Are traditional bioethics good for our health? Rights of autonomy pay little regard to the needs and interests of communities. Like neo-liberal economics, they promote individual freedom of choice, with little concern for social equality. Yet widening inequality plays a crucial role in morbidity and mortality. Its adverse consequences are overwhelming modern health care systems. How can traditional bioethics modernise to embrace “citizenship” values? And what role should the courts have in the process?

Bioethics has been quick to focus on exotic new medical technologies and how they might affect our lives. It has paid considerable attention to the doctor-patient relationship and how changes in the health system affect it. With some significant exceptions, it has not looked “upstream” from the point of view of the delivery of medical services to the role of the health care system in delivering improved population health. It has even more rarely looked further upstream to social arrangements that determine the health achievement of societies (N. Daniels, B. Kennedy and I. Kawachi, “Health Inequality or, Why Justice is Good for Our Health,” in (eds) S. Anand, F. Peter and A. Sen, Public Health, Ethics and Policy (Oxford University Press, 2006), 64).

A. The Social Determinants of Health

...lack of health care is not the cause of the huge global burden of illness: water-borne diseases are not caused by lack of antibiotics but by dirty water, and by the political, social, and economic forces that fail to make clean water available to all; heart disease is caused not by a lack of coronary care units but by the lives people lead, which are shaped by the environments in which they live; obesity is not caused by moral failure on the part of individuals but by the excess availability of high-fat and high-sugar foods. The main action on social determinants of health must therefore come from outside the health sector. Closing the Gap in a Generation - Health Equity through Action on the Social Determinants of Health (WHO, 2008), 35.

In England, almost a quarter of adults and almost a sixth of children under the age of 11 are obese. It is predicted that by 2050, 60% of adult men, 50% of adult women and 25% of children may be obese... Around 58% of the incidences of type 2 diabetes, 21% of cases of heart disease and between 8% and 42% of cancers are attributable to excess body fat (Public Health Guidance – Scope (NICE, 2011), 2).

... these health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, ‘bad’ behaviour, or difficulties in access to medical care, important as these factors may be. Social and economic differences in health status reflect, and are cause by, social and economic inequalities in society...” (Fair Society, Healthy Lives, 2010, The Marmot Review, 16).

Current investment in the NHS exceeds £100 billion. The costs of treating the various conditions arising from obesity will increase from £15.8 billion in 2007 to £49.9 billion in 2050 (ie from 6%-13.9% of NHS costs) when government income will not increase (Foresight: Tackling Obesity (2nd ed, Government Office for Science, 2013), 40).

B. Social Inequality – Global Trends

Health in the UK is improving, but over the last ten years health inequalities between the social classes have widened – the gap has increased by 4% amongst men and by 11% amongst women... Inequalities have
worsened not because the health of the poor is getting worse or even staying the same, but because the rate of gain amongst more advantaged groups (Health Inequalities (HC 286-1, Third Report, 2008-09), 26).

The past quarter of a century has seen wealth become ever more concentrated in the hands of fewer people. This global phenomenon has led to a situation where one percent of the world’s families own almost half (46 percent) of the world’s wealth. The bottom half of the world’s population owns less than the richest 85 people in the world (Working for the Few – Political Capture and Economic Inequality, 2014) 5.

Extreme caution about redistribution—and thus inaction—is unlikely to be appropriate in many cases. On average, across countries and over time, the things that governments have typically done to redistribute do not seem to have led to bad growth outcomes, unless they were extreme. And the resulting narrowing of inequality helped support faster and more durable growth, apart from ethical, political, or broader social considerations (J. Ostry, A. Berg, and C. Tsangarides, Redistribution, Inequality and Growth (IMF, 2014), 26).

Economic growth gives the opportunity to provide resources to invest in improvement of people’s lives. But growth per se, without appropriate social policies, brings no benefit to health… Growth with equitable distribution of benefits across populations is the key. Collective action may involve building social institutions and adopting regulations that both deliver people’s needs for housing, education, food, employment protection, environmental protection and remediation, and social security, and correct for market failure. Closing the Gap in a Generation - Health Equity through Action on the Social Determinants of Health (WHO, 2008), 37.

C. Neoliberal, “Autonomy” Response

I wish my life and decision to depend on myself, not external forces of whatever kind. I wish to be the instrument of my own, not of other men’s acts of will. I wish to be subject, not object; to be moved by reasons, by conscious purposes, which are my own, not by causes which affect me, as it were, from outside... (I. Berlin, Four Essays on Liberty (OUP, 1969), 123).

Ronald Dworkin - brute/option luck
Condliff v North Staffordshire PCT (2011)

D. Public Health and the Poverty of Autonomy

The Starting Point: Hobbes and Locke, or Aristotle and Rousseau?

Behavioural approaches embody a line of thinking that moves from the idea of an autonomous individual making rational decisions to a ‘situated’ decision-maker, much of whose behaviour is automatic and influenced by their ‘choice environment’… What we eat, where we go, what we do – most of us are creatures of habit and, in a very general sense, the environment that we live in.” (P. Dolan, M. Hallsworth, D. Halpern et al, MINDSPACE – Influencing Behaviour Through Public Policy (UK Cabinet Office, 2010), 73.

“Autonomy in thinking... is to conduct thinking... on principles on which all others... could also conduct their thinking. Autonomy in action is... to act on principles on which all others could act” (O. O’Neill, Autonomy and Trust in Bioethics (Cambridge University Press, 2002), 94).

Focus of Responsibility: Individual?:

- Restrict access to welfare benefits?
- Welfare dependent on voluntary work?
- Rewards for healthy behaviour?

... or Government?:

- Reform town planning requirements?
- Education policy and exercise at school
- Support disadvantaged families
- Social Progress Index (April 2014)