# Commentary

## Different ethical standards for different ethical problems? A commentary on 'Responsibility, Prudence and Health Promotion'

This short note offers a few comments on the interesting paper 'Responsibility, Prudence and Health Promotion' by Brown, Maslen and Savulescu. We agree that the development of NCDs is powerfully influenced by social and environmental forces beyond an individual's direct control. Thus, undue emphasis on individuals 'taking responsibility' for making healthy choices is unethical, sometimes stigmatizing and always unscientific. It ignores the complexity of NCD causation and promotes ineffective and inequitable NCD prevention strategies. An emphasis on 'personal responsibility' is also a well-recognized distraction tactic used by supporters of harmful commodity industries such as tobacco, alcohol and junk food.[1] Conversely, effective and successful strategies such as tobacco control comprehensively address the '3As' of affordability, acceptability and availability.[2]

Brown and colleagues are also rightly sceptical of behavioural interventions such as 'Nudge' and self-regulatory solutions. The recent failure of the UK Responsibility Deal to improve health outcomes in food and drink, alcohol or physical activity offers clear evidence in this regard.[3]

We agree that prudence is a sensible ethical standard for guiding health promotion, but respectfully suggest that different standards might be required for different types of ethical problem. Brown and colleagues' recommendations for policy design raise the question of whether a clearer distinction should be drawn between health 'promotion' and health 'protection'.

The WHO has consistently recommended a multifaceted approach to NCD prevention policy that spans the 'health promotion' spectrum from 'upstream', structural policies that create healthy environments to 'downstream', individual-focussed measures dependent on an agentic response.[4] The latter include 'health education' interventions and public health campaigns intended to improve a person's health literacy. Conversely, interventions such as tax increases and advertising restrictions could be termed 'health protection'—policies reducing or removing an identifiable risk to population health, notwithstanding individual preferences. For example, alcohol marketing is evidentially linked to higher consumption of alcohol.[5] Regulating alcohol advertising, particularly marketing designed to appeal to minors, is a strategy that protects populations against a risk to their health that they can never control, and which may alter their capacity to pursue good health before they even start to make choices.

Such interventions—examples include sugary drinks taxes and alcohol advertising restrictions—are more intrusive than health promotion campaigns, sit higher on the Nuffield intervention ladder[6] and cannot easily be justified by prudence alone, as advanced by Brown and colleagues.

Debates on the paternalistic 'nanny state' nature of health protection interventions such as sugar taxes or alcohol advertising restrictions mistakenly assume that the degree of intrusion into individuals' responsibility for health related choices is the key ethical problem.[7]

A more pressing and relevant ethical problem might be the extent to which such interventions affect inequality.[8] Industry supporters assert that sugary drinks taxes are 'regressive'. Such taxes do indeed have economically regressive impacts upon lower socio-economic groups, but this is small, costing a poor household perhaps an additional 10p per week. The ethical issue is therefore to balance that loss against the progressive and substantial health gains of the sugar tax, which disproportionately benefit the most deprived social groups.[9]

## References


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