending on the interpretation given to liberalism. For the so-called mainstream welfare liberalists the importance of individual autonomy is inviolable but they, unlike the libertarians, claim that human wellbeing requires a certain amount of positive rights and corresponding duties. In primarily self-regarding matters they speak for individual autonomy and for *state neutrality between different conceptions of good*. They value individuality, individual rights, freedom and equality, and their belief in rationality allow them to believe in social improvement.

The most important question concerning the proper limits of individual liberty is whether public health policies and public health care respect people's own wishes and interests, and, at the same time, protect them from each other's conflicting choices, even if it sometimes means that people's preferences have to be laundered in order to achieve tolerance and reciprocal forbearance. If I am ready to participate in medical costs of clotted arteries, caused by indulgence in rich, unhealthy eating habits, an antismoking butter-and-eggs eater should be equally ready to participate in costs caused by smoking.

In a liberal society public health authorities should promote autonomy-respecting health programs which ideally aim at rendering people *aware of the conditions of their own health*. What they are not allowed to do is to find ways to manipulate, threaten or coerce people into *choosing* healthier life-styles. Individuals should be entitled to make their own decisions, when these decisions concern *only or primarily themselves*. This means that people can quite legitimately make choices which are bad for their own health. The greater knowledge and impartiality of the authorities guarantee their expertise in the epistemic sense, but when it comes to matters which fall within the scope of people's self-determination and autonomy, they are morally on their own.

Kantian perspectives

Public health programs are driven by the impetus to do good in society and therefore enact moral prescriptions on how to live lives individually and collectively: Many individuals are forced to give up risky behaviour such as smoking, eating fat, living a motionless live or performing stressful work. Should citizens contribute to the health, prosperity and wealth of the community? How may collective, organized public health measures be productive in this respect? The common approach in public health and public health policy is to discuss *what kind of goals* have to be set and to *what extent* individuals may be *forced*, that is, to what extent public health programs may be voluntary or mandatory. In this respect, public health policy makers and practitioners traditionally act upon their own interpretations of what is in the public interest, although these interpretations diverge throughout the European Union depending on the political and public health traditions in the various member states.

The Kantian, liberalist view, however, puts another question: what *should be* the *social process* through which to set the goals of Public Health and what *should be* the *responsibility of public health professionals*, who claim to do good on behalf of society? On the Kantian, liberalist view autonomy and freedom are not characteristics of isolated individuals living their own separate lives, but are inherent features of social practices leading up to a vital and creative communal life. Public health, collective and coercive measures – do not smoke, do not eat fat, exercise, refrain from stress, etc. – may in fact weaken responsibilities of individuals and communities. If the mishaps associated with driving, smoking, eating fat, exercising too little, living too ambitious lives and other kinds of behaviours considered to be unresponsive to society's needs and goals, carry with them severe social and legal repercussions, citizens may decide to give up all sorts of social behaviour which are vital and creative to individuals and communities. By cutting down responsibilities, individuals and communities may draw the boundaries of their selves and their identities more narrowly than they otherwise would have done. Instead of making explicit public announcements of mandatory measures, the public health community better takes an *interactive* approach with the public and better considers autonomy and freedom as allies to promote the capacity, creativity and vitality of citizens living their lives as members of social networks and society.

Utilitarianism

It is often stated that utilitarianism is the dominant theory behind public health. While there is some truth to this, it presents a gross over-simplification. This is because there is no one definition of utilitarianism nor of public health. The normative content and depth of utilitarianism is to a large degree determined by the definition given to utility, and further prescriptive variations are brought in by the different side-constraints laid upon utility calculations.

Public health is concerned with the health of the whole population and attempts to reduce morbidity or mortality within the whole population. In this way it could be seen to echo the basic utilitarian ideals of impartiality, as the focus is raising the overall health of the public, rather than that of any one individual or group. Utilitarianism tends to make comparisons between various courses of actions and deem one better than the other based on which of alternatives leads to the best end results with the lowest cost e.g. preventive is better (cheaper) than cure. Many public health interventions e.g. vaccinations and water fluoridation, are justified by variations of the utilitarian credo that we should aim at *the greatest happiness of the greatest number*. The occasional adverse effects are seen to be acceptable because of the benefits to the rest. Similarly the more drastic measures sometimes taken in the name of public health, like quarantine, are justified by the benefits to the many. Utilitarianism is often criticised for allowing the sacrifice of individuals in the name of benefit to the greatest number and here Public Health faces similar kinds of charges. Jeremy Bentham might have allowed the sacrifice of individuals because of public health considerations, whereas John Stuart Mill, found it necessary to restrict utilitarian considerations with those of individual liberty. While Mill might have allowed quarantine because of harm to others' considerations, and would have allowed warnings on products known to be dangerous to one's health, he might have had a thing or two to say about banning self-harming goods and about other clearly coercive measures.

Side-constraints are also called for by today's Public Health authorities. Most feel that there are limits to the sacrifices that can be asked for in order to reach the greatest health benefits. If public health were utilitarian, it would most likely be described as objective and ideal, rather than subjective or preference related. That is, health as the goal is for the most given objective criteria and it is seen as an ideal. Whether Public Health would be described as positive or negative utilitarianism will depend on whether the emphasis in the definition is given to reducing ill-health or to increasing the overall health. Public health tends to assess each intervention on its own merits which would fit better with the ideals of act utilitarianism than rule utilitarianism. To the degree that public health is interested in the cost-effectiveness of its methods, it comes closer to economic utilitarianism (this is sometimes called health economics) than to the moral and political forms of utilitarianism. Preference utilitarians have problems with the objectivity of the definition of *the good* in public health, and even more Utilitarians would find the idea of health as the main good to be promoted too narrow in scope. Those Utilitarians with Millian ideas on the importance of individual liberty would find the paternalistic undertones of public health difficult to accept; and while most Utilitarians would praise the impartiality of public health, many find its emphasis on the collective unsatisfactory.

Solidarity

Individuals may be motivated to act in the interests of others out of a sense of solidarity. This is an awareness of unity and a willingness to bear the consequences of it. Through our societal role we are a member of various groups. For example, family, religious group, ethnic sub-population, each group is defined in terms of a common history, common convictions and ideals. The group is linked by a desire to further *common interests* or by *interests in common* which motivate collective action. Within group solidarity, the main focus is on the best interests of the group. The individual is part of the group and benefits if the group flourishes, but it is the collective interest that is the main concern. Within moral solidarity, the main focus is a third party individual and what doing things for them because it is the right thing to do. While there may be some expectation that others would act in the same way if the positions were reversed, in the pure sense of moral solidarity, the action is purely altruistic, and there is no expectation of personal reward of acting morally in doing the *right thing.* Within constitutive solidarity, the main focus is the individual themselves. They are working with other people, and so indirectly assisting others to advance their goals but the focus is benefit to self.

Communitarianism

Liberal theories give priority to the rights of the individual above those of society. The individualists tend to distinguish between who one is and the values one has. Rawls attempted to make this distinction in his description of the *original position* and the *veil of ignorance* in which participants are supposed to be ignorant of any information about their beliefs, norms, class, status, etc. Sandel argued that the liberal vision of the individual as the autonomous chooser of his or her own purposes presupposes that the chooser is sufficiently sovereign over, and therefore distanced from them.

Communitarians believe that this conception of the self is illogical. A self that is as open-ended as the liberal conception requires would not be so much free as *identity-less*. Only a *thickly constituted self* shaped in its very being by traditions, attachments, and more or less irrevocable moral commitments can actually make choices that count. Individualists fail to recognise that membership of a community is not necessarily voluntary, and that the social attachments which determine the self are not necessarily chosen ones. MacIntyre argued that one understands a person's life only by looking at his/her actions within a story, a *narrative.* Each person's narrative converges with the narratives of other people, who in turn become part of each other's narrative. The community (family, tribe, neighbourhood) sets up the form and structure for these narratives. Taylor, went further and instead of seeing community as being important in interpreting the individual sphere, he believed that community was a precondition for moral autonomy. Taylor argued that even the extreme libertarian acquires the desire for individual autonomy by virtue of participating in a civilisation that has learned, over the course of many centuries, to put a premium upon such aspirations. Taken out of a social-historical context, the very desire for control over one's autonomy would be void of meaning. Therefore, precisely those aspirations that define the autonomous individual are the expression of a debt to one's society, and hence represent social obligations, that are overlooked in libertarian theories.

In order to be sustainable, moral principles should be congruous with the values and practices of the society in which they are to be applied. One of the consequences of this is that it may not be possible to conceive morality in universal terms. Universal and absolute justice, for example, may be another illusion of individualism. Since the values that people hold derive from their communities, it is feasible that concepts such as justice may not be universal or absolute, if each community has a different understanding of what such moral values entail. Walzer argued that it is not possible to talk about justice without considering the sorts of goods that a particular society distributes among its members. Of course, these goods can also be socially constituted by shared experiences, communal meanings, and traditions of self-understanding that evolve through history. Therefore liberal justice cannot presume to maintain neutrality toward ends and goods.

When an individual attempts to define their personal moral code they ask *who am I? how am I situated*? and *what is to my benefit?* as well as establishing *what is good for the community?*, because, as Sandel pointed out, we are "*partly defined by the communities we inhabit*"" and are therefore "*implicated in the purposes and ends characteristic of those communities*." The exclusive pursuit of private interest erodes the network of social environments on which we all depend. The ability of an individual to exercise their autonomy depends upon the active maintenance of the institutions of civil society where citizens learn respect for others as well as self-respect. Similarly community flourishing is dependent upon the contribution of its members to shared projects. The relationship of private and public interest is manifested by a mesh of complimentary and reciprocal rights and duties. There is a recognition that there are common challenges faced by members of a community which can be addressed by common thought if not common action, with a spirit of solidarity to provide a voice and support for less well situated community members.

Personalism

Personalism is a wide-ranging cultural movement which can be divided into several trends from a philosophical viewpoint, but they have in common that their position is integrated and re-elaborated within a 'foundational' perspective and a particular philosophical anthropology: it considers the human person integrally and adequately understood. Some of the elements within personalism are particularly relevant in terms of public health ethics: (a) Respect for life: public health actions are aimed at protecting and promoting human life and health; (b) Sociality and solidarity: social solidarity means and contains a commitment to bridge the gap between the different segments in society and to integrate them into a community; (c) Responsibility: the responsibility to prevent and protect from avoidable diseases; the duty not to create irresponsible burdens for the society; the responsibility for people in need. This responsibility is also related to co-responsibility, where there is an encounter between the individual and collective responsibility.

Analysis of Public Health Structures and Policies

There is considerable variation between EuroPHEN countries in terms of the funding and organisation of health services and public health, for a combination of historical and political reasons. In some countries, public health is a branch of medicine, in others it does not exist as a medical specialty, in others it is a multi-disciplinary specialty, and in yet others it is not recognised as a profession in its own right. These factors also impact on the breadth of public health practice, ranging from biomedical interventions to policies to address inequalities. For details see full report.

Whilst most EU countries have comprehensive health policies which seek to prevent disease as well as develop health services, it does not necessarily mean that they have public health *systems*, such as an organised or connected group of agencies with a primary public health focus. In addition, methods of improving the health of the population depend upon a number of interrelated factors. These include: time; place; government style and political direction; degree of authority vested in, and exerted by, the state. Public health practice also varies according to the disciplinary base which may be narrow, predominantly focused on a medical model, or may be broader including a wider range of disciplines including political sciences. Public health practice also varies in response to new and urgent health priorities and changing governments and government bodies.

Individual countries within the EU are also expected to vary regard their underlying moral values and importance given to private verse public interests. This project has attempted to explore some of these concerns, however it should be noted that this is difficult due to methodological issues. We found that some countries tend to adopt relatively consistent patterns of the degree of liberalism versus paternalism whatever the public health issue studied (for example, Scandinavian countries tend to be more paternalistic, Western and southern European are more liberal). In addition, there is a degree of consistency between which public health policies are more liberal versus paternalistic depending on the issue, irrespective of the individual country (tobacco control and communicable disease control tend to have more paternalistic policies).

Returning to the issue of principle of subsidarity one can question to what extent these differences between public health structures is a concern. Common to all aspects of European Public Health is the shared interest of European Union to provide its population with opportunities for better health and ensuring a high level of human health protection. The precise mechanisms, structures and policies which each country uses to pursue these goals are likely to have greater efficacy as allowances can be made for differences in epidemiology, historical and moral weighting.

In the areas where the EU has not sought to harmonise policies between Member States through Directives, individual countries may be expected to vary to a greater extent and reflect their underlying moral values. Indeed we found through the analysis on the philosophical basis of public health policies revealed that there is a wide variation within and between the countries examined in terms of the degree of paternalism versus liberalism in their approach to the various public policies examined.

Most countries are paternalistic with regards smoking and communicable disease control, and the general trend is to increase the degree of paternalism with regards these two areas of policy. With regards smoking, the EU has led the way for increasing state control over smoking in public places, advertisement, sponsorship, and health warnings on packaging, and all countries have followed this guidance although Germany is slower than others, due to influential tobacco lobbyists and an emphasis on personal freedom in lifestyles.

With regards communicable disease control, the increased profile of this area of public health following real or threatened international outbreaks and incidents (the rise of tuberculosis, SARS, avian and pandemic flu, bioterrorism) has led to the development of new legislation in some countries which increase the state's power to contain and control, within limits.

The Scandinavian countries, together with Poland, also tend to be more paternalistic within drugs policy compared to other western European countries. However many of the previously more liberal countries are now moving towards a more paternalistic goal of abstention rather than harm reduction, perhaps as a consequence of a previously more liberal approach which is perceived to have failed or due to European politics.

Immunisation policy is perhaps surprisingly more liberal in Scandinavia but this may be due to a historical high level of trust in the authorities thereby requiring less legislation to ensure adequate levels of vaccination coverage.

There are explicit laws to regulate genetic testing in employment and prohibit discrimination in many Member States. Although in many countries there are exemptions from the protection of individual rights if testing would protect self and/ or others. Most countries are non-specific with regards to discrimination on the grounds of genetic tests. Because of the complexity of this issue and the continuous advances of this branch of science, these issues are under review in many countries and most seek to protect the individual worker. The overall direction is to be more paternalistic in terms of laws and punishments for non-compliance in order to protect the individual's rights, with exemptions in certain situations, in keeping with EU regulations.

There is increasing protection of children and vulnerable adults in clinical research across most countries in order to protect the individual rather than undertake research for the public good in line with EU Directives and the Declaration of Helsinki. There is variation in the degree to which these are implemented and worded and questions remain as to whether they provide the level of protection envisaged in practice. Austria, Spain, the UK and Ireland have only partial or no formal restrictions on payments to adults with capacity, a more liberal approach than the other countries which restrict this Austria, Germany, Italy and Sweden require the appointment of a proxy for the purposes of consent in incapacitated adults to be made through the courts, in other countries it is more liberal. Germany has the greatest restriction on research in children, and also has the greatest protection for pregnant women in research. This more paternalistic approach to protect the individual may be related to historical factors relating to the Nazi era.

Understanding how historical events and underlying moral values have shaped contemporary public policy is important to the development of international public health policy. Although all EU countries are subject to various Directives, these are translated into practice in different ways and to different degrees depending on the *fit* with existing policies and practices. The Scandinavian countries have a stronger history of paternalism with regards public policy and this is evident in the sections above. Childhood immunisation is a notable exception, although this may be due to a strong historical trust in authority as noted above which has not necessitated state intervention. Another notable exception is Germany which has public policy which differs from the European norm in two main areas: that of tobacco control where it is more liberal, and that of the protection of research subjects where it is more paternalistic. It has been speculated that this may be related to activities of the Nazi era, with contemporary governments keen to not repeat events of the past. Poland stands out in a number of areas of public policy as being more paternalistic than some other countries, in particular immunisation, communicable disease control, and drugs policy, these may be related to its communist past. Ireland generally is congruous with other member states except in the field of water fluoridation where it is the most paternalistic of all countries as the only country to mandatory fluoridate water supplies. Southern and Western European countries are generally more liberal, for example in terms of drugs policy, although France and Belgium are unusual in not banning corporal punishment in educational settings to protect children.

In summary, some countries tend to adopt relatively consistent patterns of the degree of liberalism versus paternalism whatever the public health issue studied (for example, Scandinavian countries tend to be more paternalistic, Western and southern European are more liberal). In addition, there is a degree of consistency between which public health policies are more liberal versus paternalistic depending on the issue, irrespective of the individual country (tobacco control and communicable disease control tend to have more paternalistic policies).

Empirical research on public attitudes

Attitudes to a smacking ban

No consensus was observed regarding the merits or demerits of smacking children among the focus group participants. There was however a general consensus that a ban on smacking was neither useful nor desirable by the majority of participants in most countries except Sweden and Finland where legislation has been in place for some time. In summary, the right of a parent to choose whether to smack or not appears strongly defended in most countries.

Attitudes to regulation regarding wearing car seat belts

Most focus group participants were convinced of the benefits of seat belt use and hence restrictions in personal freedom may be perceived as less severe if one wears a seat belt habitually. Habitual behaviour has been recognised as one of the most influential factors in improving overall compliance rates and its importance is reflected in the focus group data, being used to reinforce reasoning for both regular and irregular use of seatbelts. The focus groups highlighted the inconsistencies in seat belt use dependent on the journey taken and the perceived risk of having an accident, despite a widespread agreement on the safety benefits of seat belts. The problems identified in the focus group data regarding law enforcement are a cause for concern. In order to effectively promote seat belt use it is necessary for the police to adhere to as well as enforce the law, especially with such strong majority support for seat belts.

Attitudes to legalising cannabis

Therapeutic use of cannabis was regarded as acceptable by most respondents, in contrast, weak support was expressed for legalising possession and use by the general public. There was an association between perceived harm of cannabis and respondents' support of legalisation. This was consistent with the views of harm for cigarettes and alcohol. Slight variations were observed within age groups, with older groups expressing stronger opposition to legalisation. Creation of new users was clearly the main concern, with potential benefits including increased revenue through taxation and the regulation of cannabis products to minimise health impacts. There was little support amongst the general public for increased prosecution of personal possession and use. It may be that respondents supported efforts to separate and regulate soft and hard drug markets to combat cannabis acting as a *gateway* to hard drugs or excessive use of soft drugs. This research indicates that to counter cannabis acting as a *gateway* it may be more effective to exploit the existing view held by the general public that cannabis is a soft drug in contrast to other highly addictive and damaging hard drugs.

Attitudes to water fluoridation

Most participants were against water fluoridation, although groups in Greece, Ireland, Poland, and Sweden were more in favour. Many felt dental health was an issue to be dealt with at the level of the individual, rather than a solution to be imposed *en masse*. While people accepted that some children were not encouraged to brush their teeth, they proposed other solutions to addressing these needs rather than having a solution of unproved safety imposed on them by public health authorities that they did not fully trust. They did not see why they should accept potential side-effects in order that a minority may benefit. In particular water was something that should be kept as pure as possible, even though it was recognised that it already contains many additives. In summary while the vast majority of people opposed water fluoridation, this may be indicative of shifts away from public support of population interventions towards private interventions, as well as reduced trust in public agencies. Thus if research were to demonstrate more clear benefits of water fluoridation over and above that which can be achieved by use of fluoride toothpaste, then the public may become more supportive. However, lobby groups are likely to remain influential.

Attitudes towards compulsory immunisation

Support for compulsory immunisation was strongest in countries where certain immunisations are already compulsory (Greece, Italy and Poland). In most other countries discussions focused on the concept of risk (both to the individual and to other people), perceptions of infectious disease as a *foreign threat*, issues of trust in the advice of health professionals and fears over vaccine safety. The question of parental choice versus State compulsion was very much a secondary concern. The data suggests that the public's continuing concern over the safety of (particular) vaccinations must be addressed if levels of immunisation coverage are to be increased and maintained. Focus group participants held most trust in the advice of their family doctors and these health professionals need to be supported in their commitment to immunisation if they are to encourage concerned parents to have their children immunised.

Attitudes towards a smoking ban in public places

There was strong support for the state encouraging people to stop smoking; however paternalistic approaches such as a total ban and raising taxes were not widely supported. There was widespread support, including among smokers, for smoking restrictions in public places, however this was because smoking was seen as being anti-social rather than because of the health effects of passive smoking. Smokers were concerned that they were increasingly stigmatised. Defining what counted as a public space was seen as problematic and required a pragmatic approach. The data indicates that smoking regulation plays an important role in defining a non-smoking environment, as well as setting social norms and expectations. Regulation also plays an important part in allowing people to request others not to smoke.

Attitudes to *Not-In-My-Back-Yard* issues

The questions about how focus group participants felt about plans to build a home for people with mental illness in their neighbourhood formed part of a larger discussion about *Not-In-My-Back-Yard* (NIMBY) issues, and trust in information provided by government and public agencies. In addition to asking about how the focus groups felt about building a home for people with mental illness in their neighbourhood, they were also asked similar questions about plans to build a mobile phone mast and a chemical plant making everyday items, like plastic or pharmaceuticals. Familiarity with mental illness inversely predicted the perception of dangerousness of people with schizophrenia and to a lesser extent also inversely associated with fear and social distance. Familiarity was also inversely associated with perceived dangerousness of and desire for social distance from people with major depression. On the whole, participants within the focus groups who had some degree of familiarity with mental illness tended to be more positive about locating a home for people with mental illness in their neighbourhood.

Attitudes towards obeying rules and social norms

The focus group participants were asked whether they would obey a sign saying they should not walk on the grass. The major justification for the respondents' behaviour was based on the likely consequence of disregarding the sign. The sign acted to prime participants to the state/health of the grass, but also to the grass as the outcome of the park keepers' work and hence the impact of their action on others' *work* and *efforts*. In this regard they were also highly conscious that it was not the consequence of their single action but the collective impact of many people walking on the same route which was likely to cause harm. While a few respondents did mention the possibly of being fined, the possibly of being told off (or to move) and being seen to be breaking a social norm was more important. In addition respondents were aware that their own actions would be used by others to justify breaking the rule and lead to greater harm to the grass and they were therefore willing to obey the sign to *set an example*.

Attitudes to parental rights

State involvement in public health policies related to the upbringing of children was not always accepted by focus group participants. The majority stated that parents were probably the best judge of their children's interests, although they agreed that in extreme cases the State should intervene. There were discussions on the influence of the State and concerns were raised about a *slippery slope* of government involvement. Participants acknowledged parents' obligation to act as role models. A number of participants employed the *greater good* argument and stated that they would accept a public health measure that would be beneficial to vulnerable members of society, even if it infringed on their rights as parents. Questions were raised regarding trust and the enforceability of policies. In summary focus group participants felt that a parent's right to bring up their child as they wished should be respected. Although in principle they believed that the State was generally acting in the public interest and accepted State guidance, some participants rejected State intervention on the grounds that these interfered with individual choice.

Attitudes to incentives and enforcement

Focus group participants generally expressed a preference for incentives rather than enforcement in relation to immunisation, smoking and fluoridation. Many participants felt that if they were given good clear information then most people would voluntarily choose to accept a public health measure perceived as beneficial to (sections of) the population. Social pressure and pressure from health professionals were also cited as incentives to act or not act in certain ways, including taking the decision to immunise and to not smoke in public places. Participants also expressed concern over the difficulties in enforcing measures such as a ban on smacking children in the home. The data suggests that public health policies are more likely to succeed and have the greatest support where incentives, rather than enforcements, guide behaviour and leave the public with some elements of choice and control.

Attitudes to trust

Trust in government is low following recent food and health scares throughout Europe. With regard to the various public health policies explored in the focus groups, participants did not totally trust the information they were given by government sources, but in similarity with other studies the participants were more trusting if the information came from sources seen as independent such as scientists, health professionals or family doctors. Most felt that they should have access to all the information so that they could make their own decisions and that this information should be provided by experts who were independent from economic interests. However they were also aware that such openness carried the potential that information may be misunderstood, cause unnecessary worry/panic and harm national security interests. Overall the participants accepted some censorship of information which they characterised as different from the State actively publicising misleading information.

Attitudes to community

Most of the focus group participants took a broad view of community, able to identify different communities that they belonged to, and with what degree of attachment. The most important community was the family and immediate social networks, which were usually geographically defined although not entirely. In the younger age groups, more reference was made to global and virtual communities, reflecting their assurance with technology and possibly a politics that encompasses specific issues rather than a geographically rooted politics (i.e. municipal) Some of the in-country views were coloured by recent historical events – bombings and terrorist acts, the unification of Germany, post-communist society in Poland. There were issues around ethnic groupings raised in many of the groups – mainly *outsider* groups which were often singled out as being different, and threatening in some way – either by affecting national identity, or just by their *difference* which was a source of anxiety. This was more often apparent in the older demographic, but not entirely – in the UK younger fathers were vocal in expressing views that seem to demonise certain ethnic groups. Society and community are concepts that are used to define a set of values – and people identify such values more easily on a smaller scale although many accept that they *belong* to more than their local communities and families. Community and social networks were acknowledged to be important to the health of society and the sense of well-being that people have, but there was also an awareness of the possibility of unhealthy communities – corrupt, bullying and/ or threatening ones. The past was not always considered to have been better than the present – with a few exceptions. Most people accepted that there were societal benefits from closer neighbourhood networks, but they were equally quick to point out the disadvantages – the *nosey neighbour* syndrome. However some of the groups were very concerned about youth – young people growing up with material benefits but no parental guidance – rich and poor alike. Fear of youth was expressed in some of the groups, pity in others. The fast pace of life was commented on by many of the groups, but there did not appear to be any desire to give up the material benefit that work often brings to return to the past. There were exceptions – Poland being notable, though in this case, very little material benefit had flowed from the collapse of communism to the respondents who expressed the most dissatisfaction with their society.

Attitudes to Solidarity

Focus respondents were asked whether they preferred to live in a country where the government provides a high level of public services, but taxes are high to pay for them (Country 1) or one where taxes are low but people are expected to pay for insurance in case they become unemployed or ill and to make provision and social care when they are older (Country 2). The main advantages of Country 1 were seen as being that everyone is taken care of and has the same opportunities within a more mature and caring society. The disadvantages of country 1 were seen as a lack of choice, inefficiency, abuse by *scroungers* and loss of motivation and vibrancy in the wider society. The advantages of an individual model of society within Country 2 were principally promotion of enterprise, entrepreneurship, activity, creativity, enthusiasm, hard work, greater efficiency and competition leading to greater choice and ultimately improved standards of public provision. The minority of participants who leaned towards this system were all confident in their ability to prosper and play the system to maximum advantage to them. The disadvantages attached to Country 2 were significantly harsher than those attached to Country 1 – and for people *repelled* by this system these disadvantages were completely untenable. The disadvantages of Country 2 were the perpetuation of inequality, social unease, crime, anxiety and worry. Generally the majority felt that the foolish should be taken care of as well – based largely on the fear that *it could happen to me*. Overall the majority of the respondents involved in the study would prefer to live in country 1. Few, however, reason in *black and white* and for all but a few countries a mid-point appears most desirable and realistic. Even groups that expressed a preference for country 1 demonstrated a certain malaise or dissatisfaction with a *nanny state*.

Attitudes to Rights and Responsibilities

Many found it relatively easy to give examples of their *rights* but much more difficult to think of responsibilities. The most frequently mentioned rights (in order of frequency) were: right to an education; right to healthcare; freedom of speech/thought; freedom of choice; right to vote/democracy; right to basic level of income/pension/ social benefits; justice/civil rights/right to protest; right to work/not work; personal safety/security; housing; freedom to practice religion; respect/dignity; enough food and basic life needs; right to free movement and travel; equality; right to life/die; freedom of association/membership of trade union or political party. In order of frequency, the duties spontaneously mentioned were: to have public spirit, civil courage, show solidarity and contribute to society; to obey the law; pay tax; respect others; to look after your family especially children (and insure that they are educated) and the elderly; behave responsibly; respect environment; look after your self; to vote; to work; military service.

Most groups recognised that it was human nature to want rights rather than responsibilities and having more rights than responsibilities should be the norm in a liberal society. Some blamed the media for the greater attention paid to rights rather than responsibilities. Young men with families, particularly in the UK, felt that their responsibilities extended to themselves and their families only. Many thought that paying tax off-set the majority of responsibilities. People felt that there was a power imbalance with the State enforcing citizen responsibilities but not their rights and that they were not consulted and what responsibilities they should have as citizens.

However, it was also recognised that people may have responsibilities, but this does not always mean that they fulfil these duties. It was suggested that the perceived breakdown in society was in part because responsibilities were not enforced. Responsibilities were not always seen as being bad. Indeed, some wanted more responsibilities or felt that some citizens abuse their rights. Responsibilities were more oriented towards the personal or individual rather than society, with a loss of what is termed *civic courage*. It was recognised that citizens should have responsibilities in order for society to function and that rights come with responsibilities. It was important to act in the way that you would want others to behave towards you. Living in a community, personal freedoms may have to be constrained if there were consequences for others. Some participants criticised those who wanted to isolate themselves from society and the associated duties as a citizen. Many participants discussed rights and responsibilities in terms of a social contract. If rights were not protected by the State and citizens did not get anything in return for upholding responsibilities, many people did not feel an obligation towards social duties.

Self-Interested Altruism and ‘It-Could-Be-Me’

Almost every respondent ended up expressing a clear preference for *Country 1*, and most of these motivated their stand in ways pointing towards a stance that can be broadly described as solidaric. However, one particular minority reasoned in a more complex way. They started out with an initial preference for *Country 2*, motivating this stand with the claim that they would fare well within this type of policy, while recognising that several others would not, and therefore benefit more by it (due to lower taxes and access to a larger range of alternative health service providers). However, having made this initial declaration, they then added that although they indeed believed themselves not to belong to the *losers* in *Country 2*, *it could be me* (ICBM), and on this basis they concluded that, all in all, C1 was after all the more desirable option.

In our modern consumerist society, appeals to individuals to acquiesce to public policy that may not appear to be compatible with their direct or immediate private, interest, may not be effective. Of course, individuals may feel good by acting out of what appears to be altruism, but when designing messages for the public, policy makers need to ensure that citizens implicitly understand what they will be getting out of the policy in terms of their second order preferences. For example, that it will save them having to pay tax in the long run, or they would be similarly supported of it were to happen to them in the future, or it means that they may live in a society compatible with their goals. Thus policy makers need to be much more sophisticated in their campaign messages and hence need to research public attitudes, concerns and motivations more carefully. While the principle of autonomy is not a good basis for deriving an ethical framework for public health practice, political realities mean that if policy is to bring about improvements to the public health in a consumerist society, it will be necessary to work in partnership with the *self-interested altruist*.

Conclusions

The societal practice of public health is driven by goals that are expressed explicitly by various policy documents and regulations and/or implicitly by the way in which public health is organised, structured and motivated. Even if obvious ambiguities built into notions such as *public* and *health* are disregarded, there is a significant variation between European countries, as well as between different temporal eras of one and the same European country, with regard to what these goals are taken to be. From the point of view of a forthcoming European harmonisation of public health this fact is a serious challenge. Three main types of goals in this respect are proposed: promotion of population health; promotion of health related autonomy and promotion of health-related equality. Thus it is necessary to address the issue of what the goals of public health *should* be, and relate this issue to the more specific query of whether different types of goals may be appropriate for different countries depending on further factors, such as economic growth, actual health levels, etc. Answering this question affirmatively, it is concluded that a European policy of Public Health will have to adopt a complex, pluralistic and dynamic goal structure, capable of accommodating variations in what specific goals should be prioritised in the specific socio-economic settings of individual countries.

Policy implications

The EuroPHEN partners do not wish to make specific recommendations with regards to a code of professional ethics for Public Health. The normative framework that should underpin public health and issues in its implementation are laid out within the entire report.

Of particular importance are the sections of the report relating to the values of public health, and the challenge posed to public health professionals to reconsider their relationship with the public and the goals underpinning policy.

There are differences in approach to policy between Member States, which reflect local circumstances in terms of epidemiology and history, as well as variation in moral weight given to public versus private interest. However, these differences do not represent insurmountable challenges to developing professional codes for Public Health to be used within Member States or European Union institutions, nor for developing policy and European Directives.

The empirical research demonstrates current thinking among citizens towards public health and public policy more generally. The research also provides an indication of more effective ways of developing and implementing policy that attracts greater public support.

In summary, the following points should be considered:

1 Public health should strive to create an environment and structures that facilitate individual health, wellbeing and flourishing, and facilitate the interdependency between individuals necessary to achieve individual flourishing.

2 Public health should achieve population health in a way that respects the rights of individuals and the interests and interdependencies of communities. For some communities individual-focus bioethics is likely to be unsuitable and policy makers must be sensitive to the different needs and moral values of different communities.

3 Public health policies must take heed of the pre-eminence of autonomy in European society. However, the ability of citizens to make autonomous choices, sometimes for what may appear to be irrational behaviours that put them at increased risk of morbidity or mortality, should not be seen as an impediment to making improvements in the health of the public. Indeed, central to the normative framework proposed by EuroPHEN is the need to strengthen the autonomy of the public to promote the capacity, creativity and vitality of citizens living their lives as members of social networks and society.

4 Citizens consider themselves as *consumers* of healthcare who see health services as their *right* as tax payers. However rights have reciprocal responsibilities, and the public must be reminded of these. The method of informing the public about their rights and responsibilities as a citizen is a process that is lifelong, starting with school education.

5 Public health has a strong role to play in ensuring that people feel part of a society so that they can make a contribution to society. Identifying disenfranchised members of society is difficult because by definition they tend to be invisible and

inaudible. They may not want to be identified because they think society is not relevant to them.

6 The public are unlikely to support policies which they do not understand or which they see as unconnected to their lives.

7 Public health policy should be implemented in a transparent manner that facilitates accountability, including the provision of all information and evidence used to inform the decision making process. Policies which are seen as un-enforceable will not only decrease support but also weaken support for public health policies in general.

8 There is a need to actively build trust in public health policy and for public health structures to be seen as independent from lobby groups, political, commercial and monetary influence.

9 A balanced approach is required between incentives and restrictions. The public generally prefer incentives to change behaviour etc, rather than more explicit, direct restrictions on what may be considered to be civil liberties. However, public health polices must be cautious regarding the use of inducements as these can create distrust. Inducements directed towards the medical suppliers of public health services can be seen as creating commercial interests which may biased what is best for the individual. Inducements directed at the general public can raise *conspiracy* type worries, especially in those cases where public information is lacking or where there is conflicting information given from alternative sources.

10 Public health institutions should respect the confidentiality of information that can bring harm to an individual or community if made public. In cases where there is high likelihood of significant harm to the individual or others, suitable mechanisms should be in place to retain a level of confidentially that minimises the breach in privacy.

11 Where there are risks to health, public health institutions should act in a timely manner on the information available, taking into account the reliability of the data and other priorities.

Future Research needs

Further qualitative research

It would be beneficial to conduct further qualitative research focusing on the meaning of community and solidarity. The research could explore to what extent they are important within a 21st concept of citizenship and community. EuroPHEN conducted focus groups in 16 countries, but in further research it may be more effective to reduce the countries, but increase the demographics groups studied, and to have similar group profiles in all countries researched. It would be beneficial to explore these concepts in specific groups e.g. ethnic/religious groups, gay community etc. EuroPHEN included Poland, but with the further expansion of the EU, additional perspectives should be included by conducting the research in other central and eastern European countries and Turkey.

It seems to be a valuable prospect to conduct such research on the basis of developed versions of the initial focus group methodology. Among other things, adapted elements from other methodologies (for example, willingness to pay approaches), may be brought into the focus group set-up to facilitate more close investigations of attitudes to conflicts of interest, community concepts, etc

Quantitative research

The findings of EuroPHEN should be used to develop questionnaire surveys. Health economics techniques could be used to assess strength of support/opposition to Public Health policy e.g. willingness to pay, or compensation required.

Of particular interest is to survey, first, attitudes to particular types of policies/policy areas, and, second, particular types of value sets that may conflict in the public health context – such as, equality, economic and social efficiency, community autonomy, and individual liberty. It is moreover of interest to correlate the results of such surveys to economic features (such as growth) of the nations of the respondents, religious confession etc.

In light of the results of EuroPHEN, one other factor which is of considerable interest to survey quantitatively is citizens trust in various social institutions with regard to issues related to public health and health policy. Comparisons between different countries and connections to other issues, such as the development of ethical guidelines for the public health profession, and the value sets mentioned above.

Research with the Public Health Community

It was originally the intention of the EuroPHEN Partners to develop an ethics normative framework that could be used by public health professionals. The partners decided that further work would be needed to do this involving a consultation process, similar to that used by the Public Health Leadership Society in the USA. Although the EuroPHEN Partners do not feel that a list of principles would not be helpful, as it could address the complexity of public health practice in its various settings. This consultation should also include a discussion of goals and methods of Public Health and examine the impact of private sector, lobby groups.

There are three basic models for how this may be done: 1) a top-down approach, where public health agencies and organisations (e.g. the European Public Health Association [EUPHA] and the professional bodies in Member States) are brought together to create a shared outlook. 2) a bottom-up approach, where the ideas of individual Public Health-professionals are surveyed in various ways (using quantitative and/or qualitative methodologies). 3) a combination of these. Of these, the third option looks like the most promising, but it is also methodologically challenging when it comes to bringing the *top* and the *bottom* together. In the first instance, an international conference could be organised to initiate this process.

Conceptual projects

Perhaps the most important issue arising from the EuroPHEN report is the need to further consider the goals of Public Health. This is an important conceptual task for Public Health Professionals, public, politicians and other stakeholders.

Further philosophical research is required to explore concepts such as solidarity, equality and attitudes to risk. Such research should attempt to describe what specific public health policies would look like if based on a particular normative framework, to examine the differences between liberal, Kantian, communitarian, utilitarian approaches. It would also be beneficial to consider how to communicate/promote *public* values in *private* societies.

With special consideration to European harmonisation in the area of public health, it is of interest to relate these investigations to broader considerations about the forms and ideologies of European secularised societies, since these approach issues about the various points of conflicts between general society, sub-community- and individual interests mentioned above. In also connects to the issue of the importance of trust, and the related and crucial issue of who or what should be given the power/authority to represent the basis of knowledge that needs to underpin any activity within the public health area