The ethics of public health practice: balancing private and public interest within tobacco policy

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Introduction: Public health practice is characterized by measuring population health, assessing needs for health care and the provision (directly or indirectly) of services to protect and promote the public's health. It is increasingly explicitly concerned with issues of equity.

Sources of data: Publications discussing ethical issues in public health.

Areas of agreement: Unlike the duties of clinicians, professional standards for public health practice are not well defined. An ethics framework would help the development and implementation of public health policy.

Areas of controversy: Public health strategies have been criticized for being paternalistic and restrictive of personal choice behaviours or for being too pragmatic, and appearing to endorse illegal activities.

Growing points: Historically public health programmes have been delivered at a population level for large groups of people with varying capacity to benefit. Within more autonomy, consumer-orientated political environment, strategy must be more targeted to facilitate healthy choices as defined by the individual.

Areas timely for developing research: Debate is needed on the aims of public health, rights and responsibilities of professionals and citizens and mechanisms for developing and implementing policy.

Keywords: public health/ethics/public interest/private interest
What is public health?

While many definitions of public health are descriptive of the activities of public health, some include normative criteria, typically in the form of goals for public health to help people live longer and healthier. The goal of a clinician is to maintain health and diagnose and to treat disease in an individual, whereas the goal of the public health professional is to understand and address the health needs of communities, groups and populations. The practice of medicine is underpinned by a personal service ethic, conditioned by an awareness of social responsibilities, whereas public health is built on an ethic of public service, tempered by concern for the individual.

The influential Acheson report on the Public Health Function in England defined public health as ‘the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society’. While it is easy to measure goals aimed at adding years to life, the meaning of adding life to years and indeed health is contestable. Various instruments have been developed, which attempt to measure the quality of life; however, there is no agreed measure, and certainly no agreed measure that take into account differing values and cultures. The meaning of public is also not straightforward. For example, public no longer just refers to organizations within the public sector. The Institute of Medicine noted that ‘the mission of public health is addressed by private organizations and individuals as well as by public agencies’. A later report for the UK Government added to the Acheson definition by stating that ‘prolonging life and promoting health’ should also be through ‘informed choices of society, organizations, public and private, communities and individuals’. The UK Faculty of Public Health also added to the Acheson definition by emphasizing ‘partnerships with all those who contribute to the health of the population’.

There is increasing recognition that older definitions of public health fail to capture the breadth of public health action outside of health services. The aims of public health are increasingly widened beyond a narrow focus on physical health and even mental health. Instead, definitions are increasingly incorporating concepts such as equity, distribution of health in a population and the creation of societal conditions to allow healthy choices to be made if desired. For example, the new Swedish public health policy is aimed at paving the way for good health on equal terms for the whole population. The policy contains traditional objectives in relation to physical activity, tobacco, diet, sexual health, drug and alcohol misuse, occupational health and environmental health. However, Sweden goes significantly further by
explicitly including reductions in poverty, increasing the social capital and democratic participation. Thus, there has been a shift from the paternalistic role for public health in making the public healthier to one of helping to create a healthier society in which the public are provided with opportunities for attaining good health.

**Paternalism**

X acts paternalistically with respect to person Y by interfering with the autonomy of Y by performing or committing to perform an act without the consent of Y with the intention of improving or preventing a decline in the welfare of Y. *Narrow paternalism* only relates to interference by the state. *Broad paternalism* is less concerned about who is performing the coercion. For example, it could be the state, another organization or some other third party. While the justification is usually in terms of a calculation on Y’s welfare, *moral paternalism* claims to promote the moral well-being of Y. However, in the context of tobacco policy, the interests being assessed are short-term enjoyment of smoking versus longer terms quality and quantity of life.

It may be permissible to intervene if an individual knows that their actions or inactions could be harmful. This is described as *hard paternalism* and is in contrast to *soft paternalism* in which it is believed that the individual’s ‘harmful’ actions may not be fully informed. Thus, it is justifiable to intervene in order to determine whether a person is fully aware of the dangers or missed opportunities, with the expectation that when fully informed they will behave differently. Much of the public health policy in relation to tobacco, but in other areas too, is justified on the basis that health professionals know best, and that if only the public knew about the dangers of smoking, alcohol, drugs, poor diet, etc., then they would change behaviour. However, the evidence is that virtually all smokers are well aware of the risks of smoking, it may be that they are not able or prefer not to assess their own personal risk. Nevertheless, providing additional information on risk is unlikely to make many smokers change their behaviour and while much of the tobacco policy may be presented as soft paternalism, it actually may have a ‘hard centre’.

If the individual or group whose choices are being interfered with is identical to that/those who potentially will benefit from the paternalistic action, then the act is described as *pure paternalism*. This is in contrast with *impure paternalism* in which in order to bring about the benefit for some, a larger group of individuals must be interfered with. Tobacco policy is targeted at smokers and the tobacco industry, and largely they are the only groups directly affected, thus policy is a pure
form of paternalism, although of course there will be small percentage of smokers who are less susceptible to smoking-related disease, but without further research on genetic predisposition, it is not possible to distinguish such individuals.

Weak forms of paternalism believe that it is wrong to interfere with a person’s chosen ends. However, if the individual has chosen a course of action, where the means are unlikely to achieve those ends, then interference could be legitimate. Strong paternalism challenges the goal itself, irrespective of the means chosen to achieve those ends. (Probably) all smokers do not start off with a goal of shortening their life through developing a smoking-related disease. While they have preference for enjoying the short-term benefits of smoking (first-order preference), they also (probably) have a preference for a long and happy life (second-order preference). Any smoker who thinks that the best way of achieving a long and happy life is through smoking is (probably) misguided. At best, life long smoking is likely to result in a shorter life, initially happier, but ultimately blighted by pain and/or distress from angina, chronic obstructive airways disease, etc.

**Shift to individualized medicine and ‘individualized’ ethics**

Public health problems became less of a collective concern following general improvements in the level of individual quality of life and life expectancy. This has been achieved through improvements in hygiene, sanitation and housing in the late nineteenth and early twentieth century, together with the introduction of vaccines, antibiotics and other medical technologies from the mid-twentieth century. Public health policy now mainly attempts to create the environment to encourage healthy choices, or to ensure preventative, diagnostic and treatment facilities are available, but for many diseases the main focus is still the clinical encounter between a patient and health professionals.

The shift towards more individualized medicine has been associated with a flourishing of more individualist theories of bioethics, without the counterbalance of consequentialist or communitarian arguments. This move towards the use of the language of liberty, rights and autonomy, in particular in Anglo-American bioethics, has been associated with a move to more conservative, right wing, consumerist political ideologies, in particular as advocated by Thatcher and Reagan in the 1980s. Jonsen noted in his history of bioethics that although autonomy had been ‘launched’ by Beauchamp and Childress in 1979 as ‘one of a quartet of principles … it seemed to dominate the rest and even swap them’ as it ‘meshed nicely with the emphasis on rights abroad in the land’.
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. 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. Rawls\textsuperscript{10} attempted to make this distinction in his description of the original position in which participants are supposed to be behind a veil of ignorance unaware of any information about their beliefs, norms, class, status, etc.

Communitarians believe that a self that is as open-ended as the liberal conception requires would not be so much free as identity-less.\textsuperscript{11} Only a thickly constituted self, shaped in its very being by traditions and attachments, can actually make choices that count. Individualists fail to recognize that membership of a community is not necessarily voluntary, and that the social attachments that determine the self are not necessarily chosen ones. A person’s actions can only be understood by looking at them within the context of their life story, which converges with the narratives of other people.\textsuperscript{12}

Thus, a community is not a homogenous whole. A community is made up of overlapping individual narratives, groups and cultures, with special interests and differing abilities to make their voices heard. 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.

Taken out of a social–historical context, the very desire for control over one’s autonomy would be void of meaning as community is a precondition for moral autonomy.\textsuperscript{13} The exercise of individual autonomy depends upon the active maintenance of the institutions of civil society where citizens learn respect for others as well as self-respect. 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. Similarly community flourishing is dependent upon the contribution of its members to shared projects. As Sandel\textsuperscript{14} 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.

What is an ‘interest’?

There is a distinction between public interest and what the public is interested in. The original Latin derivation of word interest is related to
disagreement and seems to suggest that an interest was precisely not something that was shared or common but something of differential concern to a particular person, as opposed to other persons. As such public interest would be at odds with this original meaning. However, public health has become closely identified with the advancement of public interest.

At one extreme, an action has to benefit every single member of society in order to be truly in the public interest; at the other extreme, any action can be in the public interest as long as it benefits some of the population and harms none, sometimes described as a Pareto improvement. However, in practice such win/win or win/not-worse-off options are rare.

**Justice and distribution of social goods**

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 towards ends and goods.

Resource allocation decisions are a daily reality for public health professionals and it is impossible to avoid making choices between people. Prioritization decisions should be fair and equitable, based on capacity to benefit and cost-effectiveness. Where one individual or group has greater capacity to benefit, or more people may benefit because an intervention is more cost-effective compared with another, then it is just, indeed arguably ethically required, to make such choices. This is a modified version of a Pareto improvement, in which the net value of the change is positive, i.e. the total value to those who benefit, measured as the sum of money they would each, if necessary, pay to get the change, is larger than the amount of compensation that is necessary to those who lose.
Tobacco policy

The health risks of smoking tobacco have been known for many years. Combating major diseases such as cardiovascular disease and cancer will ultimately require individuals to make autonomous choices toward a healthy lifestyle. While most people would agree that promoting healthy lifestyles is an important social goal, most are also justifiably hesitant about permitting too much social intrusion into individual decisions about lifestyle and health behaviours. However, public policy measures such as prohibition of tobacco advertising, taxation on tobacco, banning of smoking in public places represent varying degrees of coercion and trade-offs between the interests of smokers and non-smokers.

While there have been dramatic falls in the prevalence of smoking in most Western countries, the fact that even a minority of the population continue to smoke is a frustration to governments and public health agencies. Stop smoking has become a mantra for public health practice. For a public health professional, it would seem irrational for anyone to voluntarily start and then continue to expose themselves to clear risk for significant morbidity and mortality. Such action could bring into question whether a smoker is behaving as a responsible autonomous agent. Indeed, Feinberg argued that challenging smokers with the ugly medical facts about the harm that they are doing to themselves is part of ensuring that the decision to smoke is an autonomous decision.

Paternalism could be justified but only if decisions of the individuals that endanger their health are the result of independently verified failures of competency. Within this line of thinking, public health agencies could be justified in taking paternalistic actions to protect smokers from themselves, as we would for young children or adults who lack mental capacity, or seek to intervene so as to restore their ability to make correct lifestyle choices. Much of public health policy on tobacco seems underpinned by a belief that smokers are controlled by their nicotine addiction. Thus any means could be acceptable to bring about smoking cessation amongst those addicts who have expressed a desire to stop smoking. However, Daniels specifically identified smoking as a health-threatening behaviour, which was not in itself evidence of diminished capacity for rational decision-making as smoking had relaxation effects that were ‘also desirable and whose payoffs individuals may weigh differently’. Indeed, social science literature provides rational explanations for why people would start and indeed continue to smoke. Thus the choices that people make must be seen within the narratives that describe their lives and those of the people with whom they interact.
When making prioritization decisions, prevention or treatment of diseases which are largely caused by risk factors largely arising from personal choices are no less important than addressing diseases where it is not possible to apportion blame to the patient. As Wikler\textsuperscript{22} has pointed out ‘a health need is a health need, equally deserving of concern and attention’.

**Outright ban on smoking**

While Feinberg\textsuperscript{20} thought that paternalism could justify taxation, regulation and other regulatory measures to make smoking less attractive, he did not believe that the State could use these arguments to make smoking illegal. Such legislation would imply that even the informed judgements of voluntary risk-takers about what is in their best interests are less accurate than those of the state and that, therefore, the individual may not act on their own assessment. Feinberg described this as *paternalism of the strong kind* with an *acrid moral flavour* that created a serious risk of government tyranny.

Given the clear evidence of the health risks of smoking, then if it was a new product it is highly unlikely that it would be legalized. But the same would probably be true for alcohol. It is easier for governments to ban new products compared with substances than have been widely used for many hundreds of years, although other drugs such as cocaine and cannabis were in use for many years and yet were still made illegal. Vested interests, lobby groups, civil liberty arguments and the significant taxation income have meant that governments have shied away from an outright ban on tobacco. Instead, increasing regulation has been used.

**Ban underage smoking**

One group for whom governments have felt morally obliged to prohibit tobacco use is children. Autonomous adults may be able to trade-off living longer or better health in older age against short-term gratification through smoking. However, children are less able to make decisions with such consequences. Given the addictive nature of nicotine they may make it difficult for themselves to stop smoking when they reach an age where they can weigh the risks and benefits of smoking. Thus, paternalism justifies restricting sale of tobacco to children. This of course does not prevent resourceful young people from accessing tobacco. Indeed, the very fact that choosing to smoke is an indicator of being *grown up*, makes smoking an attraction to some young people.
Ban on smoking in public places

While libertarian may argue that smokers can make autonomous choices to place their health at risk, some libertarian arguments permit restrictions on liberty if free choices impair the freedoms of others, e.g. to breathe clean air. In John Stuart Mill’s classic formulation of this argument:

‘[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forebear because it will be better for him to do so, because it will make him happier, because in the opinion of others, to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him, or entreating him, but not for compelling him or visiting him with any evil in case he do otherwise’.23

Exposure to second-hand tobacco smoke is an established cause of lung cancer, coronary heart disease and premature death.24 Thus many countries have introduced bans on smoking in public places within health and safety legislation to protect the health of co-workers and other members of the public. In addition to the direct benefits in reducing passive smoking, the policy further portrays smoking as a socially undesirable behaviour by punishing smokers for their unhealthy choices through exiling them into the cold or wet outside.

Ban advertising and sponsorship

All democracies to varying degrees permit or protect the right to free speech. Advertising is a form of free speech: as longs as it is legal, honest and truthful. Sale of tobacco is legal (at least to adults), therefore why should tobacco manufacturers have their right to free trade be restricted? If part of being an autonomous agent, is to make informed decisions, then arguably the restriction of advertising limits the right of smokers to receive information to make such choices? However, Goodin25 suggested that the promulgation of information from the tobacco industry has purposes apart from facilitating autonomous choice. Goodin, of course, may have a biased interpretation of the veracity of tobacco advertisements. While virtually all smokers accept the validity of risk data, the conflicting information put out by the tobacco industry raises doubts in a smokers mind with questions such as if smoking is that dangerous then why hasn’t it be banned? or the government says everything is bad for you. Smokers may look for any thread
of argument, no matter how tenuous, to justify their habit. Goodin thought that it was something deeply offensive, morally and perhaps legally, about the tobacco industry intentional exploitation of human psychology.

The advertising and promotion budgets of the tobacco industry were orders of magnitude greater than resources available for health promotion to provide the counter information about the risks of smoking. The ability of tobacco companies to promulgate information about their products has come under progressively strict restrictions, with varying degrees of success in reducing tobacco consumption.26 Governments also utilize the space on cigarette packets themselves to advertise anti-smoking messages becoming progressively larger and more graphic, including photographs of body organs damaged by tobacco.

**Increase taxation on tobacco**

For many years, several governments’ preferred method of reducing tobacco consumption has been to increase cost through taxation.27 In this way, smokers must bear the future social costs of their choices as well as the future personal costs to their health. Governments have also used taxation to influence alcohol consumption and in non-health policy areas, e.g. through taxation on landfill sites or cost of polluting carbon fuel.

**Incentives and coercion**

Incentives range from payments or benefits in kind to encourage citizens to behave in particular ways, through to coercive measures such as financial penalties.28 Nicotine replacement gum and patches or drugs to reduce nicotine craving can aid smokers who wish to stop smoking. Many health-care systems provide such drugs free or in subsidized rates for smokers. Smoking cessation advice and support are also provided to maximize the chance of people succeeding in their desire to stop. Such measures act to support autonomous choice, while facilitating behavioural change in the public interest.

Smokers are usually well aware of the risks, and choose to discount cost on future quality of life or length of life in preference to benefits in the present. However, by making the costs of smoking proportionately greater in the present, they are also being made to make choices between other activities that they enjoy. By reducing their consumption of expensive tobacco, they could increase their disposable income for buying other products, socializing with friends, holidays, etc. However,
such price sensitive decisions are dependent on relative income. All of this, of course, depends on the ability of smokers to make free choices, which may be limited by the nicotine addiction.

An anti-smoking lobby group suggested that the costs of treating smoking-related disease in England was £2.7 billion, while a pro-smoking lobby group argued that smokers paid over £9 billion in tobacco tax.\textsuperscript{28} Even though the net financial costs of smoking to society are contested, it is likely that smokers are paying a penalty over and above the contribution necessary to pay for any future health and social care costs.

Wikler\textsuperscript{29} thought that, generally speaking, justification was required only for coercive measures, not for incentives. However, as he goes on to point out, the distinction is not as clear as it first appears. Wikler offered an example of a health insurance plan that wishes to charge obese people higher premiums in order to motivate them to lose weight. Following complaints, an alternative plan is proposed where everyone has to pay the higher premiums, but discounts are offered to those who avoid being overweight. Thus, instead of coercion, the plan now uses positive incentives. As Wikler pointed out, the effect of the rate structure is identical—obese people pay more than those of normal weight.

While the distinction between coercion and incentive may seem merely semantic, Wikler\textsuperscript{29} thought a given policy could not be judged as to whether it is coercive or non-coercive without reference to a background standard from which the policy’s effects diverge favourably or unfavourably. Thus, insurance premiums or taxation rates should estimate what would be an equitable distribution of health-care costs according to risk of disease. Any charges above that fair rate would be coercive, and any below, incentive.

Wikler\textsuperscript{29} recognized that there are administrative difficulties in ensuring that the correct degree of incentive/disincentive is applied. If set higher than that to induce behavioural change then it would be unfair, if too low, then the policy would be ineffective. Higher social class smokers may be better placed to resist cost disincentives applied to tobacco. A problem with financial incentives is that they may need to be significant if they are to influence the behaviour of the rich, and in so doing would place a disproportionate burden on the poor. Perversely, government tobacco policies that attempt to encourage smokers to adopt healthier behaviours may backfire if instead poor people have to cut back on healthier diets in order to pay for their smoking habits. Heavily taxing tobacco in the UK has also encouraged unofficial import of cigarettes or loose tobacco from other countries. Such smuggling means that the UK taxpayer loses the income that would otherwise fund treatment of smoking-related disease. However, it also means that smokers are tending to use ‘roll-your-own’ cigarettes,
and so are not having any carcinogenic substances filtered from the tobacco. Thus health inequalities could increase.

**Targeted paternalism**

While the evidence of the harm associated with tobacco, and indeed other unhealthy lifestyles such as excessive alcohol consumption, fatty food, lack of exercise are widely accepted, it does remain contested by some lobby groups. It is, however, important to add a caveat here, that even epidemiological data requires interpretation in order to be converted into policy, which can be subjective and prone to bias. Thus, the benefits of intervening in the lives of citizens can be overestimated and the harm from overriding autonomy underestimated. Similarly, there is a danger that unfocused measures impacting on a range of liberties valued by an individual or policies affecting a large proportion of the population are used because it is more convenient to do so, rather than use alternative targeted strategies that require more sophisticated and expensive means of implementation. Thus, a paternalistic intervention should cause the minimum interference with individual autonomy in order to cause the desire result.

**Alcohol policy**

Many of the strategies used to address tobacco as a public health problem, can and are used in other areas of public health policy. The ethical issues discussed in relation to tobacco would also be similar. For example, alcohol is increasingly seen as both public health and wider social problems. Media campaigns are used to increase public awareness. Health information and warnings are also being placed on alcohol advertisement and products, and these will become increasingly prominent and less subtle over time, as happened with warnings on cigarette packets. There are restrictions and regulations at a point of sale. Antisocial behaviour is also being addressed. In the context of tobacco this was by restricting where people may smoke. Drunken behaviour is being targeted with increasingly strict policy and punishments. Shops who sell tobacco or alcohol to under age children are also heavily penalized. As with tobacco, pricing and taxation is seen as an important strategy to modify alcohol consumption. In both policy areas, there are also interventions offered to encourage users to cut down consumption.

One key difference between tobacco and alcohol is that alcohol consumption in moderation is not harmful and may even be beneficial. Thus, while social drinkers could migrate into harmful of dependent drinkers,
any tobacco consumption is cause for concern. UK Government’s alcohol strategy aims to minimize the health harms, violence and antisocial behaviour associated with alcohol, while ensuring that people are able to enjoy alcohol safely and responsibly. The focus for the UK alcohol strategy is therefore to target the minority of drinkers who cause the most harm to themselves, their communities and their families:

- young people under 18 who drink alcohol, many of whom are drinking more than young people did a decade ago,
- 18–24-year-old binge drinkers, a minority of whom are responsible for the majority of alcohol-related crime and disorder,
- harmful drinkers, many of whom do not realize their pattern of drinking is causing harm to their health.

This may be politically pragmatic by not seeking to alienate the majority of voters who enjoy an occasional alcoholic drink while addressing these voters concerns about antisocial behaviour. However, this also addresses the maxim of minimizing both the breadth and depth of paternalistic intervention. An example of this is pricing policy, where there is increasing support for raising the minimum cost of alcohol rather than applying a tax on all forms of alcohol. Marketing promotions in shops and bars have been increasingly criticized for making cheap alcohol widely available. Children or those more concerned about drinking as much alcohol as quickly as possible are more likely to choose cheaper forms of alcohol, and are also more sensitive to price increases. Moderate drinkers are likely to be largely unaffected by a policy of minimum price per unit of alcohol because they consume only a small amount of alcohol and also because they do not tend to buy as much of the cheap alcohol that is targeted by minimum pricing and promotion bans. They would however be affected by a policy that increased the percentage of tax on all alcohol, including premium products.

**Conclusions**

Collating and communicating evidence on risks to the public health are, and should remain central public health functions. However, there are dangers in doing this without considering the social, political and philosophical context, especially if it results in the disregard or even active violation of the expressed interests and rights of the people that public health professionals are employed to protect. Sullum criticized the claim that radical individualism was the biggest obstacle to improving the public health by saying that ‘Of all the risk factors for disease
and injury, it seems, freedom is the most pernicious. And you thought it was smoking’.

Thus, there are deeper ethical questions here, than just whether it is ethical to prohibit smoking, ban smoking in public places, increase taxation on tobacco, etc. There are fundamental moral challenges to as what should be the goals of public health. It would seem reasonable to set first-order goals for public health to help people live longer and preferably live healthier and happier, assuming it is possible to define health and happiness in this context. However, making people live longer, whether they want or not is another matter. Although even the more recalcitrant smoker is likely to have second-order preferences to live a long and healthy life, even if they also strongly hold to first-order preference to enjoy smoking tobacco. Similarly, the role of a public health professional would be untenable if it was no more than implementing the instructions of the public, as even in a democracy there is rarely unanimity, and a professional is employed precisely because they are more qualified to evaluate evidence of risk. However, the role of a public health professional is also not to slavishly set and implement targets guided by epidemiological data.

Citizens may consider themselves to be consumers of health care who see health services as their right as tax payers. However, rights have reciprocal responsibilities, and the public must be reminded of these. 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 their communities. 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.

Public health should strive to create an environment and structures that facilitate individual health, well-being and flourishing and facilitate the interdependency between individuals necessary to achieve individual flourishing. The challenge for public health is to respect the rights of individuals as well as the interests and interdependencies of communities. 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 ethos of public health practice 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.
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