Christopher Newdick
Professor of Law, Reading

Healthy Ageing Commission
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POLICY FOR HEALTHY AGEING

A. The Ethical Case

Health inequalities are a matter of social justice… Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socio-economic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unacceptable… The diseases that contribute to dramatically shortened lives and worse health of those in disadvantaged England are not those associated with destitution. They are heart disease, cancers, diseases related to drugs, alcohol, smoking, poor nutrition and obesity, accidental and violent deaths and mental illness…

Fair Society, Healthy Lives, 2010 (The Marmot Review), 37.

If, like Sen and Daniels, we regard securing equality of people's *capabilities* to be a primary responsibility of government, and of good health to be a central component of that role, then the behaviour of individuals is important as a secondary issue only.[1] Disproportionate emphasis on individual behaviour, without commensurate undertakings from government, would be unreasonable.

… the culture of autonomy has created a strange chimera as its ideal: a freestanding individual for whom privacy and autonomy are sacred virtues, independent of his community, with almost unbridled authority over his actions and with no responsibility for its consequences. It has created a society of rights without duties or obligations; of authority without responsibility.[2]

B. The Budgetary Case

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.

Government would end up having to spend more as a share of national income on age-related items such as pensions and healthcare. But the same demographic trends would leave government *revenues* roughly stable as a share of national income. In the absence of offsetting tax increases or spending cuts this would eventually put public sector net debt on an unsustainable upward trajectory…

Fiscal Sustainability Report 2011, Office for Budget Responsibility, paras 4 and 5.

Public health spending has doubled over the last seven years as a share of total health spending. It has increased to £4.7 billion (including pharmaceuticals but excluding secondary prevention) and £3.4 billion (excluding pharmaceuticals and secondary prevention), and the share of total health expenditure spent on public health and prevention in England had doubled over seven years to 3.6 per cent for 2006-07. The average share of public health spending for OECD countries as measured by the survey was 2.9 per cent

The Government's Response to the Health Committee Report on Health Inequalities (2009, Cm 7621), para 54. (Figures taken from *Prevention and Preventative Spending* Health England Report No 4 (2009), 4.)

C. Policy Responses

Condliff v North Staffordshire PCT [2011] EWCA Civ 910

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.[3]

Health Inequalities (HC 286-1, Third Report, 2008-09), 26.

Governments rush in with insufficient thought, do not collect adequate data at the beginning about the health of the population which will be affected by the policies, do not have clear objectives, make numerous changes to the policies and its objectives and do not maintain the policy long enough to know whether it has worked.

Health Inequalities (HC 286-1, Third Report, 2008-09), 5.

Randomised controlled trials (RCTs) are the best way of determining whether a policy is working. They have been used for over 60 years to compare the effectiveness of new medicines. RCTs are increasingly used in international development to compare the cost effectiveness of different interventions for tackling poverty…And they are also employed extensively by companies, who want to know which website layout generates more sales. However, they are not yet common practice in most areas of public policy.

Test, Learn, Adapt: Developing Public Policy with Randomised Controlled Trials (Cabinet Office, Bahavioural Insights Team, 2012).

The latest insights from behavioural science need to be harnessed to help enable and guide people's everyday decisions… This includes changing social norms and default options so that healthier choices are easier for people to make. There is significant scope to use approaches that harness the latest techniques of behavioural science to do this – nudging people in the right direction rather than banning or significantly restricting their choices.

Healthy Lives, Healthy People (HM Government, 2010) para 2.3 and 2.34.

(1) "Nudging"

The Nuffield Council's "Intervention Ladder" presents a spectrum of interventions on a scale ranging from least, to most intrusive: from passively monitoring current trends, to providing information and advice (eg on smoking and drinking), *enabling* and then *guiding* choice, using incentives and disincentives to modify behaviour and ultimately restricting and then eliminating choice.[4]

NICE proposes that the NHS and local authorities should play a larger role informing people about diet, encouraging healthy behaviour and measuring effectiveness.[5]

But Job seekers allowance makes some welfare benefit conditional upon gaining work experience with employers, or working *pro bono* for community projects.[6] Access to social welfare could be made dependant on achieving health objectives.[7]

(2) Duty to Reduce Inequality

… the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service (s 5, Health and Social Care Act 2012)

See to NHS Commissioning Board (s 23), Clinical Commissioning Groups (s 26) and local authorities (s 30).

Health and Wellbeing Boards.

The Mandate
1. Preventing people from dying prematurely: … in focusing the NHS on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health – by not smoking, eating healthily, drinking less alcohol, and exercising more. As the country's largest employer, the NHS should also make an important contribution by promoting the mental and physical health and wellbeing of its own workforce.

(3) Behavioural Psychology

P. Dolan, M. Hallsworth, D. Halpern et al, *MINDSPACE – Influencing Behaviour Through Public Policy* (Cabinet Office, Bahavioural Insights Team, 2010).

Messenger we are heavily influenced by who communicates information
Incentives our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses
Norms we are strongly influenced by what others do
Defaults we go with the flow" of pre-set options
Salience our attention is drawn to what is novel and seems relevant to us
Priming our acts are often influenced by sub-conscious cues
Affect our emotional associations can powerfully shape our actions
Commitments we seek to be consistent with our public promises, and reciprocate acts
Ego we act in ways that make us feel better about ourselves

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"… Policy-makers wishing to use these tools summarised in MINDSPACE need the approval of the public to do so. Indeed, these approaches suggest an important new role for policymakers as brokers of public views and interests around the ecology of behaviour (74).

(4) To Which Generations of People Should Policy be Directed?

[1] See A. Sen, *The Idea of* Justice (Allen Lane, London, 2009), Pt III and N. Daniels, "Individual and Social Responsibility for Health," in c. Knight and Z. Stemplowska, *Responsibility and Distributive Justice* (OUP, 2011).

[2] W. Gaylin and B. Jennings, *The Perversion of Autonomy – Coercion and Constraints in a Liberal Society* (Georgetown UP, 2003), 203.

[3] Within each social class, differentials of health status exist between gender (men worse than women), age (old worse than young) and ethnic sub-groups, see *ibid*, 18 and 59. It is estimated that 80-85% of variation in PCTs' mortality statistics are caused by socio-economic factors outside the control

of health care, such as poverty, intelligence and ethnicity. See *Tackling Inequalities in Life Expectancy in Areas with the Worst Health Deprivation*, HC 186 Session 2010-11, 26.

[4] See the "intervention ladder" discussed in *Public Health – Ethical Issues* (Nuffield Council on Bioethics, 2007), xix.

[5] *Obesity: Working with Local People* (National Institute for Health and Clinical Excellence, draft guidance, 2012).

[6] *Van de Mussele v Belgium* (ECtHR, 1983, App 8919/80) said of a requirement to do unpaid work: "a certain amount of personal benefit went hand in hand with the general interest which was foremost… To this extent, it was founded on a conception of social solidarity and cannot be regarded as unreasonable" (at para 39). This was justified under Art 4(2) for being "part of normal civic obligation." The duty was not unjust, oppressive, or disproportionate and left adequate time for the applicant to earn an income. By contrast, in *R(Reilly and Wilson) v Secretary of State for Work and Pensions* [2013] EWCA Civ 66, the court struck down a regulation making Job Seekers Allowance subject to unpaid work for failing to explain how the scheme should operate.

[7] West Virginia, US, makes health care entitlements dependent on patients achieving specific clinical objectives. See E. Patrick, "Lose Weight or Lose Out: The Legality of State Medicaid Programs that make Overweight Beneficiaries Receipt of Funds Contingent upon Healthy Lifestyle Choices," (2008) 58 *Emory Law Journal* 249.