Public Health England

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Public Health Wales

Public Health Ethics in Practice

A background paper on public health ethics for the UK Public Health Skills and Knowledge Framework

April 2017

This document has been produced on behalf of lead agencies across the UK including Public Health England, Public Health Wales, NHS Scotland and the Public Health Agency of Northern Ireland, in response to a need expressed by the public health workforce across the home nations. The document supports the Public Health Skills and Knowledge Framework (PHSKF) which is a UK-wide resource. A list of the steering group agencies who have supported work on the PHSKF is shown on p21.

The review of the PHSKF (including this paper) was commissioned by the Department of Health, and project managed by Public Health England.

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Published: April 2017
PHE publications gateway number: 2016566

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Acknowledgements

We would like to acknowledge and thank the trainees, practitioners and leaders within the fields of public health, public health ethics and public health law from England, Wales, Scotland, Northern Ireland and Canada who provided comments and advice on an earlier draft of this document.

In particular, we would like to thank Woody Caan, Claire Cotter, Vikki Entwistle, Anthony Kessel, Keith Syrett, Farhang Tahzib, Ross Upshur, Caroline Vass, Tom Walker, Jamie Blackshaw, Andrew Wood, Loretta Sollars and John Morris. The final document reflects the authors' views and we take full responsibility for its contents.

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1. Introduction: Ethics as a central part of public health

The Good Public Health Practice Framework 2016, produced by the Faculty of Public Health and the UK Public Health Register, defines public health as “the science and art of promoting and protecting health and wellbeing, preventing ill-health and prolonging life through the organised efforts of society”. In expanding on this definition, the document emphasises that:

- public health activity takes a population approach
- there is a shared responsibility for health across society
- this requires social co-ordination, with a key role for the government working in collaboration with other partners

The framework explains how public health activity is directed to the improvement of population health outcomes. This is an ethical mandate derived from a commitment to achieve greater good. It also says that public health agendas aim to address social inequalities in health and wellbeing. This is an ethical mandate derived from a commitment to social justice.

Given these ethical agendas, and a commitment to programmes of activity that look to the prevention of disease, promotion of wellbeing, and to ameliorating the social determinants of health, ethics clearly finds a central place in public health. The references to population approaches and social co-ordination, furthermore, imply a role for political morality in understanding the state’s public health responsibilities to assure the conditions in which people can be healthy – and understanding which means are permissible to use in establishing these conditions.

In short, the question of when practitioners, public authorities, or other actors should (or should not) act to serve population health cannot be properly answered without reference to values and ethical arguments. Nor can we evaluate how legitimate a particular intervention is without understanding its ethical implications. As such, ethics should not be viewed as an afterthought to be examined once policy adoption or intervention selection has taken place; it is an integral component of public health decision-making that should be incorporated into all aspects of policy and practice.

While ethics is central to public health policy and practice, it should not be presumed that all moral values will be equally shared by every public health policy-maker or

practitioner. This is so for different reasons.[1] Policy development and implementation can make reference to different moral values from the values used by practitioners in their individual decision-making. Individuals and groups can reasonably disagree as to relevant values or their respective weighting. Public health policy-makers and practitioners also possess varying degrees of ethical understanding and levels of ethics education/training, which can lead them to reach different moral conclusions to the same question. All of these considerations must be kept in mind, and caution exercised, when developing ethics as a core competency. This is true too when considering how ethical frameworks for public health should be developed and used.

This part of the Public Health Skills and Knowledge Framework (PHSKF) therefore provides an introduction to public health ethics both as a philosophical field of inquiry and as an applied area that guides practice and policy. Ethics in various forms can be seen pervading throughout the PHSKF in its technical, context and delivery functions. It contains commitments to professional ethics, such as responsibility for leadership and working collaboratively; to substantive ethical concerns, such as improving health outcomes and reducing health inequalities; and to procedural ethical concerns, such as including individuals and communities in decisions that will affect their health and wellbeing.

An understanding of ethics should thus be considered a key competency for people working in public health. To underscore this competency, various areas of skill and knowledge must be addressed. At times, it requires the capacity to deliberate and evaluate ethical issues, ie to be able to identify and assess the ethical components of a public health problem and the ethical implications of responding to it in different ways. This capacity can be developed through independent study, ethics courses within degree programmes, and continuing professional development.

There are also ethical decision-making tools available to practitioners and policy-makers that can help in recognising and responding to ethical issues. Some of these tools are focused on providing ethical guidance to individuals, eg a statement of professional values that can be used as a deliberative aid in reasoning through what to do in different circumstances. Other tools are focused on providing ethical regulation to an entire group, eg regulation or policy on a specific issue that dictates how practitioners should specifically work their way through a morally-contentious issue. In addition to materials available from scholarly sources, various public health agencies around the world have been developing materials, such as case books, which provide useful resources that can be drawn on.[2]

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[1] See, for instance, Barry N Pakes, Ethical Analysis in Public Health Practice (PhD Thesis, University of Toronto, 2014); Maxwell J Smith, Public Health as Social Justice? A Qualitative Study of Public Health Policy-Makers' Perspectives (PhD Thesis, University of Toronto, 2016).

[2] See, for instance, Canadian Institutes of Health Research – Institute of Population and Public Health, Population and Public Health Ethics: Cases from Research, Policy, and Practice (Toronto: University of Toronto Joint Centre for Bioethics, 2012); CDC, Good Decision Making in Real Time: Public Health Ethics Training for

The overview of public health ethics in this document is a precursor to an inclusive, directed exercise that will lead to the development of a public health ethics framework and associated materials.

This document is organised as follows:

Section 2: explains public health ethics with reference to the longer-standing field of bioethics.

Section 3: indicates in greater depth the scope of public health ethics as a field of philosophical inquiry.

Section 4: explains the links between that field and public health ethics as a direct source of professional norms and standards.

Section 5: concludes with a list of references to useful materials.

Different points are made with reference to case study examples. The importance of ethics to good public health practice and policy cannot be overstated. As such, a grounding in public health ethics skills and knowledge is a crucial responsibility for practitioners, public health leaders, and policy-makers.

Local Health Departments (Atlanta: CDC, 2012); WHO, Ethics in Epidemics, Emergencies and Disasters: Research, Surveillance and Patient Care (Geneva: WHO, 2015); Drew H. Barrett, et al. (eds.), Public Health Ethics: Cases Spanning the Globe (Springer, 2016).

2. Public health ethics and bioethics

Public health ethics may be viewed as a part of bioethics. However, as this section demonstrates, public health ethics is widely, and with good reason, considered a field in its own right. Different histories of bioethics present contested accounts of when it emerged as a field, with what rationales, and with what purposes. Notwithstanding these conflicting accounts, it is possible to identify the second half of the twentieth century as a time when scholars from fields including philosophy, theology, law, sociology and medicine developed bioethics as a concerted area of study and practice.

In principle, and to a great extent in practice, bioethics focuses on any moral question concerning life, so embraces areas as diverse as environmental ethics, science ethics, and veterinary ethics, to name just three. Nevertheless, many commentators have observed that bioethics, whilst touching such areas, has had an overwhelmingly dominant concern with medical ethics. This dominance has arguably distorted ethical analysis and practice in fields outside of clinical medicine, including public health. As such, it is instructive to consider and contrast emphases that have been taken from the medical ethics literature, and explain why these are inappropriate for public health ethics.

As noted in the introduction, public health activity requires a focus on health at a population level, it looks to questions regarding overall and differential health outcomes across society, and works through effecting measures that prevent ill health and promote good health. As such, the ideas of ‘treatment’ and ‘the patient’ are often radically different in a public health context as compared with a clinical context. In the latter, the focus is generally on the immediate impact and implications of an intervention between a physician and a patient. Nevertheless, the dominance of norms from within medical ethics is so strong that they have impacted on how people approach public health ethics.

A variety of philosophical literatures exists in medical ethics, but particular values have come to predominate. This fact has arisen out of a concern that, historically, the practice of medicine gave insufficient account to the rights of the patient, favouring a paternalistic, ‘doctor knew best’, approach (intervening to serve a person’s wellbeing rather than focusing on informed consent). Such a view was compounded by a related concern that medicine was governed too much by professional self-regulation, with inadequate legal oversight and accountability. The most famous and influential position within medical ethics is the so-called ‘Georgetown mantra’, which presents the ‘four principles of biomedical ethics’: autonomy, non-maleficence (do no harm),

beneficence (do good), and justice.[3] Prominent works in bioethics seek to explain how ethical medical decision-making requires attention to these principles, and why the principle of individual patient autonomy should be considered the ‘first among equals’.

Even within medical ethics, there are critics of the high value placed on autonomy in a clinical context. It is argued, for example, that we have moved from a situation in which patient autonomy was wrongly disregarded to a situation where it is wrongly treated as being of supreme importance. Critics of the dominance of patient autonomy paint a picture wherein individual choice wrongly counts for everything, where paternalism is considered always to be wrong, and wherein other important values are ignored. Furthermore, it is argued that this form of medical ethics fails (even with its reference to justice) to account for population-level concerns and approaches. The practical focus of mainstream medical ethics is distorted by a lens that is set to focus on individual clinical interventions.

Given that public health agendas address whole populations rather than just individuals, advocate for prevention more than treatment, and are concerned with values beyond autonomy, a mainstream medical ethics is not suitable as a basis for public health ethics.

It is important to understand the nature of the concern here. Within public health ethics there are advocates who favour a great premium being given to individual liberty or autonomy: libertarian theorists, and many political commentators opposed to the ‘nanny state’, for example, argue against health promotion campaigns or public funding of health systems as being illegitimately intrusive.

The fundamental problem regarding the reduction of public health ethics to medical ethics is that medical ethics, as generally conceived, is not apt in the first place to address public health problems. A starting-point of autonomy and individual consent disregards the fact that many population-level interventions cannot be governed according to medical norms that regulate, for example, processes to achieve informed consent. Public health measures incorporate general policies, focus on populations, and involve the co-ordinated and collective regulation of a wide range of actors (eg manufacturers, advertisers, local authorities).

Public health ethics must be developed in a way that is appropriate to the practical arena of public health. Reference to medical ethics is of (at best) limited utility. Rather, knowledge and understanding of public health ethics will only be achieved if we can account for:

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[3] Tom L. Beauchamp and James F. Childress, Principles of Biomedical Ethics, seventh edition (Oxford: Oxford University Press, 2012)

- what it means to take a population approach, including population-level ethical analysis
- the principle that responsibility for health is shared across society; it is not just a question for individuals considered in isolation
- the need, rather than focus on an individual, reactive intervention, to consider ethical methods of social co-ordination, which incorporate measures that target whole populations, often whose constituents are not (yet) unwell

The following two sections will explain these points in greater depth, first by considering how philosophical theory should be understood in relation to the above points, and then explaining how philosophical ethics connects to professional ethics. Prior to that, though, consider the following case study, which exemplifies why public health ethics cannot be addressed by a bioethical approach that is reduced to medical ethics.

Case study 1: Reducing childhood obesity

According to the WHO, 'childhood obesity is reaching alarming proportions… and poses an urgent and serious challenge'.[i] Levels of obesity are rising generally across the UK, and it is a phenomenon that is particularly prevalent among members of poorer, urban communities. While we might all agree that we should try to reduce levels of childhood obesity, particularly in disadvantaged groups, there are many different public health interventions that could be adopted in designing a multi-faceted campaign to achieve this outcome. We want to ensure the interventions we select can be ethically justifiable.

If our ethical framework were grounded in medical ethics, it might allow us to evaluate the appropriateness of implementing interventions aimed at individual children (eg one-to-one behaviour change or gastric band surgery). So long as we obtain parental consent and the intervention is in the child's best interests, for instance, we could justify undertaking such measures.

Most of the interventions we would want to undertake, however, will be aimed at all children who are, or are at risk of being, overweight and obese as a population. With a medical ethics framework focused on individual patients in the clinical setting, and the primacy of obtaining consent before we subject anyone to any intervention, we would find it very difficult ethically to justify interventions aimed at the population level. Anything from simply measuring, monitoring and reporting on levels of obesity (eg national child measurement programme) to public information and education campaigns (eg nutrient labelling systems, nutritional literacy courses within school curricula) to interventions that may end up targeting persons who may not have a problem with obesity (eg sugar tax, banning the use of trans-fats) involve a population focus that requires a different kind of ethical framework that can account for these relevant considerations. A medical ethics approach would also not be helpful in providing guidance as to how to obtain permission to run such interventions or whether opt out versus opt in arrangements are more appropriate.

In designing and selecting ethically appropriate interventions to reduce childhood obesity, standard frameworks from medical ethics do not provide what is needed. We need to make use of ethical frameworks that can incorporate population factors and social determinants of obesity, can account for all of the actors responsible for reducing obesity (eg government, industry, schools) and be able to evaluate the tools and approaches used by these actors to achieve the social co-ordination necessary to implement effective, population-wide interventions. It is only public health ethics frameworks that provide this, especially with their reliance on moral, political and legal theory as a basis to address these wider questions.

i World Health Organization, *Report of the Commission on Ending Childhood Obesity* (Geneva: WHO, 2016), p. vi

3. Public health ethics: moral and political theory

The previous section has explained why mainstream medical ethics is not well suited to questions in public health. To move more positively towards an applicable public health ethics, it is important to have an understanding about the value of theory and the implications of different sorts of theory. As well as this being important in itself – for example, to assist in deliberation on and evaluation of different ethical problems – it is theory that ultimately underpins more prescriptive professional ethical frameworks, such as those that are discussed in the next section. Consider, therefore, how public health ethics theory operates.

First, it should be understood that theories can have both explanatory and normative roles. It is through theories that we explain, for example, why a particular social group suffers health inequalities, and through theories that we analyse whether that group's unequal status is permissible, or whether there is an obligation to address it. The first sort of theory here is descriptive: it is empirically grounded and reports how the world is (eg scientifically robust epidemiological studies underpin the claims that are made about the health status of populations).

The second sort of theory is normative: it is philosophically grounded and reports how the world should be. The force of normative reasons is what supports the claims made. These normative theories may be evaluative (eg stating why health inequalities are bad or worse than some other status) or prescriptive (eg stating why we ought to take particular means to reduce or alleviate health inequalities).

Scientific evidence will tell us that a particular social group disproportionately suffers poor health outcomes. A normative theory will tell us why health inequalities are a question of justice, and whether and why we should act to respond to these inequalities as a moral problem – and not merely a technical problem of how to reduce gradients of inequality.

Questions of justice pervade much of public health policy and practice – and there are diverse normative theories that can be used to address questions in public health. Through engaging with normative theories – and ethical frameworks informed by them – we are able to make use of a specialist language that articulates key concepts and ideas for understanding ethical questions raised by public health. These theories also provide us with a basis for analysing the reasons, evidence and arguments in favour of, or against, undertaking potential public health interventions from an ethical perspective. Such theories, for instance, can provide an account of why health

inequalities are unfair, why this unfairness is also unjust and what we would be justified in doing to remedy such health inequalities.

The Faculty of Public Health expresses widely-held views about the problems of social inequalities in health: a guiding ethical concern in public health is to address such inequalities. However, agreeing on why and how inequalities are problematic raises many questions. Are we concerned with the equality of achievement of good health, or just equality of opportunity to achieve it? Are we concerned about equality of values other than health (for example, happiness, financial security, friendship), and if so how are they to be balanced against one another? How are we to identify particular social groups as deserving prioritisation? What resources is it acceptable to redistribute, and interventions to institute, in order to achieve better health equality?

In order to explore and answer complex questions such as these, it is necessary to understand that they fall within the realm of political philosophy. Political philosophy does not limit itself to the study of interpersonal ethics. Rather, it examines our obligations as citizens, explains how we may understand the obligations of institutions (including, for example, the royal colleges, industry actors, universities), and how we understand legitimate government power and its limitations.

Philosophical work in public health ethics, conceived as a study in political philosophy, allows theorists to explain what duties the state has, for example, to ensure food quality standards, to ensure that there is a sound public health infrastructure, or to respond to environmental hazards that arise. These wider questions of political morality are important to consider in how political and democratic processes impact on the delivery of health, social care and other services (cf. PHSKF Function B4)

Relevant political ideas here are philosophical rather than ‘party political’. They concern what we as socially-related and interdependent persons should do in structuring our lives and institutions in the regulation of our collective actions together. Case study 2 explains the fundamentality of political theory to public health ethics.

Case study 2: Fluoridation, political theory and public health agendas

Most agree that people have a right to access clean water. Whether fluoride should be added to public water supplies is, however, regarded by some as a controversial question, despite the consensus of scientific bodies around the world that it is an effective and safe public health measure. According to Public Health England, 'Dental caries (tooth decay) is a significant public health problem in England. Sizeable inequalities in the incidence of caries exist between affluent and deprived communities, and it is a common cause of hospital admissions in children.'[ii] Yet, despite this, some people oppose community water fluoridation as a public health intervention on ethical grounds.

Given the nature of the intervention, community water fluoridation reaches all people connected to the public water supply and will be implemented by government agencies using public funds. Those who do not want fluoridated water may find it inconvenient and costly to make alternative arrangements for their drinking water. Evasion would be costly and burdensome. There is a whole host of ethical questions to face in deciding whether it would be ethically appropriate to fluoridate the public water supply. Are we justified in overriding individual wishes for the common good? Should the fact that the people who would benefit most from this intervention suffer from higher levels of disadvantage and ill health create an extra claim in favour of fluoridation? Should interventions that affect whole populations be subject to public engagement exercises to be seen as legitimate? Does the likely difficulty for individuals to make alternative arrangements where they are opposed to the intervention make it unduly coercive or burdensome? Is this different to opposition to any other aspect of the public water supply such as the raw water composition or chemicals added to render it potable, such as chlorine or aluminum compounds? These are the kinds of questions that political theory engages with and has the theoretical resources to evaluate on which basis public health interventions can be justified.

Different ethical values will be raised in debates on fluoridation. Some will argue that individual autonomy is so important that the government has no right to fluoridate, regardless of any potential benefits. Others will argue that solidarity and fairness require that such a programme is necessary to protect vulnerable groups. Others still will disagree on the relative weights of the benefits and harms, or on the standards/level of evidence necessary before a decision should be made. Recourse to normative theories can provide public health practitioners and policy makers with a robust way to evaluate and adjudicate different arguments in relation to the justifiability of community water fluoridation and allow for the provision of coherent and consistent conclusions.

ii Public Health England, *Water Fluoridation: Health Monitoring Report for England 2014* (London: PHE, 2014), p. 4

4. Public health ethics: professional ethics

We have seen how ethical questions are intrinsic to public health, and how public health ethics must draw from political philosophy rather than medical ethics. For public health policies and interventions to be ethically justified, they must be defensible by reference to political theory. For a sound public health ethics, an underpinning political theory will explain the basic justification for (or for not) making a particular intervention. This can be, for example, a theory of political liberalism, against which problems, such as those outlined in case studies 1 and 2, may be evaluated.

However, it is clearly not always possible for practitioners to examine public health questions in philosophical depth. Just as it is appropriate for evidence bases to be condensed and decision-making tools developed, so it can be desirable for ethics frameworks and models to be created to assist public health policy-making, deliberation and activity.[4] Such frameworks will serve in addition to general concerns of professional ethics (eg through commitment to values such as openness, honesty, and transparency). Decision-making tools focused specifically on public health problems must be based on robust theory, as per the discussion in the previous section. But they will provide a simplified means for their users to engage in public health ethics without direct engagement in theory.

Ethical frameworks can aid deliberation in various ways. They may serve to increase ethical awareness, for example, by exposing previously implicit ethical dimensions. They may provide direct guidance, for example, by providing clear and explicit rules of action. They may deepen deliberation by reinforcing ethical knowledge or understanding. Or they may show how a public health activity is justified, by explaining its ethical basis. As such, public health ethics may provide substantive guidance (ie speak directly to the ethical acceptability of a particular intervention or activity) or procedural guidance (ie direct on the proper steps that have to be followed in order to reach a decision ethically).

Ethical models, meanwhile, provide less reflective guidance and rather provide their users with reminders of particular points of ethical concern. Both frameworks and models are important tools for decision-makers in public health depending on the task and level of complexity involved. When considering the need for these sorts of decision-making tools, it is important to consider what benefit they are intended to serve. Sometimes it will be desirable to refer to a general framework for public health activity articulating values that underpin its mission and overarching objectives. Sometimes a specific framework or model will be appropriate, for example, to aid

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[4] John Coggon, Keith Syrett and A.M. Viens, *Public Health Law: Ethics, Governance and Regulation* (Routledge, 2017), pp. 32-35

decision-making on particular areas or questions, such as pandemic preparedness and response planning.

The development of ethical guidance must take note of three main areas of specificity. First, ethical guidance must be context specific. There are different ethical questions and issues that will arise in different areas of public health work, including policy development and implementation, legislative and regulatory enactment, research, and areas of practice, such as screening, surveillance, health protection and promotion. Core public health functions will require independent ethical attention and, often, different forms of ethical guidance.[5]

Second, ethical guidance must be task specific. For instance, the task of deciding what kind of obesity policy to develop will be different from the task of deciding which particular public health measures should be implemented to reduce obesity. Further still, these tasks will differ from, for instance, devising community engagement/empowerment programmes that directly involve public groups in tackling obesity. Ethical guidance can assist public health workers to undertake each task in a way in which the design, methodologies and implementation are ethically appropriate.

Third, ethical guidance must be level specific. Public health policy-makers and practitioners will have different spheres of influence and will differ in how their activities impact on individuals and populations, which include different levels of power, resource allocation, priority setting and moral responsibility. As such, there is a need for ethical guidance that can take into account the ethical underpinnings of both the influence and impact of different levels of public health action.

[5] See, for instance, Public Health Ontario, A Framework for the Ethical Conduct of Public Health Initiatives (Toronto: Public Health Ontario, 2012)

Case study 3: Pandemic preparedness

In 2007 the Department of Health published Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning. The framework provides a set of ethical principles – respect, harm minimisation, fairness, working together, reciprocity, proportionality, flexibility and good decision-making – that can be used in developing policy and making decisions that act as '…a checklist [that] can help to ensure that the full range of ethical issues is considered' in relation to pandemic influenza.[iii]

As noted above, there are different kinds of ethical frameworks and they can be used in various ways, but using the Responding to Pandemic Influenza framework here can be illustrative of the different reasons why we may want to use ethical frameworks in practice.

If we use this framework for increasing ethical awareness, we can look to these ethical principles to help us to identify and distinguish technical issues from ethical issues (eg the use of restrictive measures, such as quarantine or social distancing, are effective means of reducing infection transmission, but the principle of harm minimisation reminds us that restrictive measures have moral implications and that we should implement these measures in ways that reduce the harm associated with restricting movement).

If we use this framework for assessing ethical justification, we can look to these ethical principles to help us reason through what would provide the best ethical defence of particular polices or interventions (eg the principles of respect, harm minimisation and fairness could be used to justify that everyone in a pandemic has a moral obligation not to infect others and should take all reasonable means to ensure they do not become a vector for influenza).

If using this framework for ethical deliberation, these principles can be used by individuals, such as public health practitioners, to deliberate and guide their action in relation to particular choices (eg the principle of reciprocity can be used within moral deliberation to think through how to balance the increased risks and burdens health care workers face in treating exposed and/or infected patients and what kind of support they should ask for in carrying out this work).

If using this framework for ethical regulation, these principles can be used by policy makers or leaders within institutions to frame and develop policy that governs the action of all practitioners in relation to a particular ethical issue (eg in allocating scarce anti-viral medication, the principle of fairness and good decision-making could favour developing guidelines that individuals who are most vulnerable, such as children and the elderly, should receive priority access to available anti-viral medication before anyone else).

Whether or not an ethical framework can be used in all these ways depends on whether it adequately addresses the context, task and level for which it is being used. Nevertheless, choosing the appropriate ethical tool for the question, issue or topic at hand can provide public health trainees, practitioners and leaders with an ethically defensible framework through which to address policy and practice.

iii Department of Health, Responding to Pandemic Influenza: The Ethical Framework for Policy and Planning (London: DH, 2007), p2

5. Further reading

5.1 General reading

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A repository of public health ethics frameworks, maintained by the National Collaborating Centre for Healthy Public Policy, is available at:
www.ncchpp.ca/708/Repertoire_of_Frameworks.ccnpps.

Steering group agencies

Association of the Directors of Public Health
Chartered Institute of Environmental Health
Council for the Awards of Care, Health and Education
Department of Health (England)
Faculty of Public Health
Health Education England
Local Government Association
NHS Scotland
Public Health Agency for Northern Ireland
Public Health England
Public Health Wales
Royal College of Midwives
Royal College of Nursing
Royal Society for Public Health
UK Health Forum
UK Public Health Register
University of Brighton