NICE CITIZENS COUNCIL REPORT

MANDATORY PUBLIC HEALTH MEASURES

LONDON, JUNE 30 – JULY 2 2005

Contents

1 Introduction 5

2 What we were asked to consider 7

3 How we worked 9

4 What we recommend 11

4.1 Introduction 11

4.2 Recommendations 12

5 How we reached our recommendations 17

5.1 Introduction 17

5.2 Recommendations 18

6 The Council's statements in full 31

Appendix 1 – Briefing paper to Citizens Council 39

Appendix 2 – Programme 51

Appendix 3 – Speakers' biographical details 53

Appendix 4 – Who are the Citizens Council? 59

Appendix 5 – A Fence or an Ambulance 61

1 Introduction

The National Institute for Health and Clinical Excellence (NICE) exists to advise clinical and public health professionals on how to achieve the highest attainable standards of care. The Institute and its advisory bodies base their conclusions on the best available evidence. In doing so, however, they also have to make scientific and social value judgments.

The Institute and its advisory bodies are well qualified to make scientific judgments but have no special legitimacy to impose their own social values on the National Health Service (NHS) and its patients. These, NICE believe, should broadly reflect the values of the population who both use the service (as patients) and who ultimately provide it (as taxpayers). NICE has therefore established a Citizens Council, drawn from the population of England and Wales, to help provide advice about the social values that should underpin the Institute's guidance. The council meets twice a year.

The members of the council reflect the demographic characteristics of the English and Welsh populations. They serve for three years with one third retiring annually. They do not represent any particular section or group in society; rather they are a cross-section of the population with their own individual experiences, attitudes, preferences and beliefs.

At this three day meeting of the council, members were asked about the circumstances when it is (or would be) appropriate to impose mandatory (involuntary) public health measures on the population as a whole. The imposition, on society, of such measures (such as the fluoridation of water or banning smoking from enclosed public places) can be very controversial. Since NICE has now assumed (since April 2005) responsibility for providing public health guidance, these issues will be very important in the formulation of the Institute's advice.

The council's report will be available for public consultation before it is presented to the Institute's board with a view to incorporating the council's conclusions into the next edition of NICE's guidance on social value judgments for its advisory bodies.

Once again, the Institute is extremely grateful to the council for its continuing help in developing its social values.

Professor Sir Michael Rawlins

Chairman

2 What we were asked to consider

The council was asked to suggest principles that should govern the imposition of public health measures on the UK population, paying due attention to:

- the relative roles and responsibilities of individuals to look after the health of themselves and their families, as against the roles and responsibilities of the state
- issues relating to interventions that may sustain or improve the overall health of the population, while nevertheless inconveniencing many, or even harming a minority

In formulating its recommendations it was suggested that we might wish to produce a list of principles, ranked in order of importance, to be considered whenever a mandatory public health intervention is being contemplated.

The following list of principles was put forward as a starting point, but we were strongly encouraged to change, add and delete these if we wished:

- the nature of the disease or condition being prevented
- the nature of the benefits of the intervention – are they to the individual (like fluoride) or to society (like banning smoking in public places)?
- the seriousness of the disease or condition being prevented
- how common is the disease or condition being prevented
- the seriousness of the side-effects of the intervention
- how common are the side-effects of the intervention
- the evidence we have that the intervention is likely to work
- how well the intervention is likely to work
- the likely cost impact of the intervention
- the likely cost effectiveness of the intervention
- whether it is possible to identify people who have suffered side-effects of the intervention
- whether people who have suffered side-effects should be compensated
- whether there might be long term side effects or harms from the intervention
- how serious these side effects or harms might be
- how accepted or opposed is the intervention
- whether the intervention is likely to benefit everyone in society or only certain groups within society
- whether the intervention will widen health inequalities

For more information about the question we asked see Appendix 1.

3 How we worked

The council met over three days between June 30 and July 2 at NICE (see Appendix 2 for programme). We heard a range of presentations about different public health initiatives and were also involved in a number of breakout sessions to discuss the implications of what we had heard. During these sessions we were encouraged to draw up a list of criteria on which we would base mandatory interventions, to produce our own ideas for interventions in areas such as obesity and then to test these ideas against the criteria we had produced and to amend the criteria accordingly.

At regular intervals we also reconvened in plenary sessions to compare notes. On the final day a comprehensive list of recommendations and suggestions was produced which we were asked to score. The list of principles and points to consider in Section 4 is a distillation of this process (see also Section 6).

Although the council is made up of 30 members, only 25 were able to attend the meeting on mandatory public health interventions. Of these, two were absent when we came to vote on our recommendations on the final day. One voted later, which means that the maximum number voting on each statement is 24.

The main presentations over the two and a half days were:

- What is public health and what is it trying to achieve?
- Providing a framework in which discussions can be held in a respectful and sensitive way with different values and perspectives present
- The politician's view – the political dimension explained by an ex-minister
- Fluoridation – the case for and against
- Paracetamol – a case study relating how packet size was limited and the consequent impact on suicides among young people
- Obesity – the scale of the problem and a discussion of its causes and possible remedies

For biographical details of speakers see Appendix 3.

4 What we recommend

4.1 Introduction

We have produced a number of principles which, we believe, should be applied when making decisions about mandatory public health interventions.

Some of these principles were produced through debate within the breakout groups, others were individual suggestions. These were then collated and grouped under eight (later reduced to five) categories:

- Who has responsibility for the public's health, individuals or the state?
- Where does the balance lie between needs and benefits versus harms and inconvenience?
- When and how should the state intervene?
- How should mandatory interventions be introduced and monitored?
- Openness, trust and public involvement

We were then asked to score each of the resulting statements on a five-point scale from strongly agree to strongly disagree. The following list of recommendations is the result of this process and is in turn divided into broad principles and points to consider, both of which were agreed by the overwhelming majority of the council. Areas of disagreement and minority viewpoints are touched upon in 'other perspectives'.

It should be emphasised that the Citizens Council's purpose is not necessarily to achieve consensus but rather to explore and explain the different perspectives that arise over an issue. The views of the council are rarely unanimous and may change over time. This is a reflection of the cut and thrust of any vigorous debate and the fact that when challenged, open-minded people may change their views! Readers of this document should take this report as a whole. **Not all statements will stand-alone and must be read in the context of the discussions that we had, which are contained within this account.**

We also try to give due weight to the views expressed by a minority of council members because they may often be voicing uncomfortable truths as well as reflecting important aspects of the public's opinion.

The full debate is covered in section 5.

For ease of reading we have used terms such as 'most', 'several' and 'a few' when discussing the balance of opinion rather than always providing the exact numbers. Sometimes this is necessarily unquantifiable because it refers to the mood of a discussion. Where it relates to the final vote on recommendations 'most' or 'majority' denotes that at least 18 out of 24 people supported the statement. 'Some', 'several' and 'few' are used interchangeably to indicate that between two and six people held these views. For exact numbers see Section 6: 'The Council's statements in full'.

4.2 Recommendations

4.2.1 Who has responsibility for the public's health, individuals or the state?

Principles

Where possible, people should have freedom of choice and be responsible for their own health. We should attempt to educate people to adopt a healthier lifestyle and try to persuade them to access the help they need voluntarily. But ultimately, and if necessary, we should adopt mandatory measures.

Freedom of choice is overridden by the responsibility not to cause harm to others. Where others are being harmed by a particular activity the state has a right to intervene.

Points to consider

An individual whose behaviour deliberately puts others at risk could face legal penalties.

Other perspectives

A few of us (six) thought that public health interventions should target problems that affect the majority, but also problems affecting the minority.

4.2.2 Where does the balance lie between needs and benefits versus harm and inconvenience?

Principles

Any mandatory measure should lead to overall improvement in the health of the population.

Interventions that provide benefit for the greater number are justified even where a small minority might be disadvantaged.

Minor inconvenience resulting from an intervention should have little bearing on whether or not it is made mandatory.

Mandatory measures should lead to worthwhile benefits compared to the cost. A broad view of costs and benefits needs to be taken as some may not be immediately apparent.

Points to consider

Care should be taken that interventions address a genuine public health problem rather than the latest media fad.

Other perspectives

Most of us (21) support interventions that offer benefit to significant numbers of the population 'even when a small minority might be disadvantaged'. However, two disagreed. One was concerned about the disproportionate impact that even worthwhile interventions might have on businesses and small enterprises.

Many of us (19) emphasised that preventive health must be adopted on its own merits and should not be seen as a way of avoiding proper spending on acute services.

One felt the degree of disadvantage that was considered acceptable when introducing an intervention might need to be defined further. 'If the intervention could cause the death of some people, is it still OK?

4.2.3 When and how should the state intervene?

Principles

Choice of intervention should be based on the seriousness of the problem, the extent of harm or danger within the population and the number of people it will affect.

It should be accepted that the quality of the evidence needed to justify a public health intervention might be lower in the case of an urgent national emergency, for example bird flu or bio-terrorism.

Mandatory public health measures should aim to promote equality of outcome. This may mean treating some people differently from others in order to reduce health inequalities.

The potential adverse effects of a mandatory public health intervention on vulnerable members of society should always be considered.

Points to consider

If the condition being addressed is common, it is right to target the intervention at the most vulnerable groups. For example, flu vaccinations are targeted at older people and those most likely to suffer serious side effects if they get flu.

Interventions should attempt to address the cause of a public health problem (for example, promoting healthy foods to children) as well as focussing on the actual problem (for example, prescribing exercise for already obese people).

Other perspectives

Whilst many of us (21) were concerned that measures should address the cause of the problem as well as the problem others pointed out that this might not always be possible either because of the problem's complexity (for example, obesity) or its urgency (for example, treating an outbreak of bird flu).

We agreed that these difficulties should not put a promising intervention at risk. ‘Sometimes the cause may be very hard to address, e.g. psychological origins of over-eating, and the best you can do is treat the condition.’

A majority of us (17) felt it was important to openly acknowledge if someone suffered an adverse effect and to provide compensation. But a few disagreed (four), believing this only encouraged the ‘compensation culture’.

More than half of us (14 members) felt exemptions should be allowed for certain groups on the grounds, for instance, of religious belief – so long as it did not affect the effectiveness of the intervention as a whole. But a minority (five) disagreed, feeling this would inevitably dilute its effectiveness. ‘Too many opt outs can cause apathy amongst those who cannot opt out,’ was one comment.

But some of us (one or two) disagreed and two or three were undecided. One person pointed out that dental fluorosis, the one agreed side-effect of fluoridation, did not amount to harm or danger but should still be taken into account.

A few of us (three) opposed giving preferential treatment to the most vulnerable, largely on the grounds of impracticality. One felt that mandatory measures should apply to all equally. Three also had doubts about treating some people differently to others in order to narrow the inequalities gap.

Others among us (five) questioned the practicality of treating everyone impartially. ‘While you should not gratuitously discriminate against any person or groups, in some cases in public health you need to treat people differently in order to help them.’

4.2.4 How should mandatory interventions be introduced and monitored?

Principles

Any mandatory measure should be monitored on an ongoing basis once implemented. If monitoring reveals significant harmful consequences, the measure should be reconsidered in order to limit damage.

Where vulnerable groups are at risk, monitoring should be particularly rigorous.

Points to consider

Measures should only be introduced if they are practical and achievable.

Wherever possible, measures should be piloted first before being extended to the whole country.

There should be a provision to review and stop the measure in the future if it turns out to be unfavourable. It is important that measures are reversible.

Other perspectives

Two of us were doubtful about making practicality one of the tests of whether to introduce a measure – 'if it is serious enough to warrant mandatory measures it must be made to work' was one comment; 'sometimes we will only know this after a period of time has elapsed' was another.

Whilst we generally supported piloting interventions, a few of us (three) were concerned that pilots would involve some people being treated like 'guinea pigs'. In some cases there might not be time to run a pilot. All agreed on the desirability of research in advance, but essential interventions should not be delayed because of a lack of detailed evidence. Some of us (six) were anxious that the effect of an intervention might be undermined if some groups were allowed to opt out.

4.2.5 Openness, trust and public involvement

Principles

There must be openness and transparency in implementing mandatory measures and in explaining the reasons behind them.

Wherever possible, public health interventions should be preceded by public information and/or consultation, debate and feedback.

Other perspectives

Most of us (18) also felt it was important to consider whether a measure had enough support to make its imposition practical. But six disagreed. Several pointed out that many successful public health measures, such as compulsory seatbelts and the breathalyser, were extremely unpopular when first introduced.

Several of us (six) were unhappy about linking implementation to prior public support, pointing out that sometimes a measure can be unpopular and right. There are also a number of instances where people accept a measure once implemented even though they didn't before (for example, drink driving laws).

One of us was opposed to automatic public consultation, noting that often it only served to inflame the situation. 'It may be unhelpful, costly and simply act to heighten fears over what is really common sense.'

5 How we reached our recommendations

5.1 Introduction

The 25 members of the current Citizens Council are not a homogenous group and over the course of the meeting we expressed a wide range of views on this difficult topic. Unsurprisingly, members laid a different emphasis on particular recommendations, but there was also some evidence of a convergence of views over the course of the sessions.

Many of us began by expressing support for personal freedom and individual choice. There was concern about the 'nanny state' and a widespread feeling that many of today's social problems were the result of the collapse of discipline and poor parenting.

It followed that the way forward was through education rather than yet more government edicts; and that people needed to regain a sense of personal responsibility for their actions. 'It seems to me that education in these areas is the best way forward. Imposition I don't think is possible,' said one member.

At the same time it was felt the state would always provide a safety net for you however much you messed up. This in turn could lead to a feeling of helplessness and not having control of your own destiny.

By the end of the meeting the mood had changed subtly. Having listened to the presentations we still emphasised the importance of personal freedom but were now prepared to accept that mandatory measures were appropriate in some circumstances. We unanimously supported a strategy that made education the first line of attack in health promotion, backed up by mandatory measures as a last resort.

As one member said: 'I started off thinking there was a choice between personal freedom and mandatory measures. But over the last day I've come round to thinking you try to educate but if you can't then mandatory comes in afterwards.'

Not surprisingly our understanding of the scope and scale of public health interventions altered over the course of the sessions. People learnt these could extend well beyond the health service, taking in things such as transport, work, leisure, supermarkets and schools.

We also became aware that mandatory did not necessarily mean draconian or even restrictive. Clearly some, such as fluoridation or seat belt legislation, do restrict people's freedom. But others, such as food labelling, are permissive rather than punitive.

Again, the weight given to evidence as a justification for a particular intervention changed after hearing the presentations on fluoride and paracetamol. The first underlined the difficulties of relying on evidence when

opposing sides of the argument can draw entirely different conclusions from the same piece of research. The latter showed the success of an initiative that was based not on detailed research but a hypothesis that could only be tested by implementing it and then standing back to observe the results.

It was clear by the end of our discussions that more people accepted the need for mandatory interventions, and at an earlier stage, than they had at the start. One person had expressed the view, at the beginning, that no interventions were justified unless it was a national emergency like bird flu or bio-terrorism. All other aspects of health promotion should be the responsibility of families and communities.

By the third day most of us had accepted the necessity of some degree of public health intervention in order to help people help themselves.

Finally, we all learnt a lot during the three days about the substantial benefits of public health. On the last day one member unearthed a poem – originally penned by an anonymous author to highlight the horrors of war, apparently – that seemed to encapsulate its purpose.

Entitled 'The Ambulance in the Valley' it describes how for generations townsfolk concentrated on providing ambulances to pick up the injured who had fallen from the cliff above, ignoring the possibility of preventing people falling off in the first place. But now, it concluded, it was time to be rational: 'Let's build up the fence and let's dispense with the ambulance down in the valley'. For the poem in full, please see Appendix 5.

It is a sentiment that we all endorse.

5.2 Recommendations

5.2.1 Who has responsibility for the public's health, individuals or the state?

Principles

Where possible people should have freedom of choice and be responsible for their own health. We should attempt to educate people to adopt a healthier lifestyle and try to persuade them to access the help they need voluntarily. But ultimately, and if necessary, we should adopt mandatory measures.

Freedom of choice is overridden by the responsibility not to cause harm to others. Where others are being harmed by a particular activity the state has a right to intervene.

Points to consider

An individual whose behaviour deliberately puts others at risk could face legal penalties.

Discussion

Most of us felt strongly that individuals should have the personal freedom to make decisions for themselves wherever possible.

Many of us were concerned about a culture where anti-social behaviour, such as binge drinking, appeared to be on the increase. Some of us thought that good parenting could help alleviate this problem. Another suggested that responsibility rested with society as a whole, not just within the family. But for some, health was a personal matter – so long as it didn't interfere with anyone else. 'If somebody wants to spend £20 on alcohol and they've only got £30 for the week, that's their choice,' said one. 'Why should society jump in?'

Several of us had the same response to the issue of obesity. 'Whatever the underlying reasons, you become obese because you put too much food in your mouth and that's it,' said one. 'I see this as an individual problem,' said another. 'If you're overweight then you cut out a meal until you're the right weight – it's as simple as that. If I over-eat I need to work it off.'

'I have a right to be fat if I want to be fat,' said another member. 'They can educate and cajole me as much as they want but they have no right to legislate against me being fat.' He would also extend the same principle to the family. 'The state has no right to interfere in my family. If my child is obese that's my problem and no one else's.

'State intervention should be based on the seriousness of the thing. So if there's an epidemic I can see the justification. But things less serious like obesity I don't think that justifies the state interfering in my family.'

The crucial point was whether your actions affected others. So the state had a right to interfere if an individual was likely to harm others. But if his actions only affected his own health and safety – such as wearing a seat belt – he should be free to decide.

Others pointed out that personal choices affect others more often than one might think. So, for instance, not wearing a seat belt and being injured in an accident as a result produced a cost to the health service and diverted resources from some other part of health care.

There was also the question of whether everyone actually had a free choice when it came to something like poor nutrition. As the speakers on obesity pointed out, many people tended to buy unhealthy, processed food because it was cheaper and because information wasn't readily available about nutritional contents.

Equally, if a three-year-old child was obese because its parents didn't have the knowledge or skills to feed it properly then surely society had some responsibility to step in to protect that child?

Some of us had fewer qualms about the merits of intervention, feeling that the whole point of public health measures was to protect people from themselves. 'I think we're scared to death in this country of telling people what they're

doing is wrong even when it's evidently self-destructive,' said one. Choice wasn't always good for you. The recent TV series about school food showed that children quickly accepted nutritious chip-less school meals when they had no choice – but 'give people the choice and they'll eat unhealthily'.

Although divisions remained about the merits of mandatory intervention, most of us felt they were more justified where people's health was concerned – and especially where children were involved since they were not in a position to take responsibility for themselves. One person also commented that where there was good reason to believe that education would not be effective, a mandatory intervention might be the best option.

Having said that, several pointed out that personal responsibility was also a vital foundation stone for good health. For at least one member the recommendation that people must take responsibility for their own health care was the most important statement of all. 'People must be taught to be responsible for their own health otherwise we'll continue going down the wrong road.'

'We over-legislate and make too many things mandatory,' he added. 'You can't legislate for everything because you won't have a free society.' Where the decision to intervene has been made, it is better to offer as much choice as possible. For example, with school dinners, 'if you only had a single choice, you wouldn't get people to eat it, they'd go elsewhere. If you give choice within a healthy food area that surely makes more sense.'

Another felt the idea of the state doing things to the individual ran the danger of increasing the sense of helplessness and lack of control felt by the more downtrodden people in society. 'I would like to see a measure to say this is why we're going to encourage you to change your way of life.'

What followed from this for most of us was that information, education and persuasion should be the method of choice when trying to persuade people to change their lifestyles and improve their health. Only if or when this failed to achieve its objectives should mandatory measures be considered. And even then they should be undertaken with extreme caution.

There was also support for imposing legal or financial penalties on individuals who knowingly put others at risk through their behaviour (e.g. spreading HIV/AIDS). But three of us disagreed. Did that mean that parents who fed their children an unhealthy diet would end up being fined, asked one?

5.2.2 Where does the balance lie between needs and benefits versus harm and inconvenience?

Principles

Any mandatory measure should lead to overall improvement in the health of the population.

Interventions that provide benefit for the greater number are justified even where a small minority might be disadvantaged.

Minor inconvenience resulting from an intervention should have little bearing on whether or not it is made mandatory.

Mandatory measures should lead to worthwhile benefits compared to the cost. A broad view of costs and benefits needs to be taken as some may not be immediately apparent.

Points to consider

Care should be taken that interventions address a genuine public health problem rather than the latest media fad.

Discussion

Most of us had no doubt that where a particular intervention stood to benefit the health of the population we should be prepared to put up with some degree of inconvenience.

The most commonly cited example was the change to paracetamol packaging. This caused many people inconvenience because they had to make more trips to the chemist than previously but everyone agreed this was easily outweighed by the 40 fewer deaths each year from paracetamol poisoning.

The bigger dilemma came when people started to consider interventions that produced a major benefit to most people in the population – for instance, immunisation – but also risked some physical harm to a minority. Surely we couldn't be saying that any harm to anyone would be sufficient reason to halt an intervention?

'I'm nervous about saying that because 0.0001% of people are adversely affected by a particular measure we say, no it can't be done,' one of us commented. A small minority of 'highly vocal people' shouldn't be allowed to 'derail necessary action'.

It also had to be weighed against the harm that might occur if no action was taken. What about the harm to the health service if certain activities such as alcoholism were allowed to continue unabated, for instance? Or the harm to children from, say, obesity if no-one acted?

In answering these issues we considered some sliding scale in which benefits were measured against harms. 'It's an issue about the size of the harm,' commented one. 'The more appreciable harm, the more you have got to think about the intervention – though I'm not saying you wouldn't still do it.'

Another felt the acceptability of an intervention had to be based on the seriousness of the issue being tackled and the number of people involved. 'If the problem is more serious but affects fewer people, or less serious but affects more people, it's acceptable to intervene.'

It was generally agreed that the greater the risk of harm of the intervention the more credible the evidence had to be. One person went further: ‘you also need credible evidence that it’s going to be beneficial. In the past we’ve been told things that have proved to be untrue and several years down the line they’ve had to be cancelled.’

Others contrasted the paracetamol and fluoride cases. ‘The big difference between the two,’ said one member, ‘is that with fluoride everyone’s getting it whether they like it or not. With paracetamol it may be inconvenient but it hasn’t affected people in other ways.’

Paracetamol was based on weak evidence but this wasn’t a major problem since the changes were doing no more than inconveniencing people. The conclusion was that ‘the greater the chance or incidence of harm, the stronger should be the evidence of effectiveness.’

We felt strong evidence and clear benefits to most people had to be the overriding criteria for imposing mandatory measures. ‘The cost of the benefit should be measured against the degree of the benefit and the long-term saving to the NHS,’ suggested one. Another felt it ‘should lead to an overall improvement in the health of the vast majority of people’ and a third proposed ‘the benefit to society should outweigh the risk of harm to the few.’

We also agreed there would be some instances – such as bird flu or SARS - where the immediate needs of the majority were so pressing there could be no argument (see also section 5.2.3).

But some had doubts whether it was sensible to make the needs or health of the majority the decisive factor in other situations. One person was concerned that rare conditions might be ignored or downgraded on this basis.

‘I’m slightly worried that people feel strongly that you should treat a widespread condition and not necessarily invest time and money in rarer but more serious conditions. I don’t want these people missed out. You don’t just want to treat colds and miss out on a small group of people who have a rare condition.’

Another observed that much public health work was actually directed at minorities not majorities. ‘With obesity, for example, virtually everything we are doing is trying to help the hard to reach minority without damaging the majority.

‘All our public health interventions are largely about the minority. For instance, with paracetamol it was a very, very small minority at risk of suicide. Thirty per cent of children are overweight or obese – that’s common but it’s not a majority.’

Others of us pointed out that this was the case in most health care. ‘It’s only the minority that have most of the costs of public health and the NHS. The majority don’t need intervention…we’re going for the minority all the time.’

But some felt that in its widest sense most public health measures were benefiting the majority because they were saving public money and would have a wider impact on future generations.

And today's minority could become tomorrow's majority, another pointed out. 'With obesity one in three children are at risk at the moment but on current trends that could go up to two in three if nothing is done. That's what we mean by the majority.'

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While everyone agreed an intervention should lead to worthwhile benefits compared to the costs, we recognised that defining those benefits was problematic. 'It's difficult to put a price on the benefit of living a longer, healthier life,' commented one. And some things were intangible. 'How do you determine whether someone may or may not have required social services?'

We also noted that some benefits might be indirect and could take years to emerge. Someone else suggested benefits might include the savings to the NHS and promotion of active citizenship.

We agreed that measures should not be introduced simply to save money or as a knee jerk reaction to something that had hit the headlines.

'I'm concerned that any measures introduced should have some benefit to the public and shouldn't just be a case of if we introduced this we could get £1m off the NHS budget,' said one member.

An equal but opposite danger was that politics might prevent some actions being taken. 'There's a danger that politicians end up bottling things that will have a profound effect on health because of public opinion,' said one of us.

Most of us felt that public health decisions should not be based solely on financial considerations. Having said this, some noted that in the real world cost would always be a major factor. It was also in its broadest sense a reasonable way of measuring the effects of an intervention.

'The problem is there isn't any other measure than cost,' said one member. 'There is no other measure that we can apply to how much crime we have saved or how much healthier we are. It's unfortunate but there isn't.' While another asked, 'aren't all interventions going to save money in the long run? Isn't that the purpose of all campaigns?'

The outlay of money had to be a factor in deciding whether to go ahead, in at least one member's view. 'The cheaper it is, the more willing I am to take a risk.'

Another felt strongly that 'where there is a risk to vulnerable groups (such as pregnant women or children) then strict criteria should be in place whatever the cost.'

‘It’s not good enough to say to vulnerable mothers this is fine and expect us to accept that. They have to give us some kind of evidence that it hasn’t caused any damage.’

5.2.3 When and how should the state intervene?

Principles

Choice of intervention should be based on the seriousness of the problem, the extent of harm or danger within the population and the number of people it will affect.

It should be accepted that the quality of the evidence needed to justify a public health intervention might be lower in the case of an urgent national emergency, for example bird flu or bio-terrorism.

Mandatory public health measures should aim to promote equality of outcome. This may mean treating some people differently from others in order to reduce health inequalities.

The potential adverse effects of a mandatory public health intervention on vulnerable members of society should always be considered.

Points to consider

If the condition being addressed is common, it is right to target the intervention at the most vulnerable groups. For example, flu vaccinations are targeted at older people and those most likely to suffer serious side effects if they get flu.

Interventions should attempt to address the cause of a public health problem (for example, promoting healthy foods to children) as well as focussing on the problem (for example, prescribing exercise for already obese people).

Discussion

We all agreed that urgent situations such as a national emergency took precedence when interventions were being considered and that the quality of evidence might not have to be so high.

Even so there were some caveats. ‘If there were a national emergency I want the government to react as quickly as possible,’ said one of us. ‘But I would want to see measures in place to rectify and acknowledge any harm to the population caused by their intervention.’

‘You’ve got to be careful about urgent cases because you may take short cuts that you may later regret,’ said another. ‘You have got to show due diligence in what you’re doing.’

But what constituted a crisis or emergency? We agreed that saving life was a top priority but could it not be argued that obesity levels amounted to a crisis

because if they were not tackled they would lead to a range of fatal conditions in the future?

This highlighted a particular difficulty with public health, observed one of us. ‘In medicine you have the sick person in front of you so you have got to treat them. But here you don’t have a sick person. You only have a hypothetical person in front of you.’ A hypothetical situation was always easier to ignore than a real one.

We were more divided about whether someone suffering adverse effects as the result of a mandatory intervention should be compensated. Sixteen agreed with this statement but three were undecided and four disagreed.

One person felt this depended on the severity of the adverse effect: ‘minor effects may not be compensated’. Another disagreed with the idea of compensation - ‘adverse effects should be acknowledged and as far as possible avoided or rectified.’

Several of us were worried this might give a further boost to what they saw as the ‘compensation culture’. ‘Mistakes get made but if that’s the case individuals should take personal action’ said one. ‘To even think about mentioning compensation is opening the floodgates.’

For another member the issue was simple: ‘If we broke it then we should fix it’.

‘It’s not like where you go for elective surgery where you have made a choice,’ said someone else. ‘If society is doing something to you, then maybe society has got to make amends as well if things go wrong.’

Another of us said, 'The state must be open about the risks to any individual of a mandatory health measure and accept the costs of any serious harm caused as a result of an intervention such as immunisation’.

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Several of us were uneasy about the idea of treating some people differently from others in order to narrow the health inequalities gap.

One person wondered if this was an appropriate way to look at the problem. ‘We have eliminated some of the most glaring inequalities. How far is it still legitimate to assume the target outcome is absolute parity of expectation? Isn’t there a danger we’ll spend a vast amount of effort trying to bring the last 2% up to the rest?’

‘So much has been done since Victorian times to cut this gap that you begin to wonder how much further you can go and how much longer are we going to spend trying to do this?’ agreed a colleague.

Others of us were concerned this could have a levelling down effect. ‘Gaps are always going to exist,’ said one. ‘If we try to start closing them you’re going to have to drag those with better health down to meet people with poorer health.’

But most of us were convinced the huge gaps that still existed in life expectancy between some parts of the country and others justified action. It was only when large amounts of money were being pumped in for very small returns that they would have doubts. Eighteen supported a statement that narrowing the inequalities gap and promoting equality of outcome should be factors in mandatory interventions. Three continued to disagree.

One of us suggested there was a big difference between an investment that had a major impact on narrowing the gap and pumping a large amount of money in to make only a small difference – in the latter case you wouldn't do it.

Nearly all of us (20) agreed it was important to take into account people's specific health circumstances – including cultural, social and religious beliefs and even geography – when considering compulsory interventions. And that the needs of vulnerable members of society, who might not be able to make decisions for themselves, should always be borne in mind.

Again, most of us accepted that if a disease or condition was common then the most vulnerable should be prioritised.

But several disagreed. Three of us felt this might be impractical and difficult to target. Another felt that if a measure was mandatory it should cover everyone equally, while another, who agreed with the main statement, pointed out that it might be difficult to decide who needed treatment first.

And there was concern about some of the implications of a health inequalities campaign. One health promoter told us that campaigns on issues like obesity were very successful in changing the habits of the middle class but had little effect on lower socio-economic groups who benefited more from one-to-one approaches. So ads on TV about good nutrition were having the effect of making the middle class healthier and so effectively widening the gap between them and more deprived groups,

This worried one of us. 'It would be very perverse if you didn't advertise healthy diets because you knew it would make the gap bigger when what's actually happening is some people are getting healthier and eating better.'

But our biggest debate centred on a statement that everyone should be treated impartially irrespective of their lifestyle choices, ethnicity, social group or background. Fifteen of us eventually supported this statement but five disagreed.

Most of those who disagreed felt the statement directly contradicted the earlier recognition that people had to be treated differently if public health interventions were to be effective. 'While you should not gratuitously discriminate against any person or groups, in some cases in public health you need to treat people differently in order to help them,' said one objector.

And if lifestyle was to be ignored, said another 'why are we looking at obesity? That is a lifestyle choice.'

Someone else suggested that the statement should be restricted to a general pronouncement that impartiality of treatment for all was the target. ‘There is no need to give examples of backgrounds etc – someone will be the first to say, what about me?’

5.2.4 How should mandatory interventions be introduced and monitored?

Principles

Any mandatory measure should be monitored on an ongoing basis once implemented. If monitoring reveals significant harmful consequences, the measure should be reconsidered in order to limit damage.

Where vulnerable groups are at risk, monitoring should be particularly rigorous.

Points to consider

Measures should only be introduced if they are practical and achievable.

Wherever possible measures should be piloted first before being extended to the whole country.

There should be a provision to review and stop the measure in the future if it turns out to be unfavourable. It is important that measures are reversible.

Discussion

One of the most important questions about any public health intervention has to be: will it work? Most of us were clear there was little point going ahead with a measure, however theoretically worthwhile, if it had no hope of successful implementation.

It was also important to know if it might have side effects or other consequences in the future. But it was also clear from the paracetamol experiment that it isn’t always possible to know the effect of an action until you’ve tried it.

Moreover, the quality of the evidence might be limited (paracetamol again) or it might be contested (fluoridation). What then?

The presentations on fluoride underlined the difficulties of relying on evidence when opposing sides of the argument were able to draw entirely different conclusions from the same piece of research (i.e. the York CRD study).

‘You can always find evidence to back up anything,’ said one member a touch cynically.

Most of us felt it was important to carry out a pilot before implementing a measure across the country.

But a few of us felt this could be impractical – 'it depends on the urgency,' commented one member, 'in some cases one may not have time to do a test trial. It depends on how big the intervention is.' Others saw it as unethical because you might be testing something out on one part of the country alone.

There were also doubts raised about the practicality of demanding evidence that a measure would work prior to implementing it. 'Sometimes we will not know this until a period of time has elapsed,' said one of us. Another pointed out that in some cases the only evidence was provided by implementation – as in the paracetamol case.

We all agreed that once a mandatory measure had been put into effect it should be monitored on an ongoing basis. Moreover if this monitoring revealed harmful consequences 'to a significant degree' the measure should be withdrawn and the damage limited.

We were particularly concerned about interventions – such as fluoridation – that might be irreversible. In other words, if a public health measure was shown to have undesirable side-effects you could stop it, but for some people that might already be too late.

We were anxious to prevent a situation where, for instance, a public health measure introduced chemicals into the water supply, which then proved impossible to extract. Another member raised the possibility of a drug subtly altering the genetic make-up of future generations. By the time these harmful side-effects were discovered, however, it would be too late to reverse the situation.

Most people supported a provision to reverse a measure if it was subsequently found to be 'unfavourable'. 'Don't burn the bridges' was one person's plea.

But there were a few words of caution. In some cases it might be too dangerous to the majority to stop the measure, said one. Another pointed out that some things were simply not reversible. And a third suggested it might not have to be all or nothing - ' you can probably improve it or look at the harm and address it'.

And while the majority agreed that if an intervention had a harmful effect it should be withdrawn, it was acknowledged there had to be some financial limits. One member gave the example of Tetra masts that were thought by some to have a harmful radioactive effect, but the member thought that they could not now be withdrawn because of the prohibitive costs involved.

'So if it's going to cost too much to take it away and stop the harm then you're saying just leave it?' asked one clearly unhappy member.

Most of us were also keen that any public health intervention should attempt to tackle the cause of a problem as well as its symptom.

But others felt this was often impossible and should not be a bar to introducing particular measures. For instance, the underlying reasons for someone's obesity might be extremely complex and could take a long time to establish. But this shouldn't stop us tackling the immediate problem.

It was also noted that sometimes the urgency of an intervention such as bird flu might be so great you could not afford to wait to address the underlying causes.

5.2.5 Openness, trust and public involvement

Principles

There must be openness and transparency in implementing mandatory measures and in explaining the reasons behind them.

Wherever possible, public health interventions should be preceded by public information and/or consultation, debate and feedback.

Discussion

An open, transparent statement of the case for intervention and an explanation of why it was being undertaken were felt to be essential.

This was why education and information were so important. It was felt the current apathy and, in some cases, cynicism about health initiatives might be because people were not being given enough information and this led to a general lack of trust.

'A lot of it stems from a feeling of helplessness,' suggested one. 'Individuals feel more helpless in our complex world than they did 50 years ago when communities seemed to live by simpler rules.'

'So much of what we've been talking about is educating the public and influencing opinion and causing change,' said one member. 'It's very difficult to achieve that sea change within society. Frankly I'm at a loss how to do it. The easy answer is to say involve the media but as we know they don't always behave responsibly.'

'You can impose measures on people but you really need to carry people with you because peer pressure is so strong. I don't have an easy answer for it but I think it's crucial for the success of campaigns.'

It was vital wherever possible to precede any intervention with public information and debate to ensure that when it was introduced it would be received positively.

Most of us also felt it was important to consider whether a measure had enough support to make putting it in place practical. As one person said, 'the best criteria would be the one that was introduced as a result of popular demand. That would be the one that should be dealt with first.'

Another highlighted the possible civil liberties problems if something was introduced that was strongly opposed by a significant proportion of the population. Would the benefits promised by the measure be outweighed by the civil unrest created?

But six of us disagreed. As several noted, public opinion was not necessarily the best criterion – often it took the imposition of a measure such as compulsory seat belts to win people round to its merits. ‘Some measures will be unpopular but it turns out gradually people will accept them and think this is a good idea.’

‘I don’t think this is too important as many people conform to and accept measures – for instance, car seats for babies, paracetamol, seatbelts,’ said another.

Most of us agreed health promoters needed to take public opinion into account and encourage public involvement where possible. But this should not necessarily be a deciding factor.

There was also general support for widespread public consultation ‘wherever possible’ before launching any mandatory intervention.

However, one person disagreed, contrasting the different ways the paracetamol and fluoridation debates were handled. ‘With paracetamol there wasn’t a great deal of consultation but they went ahead and did it and as a result saved a lot of lives.

‘With fluoride I think I could imagine what the local public consultation would be like. It would cost a lot of money and what they [the National Pure Water Association and the UK Councils Against Fluoridation] were saying would scare right-thinking people halfway to death.

‘On pretty much any issue you will find a small but vocal minority that will oppose what you want to do and scare the local population. Local consultation will just inflame that.’

On the other hand, he fully supported preceding any mandatory intervention with public information – ‘because giving good information is helpful in a way that offering a platform to any crank to scare and confuse is not!’

6 The Council's statements in full

For a full explanation as to how we produced these statements, please refer to Section 4.1.

Key:
SA – Strongly agree
A – Agree
N – Neither
D – Disagree
SD – Strongly disagree

	SA	A	N	D	SD
RECOMMENDATIONS					
Benefit to society v benefit to individual					
What the council agreed in plenary session					
Personal freedom is important. Attempt to educate people into a healthier lifestyle, try to get people to access voluntary help that they need, but ultimately if necessary, go for mandatory.	21	3	0	0	0
What we wrote on our individual sheets					
Freedom of choice is overridden by responsibility not to cause harm to others, therefore the state should intervene.	8	14	1	0	0
If it goes against religious beliefs should be able to opt out.	0	8	6	5	5
Intervention that provides benefit for the greater number even when a small minority could be disadvantaged.	6	13	3	1	1
Public health interventions based on rare conditions.	0	6	11	6	1
The measures should improve not only the health and well	4	10	3	6	0

being of the individual. E.g. seatbelts.					
Where it does not affect the efficacy of the intervention as a whole, exemptions should be allowed for certain groups, e.g. religious example Sikhs wearing helmets.	8	6	5	3	2

Majority versus minority

What the council agreed in plenary session

Future impact of health of individual as well as impact on family environment and community.	9	13	2	0	0
The scale of the impact of the disease/condition on the community should determine the action.	11	11	2	0	0
Intervention that provides benefit for the greater number even when a small minority could be disadvantaged.	6	15	1	2	0
Where personal choice undertaken knowingly or with intent impacts on risks to others there could be legal or financial penalties.	7	11	3	1	2
Where possible individuals should have freedom of choice and be responsible for their own health.	12	11	1	0	0
Where possible the intervention should be favoured that gives autonomy to the individual to join initiatives.	6	15	3	0	0
The potential to benefit society should outweigh the possible risk of harm to the few.	10	10	0	4	0
The needs and benefits of society should be a deciding factor	11	11	1	0	0

on mandatory measures.

What we wrote on our individual sheets

It would lead to overall improvement and health to the vast majority of people.	8	12	3	0	0

Cost benefit

What the council agreed in plenary session

You can see that it will lead to worthwhile benefits compared to the cost. A broad view of benefits needs to be taken as some benefits may be indirect and may take years or decades to emerge.	13	10	1	0	0
The cost of the benefit should be measured against the degree of benefit gained by the nation and the long-term savings to the public purse.	12	9	1	2	0
Decisions on public health should be based not on pure financial advantage.	9	12	2	1	0
The measures should treat the cause as well as the symptom; otherwise it’s not justified.	7	14	0	2	1
Benefits need to outweigh the costs of any mandatory measure – both the cost to society and financial implication.	6	14	2	2	0
Is the intervention for short-term gain with no regard for the long-term consequences?	1	8	12	2	0

What we wrote on our individual sheets

Decisions should be based on health reasons and not financial advantage.	4	13	5	2	0
Health prevention is not a device to avoid proper spending on acute services.	6	13	3	1	0
If the measure deals with treating the illness without attending to the cause it should not be justified.	7	8	3	6	0

Managing risk – urgency

What the council agreed in plenary session

Open acknowledgement of sufferers of adverse effects of an intervention. We need to rectify or compensate.	6	11	3	4	0
In urgent national emergencies quality of evidence may be lower before taking action.	11	12	1	0	0

What we wrote on our individual sheets

Extent of the harm/danger within the population.	1	20	2	1	0
How serious is the disease/problem – how many does it effect?	2	18	3	1	0
Public health interventions based on the seriousness of the condition.	3	15	3	2	0
Urgency based on individual need.	0	13	7	1	2

Measuring and monitoring – effectiveness

What the council agreed in plenary session

Any compulsory mandatory measure implemented must be monitored and recorded strictly and continually. If monitoring shows development of harmful consequences to a significant degree of the implemented measure must be withdrawn and the damage limited.	16	8	0	0	0
Does it work?	4	15	4	0	0
Go through a test trial before introducing it?	3	15	3	2	1
Is the proposed mandatory measure practical and achievable and if not, how can we make it so?	2	15	0	1	1
Is there a provision to review and stop the measure in the future if it turns out to be unfavourable? Something about irreversibility?	10	11	1	1	0
Research and trials must be done not only on the benefits but also on the side effects.	10	12	2	0	0

What we wrote on our individual sheets

Will a few not sticking to rules completely mitigate the effect of the intervention?	2	10	6	3	3

Needs and benefit versus harm / inconvenience

What the council agreed in plenary session

Is the condition one that genuinely addresses real public concern rather than the latest media fad?	7	15	2	0	0
Minor inconvenience should have no bearing on whether or not the intervention is made mandatory. Harm to the public should be.	2	10	2	0	0

What we wrote on our individual sheets

Compensation should not be considered society has become too compensation orientated.	1	7	2	4	9

Openness, trust and public involvement

What the council agreed in plenary session

Is the measure likely to gain enough public support to make the imposition practical?	2	16	1	6	0
Openness and transparency and knowing the reasons for the mandatory measure.	16	8	0	0	0
Wherever possible, genuine public consultation should take place beforehand.	14	7	1	1	0
Wherever possible, interventions should be preceded by public information and / or debate and feedback. (Refers to public health measures as opposed to clinical measures).	12	11	7	2	0

What we wrote on our individual sheets

If the measure increased general trust in the NHS and procedures to be safe and reliable then it should be considered.	4	11	7	2	0

Reducing inequalities

What the council agreed in plenary session

Important to consider the specific health issues of different groups of people when considering the implementation of mandatory treatment. These groups could be defined by their social, cultural, religious beliefs or even by geography.	5	15	4	0	0
If a disease or condition is common the most vulnerable should be helped first then the less vulnerable.	6	12	3	3	0
Promoting equality of outcome should be a factor in determining mandatory public health interventions. This may mean treating some people differently from others to (narrow the gap) / (improve general health).	5	14	2	1	2
Protection of the vulnerable members (e.g. those not able to make decisions) of society has to be considered.	8	16	0	0	0
Where risk to vulnerable groups is a factor – strict criteria and monitoring should be employed with due consideration to withdrawal (e.g. immunisation).	11	11	1	1	0

What we wrote on our individual sheets

Treat all impartially of their lifestyle choices /ethnicity / social group or backgrounds.	8	7	3	2	3

Appendix 1 – Briefing paper to Citizens Council

National Institute for Health and Clinical Excellence

Citizens Council Briefing

Mandatory Public Health Measures

Background

Since 1 April 2005 the Institute has had responsibility for advising on effective and cost effective measures to promote public health. These new forms of NICE guidance will be relevant for the NHS and in some circumstances for the wider public health community and those bodies and organisations with public health responsibilities (for example, local government, schools, police and transport).

Public health can be considered as the collective measures necessary to maintain and improve population health as a whole. Some public health interventions are provided by NHS staff (for example, immunisation against disease, or screening for cancer); but much is delivered by those working in local government (for example, environmental health officers inspecting restaurants), schools (for example, teachers and school nurses teaching pupils about smoking and drugs issues, or and sex and relationship education), transport (for example, road traffic calming measures), police (for example, speed cameras) and non-governmental organisations (for example, healthy living initiatives).

In the past, NICE has asked the Citizens Council questions relating to the medical care of individual or patients being treated within the NHS. With its extended remit NICE will now cover a much wider area which will be reflected in the questions presented to the council in the future.

Introduction

Some public health measures are “imposed” on people with either little or no opportunity to avoid them. Some examples are shown in Table 1. Their purpose includes:

- preventing the spread of communicable diseases
- preventing other causes of premature death or chronic ill-health
- reducing the costs of treatment (for example, hospital care)
- reducing the burden on society from the premature death or disability of those with dependent families
- reducing the burden on society and the NHS from chronic ill-health
- promoting a healthier society.

Table 1 – Examples of mandatory public health measures adopted in developed countries

Measure	Reason	Comment
Public sanitation	Prevention of infections from sewage	Introduced in the late nineteenth century. With secure drinking water, probably the most useful health intervention of all time.
Secure drinking water	Prevention of water-born infections	Introduced in the late nineteenth century
Drink-driving legislation	Prevention of road traffic injuries to drivers and pedestrians	Unpopular when introduced but minimal or no opposition now
Speed cameras	Prevention of road traffic injuries to drivers and pedestrians	Still very unpopular with some drivers, but evidence is that they reduce injuries.
Traffic calming schemes	Prevention of road traffic injuries to drivers and pedestrians	Generally popular with local residents but often unpopular with drivers and sometimes claimed to cause problems for emergency vehicles
Seat belt legislation	Prevention of road traffic injuries to drivers and passengers	Originally very unpopular but now widely accepted. Some exemptions (for medical reasons) are allowed
Motor cycle helmets	Prevention of road traffic injuries to riders	Initially strongly opposed on libertarian grounds, but now seems to be accepted. Some exemptions are allowed
Building regulations (some aspects)	Prevention of fires in public places and private dwellings	Adds to the expense of building but generally accepted and followed.
Restricted availability of over-the-counter paracetamol	Reduction of deaths from accidental or deliberate overdose (see Annex 4)	May cause inconvenience for consumers but seems to be accepted
Provision of free smoke alarms to deprived urban households	Prevention of fire in communities that have a higher than average rate of deaths and damage from fires	Thought to be a good idea limited success as smoke alarms were not correctly installed and maintained (for example, many did not have batteries)
Screening for hepatitis C in all donated blood	To prevent transmission of hepatitis C through donated blood	Found to be highly cost ineffective. Cost may be as high as £30m to save a single year of life (approximately £1.2bn per life saved)
Immunisation [a]	*Prevention of communicable disease (for example, smallpox, polio, TB, diphtheria, whooping cough, tetanus, mumps, measles and German measles)*	*Smallpox immunisation was introduced in the late 1800's, others were introduced later. Immunisation isn't compulsory in the UK, but very strong incentives for compliance exist in countries such as France and the USA*
Fluoridation of drinking water [a]	*Prevention of tooth decay (see Annex 1)*	*Has been introduced in some areas of the UK, with vociferous opposition in some places.*
Fortification of flour with folate [a]	*Prevention of serious birth abnormalities*	*Introduced in Canada and the USA in 1998. Not yet in the UK or EU.*
Controls on smoking in confined public spaces [a]	*Prevention of smoking-related diseases amongst passive smokers*	*Introduced in various places including New York and Eire. Controversial in the UK but legislation anticipated in 2008.*

[a] These measures (in italics) are not mandatory across the UK

Many of the measures shown in Table 1 were very unpopular at the time they were introduced in the UK. Reasons for initial opposition included:

- Immunisation has always been controversial. Mandatory immunisation against small pox was introduced in the late 19th century for those who were receiving "Poor Law Relief". Immunisation was alleged to be responsible for numerous other conditions (including cancer and venereal diseases).

- Drink-driving laws were attacked when they were originally introduced (by the late Barbara Castle) on the grounds that many people could tolerate high levels of alcohol in their blood without impeding their driving ability. They are now widely accepted as a proportionate means to reduce the toll of injury and death.

- Motor cycle helmet legislation was originally criticised on the grounds that it was the responsibility of individuals, and not the state, to decide whether or not motor cyclists should take measures to protect themselves from head injury.

- Seat belt legislation, when first introduced, was regarded by many as an affront to personal liberty.

- The introduction of speed cameras, to deter drivers from exceeding speed limits, continues to be the subject of controversy with opponents arguing that speed cameras do little to save lives or improve driving standards, but are unduly restrictive to drivers.

Other interventions were popular when introduced, but were found to be much less effective than hoped. Two examples are given in table 1.

Some of the issues relating to fluoridation of water and restrictions on the over-the-counter availability of paracetamol are discussed in Annexes 1 and 2 (respectively). Please note that these are case studies intended to stimulate discussion about mandatory public health interventions – the council is **not** asked to make recommendations about the introduction of these interventions in the UK.

The issue

The council is asked to suggest principles that should govern the imposition of public health measures on the UK population, paying due attention to:

- the relative roles and responsibilities of individuals to look after the health of themselves and their families, as against the roles and responsibilities of the state
- issues relating to interventions that may sustain or improve the overall health of the population, whilst nevertheless inconveniencing many, or even harming a minority

In formulating its recommendations the council may wish to produce a list of principles, ranked in order of importance, to be considered whenever a mandatory public health intervention is being contemplated. The following list of principles provides a starting point, but the council is strongly encouraged to change, add and delete these if they wish:

- the nature of the disease or condition being prevented
- the nature of the benefits of the intervention – are they to the individual (like fluoride) or to society (like banning smoking in public places)
- the seriousness of the disease or condition being prevented
- how common is the disease or condition being prevented
- the seriousness of the side-effects of the intervention
- how common are the side-effects of the intervention
- the evidence we have that the intervention is likely to work
- how well the intervention is likely to work
- the likely cost impact of the intervention
- the likely cost effectiveness of the intervention
- whether it is possible to identify people who have suffered side-effects of the intervention
- whether people who have suffered side-effects should be compensated
- whether there might be long term side effects or harms from the intervention
- how serious these side effects or harms might be
- how accepted or opposed is the intervention
- whether the intervention is likely to benefit everyone in society or only certain groups within society
- whether the intervention will widen health inequalities

Citizens Council Committee

June 2005

Annex 1 – Water fluoridation – the case for and against

Background

Fluoride can make teeth stronger and prevent tooth decay especially in childhood. It can be applied directly to teeth via toothpaste or mouth rinses, or ingested in tablet form or in water. Too much fluoride can cause mottling (fluorosis) of teeth.

There are inequalities in dental health. Children from less well-off backgrounds have five times more tooth decay than those in the highest social classes. (Department of Health, 1999)

Fluoride occurs naturally in water in the UK but at varying levels. Some areas with low levels of naturally occurring fluoride have added fluoride to drinking water. Around 10% of the UK population drinks fluoridated water. The Water Act 2003 has given Strategic Health Authorities the power to have fluoride added to drinking water but it must follow a public consultation which demonstrates that there is local support.

The question

The question is whether fluoride should be added to drinking water in areas with low levels of fluoride.

Do the potential benefits to a large group justify the potential harm to the few?

What are the likely positive effects on tooth decay, in particular among children from poorer families?

Could this be achieved by other interventions such as fluoridated toothpaste?

What are the likely negative effects – to teeth in particular and to health in general?

The evidence

The Centre for Reviews and Dissemination (CRD) at York University was commissioned by the Department of Health (DH) in 1999 to conduct a systematic review into the efficacy and safety of the fluoridation of drinking water. (McDonagh et al, 2000)

They found a range of studies that were included in the review.

- The evidence they found suggests that water fluoridation is likely to have a beneficial effect, but the effects could range from a substantial benefit to a slight ‘disbenefit’ to children’s teeth. The beneficial effect comes at the expense of an increase in the prevalence of mottling of teeth. The quality of this evidence was moderate.

- They did not find any association of water fluoride with other adverse effects on health such as cancer, bone fractures and Down's Syndrome. However, the quality of the evidence here was poor.
- There was some evidence that water fluoridation reduced inequalities in dental health in children. This evidence was of low quality.

Cost

Water fluoridation has been found to be cost-effective when compared with other strategies to reduce tooth decay (quoted in BMA, 2004).

The case for

Health Ministers have publicly expressed support for fluoridation.

The National Alliance for Equity in Dental Health is a consortium of professional and academic organisations which support the addition of fluoride to water on the grounds that it will reduce inequalities in dental health. It is co-ordinated by the British Medical Association, the British Dental Association and British Fluoridation Society, an organisation which specifically aims to promote fluoridation and receives funding from the DH.

The All Party Parliamentary Group on Primary Care and Public Health recommended fluoridation as a legitimate and effective means of tackling dental health inequalities.

The case against

Adding fluoride to drinking water takes away the choice for the individual. This makes it a favourite public health intervention because the assumed effect is not dependent on the health behaviour of the individual. This is also the crux of the matter for the opposition who considers it a violation of the right to freedom of choice.

Those who are against artificial water fluoridation dispute the benefits and express concern about potential harmful effects. It is argued that it is not justified to take measures that may be harmful for dubious benefits to a relatively small number of people when any beneficial effects could be achieved by other means such as fluoride in toothpaste.

There are some locally based community groups such as the Lancashire Campaign against Fluoridation that fight the issue as well as a national organisation, Britain Against Fluoridation Group. The Pure Water Association campaigns for safe drinking water in general and opposed fluoridation.

The Green Party is opposed to fluoridation on safety grounds. There are further concerns about the links with the chemical industry that supplies

artificial fluoride and the compulsory nature of its addition to drinking water that denies consumers choice.

The Water Utilities are concerned that they may be liable to pay compensation if they are sued as a result of someone suffering ill health.

Evidence of public opinion

A National Opinion Poll commissioned by the British Fluoridation Society in 2003 showed that two thirds of the respondents were in favour of adding fluoride to drinking water.

A MORI survey of 1,530 people in the West Midlands in 2000 showed that 71% of people said 'yes' when asked, 'Do you think fluoride should be added to water if it can reduce tooth decay?' (quoted in West Midlands Regional Dental Health Promotion Group, 2004).

References

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McDonagh, M et al (2000) *A systematic Review of Public Water Fluoridation*. NHS Centre for Reviews and Dissemination, University of York.

West Midlands Regional Dental Health Group (2004) *Fact Sheet on Fluoridation: Professional and Public Opinion.* West Midlands Health Services.

Annex 2 – Restricting the pack size of paracetamol, a case study

Background

Paracetamol is a very widely used pain-killer, and is the active ingredient of many proprietary products like Hedex and Panadol. At therapeutic doses, paracetamol is extremely safe. After an overdose, however, it produces severe liver damage which can lead to death from liver failure.

Paracetamol is available on a doctor's prescription; but it can also be readily purchased as 'over-the-counter' medicine (that is, without prescription) at chemists' shops, or at general retail outlets (for example, supermarkets, general stores and petrol stations).

The problem

Excessive intake of paracetamol is one of the commonest causes of admission to hospital for 'self-poisoning' or overdose. Instances of self-poisoning with paracetamol are either due to inadvertent ingestion of too great a quantity or, more commonly, as a result of a deliberate attempt at self-harm.

Individuals who take overdoses of paracetamol can be successfully treated with an antidote, provided this can be given before serious liver damage starts occurring. In practice, this means that patients need to be treated within 12 to 24 hours. For individuals who seek help at a later time, the antidote is ineffective and serious liver damage is likely to develop. Serious liver damage can lead to what is known as 'fulminant liver failure' and this will cause 95% of patients to die within 48 to 72 hours unless they receive a liver transplant.

Liver transplantation after paracetamol poisoning is associated with two special problems: first, livers for transplantation are in short supply, and patients with fulminant hepatic failure due to paracetamol poisoning may die before one becomes available; and second, liver transplantation for someone with paracetamol may deprive others, with severe liver disease from other causes, the opportunity to receive life-saving surgery.

Those who take a deliberate overdose of paracetamol are usually young people making a 'cry for help'. It is exceptional for them to want to die; and most do so impulsively after an argument with their parents, girlfriends, or boyfriends. The evidence, moreover, shows that most of those who take overdoses of paracetamol just raid the family medicine cabinet, and take handfuls of whatever pills are inside; and since paracetamol is so widely used, it is the one most commonly present in a family's medicines cabinet.

The scale of the problem

By 1995 the frequency of fulminant liver failure, and death, from paracetamol poisoning had become a serious problem with 160 to 190 recorded fatalities

each year from preparations containing paracetamol alone. These deaths were not only tragedies for individuals and their families; but the numbers of patients were causing problems for liver transplant surgeons who had to make extremely difficult choices about which patients should be treated when a liver for transplantation became available.

In 1995 the Committee on Safety of Medicines (the body with responsibility for advising on the efficacy, safety and availability of medicines) considered what measures it might recommend so as to reduce the number of deaths from paracetamol poisoning. Making paracetamol available as a prescription only medicine would have reduced the availability of a widely used treatment for pain caused by headaches, toothache, period pains, migraine etc. The committee therefore proposed three measures which, it was hoped, would reduce the frequency of deaths from overdose with paracetamol:

1) It recommended that paracetamol packs should included a warning about the dangers of overdoses. This was controversial because there were fears amongst some experts that “advertising” the lethal potential of paracetamol would encourage its use for deliberate self-poisoning rather than diminish the chances of inadvertent or accidental self-poisoning. Nevertheless, the view that consumers were entitled to be provided with this information, eventually prevailed.

2) It recommended that no more than 16 paracetamol tablets should be available in each pack that could be purchased in general retail outlets while up to 32 were available in pack purchased in pharmacies; and that not more than one pack could be purchased at any one time. The reason for limiting purchases to 16 tablets was that this number was below the minimal lethal dose of around thirty. This measure, it was hoped, would limit the availability of paracetamol in families’ medicines cabinets, and hence reduce the frequency of impulsive self-poisoning with lethal quantities of this medicine.

3) In order to prevent substituting self-poisoning with paracetamol to aspirin similar restrictions on its ‘over-the-counter’ sales were also applied. This was extremely important because these medicines, after overdose, also produce serious (and sometimes lethal) damage, albeit to different bodily functions.

So that people with chronic painful conditions (mainly arthritis) would not be denied reasonable access to needing paracetamol or aspirin, supplies on a doctor’s prescriptions were allowed to be for up to one month’s treatment.

The debate

The announcement of these measures was not popular. Two particular objections were raised:

1) Limitations on the availability of these pain-killers were considered, by some, to be an unreasonable imposition for the majority of the population who use these medicines responsibly. It was claimed that thousands (if not millions) of people would be inconvenienced by these measures; and that they would, on occasions, be deprived of safe and effective remedies for common, everyday aches and pains.

2) It was suggested that individuals who were determined to harm themselves would merely visit three of four retail outlets and purchase sufficient quantities of drugs in this way.

Both of these objections had merit. Limiting the availability of these medicines would unquestionably inconvenience the general population; but, on the other hand, it might save the lives of some (albeit unknown) number of young people. Whether the measure would be effective was unproven. But, since it could only be introduced by a change to the existing legislation, there was no opportunity to test it by introducing the measure, on a pilot basis, in some areas of the country.

The impact

The measures were complicated to introduce. Not only was legislation needed to reduce the pack sizes of products with these pain-killers, but many hundreds of manufacturers' licences had to be altered, compulsorily, in order for the labelling changes to be made. They also had (by law) to be given the opportunity to appeal against the proposed measures (although none ultimately did so). Following this, manufacturers had to arrange for the production of new packaging materials, and retailers had to exhaust their existing stocks and replenish with new ones. Consequently, the measures only took full effect from September 1998 although some manufacturers and retail outlets began making changes earlier in that year.

There was a 34% reduction in mortality rates from paracetamol poisoning comparing the two years before, and the second and third years after legislation: and there was a 70% reduction in deaths from aspirin poisoning over the same the same years. The total deaths (around 2,100 per year in the mid-1990s) from poisoning fell by 7% during the same time periods.

The number of patients undergoing liver transplantation for paracetamol-induced liver failure fell from 33 (in 1996) to 21 (in 2002): and the number of patients attending hospitals in England, with paracetamol only overdoses, fell by 7%.

Conclusions

The measures introduced in 1998 appear to have reduced the numbers of fatalities from paracetamol poisoning by about 40 people per year. On statistical grounds we would expect that most of those in whom death has

been prevented are adolescents and young adults. There has been no substitution of poisoning with aspirin. Nevertheless, the general public has been inconvenienced!

Appendix 2 – Programme

Thursday 30 June 2005		
8.30 – 9.15	Introduction to the meeting: • Welcome from Andrew • Update on progress at NICE • Social Value Judgements Guidelines • Welcome from the facilitators • Update on organisational arrangements for the Citizens Council • Q&A	Andrew Dillon, Magnus Anderson, Facilitators
9.15 – 9.30	Introduction to the question	Mike Rawlins
9.30 – 10.15	Introduction to Public Health: what is public health and what is it trying to achieve	Ruth Hussey
10.15 – 10.45	Break	
10.45 – 12.30	Making decisions about mandatory public health interventions: two different views	Bill Fulford Stephen Twigg
12.30 – 13.30	Lunch	
13.30 – 14.40	Case study: fluoridation of water	Ian Wylie Michael Lennon Liz Vaughan Sheila Gibson
14.40 – 15.10	Break	
15.10 – 16.10	Case study: Restriction of paracetamol pack sizes	Mike Rawlins
16.10 – 17.00	Wrap up and close	Facilitators

Friday 1 July 2005		
9.30 – 10.30	Recap from yesterday Debate and discussion	Facilitators
10.30 – 11.00	Break	
11.00 – 13.00	Obesity	Mary Corcoran Caroline Mulvihill Louise Diss
13.00 – 14.00	Lunch	
14.00 – 15.30	Debate and discussion	Facilitators
15.30 – 16.00	Break	
16.00 – 17.00	Debate and discussion	Facilitators

Saturday 2 July 2005		
9.00 – 12.30	Deliberation and developing conclusions	Facilitators and Peter Littlejohns
12.30 – 13.00	Next steps: • Developing the report • Consulting on the report • Retirement arrangements • Dates of the next meeting – 26 to 28 January 2006 Wrap-up and thank you	Ela Pathak-Sen Peter Littlejohns

Appendix 3 – Speakers' biographical details

Dr Mary Corcoran – Director of Public Health, Gedling PCT

Mary Corcoran qualified from Liverpool Medical School in 1975. After working in Tanzania for two years, she commenced training in public health - initially in Sheffield and subsequently in Hampshire. She has since worked in West Sussex, Uganda and Nottingham, becoming Director of Public Health of Gedling Primary Care Trust in May 2002. She has special interest in Diabetes and Medicines Management.

Louise Diss – Operational Director of the charity TOAST (The Obesity Awareness & Solutions Trust)

The Obesity Awareness & Solutions Trust (TOAST) is a national advocacy charity (Reg. No. 1088049) committed to ensuring that people whose lives are directly affected by obesity have a voice which enables them to have an impact on policy, treatments and services. TOAST also aims to expand and develop frontline action to prevent and solve the problem of obesity. TOAST is also a ASET Accredited Training Centre and offers Nationally recognised training courses.

TOAST is dedicated to encouraging a better understanding of obesity, its causes and practical solutions through stimulating informed debate, developing and delivering training packages about and researching into obesity. TOAST runs an information desk for the obese, overweight, post obese, compulsive overeaters and for those who work with obesity or the obese and is launching a National Help and Information Line. They are running a number of proactive programmes such as training packages "Obesity-psychology and diversity" aimed at professionals in all areas including health and education and are piloting a Lifestyle Management programme that is designed to arm the overweight and obese with the skills to challenge their attitudes to food and themselves.

TOAST works closely with academia, patient groups, the medical profession, consumers, local government and a wide range of industries, to raise awareness of and seek solutions for the treatment and prevention of obesity. It also seeks to share its experience and expertise in dialogue with policy makers and regulators on a national level, decisively to confront the obesity epidemic and to challenge discrimination and stigma.

Louise Diss was appointed as the Operational Director of the Charity TOAST (The Obesity Awareness & Solutions Trust) in December 2004. She has a wealth of experience of working in the public and voluntary sectors as a Psychiatric Social Worker and trainer. Prior to taking up her previous post as development worker for the Charity she worked as an Obesity Counsellor and, with personal experience of obesity, has a clear understanding of the physical and emotional effects that obesity can have on individuals. Louise writes articles for newspapers and magazines on behalf of TOAST and has represented the charity on national and local television and radio.

Professor Fulford – Professor of Philosophy and Mental Health, University of Warwick

Bill (KWM) Fulford is Professor of Philosophy and Mental Health in the Department of Philosophy, University of Warwick, where he runs a Masters, PhD and research programme in Philosophy, Ethics and Mental Health Practice. This is the first centre of excellence for inter-disciplinary work between philosophy and mental health.

He is also an Honorary Consultant Psychiatrist in the Department of Psychiatry, University of Oxford; Visiting Professor in Psychology, The Institute of Psychiatry and King's College, London University; Visiting Professor in Philosophy and Professional Practice Skills in the Centre for Professional Ethics, University of Central Lancashire; and Visiting Professor, Kent Institute of Medicine and Health Sciences, University of Kent. He is the Founder Chair of the Philosophy Special Interest Group in The Royal College of Psychiatrists (over 1600 members). He is a Fellow of both the Royal College of Psychiatrists and The Royal College of Physicians (London).

He was Director of the Oxford Practice Skills Programme which set up the Oxford Practice Skills Course in the University of Oxford Medical School. This course brings together ethics, law and communication skills in a problem-solving approach to medical student education. He is the founder and Co-Editor of the first international journal for philosophy and mental health, PPP - Philosophy, Psychiatry and Psychology. He has published widely on philosophical and ethical aspects of mental health (see below).

He is currently seconded part time to the Sainsbury Centre for Mental Health to develop in-service training programmes in philosophy for mental health practitioners (nurses, social workers, psychologists etc). He has recently been appointed National Fellow for Values-Based Practice in the National Institute for Mental Health in England (NIMHE), part of the Modernisation Agency in the UK government's National Health Service.

Sample Publications:

- In philosophical value theory - a) Fulford, K.W.M. (1989, reprinted 1995 and 1999; Second edition forthcoming) Moral Theory and Medical Practice. Cambridge: Cambridge University Press, b) Teleology without Tears: Naturalism, Neo-Naturalism and Evaluationism in the Analysis of Function Statements in Biology (and a Bet on the Twenty-first Century). Philosophy, Psychiatry, & Psychology, 7/1:77-94 and c) Fulford K.W.M. (forthcoming 2003) Ten Principles of Values-Based Medicine in Radden J ed. A Companion to the Philosophy of Psychiatry. New York and Oxford: The Oxford University Press.
- In psychiatric ethics - Dickenson, D. and Fulford, K.W.M. (2000) In Two Minds: A Casebook of Psychiatric Ethics. Oxford: Oxford University Press,
- In healthcare ethics - Fulford, K.W.M., Dickenson, D. and Murray, T.H. (eds) (2002) Healthcare Ethics and Human Values: An Introductory Text with Readings and Case Studies. Malden, USA, and Oxford, UK: Blackwell Publishers.

- In the philosophy of psychiatry – Fulford, K.W.M., Morris, K., Sadler, J.Z. and Stanghellini, G., eds, (2003) Nature and Narrative: An Introduction to the New Philosophy of Psychiatry. Oxford: The Oxford University Press (launch volume for a new book series from OUP on International Perspectives in Philosophy and Psychiatry).

Dr Sheila L. M. Gibson M.D., B.Sc. Hons. (Biochemistry), M.F.Hom. – National Pure Water Association.

Dr Gibson has carried out research in toxicology and genetics in the University of Glasgow's Departments of Medicine and Medical Genetics respectively where she researched the effects of fluoride's toxicity on the immune system.

Dr Gibson has been a lecturer in Medical Genetics at the University of Glasgow and research physician at the Homeopathic Hospital. She was a medical member of the advisory panel of the York Review and is currently a practising physician. Dr Gibson has also been called as an expert witness in fluoridation cases in Strathclyde and Fond Du Lac.

Dr Gibson is a vice president of the National Pure Water Association and a medical advisor to UK Councils Against Fluoridation.

Dr Ruth Hussey OBE – Director of Health Strategy/Medical Director at Cheshire and Merseyside Strategic Health Authority

Ruth is the Director of Health Strategy/Medical Director at Cheshire and Merseyside Strategic Health Authority (since 1 April 2002). Her remit includes:

- Health and Health Service Strategies both short & long term
- Future Health Investment Plans
- Health Improvement, Health Protection and Health Inequalities
- Clinical and R&D Governance
- Clinical and Public Health Networks and Medical Leadership

Ruth previously held the post of Director of Public Health for Liverpool (1991 - 2002). Before that she was a Senior Lecturer in Public Health at Liverpool University. Early clinical training took place in hospitals and general practice. Ruth is an Honorary Fellow at Liverpool John Moores University and a visiting Professor at the University of Liverpool.

Ruth is a member of the NHS Reference Group for health inequalities; NHS Advisory Committee for Resource Allocation; Health Care Commission Public Health Expert Group and the National Leadership Network for Health and Social Care.

Ruth is particularly interested in inequalities in health and the importance of involving communities in decisions about their own health and health care.

Professor Michael Lennon – Chair of the British Fluoridation Society

Professor Lennon graduated in dentistry from University of Liverpool in 1966.

In 1969 he was appointed Lecturer at the University of Manchester, becoming Senior Lecturer in Community Dentistry there in 1980, and Honorary (NHS) Consultant in 1983.

From 1985 to 1989 he was Regional Dental Officer for the North Western Regional Health Authority.

From 1989 until 2002 he was Professor in Dental Public Health at University of Liverpool and Head of the Department of Clinical Dental Sciences.

Since retiring from his post in Liverpool he has taken up an innovative part-time post at Sheffield University organising and evaluating the training of the dental team in primary care settings. He is currently collaborating in a randomised controlled trial of outreach training.

Professor Lennon has published around 100 peer-reviewed articles, and has been a member of many expert groups – including the Advisory Panel for the University of York Systematic Review of Fluoridation, and the Medical Research Council's Working Group on Water Fluoridation.

He is a World Health Organisation advisor, most recently addressing W.H.O. conferences in Rome in November 2003 on the desalination of water; and, in Cairo in December 2003, on the use of fluorides in general.

He is recognised as an expert in dental epidemiology, improving dental health in areas of social deprivation, and water fluoridation.

He has chaired the British Fluoridation Society, a government funded health promotion group, since 1987.

Dr. Caroline Mulvihill – Analyst (Research), Centre for Public Health Excellence, NICE

Dr. Caroline Mulvihill has a background in nutrition and is a Registered Public Health Nutritionist. Prior to joining the Health Development Agency, Caroline was the food and nutrition research manager for the Health Education Authority. Caroline has also worked at the University of London (King's College and the Institute of Education) on a number of research projects concerning the health of children and young people, for example iron deficiency anaemia, physical activity and the National Healthy Schools Standard.

At the HDA Caroline led on developing the evidence base for diet, nutrition and obesity. She is an author on the HDA evidence briefings for the management of obesity and overweight, alcohol misuse prevention, promotion of breastfeeding, prevention of low birth weight, home visiting and housing interventions.

Caroline is currently working on the NICE programme guidance on obesity and maternal and child nutrition.

Stephen Twigg

Stephen was the Labour MP for Enfield Southgate between 1997 and 2005. His 1997 victory over Michael Portillo was voted the third greatest TV moment ever but the traditional Conservative seat reverted to form last month.

He spent a year as Deputy to the Leader of the House of Commons (2001/2) followed by three years at the Department for Education and Skills as Schools Minister.

Prior to his election to the House of Commons he spent five years as an elected councillor in the London Borough of Islington.

He is a governor of Southgate Comprehensive school which he also attended as a pupil.

Stephen is 38 and lives in Southgate, north London.

Cllr Liz Vaughan – UK Council Against Fluoridation

Cllr Vaughan worked as a cytotechnologist in a hospital laboratory. When fluoridation was proposed in the North West of England in 1988 Liz was naturally interested in the cyto toxic effects of fluoride. After discussions with Barrow in Furness Borough Council who organised a seminar inviting councils in the North West, it was decided to form North West Councils Against Fluoridation. In 1992 the water company decided not to fluoridate because they regarded the councils opposition as representing the views of the majority of their customers. Cllr Vaughan was then invited to be chairman of the National Pure Water Association.

Now fluoridation is again on the Government's agenda the councils of NWCAF decided to expand membership and become UK Councils Against Fluoridation, Liz is still their information officer and they have a panel of medical, scientific and dental advisors.

Ian Wylie, MA (Oxon) DPhil, MIPR, Hon MFPH – Chief Executive of the British Dental Association

Ian Wylie, 49, is a graduate of Oxford University, where he also holds a doctorate in English Literature. He joined the NHS in 1982, working first in primary care services for homeless people before moving to Hackney as liaison officer in primary care, and then public relations manager for City & Hackney Health Authority, based at Barts Hospital.

In 1988, Ian was appointed to the post of head of media & information for Oxford City Council, and he returned to the NHS as director of corporate communications for Oxford Regional Health Authority. In 1994, he joined the King’s Fund and became executive director of corporate affairs.

In January 2001, he became Chief Executive of the British Dental Association.

Appendix 4 – Who are the Citizens Council?

John Baldwin - an electrician who lives in Widnes, Cheshire

Auriol Britton – a singer who lives in Bristol.

Brian Brown - an electrical engineer, from Chester-le-Street, County Durham.

Jennifer Brown - a local government accounting technician and a part-time fitness instructor who lives in Derby, Derbyshire

Sylvia Brown - a retired local government officer who lives in London.

Rod Crowshaw - a store assistant who lives in Castle Bromwich, West Midlands.

Trevor Davison - a supervisor scaffolder, who lives in Lincoln, Lincolnshire.

Geraldine Fost - a retired careers guidance manager, who lives in Hungerford, Berkshire.

Marie Goorun - a dressmaker and part-time French tutor who lives in Gillingham, Dorset.

Terry Hamer - lives in Southampton. He works on the cruise ships at the terminal.

Mark Handley - a project manager who lives in Kingston-upon-Thames, Surrey.

Susan Glendinning – a clerical assistant who lives in Cardiff, Glamorgan.

Lorna Girling - lives in Norfolk, and is a part time literature student and a housewife and mother of two.

Robert Jones - works as a warehouse operative and is a football referee in his spare time. He lives in Cwmbran, Wales.

Arun Jotangia - lives in Bolton. Arun currently works in a post office, but used to be a hairdresser.

John Mahoney - who lives in London, is a former foreign editor for the BBC and for ITN News at Ten.

Melanie McClure - a mother of one who lives in Hebburn, Tyne and Wear.

Susan McNeill - a secretary who lives in Market Harborough, Leicestershire.

Tony Messenger – a retired insurance broker who lives in Windsor, Berkshire.

Sharon Morgan - a milliner who lives in Birmingham, West Midlands.

Linda Moss - currently unemployed, trained as a TEFL teacher and now lives in Todmorden, West Yorkshire.

Bob Osborne - a retired former pilot who lives in Horsham, West Sussex.

Paul Pendlebury - an assembly worker, who lives in Preston, Lancashire.

Lisa Spinks - lives in Bradford, and is a communications operator for the police.

Heena Sabir - worked for a while in human resources, and has recently moved to Huddersfield, where she is looking for suitable work.

Ian Simons - a taxi driver, who lives in London.

Paddy Storrie - a secondary school Deputy Headteacher, lives in Harpenden, Herts.

Fiona Taylor - a legal assistant, who lives in Sidbury, Devon.

Peter Thomas - a teacher, who lives in Rhondda, Cynon Taff.

Judith Ward - a wood turner, who lives near Stoke on Trent, Staffordshire.

Membership at June 2005

Appendix 5 – A Fence or an Ambulance

'Twas a dangerous cliff, as they freely confessed,
Though to walk near its crest was so pleasant;
But over its terrible edge there had slipped
A duke and full many a peasant.
So the people said something would have to be done,
But their projects did not at all tally;
Some said, "Put a fence around the edge of the cliff,"
Some, "An ambulance down in the valley."

But the cry for the ambulance carried the day,
For it spread through the neighbouring city;
A fence may be useful or not, it is true,
But each heart became brimful of pity
For those who slipped over that dangerous cliff;
And the dwellers in highway and alley
Gave pounds or gave pence, not to put up a fence,
But an ambulance down in the valley.

"For the cliff is all right, if you're careful," they said,
"And, if folks even slip and are dropping,
It isn't the slipping that hurts them so much,
As the shock down below when they're stopping."
So day after day, as these mishaps occurred,
Quick forth would these rescuers sally
To pick up the victims who fell off the cliff,
With their ambulance down in the valley.

Then an old sage remarked: "It's a marvel to me
That people give far more attention
To repairing results than to stopping the cause,
When they'd much better aim at prevention.
Let us stop at its source all this mischief," cried he,
"Come, neighbours and friends, let us rally;
If the cliff we will fence we might almost dispense
With the ambulance down in the valley."

"Oh, he's a fanatic," the others rejoined,
"Dispense with the ambulance? Never!
He'd dispense with all charities, too, if he could;
No! No! We'll support them forever.
Aren't we picking up folks just as fast as they fall?
And shall this man dictate to us? Shall he?
Why should people of sense stop to put up a fence,
While the ambulance works in the valley?"

But a sensible few, who are practical too,
Will not bear with such nonsense much longer;
They believe that prevention is better than cure,

And their party will soon be the stronger.
Encourage them then, with your purse, voice, and pen,
And while other philanthropists dally,
They will scorn all pretence and put up a stout fence
On the cliff that hangs over the valley.

Better guide well the young than reclaim them when old,
For the voice of true wisdom is calling,
"To rescue the fallen is good, but 'tis best
To prevent other people from falling."
Better close up the source of temptation and crime
Than deliver from dungeon or galley;
Better put a strong fence round the top of the cliff
Than an ambulance down in the valley.

by Joseph Malins (1844-1926)

Malins, Joseph. “A fence or an ambulance.” Best loved poems of the American people. Ed. Hazell Felleman. Doubleday, 1936