Voices, Values and Health

Involving the public in moral decisions

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Contents

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Summary

The health of the population cannot be improved by people acting alone. It requires collective action through the machinery of government. However, deciding what the State ought to do presents moral dilemmas for the whole of society. For example should individuals be made to act against their wishes in order to promote their own health?

Public values[1] inform our views of whether and how the State should act. Making a public policy decision frequently involves giving more weight to one value than another. For example, reducing risk is often achieved only by restricting freedom of choice. Such value conflicts underpin the biggest political controversies in public health. There are difficult and persistent questions about how to make trade-offs and who should decide.

This project has engaged Londoners in a debate about how such value conflicts should be resolved in relation to 'live' public health issues in the capital. It has provided a deeper understanding of what Londoners believe to be important principles for public health policy, as well as their views on how such policy decisions should be made.

The public debate took the form of discussion groups, deliberative workshops and an opinion survey. Participants discussed fictional scenarios that reflected current policy dilemmas in London. They were asked their views on how these dilemmas should be resolved, particularly in terms of what *ought* to be done, rather than how to solve the problem. Most of the debate centred on the discussion of two major topics: the introduction of congestion charging in London; and how to distribute resources to address inequalities in heart disease.

As expected the debate around public values proved highly contentious and difficult to resolve. However, the following key themes emerged:

- Participants consistently prioritised improving the *collective* health of Londoners over and above all other values.

[1] Public values are defined as '*conceptions of the morally desirable in the realm of state activity*'.

- The majority concluded that decision-makers should act to protect the health of the population, even if such policies restricted people's freedom or met with public opposition.

- Participants believed that involving the public in a moral debate around public health could help to gain support for controversial policies. However, this was critically dependent on there being strong and reliable evidence to support any moral arguments.

- There was a consistent difference between the views of the participants and their expectations of their fellow citizens. While participants were sure of their own ability to think in terms of broad public interest, they were convinced that most other people would only think of themselves.

- Participants recognised the extreme difficulty in gaining the acceptance of people who would appear to 'lose out' from any policy, especially if that loss was perceived as a reduction in health care.

Participants strongly supported involving the public in making public health policy decisions. They thought it essential to ensure legitimacy of the decision-making process. However, the majority wanted the final responsibility to lie with the politicians and other professional decision-makers. The role of the decision-makers was then thought to be:

- to listen to the broad range of interests and concerns of the public
- to make a final decision that is morally defensible
- to justify the final decision publicly to explain how the public's concerns have been addressed.

Therefore, decision-makers were seen to have a duty to consult the public. Participants identified the following criteria for a legitimate and reliable public consultation process:

- it must be independent of government and any other vested interest
- it must be inclusive of a diverse range of views
- it must provide opportunities for deliberation and sufficient time to review and discuss evidence

- it must be on-going, so that decisions can be revised in light of new evidence
- it must involve a discussion of what ought to be done at the start of any decision-making process, as well as discussion of practicalities once a decision has been made.

However, participants placed limits on the value of public consultation. They were concerned that it would be an inefficient use of resources and could result in decisions not being made at all. They also concluded that if decisions reached by the public were morally unjustifiable, then those decisions should be over-ruled.

Involving the public in debates around public values can offer several advantages to policy-makers:

- it brings legitimacy to the decision-making process and makes policy-makers more accountable to the public
- it can help to limit conflict by enabling decision-makers to separate resolvable from irresolvable issues
- it encourages consideration of collective concerns, and moves people beyond thinking only of their individual interests.

1. Introduction

This report summarises the main findings of a project designed by the King's Fund to engage Londoners in a public debate around controversial issues arising from current public health strategies in the capital. The aims of the project were to:

- identify the means of eliciting values in a public debate
- provide a deeper understanding of what Londoners feel are important principles for public health policy
- explore Londoner's views on how public health policy decisions should be made when public values conflict.

The project was commissioned by the R&D Directorate at the London Regional Office of the NHS Executive with a view to informing the work of developing *London's Health Strategy*.[1] It has revealed the value judgements underpinning the public's views on public health policy dilemmas, as well as what people believe to be their role in shaping such decisions, and their expectations of public representatives. These findings have been analysed for their implications for policy-makers and public health practitioners.

2. Background

A companion literature review[2] has discussed in detail the issues around public values in public health. The main conclusions are summarised here.

2.1 What is public health?

Public health involves collective action by and for society as a whole. Public health policies aim to create conditions in which populations can be healthy,[3] rather than directly treating people who are ill. Strategies to achieve public health include:

- preventive aspects of medical care, e.g. immunisation and screening programmes
- health education and behavioural modification, e.g. advice to give up smoking, compulsory seat-belt use
- control of the environment – physical, biological and social, e.g. measures to reduce traffic pollution, to improve food hygiene and to regenerate urban neighbourhoods.

Such strategies are usually implemented through the agencies of the State, and cannot be achieved by individuals acting privately. Debates about what ought to be done in public health therefore revolve around defining the acceptable limits on health-promoting State action.

2.2 What is a public value?

Values have been defined[4] as 'qualities that are worthy of esteem' which 'generate principles to guide us in our thinking and actions, and standards against which we judge ourselves and others'. *Public* values have been summarised as 'conceptions of the morally desirable in the realm of state activity'.[5] Therefore public values go beyond individual preferences. They relate to the collective action and choices of society and how governments should act on behalf of the general public. They do not refer directly to what the public's values actually are. They are not like private judgements such as 'how much do I value this car?' nor are they the same as questions of private morality such as 'have I acted as a true and consistent friend?'. Public values are concerned with *State intervention to promote morally desirable ends*.

In relation to a public health policy such as smoking cessation, a debate on public values would revolve around a discussion of the limits on government action to reduce smoking. It would ask questions like 'would a ban on smoking in public places be acceptable?' or 'is it acceptable to place a heavy tax on cigarettes?'. It may include limited discussion of what individuals think is important

when they decide whether to smoke or quit, but only so far as to illuminate the effectiveness of different policy options. For example, when debating the efficiency of tobacco taxation, it would be important to know whether raising the price of cigarettes motivates individuals to give up.

Seven specific values have emerged from the analysis of the ethics-based public health literature.[6] These values underpin the broad range of public health activity, from policies addressing the social determinants of health to more traditional interventions such as immunisation:

1. **Equity** – reflects the understanding that everybody should get their fair share and that people should only have what is their 'due'.
2. **Compassion and altruism** – reflects the importance we place on selflessness and putting others before oneself.
3. **Security** – reflects the importance we place on controlling the future, minimising risk and reducing anxiety.
4. **Efficiency** – reflects a desire to get the most out of the resources available, always paying attention to the costs of actions and decisions.
5. **Choice and autonomy** – reflects the freedom to act and make decisions on the basis of one's own desires, in the absence of State-imposed restraints.
6. **'Health'** – reflects a widespread conception of what is 'good' for people in terms of how they treat their own bodies.
7. **Democracy** – underpins the authority of the Government to act, on the understanding that policy implementation requires the consent of the people.

2.3 Value conflicts underpin the most controversial issues in public health

In some areas of public health policy, different public values can work in harmony – for example, policies that successfully reduce inequalities in health may also increase security by reducing risks of life-threatening disease. More often though, values come into conflict. Doing better along one dimension, such as equity, may involve doing worse along another, say autonomy. These value conflicts present complex and challenging dilemmas to policy-makers in public health.

Conflicts between autonomy and other public values are the most common, since the Government's desire to promote the health of the population often comes at a cost to individual freedom. These conflicts pose some of the most difficult questions for public health policy-makers and indeed for decision-makers in many other areas of public policy: How far should the State be allowed to

intervene? What is the proper balance between State intervention and individual responsibility? When should people be free to make their own choices?

2.4 Involving the public in public health policy decisions

Public involvement in policy decision-making is often supported on the grounds that it can:[7,8]

- provide a better understanding of the public's concerns
- promote renewed interest in civic responsibility
- offer power to otherwise disenfranchised people
- ensure debates are conducted in an accessible way.

Simply engaging the public to inform decision-makers about their opinions is relatively uncontroversial. However, if their opinions are given more formal authority in order to ensure genuine public participation, then value conflicts become unavoidable.[9,10] A highly democratic process that involved endless rounds of consultation with representatives from every part of the community may be too expensive or not good at 'getting things done'. A democratically-made decision may not be morally justifiable, and different decision-making bodies may vary in their conclusions, thus contravening the principle of equity. If the public needs to be 'encouraged' to take part or decisions restrict the liberties of others, then public involvement may also conflict with autonomy. Hence, defining the role of public involvement in public health policy decision-making again involves another value-based debate.

2.5 Key questions for public debate

The pursuit of public health policy goals will often involve trading off one value against another. There is no fixed hierarchy of values and people will trade off values in ways that reflect their individual view of what is important. This raises two fundamental questions in relation to any public health issue:

- what trade-offs should be made between different values?
- who makes the final judgement?

These questions formed the basis of the King's Fund debate on 'Public Health and Public Values'. Citizens of London were asked to discuss their views on value trade-offs in relation to 'live' policy

dilemmas in the capital. They were then asked how disagreements about values should be resolved, in particular to discuss the respective roles of the public, the ‘experts’ and elected representatives.

3. The public involvement strategy

A public involvement strategy was developed in collaboration with an expert advisory group and Opinion Leader Research, a market research company commissioned to facilitate the public debate. A list of members can be found in Appendix 1. The group provided advice on how to structure the agenda, how to elicit values through discussion and the choice of appropriate methods.

3.1 The agenda for debate

Public values and value conflicts are difficult to discuss in the abstract, but can be implied by the choices people make in relation to practical issues. Therefore participants in the public debate were asked to discuss what should happen in fictional scenarios posing real life policy dilemmas. Their discussion of alternative practical solutions helped to illuminate what people thought and felt to be important. However, it proved necessary to draw participants away from debating 'what to do' and to steer them towards discussing 'why' to take a particular action and 'what matters'.

Five different scenarios were used as stimulus material for the debate (described in section 4.1.1 and Appendix 2):

1. Introducing congestion charges in London
2. Preventing heart disease in Greyton (a fictional London borough)
3. English classes for Bosnians in Greyton
4. Drugs versus alcohol
5. Testing for gonorrhoea.

These scenarios were developed to ensure that they:

(i) ***reflected 'live' issues faced by policy-makers in London***

Public health issues of current concern were identified through semi-structured interviews with two representatives of each of the following:

- HAZ directors
- health authority directors
- local authority chief executives
- PCG members
- directors of public health

- members of the NHS Executive.

(ii) ***reflected the priorities of the draft Health Strategy for London***,[11] which are:

- inequalities and poverty
- regeneration and health
- the health of black and minority ethnic people
- transport.

(iii) ***incorporated the common value conflicts identified through the literature-based research commissioned for this project***[12]

3.2 Methods of debate

The public debate was structured to include small-scale deliberative and interactive forums as well as a large-scale opinion survey to generate complementary information. The deliberative forums enabled participants to reflect more fully on the complex questions about trade-offs and the role of the public. They provided an indication of what a more informed public would come to think given time and information. The survey provided an opportunity to measure people's 'gut reaction' to the values debate in the absence of informed deliberation.

The debate therefore included the following three stages:

Stage 1: Discussion groups

The discussion groups provided a preliminary exploration of the issues and tested the scenarios ahead of the deliberative workshops. Participants were recruited by 'face-to-face' interviews, screening out health professionals, researchers and people with previous experience of focus groups. People were selected to constitute the six groups described in Appendix 3, so that each group was made up of the same gender, with people from the same age range and socio-economic grouping and to include a range of ethnicity representative of the group location. The group discussions lasted for one and a half hours as detailed in Appendix 3, and participants were also provided with opportunities to express their views anonymously and privately through a questionnaire (Appendix 4).

Stage 2: One-day deliberative workshops

Two day-long deliberative workshops were held with 12 to 13 participants, one with residents of inner London and one with those from outer London. The groups were recruited face-to-face, as for stage 1, in order to match London's demographic profile and to include people of different age, gender, socio-economic status and ethnicity.

Analysis of the discussions in stage 1 helped to shape the agenda for stage 2. Two scenarios were selected for more in-depth discussion. Scenario 1, *Introducing congestion charges in London*, was selected because this issue had stimulated the most debate in the discussion groups and was very much a 'live' issue in London. Scenario 2, *Preventing heart disease in Greyton* (addressing health inequalities), was also chosen, even though it proved less contentious. All the key informants interviewed in the research phase had identified policies that addressed health inequalities as causing the greatest conflict with local communities, while all the discussion group participants were unanimous in their support for such policies. This discrepancy merited further investigation. To heighten the debate in the forthcoming workshops, Scenario 2 was slightly modified as described in Appendix 2.

In order to promote discussion of values and principles, a series of 'value statements' were distributed for each scenario in addition to a sheet of relevant facts and figures. The discussions were more structured than in stage 1, and combined plenary sessions with small breakout groups. Importantly, participants had more time and information available than in the discussion groups. A copy of the agenda for the workshops is included in Appendix 5. At the end of the workshops, participants completed anonymous questionnaires, shown in Appendix 6.

Stage 3: An opinion survey

Analysis of stages 1 and 2 informed the development of the questionnaire for the survey. Scenario 1, *Introducing congestion charges*, was selected to form the basis of the survey because Londoners' familiarity with this issue made it easy to discuss. It was also the issue that stimulated most debate in the discussion groups and the workshops. The survey aimed to test people's immediate reactions to the values debate. Five hundred 15-minute telephone interviews were held with a cross section of Londoners, representative of London's demographic profile, including a broad range of age, gender, socio-economic status and ethnicity. A copy of the questionnaire is in Appendix 7.

The strengths and weaknesses of the three stages of this public involvement strategy, in terms of eliciting public values through a public debate, are discussed in section 4.3.

4. Key themes from the public debate

The key themes from all three stages of the public debate are discussed in relation to the three main areas of investigation in the following order:

- participants' views of the principles that should guide public health policy in London
- participants' views of how public health policy decisions should be made when public values conflict
- eliciting public values through public debate.

4.1 Participants' views on the guiding principles for public health policy

In this section the issues raised by all five scenarios in the discussion groups are described first (section 4.1.1). The verbatim quotes (in italics) are attributed to members of the different groups. In sections 4.1.2–4.1.4, the issues raised by Scenarios 1 and 2 are discussed in turn, drawing on the discussions in the workshops *and* the results of the survey. Workshop participants discussed only Scenarios 1 and 2 (congestion charging and preventing heart disease), and survey respondents considered only Scenario 1, congestion charging. In these sections, all quotes (in italics) are attributable to participants from one or other of the workshops. Individuals have not been identified, since the workshops were constituted by a broad range of general citizens, nor have the different workshops been distinguished, as there were no discernable differences in opinion attributable to being a resident of outer or inner London. All quotes have been selected to provide a flavour of the kind of opinions that were expressed in relation to key themes of the discussion.

4.1.1 The discussion groups' views on all scenarios

In the limited time available in the discussion groups, participants invariably tended to try to solve the problem presented in each scenario in a practical way, drawing on their personal experience. Rather than automatically exploring matters of principle, they tended to explore different options only insofar as they thought these would *work*. Here they also referred to their individual interests in terms of whether they thought they would be personally affected by the various policy options. These discussions are summarised in relation to each scenario below:

Scenario 1: Introducing congestion charges in London

Participants were presented with information as to why and how congestion charging might take effect and were asked 'should a congestion charge be introduced?'. Most of their discussion centred on the likelihood that congestion charging would not work unless alternative forms of transport

were improved first. Participants therefore spent a long time discussing practical means of improving public transport. Some participants did raise concerns about whether charging would be fair and whether people's freedom of choice would be too severely restricted:

> *Improve public transport first – we are already taxed 80% on fuel – it isn't fair. Reduce cost of trains/tubes as an incentive.*
>
> (Male, 18–30, AB)

> *Charges should be introduced after careful consideration of how best to help low-income families and individuals.*
>
> (Female, 56+, AB)

Scenario 2: Preventing heart disease in Greyton (a fictional London borough)

Participants were asked how resources for a healthy heart campaign should be divided between two equal-sized populations, when the poorer population suffered much more from heart disease, and public opinion favoured a 50:50 distribution. There was unanimous support for an uneven distribution of resources to give more to those most in need. However, when asked to put themselves in the position of those who would appear to 'lose out', participants slightly changed their position. Rather than an 80:20 split, they opted for a 70:30 or 60:40 distribution. They also thought that the only people who would bother to take part in a telephone poll would be those strongly motivated by self-interest:

> *If more people are suffering in the North than in the South, a bigger proportion should go to the North.*
>
> (Male, 56+, DE)

> *It is human nature to look after number one, therefore I feel that one would vote for the thing that would look after your own self-interest.*
>
> (Male, 31–35, C1C2)

Scenario 3: English classes for Bosnians

Participants were asked whether resources should be taken away from existing adult education classes in order to provide English lessons for Bosnians. It proved difficult for participants to

divorce their personal interests from the scenario presented to them. Their choice of action depended on how they saw themselves in relation to asylum seekers. The 31–55 year old DE women felt their needs to be as great as the Bosnians, and were opposed to stopping the adult education classes they saw as being an essential route to employment for people like themselves. In contrast, the 18–30 AB men saw the Bosnians to be in much greater need and were prepared to give up the luxury of their 'pottery classes' for their benefit. However, this group also stressed that the needs of the Bosnians should not supercede the needs of local English residents. The men expressed more racially prejudiced comments privately in the questionnaire.

> *They should give help here to us first – well not us, the people here – and then think about refugees after.*
>
> (Female, 31–55, DE)

> *We're all humans, yeah, and I'm quite glad to see some of my taxes going to help somebody in a less privileged sort of manner.*
>
> (Male, 18–30, AB)

> *We are a 'soft touch' – don't let the majority economic migrants take the proverbial!*
>
> (Questionnaire response, Male, 18–30, AB)

Scenario 4: Drugs versus alcohol

Participants were asked whether resources should be taken away from an existing drug treatment programme to fund a campaign to reduce alcohol consumption. Again participants found it difficult to divorce their personal interests from the scenario. They perceived *themselves* to be more at risk from 'mugging by drug addicts' than by alcoholics. Alcohol was therefore seen to be the lesser of two evils despite being provided with information to the contrary. It was also thought that the alcohol problem could only be tackled effectively at a national level, since drinking behaviour was perceived to be heavily influenced by national culture. Participants were also adamant that money should not be taken away from a programme that 'works', and so opposed stopping the methadone treatment in this scenario:

> *Alcohol, that's more of a cultural, I would say it's a cultural problem.*
>
> (Male, 31–55, C1C2)

They're throwing money at a cloud with an alcoholic programme but with the drug programme, it is there and it's concrete, there are results.

(Male, 31–55, C1C2)

Scenario 5: Testing for gonorrhoea

Participants were asked whether resources should be given to a scheme offering testing to the partners of affected individuals or to a general health education campaign. There was some discussion in the group about protecting individuals' autonomy and their 'freedom not to know', but the overriding concern was how best to protect people's health. Most of the discussion centred on what participants thought would 'work', whether people would really provide information on their sexual history and the best way to advertise or provide information to encourage people to be tested:

I don't think a lot of people will do it [give details of partners] *whether it's right or wrong. I just think they are going to be too embarrassed to say, 'Oh, I slept with this person you know.'*

(Female, 18–30, C1C2)

It needs to be something punchy that is going to make people think … not a postal campaign … the letters just end up in the bin anyway.

(Female, 18–30, C1C2)

4.1.2 Workshop participants' views on congestion charging

The longer time frame and more structured agenda enabled workshop participants to engage in more in-depth discussions around public values (see section 4.3). Most of the discussion centred on the following key principles:

- whether the charges would be fair – reflects concerns about **equity**
- whether charges would restrict people's freedom to drive – reflects concerns about **autonomy**
- whether Londoners would support the charges – reflects concerns about **democracy**
- whether charges would be effective, i.e. whether they would really reduce car use and deliver the potential health gains, and thus whether introducing charges is an efficient use of government time and effort – reflects concerns about **efficiency**.

Equity and autonomy

Concerns that congestion charges would unfairly discriminate against the poor lay behind the strongest opposition to the introduction of charges. There was a perception that rich people would simply continue to drive and might even feel justified in doing so because they were 'financially supporting the public transport system'. This opposition to the charge was reinforced by the concern that the choices of the less well off would be more severely restricted:

> *All the rich people with their big BMWs will pay £5 a day like that, it's not a problem, and you just get a completely inequitable transport system.*

> *The poor wouldn't be able to work there. They're not going to be able to travel there and basically you're only going to get wealthy people working in London.*

Some participants also believed that the charges would be fairer if they reflected how often individuals used their car, in line with the principle 'the polluter pays'.

Concerns about fairness prompted suggestions of alternative means of restricting car use that would not depend on financial status, such as banning certain registration numbers on particular days. However, no one in the workshops supported a complete ban on cars, indicating the limits of their tolerance for restricting people's autonomy.

Autonomy versus efficiency (maximising health gains)

Some participants were strongly opposed to the charge because they believed it to be too severe a restriction of civil liberties and an infringement of an individual's 'right to drive'. This principle of protecting autonomy gained more support when considered in relation to the individual's own health. It was thought that *individuals* should be free to make their own choices about their behaviour, whatever the consequences:

> *It's not the powers that be's choice to decide how you manage your own health. It sounds very very selfish but take that away from people and you have like a big brother system where somebody else makes all the decisions for you.*

However, when weighed against the 'health of everyone', protecting individual autonomy was perceived to be less significant. Shifting the focus from individuals to populations changed participants' views on acceptable value trade-offs:

> *Smokers say, 'I've got the right to smoke, it's a free world and that's my decision', but smoking affects absolutely everybody around you, the same issue with transport.*

Thinking about car drivers' impact on the health of Londoners in general appeared to sway the majority in favour of introducing the charge. However, participants were emphatic that they would need to see evidence of a reduction in traffic and subsequent health gains. The perception that the 'rich' would be able to continue the 'unhealthy practice of driving' raised questions as to whether health improvement was a real outcome. Some participants concluded that the health improvement arguments were being used to disguise the real motivation for congestion charging, namely, a means of raising money for public transport.

Efficiency (maximising health gains) versus democracy

Participants were even convinced that potential public health benefits merited the introduction of charges in the face of public opposition and thus placed limits on the value of democracy. A large majority agreed that 'it's the responsibility of decision-makers to make sure our taxes are spent in the best way to improve health even if it is unpopular'. Most participants also believed that if Londoners were made more aware of the health benefits of reducing traffic, they would be more supportive of the charges. In much the same way that attitudes to drink-driving laws have changed, it was thought that public opinion could be altered over time. Some participants believed that the public should be convinced of the merits of introducing charges *before* any decision was made. However, even they reluctantly concluded that if the majority of people still opposed charges, decision-makers should overrule them:

> *People will automatically think of finance. Their first reaction won't be on health. They're going to think of the money before the health issue.*

> *They have to really work hard and prove all the good points of the congestion charge and why they're putting a charge, health reasons as well, and there will be the majority of people who will agree with them, especially about health.*

4.1.3 Survey respondents' views on congestion charging

The survey aimed to test people's immediate reaction to the values debate posed by Scenario 1, *Introducing congestion charges in London*. Respondents were first asked about their views on the impact of congestion charges and then asked their views on the value trade-offs identified in the workshops.

In terms of the impact of charges, respondents replied as follows:

- 52% thought the introduction of congestion charges would improve the health of Londoners; 37% thought it would have no impact
- 60% thought car drivers were somehow responsible for the health of Londoners; 34% did not think they were responsible
- 57% thought it unfair if everyone paid the same congestion charge; 37% thought it fair
- 65% thought congestion charges would restrict people's freedom to choose to drive a car; 31% thought it would have no impact
- 60% thought it would reduce the amount of traffic on the road; 33% thought it would have no impact
- 59% thought the majority of Londoners would be against the introduction of charges; 22% thought the majority would be in favour.

When asked which principle should guide the Mayor's thinking on this issue, respondents consistently chose 'improving health' over all other values:

- 50% thought the Mayor should think about whether the charges can help improve health, as opposed to 41% who thought he should think about whether the charges are fair
- 58% thought the Mayor should think about whether the charges can help to improve health, as opposed to 33% who thought he should consider whether Londoners will oppose congestion charges
- 59% thought that the Mayor should consider whether charges can help to improve health, as opposed to 30% who thought he should consider whether charges will restrict people's freedom to drive a car.

Even though a large majority thought charges would restrict people's freedom to drive, less than half of those people ranked protecting autonomy higher than maximising health gains. Likewise,

many believed the majority of Londoners would oppose charges but thought this to be less of a concern than whether charges would improve health. It is interesting to note that the gap is narrower when respondents considered health in relation to fairness, indicating that the principle of fairness rates nearly as highly as protecting the public's health.

Respondents also concluded that 'better health through less pollution' ranked as highly as 'money for public transport' and 'reduction in traffic' as the most convincing arguments in favour of introducing congestion charges. At the end of the interview, having answered a range of questions about the rights and wrongs of congestion charges, respondents were asked to vote on whether the charges should be introduced. 53 per cent responded in favour while 39 per cent were opposed. However, 59 per cent thought the majority of people would be against charging, revealing a surprising contrast between respondents' own views and how they thought their fellow citizens would vote.

4.1.4 Workshop participants' views on preventing heart disease

Most of the discussion of this issue in the workshops centred on the following key principles:

- whether an unequal distribution of resources was fair – reflects concerns about **equity**
- whether an unequal distribution of resources would maximise health gains – reflects concerns about **efficiency**
- whether the public would oppose an unequal distribution of resources – reflects concerns about **democracy**.

Equity and efficiency

Participants were unanimous in their support for distributing resources to ensure an equitable outcome, one in which everyone received the health care they needed. This view was reinforced by arguments for efficiency – money would be wasted if spent on a population in less need. However, participants emphasised that if resources were to be allocated according to need, then 'need' should be regularly assessed:

> *Surely the resources should be put into the area where there is more heart disease.*

> *It makes sense that the money should go where it's needed most.*

> *It might be in two years' time the South* [of Greyton] *has more heart disease than the North. Then need comes in there.*

A distinction was also made for resources invested in health promotion. Some thought that if the campaign was purely about educating people, then resources should be split equally between the two populations. Everyone should have access to this information, not just those more at risk from heart disease.

There was some debate as to whether it was fair for the healthier population to be asked 'to make sacrifices' for the unhealthy population. Some argued that since individuals are responsible for the decisions they make about their own lifestyle and health, the healthy population should not be penalised for 'having made good decisions'. However, the majority recognised that not all choices are free and the poorer population would require more investment to enable those people to make healthier choices for themselves:

> *The fact is that if you get a poor area you do get these problems and people do indulge in smoking and drinking. They are corporate choices; they are not the choice of each individual person. I do believe there are choices made because of the situation that you find yourself in.*

There was also support for the view that recipients should take some responsibility for making use of the resources available to them:

> *If you've gone to the doctor and the doctor has told you to quit smoking or lose weight and then you don't go and do it and then you go back to the doctor again because you're still unwell then it is down to you, it's your responsibility. He's done his job and you have to do your job.*

However, a minority of participants thought that a health promotion campaign would never work as adults in particular would be unlikely to change their behaviour. They favoured campaigns targeted at children, which they believed would have more influence. They therefore argued that resources would be wasted on the campaign and would be better spent on treating the inevitable heart disease. In contrast, the vast majority of participants favoured investment in prevention measures rather than 'cures'.

Equity versus democracy

Participants easily recognised that public consultation processes that are self-selecting, such as phone-in polls and public meetings, are likely to be dominated by people motivated by self-interest. They believed that the residents in South Greyton would dominate the telephone-poll in the scenario, as they were the people who stood to 'lose out'. It was also thought that the residents from the more affluent South Greyton would be more politically aware and generally better prepared to 'defend their rights'. Great emphasis was placed on ensuring a more rigorous system of seeking public opinion, to include those that might otherwise not be heard:

> *The* [telephone-in] *poll would be bogus … it can be abused and it needs legitimate, independent research.*

While participants argued that decision-makers could question the validity of the poll in this scenario, there was some concern that decision-makers should not be able to ignore polls just because they did not like the results:

> *What's the point in doing a poll if you're going to ignore the result ... It's like if it doesn't prove the theory just do another one.*

Participants were not convinced that the people who stood to 'lose out' in this scenario would ever be persuaded to act altruistically even if they understood the moral arguments for an unequal distribution of resources. They concluded that such individuals should not be given responsibility for decisions on this matter. It was thought that responsibility should lie solely with the decision-makers, who were duty bound to act in the best interests of the population as a whole:

> *The South would never volunteer to give more money to the North … regardless of the evidence.*

> *Decision-makers should overrule the South.*

4.1.5 Conclusions

As expected, the debate around public values proved highly contentious, messy and difficult to resolve. Different people hold strongly opposing views and even individuals' own values can conflict with each other. However, some key themes have emerged:

(a) protecting the public's health was thought by the majority of workshop participants and survey respondents to be the most important principle to guide decision-making on these two issues (sections 4.1.2–4.1.4). This reflects the value of **efficiency**, in terms of maximising health gains. Importantly, it does not reflect a simple desire for more of a 'public good', in the way that people will always ask for 'better health' or 'better education'. Participants made a clear distinction between the health of individuals and that of the whole population. They argued that individuals should be free to 'indulge in unhealthy behaviour' whatever the costs to themselves, but only on the condition that no harm was done to anyone else. The only value participants prioritised over all other values, was that of protecting *collective* health.

Given that participants in the workshops thought that the public would be more supportive of charges if they knew more about the potential health benefits, the survey may actually underestimate how many Londoners would be in favour of charging. Survey respondents were not provided with much information about the impact of traffic on health, nor were they able to discuss their views with others. Information and deliberation were thought by workshop participants to be an essential means of encouraging the public to think beyond their self-interests. Without these features, the survey may have been biased towards detecting people's individual concerns.

(b) while the majority of workshop participants prioritised protecting the public's health in Scenario 1 (congestion charges) and were convinced that their fellow citizens could be persuaded to think beyond their individual interests (section 4.1.2), they were less certain that the public would be influenced by the moral arguments for equity, in relation to tackling inequalities in heart disease in Scenario 2 (section 4.1.4). The reason for this distinction may lie in the perceived costs/threats to individuals. In Scenario 1, no great threat is posed by restricted car use and individual costs are much less when many Londoners do not own a car, and there are alternative forms of transport. In contrast, in Scenario 2 the unequal distribution of resources may be perceived to be 'life-threatening' to those deemed to 'lose out'. The very high value placed on health may underlie the extreme difficulty of persuading people to accept a reduction in health services. It would be interesting to assess whether people feel as strongly about an unequal distribution of a non-health related service. Likewise, it would be worth clarifying whether people make a distinction between health education/information (e.g. advertising), health promotion services (e.g. advice from a nutritionist), and health care provision (e.g. GP services),

in terms of the acceptability of an unequal distribution of resources. There was not time to make all these distinctions clear in the workshops.

(c) there is a consistent difference between the views expressed by participants in the debate and their expectations of their fellow citizens. While participants were sure of their own ability to think public-spiritedly and protect the public's interest, they were convinced that most other people would think only of themselves. Why was there such a discrepancy? Workshop participants thought the difference lay in their being able to think collectively as a group and to listen to a wide range of opinions. In contrast they thought individuals would think just of themselves and their immediate family, and might not even be aware of how their actions impact on others. This may also explain why survey respondents also reported distrust of the citizenry.

4.2 Participants' views on the decision-making process

In the workshops, participants debated who should be involved in making a decision and who should have the final say in relation to Scenarios 1 and 2. Individual views were captured by questionnaire as detailed in Tables 4.1, 4.2 and 4.3. Respondents in the survey were asked who should be involved and who could be trusted to make a decision about congestion charges. The results of all these three methods of consultation are discussed below.

4.2.1 Workshop participants' views on who should be involved

Table 4.1: Workshop participants' views of who should be involved in decision-making as assessed by questionnaire

Who should be involved?	**Scenario 1** **Congestion charges**	**Scenario 2** **Preventing heart disease**
National politicians	6	13
Local politicians	14	11
Local council officers	9	9
Experts (academics, medical professionals etc.)	15	19
General public	20	18

Table 4.2: Workshop participants' views of who can be trusted to make decisions, as assessed by questionnaire

Who would you trust to be involved?	**Scenario 1 Congestion charges**	**Scenario 2 Preventing heart disease**
National politicians	4	8
Local politicians	11	6
Local council officers	8	6
Experts (academics, medical professionals etc.)	15	15
General public	13	11

The key factors that influenced workshop participants' views of who should be involved in decision-making were:

- whether an individual was biased or motivated by self-interest
- whether an individual was informed
- the nature of the decision.

Politicians, MPs and local government officials were perceived to be biased, motivated by opportunities for promotion or re-election and therefore not to be trusted. Workshop participants believed that 'too many decisions are made behind closed doors' by politicians who do not have the public interest at heart. Government officials were seen to be 'corrupt', 'out of touch', and to 'not know much about the general public'. Decisions made solely by politicians were thought to be more likely to meet with public resistance:

> *People like the Mayor and Government has got all the money and they've got biases haven't they. They've got axes to grind and different viewpoints that would influence it.*

> [In such cases] *people are just angry that they haven't been asked.*

Participants made clear distinctions as to which politicians should be involved in decision-making in the two different scenarios. They thought local politicians should be more involved in decisions about congestion charging as this was seen to be a local issue. In contrast, national politicians were

favoured in the second scenario because the lifestyle changes were perceived to be culturally influenced and therefore in need of addressing at a national level.

The public were thought to have a right to take part in the decision-making process because they would be the ones most influenced by the outcome. It was thought that the public could add a 'realistic' point of view 'based on personal experience', which may otherwise be lacking. Consulting the public and making them feel involved was thought to be essential for public acceptance of any final decision:

> *It helps if you feel you are being consulted.*

There was a strong feeling that whoever was involved in the decision-making process should be well informed and participants were concerned that an uninformed public would make poor decisions. This led to greater support for the involvement of academics and health professionals who were perceived to have access to all the 'facts and figures'. Community groups were seen in a similar light:

> *They* [the public] *are ignorant of the issues and they make decisions that ultimately are harmful because they have not received all the information. You need decisions to be made by people who have an informed view and know what they are talking about.*

> *They're* [community groups] *ordinary people that have become motivators, in which case they've got more information to hand.*

There was strong agreement that in order for the general public to be *consulted*, they must first be *informed*. Participants emphasised that information should be provided in a basic and accessible form. If the public were made aware of all the 'facts and figures', it was argued that they would be just as able to make decisions in the public interest:

> *When we say educating people we don't mean like in terms of schooling. Educating people like telling people in basic jargon. I mean this country is full of multi-cultured people, talk to them basically, this is what's going to affect you. Not the big words. It's education in terms of basic day-to-day life.*

If they've got all those facts and figures why don't they supply us with the facts and figures and we'll make our own educated decision. They're insulting our intelligence.

Importantly, providing information was also seen as a means to encourage people to think differently about the issues, to move beyond their individual concerns.

However, it was recognised that not all members of the public would wish to be involved, nor was it practical to consult everyone. There was a concern that if everyone were consulted on a regular basis, the process would take so long that decisions would never get made. Participants argued for striking a balance between not leaving decision-making to too few, but not including so many that decisions couldn't be made quickly and effectively:

The public doesn't have an opinion about all of these things and nor should they necessarily have one. There's nothing the matter with saying I'm not interested. In the US only half the electorate votes at elections. What are you going to do – dragoon the other half in and say you must vote?

Ideally I think we'd all like to be consulted but I also think that it's just going to be a long drawn out process. So I think you have to draw the line somewhere. I don't think the public can be consulted on everything.

There was a general perception that the public is currently apathetic about the political process and that the pressures of modern life made it difficult for people to find time for civic duties:

People don't want to do it. Too busy. There's a big split-off between the kind of civic responsibilities that people perhaps used to do out of commitment whatever and people are now very frightened of that and say I just don't have time to do that.

Participants thought this must be of some concern to decision-makers and recognised that if the public did not get involved, decisions would have to made by others on their behalf:

That's exactly what the Government would love to see. When they see the public not interested they just go ahead and they make the decision for you, and if the decision is not popular, well, tough. You should be more interested in the first place.

It was thought that the public might have a duty to be involved in the decision-making process. Simply taking part in the discussions at the workshop appeared to reinforce this point of view:

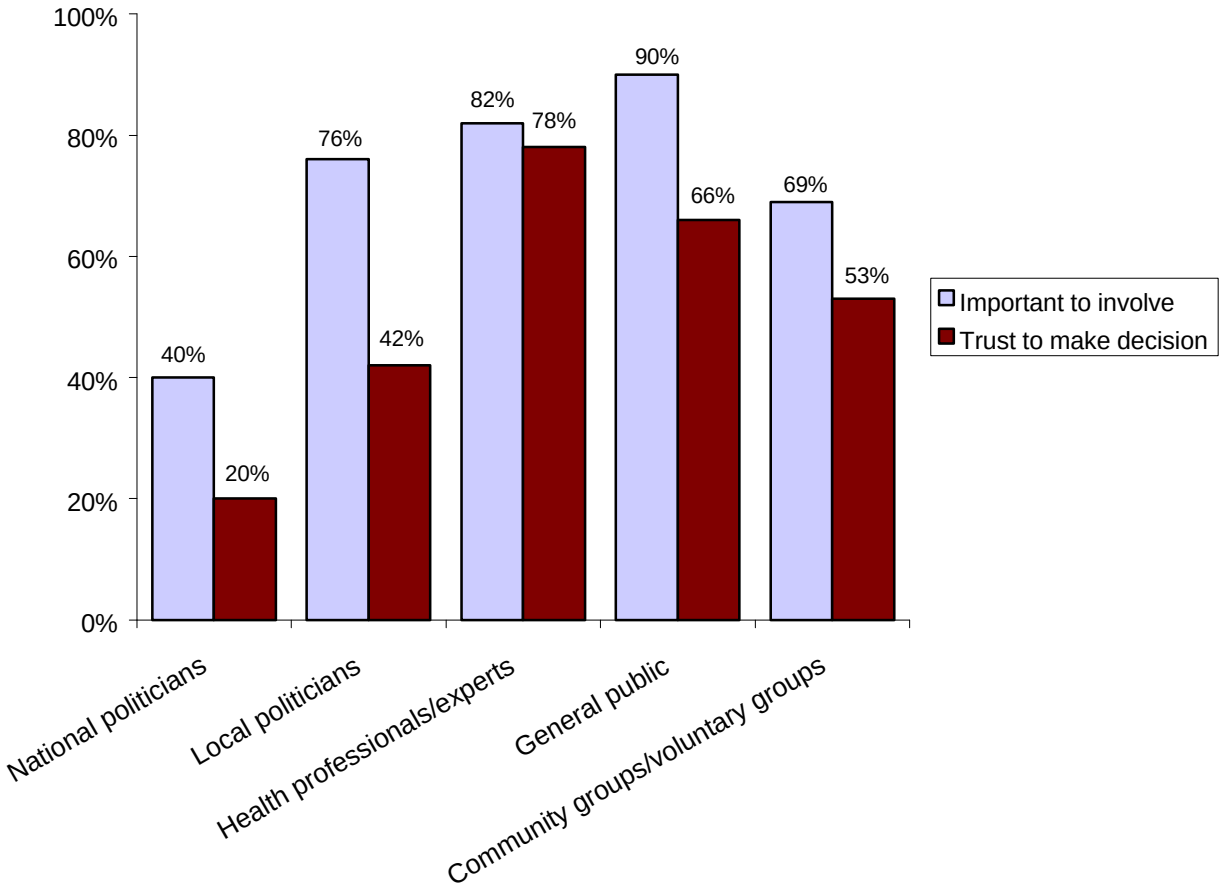
> *I think we should take more interest in what's around us and like in the past I couldn't be bothered. But listening to everyone's views here I think I should be bothered.*

4.2.2 Survey respondents' views on who should be involved

Survey respondents placed a very high priority on involving the general public in decision-making. However, when it came to who respondents would *trust*, the majority of respondents rated health professionals and experts higher than any other category, as shown in Figure 4.1.

In relation to congestion charging, local politicians again gained more support than national politicians. Only 18 per cent thought it very important for national politicians to be involved compared with 42 per cent who thought it very important for local politicians to take part. Moreover, only 20 per cent said that they would trust national politicians to make decisions on this issue, compared with 42 per cent who would trust local politicians.

Figure 4.1: Survey respondents' views on who should be involved in decisions about congestion charges and who can be trusted.



Respondents also suggested a range of other people to involve in decision-making on this issue, for example transport agencies, motoring organisations, the police, and environmental groups.

4.2.3 Who should have the final say?

This issue was discussed in depth at the workshops and individual views collected through the questionnaire as detailed in Table 4.3.

Table 4.3: Workshop participants' views on who should have the final say in Scenarios 1 and 2, as assessed by questionnaire

Who should have the final say?	Scenario 1 Congestion charges	Scenario 2 Preventing heart disease
National politicians	2	6
Local politicians	2	3
General public	6	3
National & local politicians	2	1
Politicians (national and/or local) and the public	5	–
Local politicians plus experts	1	–
Experts	–	3
National politicians plus experts	–	3
Experts and the public	–	1

As the table shows, participants were divided as to who should have the final say in Scenarios 1 and 2. The key factors influencing their decisions were:

- differing views of the responsibilities of government and majority rule
- whether individuals would be motivated by self-interest
- the nature of the decision.

There was limited support for experts being solely responsible for final decisions. Much stronger emphasis was placed on their *advisory role*. However, experts were given more responsibility in Scenario 2, where the more medical nature of the problem was seen to require greater input from health professionals.

Some participants felt very strongly that the public should have the final say. They reasoned that since a majority vote decides who should be in government, a majority vote could decide upon the actions of that government, and that the public would know what was in their best interest.

> *Surely what's best for the majority should be governed by what the majority want.*

However, this view was opposed by those participants who were concerned that the public might be motivated by self-interest and may not be best placed to judge the effects of its decisions on society as a whole. They perceived the role of government to be to listen to the broad range of interests, not just the majority or vocal minority views, and to strike a balance between all concerns. They were therefore in favour of government having the final say. This view gained greater support in relation to Scenario 2, where the methods of obtaining a measure of public opinion were perceived to be heavily biased by the public's self-interest:

> *The Government have been put there to make decisions but if you don't trust them to make the decisions then they shouldn't be our government basically. They need to make big decisions but only if they're willing to take the blame. They have to make the best decisions for the country and not the individual.*

> *A lot of people, I won't say most, will think entirely of the financial side. Not the health side. Whereas I think if a government were to make those decisions they would make it for health reasons.*

However, there were few that thought Government could make those decisions alone. Many more strongly supported the view that the Government has a duty to consult the public before taking final decisions and that it is important for decision-makers to consider as many different perspectives as possible. Participants recognised that there was no single view that could be said to represent 'public opinion' reinforcing the need to 'embrace diversity':

> *You've put them* [the Government] *there to make the decisions on the basis that they're going to listen to the people that they're meant to be making the decisions for.*

What is popular opinion, 'cause I've heard so many different opinions in this room already? There are so many different opinions and ultimately you have to make a decision that's unpopular … Before you make that decision you listen to as many people as you can.

They [the policy-makers] *should make the decisions but we should be involved like with them making that decision.*

Participants recognised that it was unlikely that any public consultation would provide a single, simple answer and that all controversial decisions would inevitably be unfavourable to some. They therefore placed great emphasis on the decision-making process being seen as clearly taking the wide range of people's views into account. They thought it would be impossible to convince everyone that a decision was the 'right' one, but that the public would be much more accepting if they understood the reasoning behind it. Not consulting the public was thought to lead to public hostility and public distrust of those making the decisions:

We need to educate before the [congestion] *charge is introduced and we don't think that Britain on the whole has been educated enough … Things go to worse first and then we think afterwards.*

The public should be involved and the Government should at the end of the day take account of what people have said.

In thinking about how public involvement might be achieved, participants suggested developing a system similar to a jury building in opportunities for evaluating evidence 'for' and 'against' different policy options. There was some disagreement as to whether the jury should be constituted from members of the public alone or other stakeholders, and who should then have the final say. However, the important principle was to provide people with information and time for deliberation:

Just how they pick juries is how they should do that because they're ordinary people.

You'd have people from government, from local government, you'd have community leaders and you had ordinary people, and that becomes a working party and ultimately as the informed jury, make a decision.

4.2.4 Conclusions

There was strong support for public involvement in the decision-making process, but the majority thought that the final responsibility ought to lie with the politicians and other professional decision-makers. The decision-makers were seen to have a duty to consult the public through legitimate and independent means. Participants thought that the consultation process would have to meet with the following criteria, if it were to be a reliable indicator of public opinion:

- people should have time to weigh up evidence for and against different policy options before being asked to give an opinion and any information should be provided in an accessible format
- people should have opportunities for deliberation with other members of the public and a diverse range of views should be included in the discussions
- there should be a built-in capacity for ongoing consultation, so that decisions can be revised in the light of new evidence.

Importantly, participants thought that the public should consider the value conflicts underpinning different policy options in addition to the 'facts and figures' since they recognised that every policy decision raises moral dilemmas:

> *All technical decisions have morals behind them because people are caught in the crossfire and the people caught in the crossfire are where you get your moral dilemma.*

Participants also placed great value on enabling debate between people with opposing views. This was seen to provide an important means of encouraging people not to think of themselves as isolated, self-interested individuals, but as members of a group working together to reach a decision for the common good. This led to a contradiction in participants' minds as to which members of the public should take part. On the one hand, the public were perceived as having a legitimate place at the table, because they would be the ones most affected by any decision. On the other hand, those motivated only by self-interest were ruled out on the basis that they could not be trusted. It has been suggested that this dilemma could be resolved by involving the public in two capacities, as patients/service users with recognised individual needs, and as 'disinterested' citizens with broader and longer-term interests in the fair distribution of public resources.[13,14]

In the case of congestion charging, it would be near impossible to identify any citizen of London who did not have some interest in the policy outcome. Indeed, it has been argued that it is

impossible to distinguish between people who are affected by a decision and people who are not.[15] Perhaps, as some participants suggested, it is more important that the people who take part in the debate are open and honest about their concerns to ensure that the process is not dominated by any single vested interest. More importantly, the people carrying out the consultation must be visibly independent of any of the public's or Government's interests.

Participants' spontaneous description of a 'legitimate' process of public involvement exactly describes a citizens' jury (section 4.2.3), which uniquely combines *information, time, scrutiny, deliberation* and *independence.*[16,17] The majority of participants' views were more in accord with a 'deliberative' model,[18] where the jury engages in 'guiding policy-makers and offering feedback and opinion from the community'. Far fewer supported a process more akin to a 'decision-making' model[19], where the jury 'adjudicates on an issue'. A similar conclusion was reached in citizens' juries on rationing.[20] Jurors did not want to have the only or final say, but felt that 'the public should be consulted about their opinions, which should be taken into account along with other interests'. However, participants also had some concerns about such a process, particularly in terms of the efficiency of decision-making and costs in time and money. Such concerns are a recognised drawback to citizens' juries, but it has also been argued that high quality citizen input at the beginning of a process is ultimately more efficient than low quality citizens' input, perhaps when it is too late.[21,22]

4.3 Eliciting public values through a public debate

The following section examines the strengths and weaknesses of the public involvement strategy insofar as the process enabled discussion of public values. Suggestions are made as to how the process might be improved.

4.3.1 Discussion groups

In the free-ranging discussion of the groups, participants tended either to refer to their personal experience to solve practical problems or to what was most important to them in order to choose between different policy options. It is therefore evident that the public does not instinctively reflect on public values when making decisions about public health policy. This does not mean that public values are thought to be unimportant, as the workshop discussions clearly demonstrated. It simply indicates that the public needs to be encouraged to articulate their views on these issues, views that may otherwise go unexpressed.

In this project, the discussion groups performed an essential role in testing out the scenarios before the workshops and helping to identify those scenarios that stimulated most debate. The groups revealed where there were stumbling blocks in discussion of the scenarios, any language problems and the limitations of the overall approach. Specific comments on each scenario are found in Appendix 2. The reactions of members of the groups to Scenarios 1 and 2 prompted the development of the 'values statements' (see Appendix 5). These statements proved very effective in steering discussions in the workshops towards more in-depth debate of *public* values.

The use of the anonymous questionnaire filled in by discussion group members revealed discrepancies between views expressed by individuals in the groups and the views expressed by the same individuals in private. However, this distinction was limited to discussion of Scenario 3, where in one group racist views were more strongly voiced in the questionnaire. It could be argued that this reveals one of the important advantages of group discussions: they can help to promote civic-mindedness and counterbalance prejudiced opinions. However, it also indicates that group discussions may disguise people's true values, which could in fact hinder progression of debate. People need to be able to air and discuss their views if their opinions are to be understood by decision-makers and effectively challenged.

4.3.2 Workshops

The workshops offered several advantages over the discussion groups in enabling a discussion of public values. In particular, the discussion was more structured and staged over a longer period of time. The structure worked well and the 'value statements' effectively focused discussion on public values without constraining or limiting participants' input. For example, the discussion on what would constitute a fair charging system was not limited to discussion of people's ability to pay but also considered the individual's contribution to the pollution/congestion problem.

Having more time enabled participants to discuss the complexities of value conflicts in greater depth, but even a day proved not quite long enough. There was only enough time to air different views and identify points of agreement and disagreement. An extra 2 or 3 days would have allowed more discussion of how to resolve value conflicts and further discussion of the nuances of the trade-offs that people made.

The anonymous questionnaires filled in by workshop participants provided a valued opportunity for people to feed in their individual comments and concerns at the end of the day. They revealed that

the groups had by no means reached consensus and that single individuals still held conflicting views. Some participants viewed the process as being useful in providing 'a forum that gave a voice to all'. Others raised concerns that group dynamics had prevented everyone from having their say. Some thought this was inevitable since a natural spokesperson was likely to emerge out of any group, but others felt that vocal members had sometimes dominated the discussions. Again, an extended workshop, with additional break-out groups, may have overcome some of these issues.

4.3.3 Opinion survey

The opinion survey sought to test people's immediate responses to the value conflicts posed by the introduction of congestion charges. The survey did reveal some consistency of opinion in the views of participants in the deliberative workshops. The majority of the survey respondents also prioritised efficiency (in terms of improving collective health) over all other values (see sections 4.1.3 and 4.1.5). However, opinions that surfaced through the survey differ in two important ways from those revealed in the workshops. First, the opinions of survey respondents are largely uninformed, and based on individuals' immediate responses to the issues. In contrast, workshop participants had opportunities to consider additional information and debated the issues with others. Second, survey respondents were asked to weigh up pairs of principles and to state those they felt to be more important. Such either/or options may not reflect the kinds of real-life value judgements that inform decisions. There is no fixed hierarchy of values, and they will be traded-off in relation to the whole complex picture, rather than in isolation. The survey therefore provides a simple picture of where members of the public are now, in contrast to where they could be, given more information.

4.3.4 Conclusions

If this process were to be repeated as a method of eliciting values, the following changes could help to improve the process:

- the number of discussion groups could be reduced, limiting their role to testing scenarios and value statements prior to workshops
- the workshops should be held over a longer period, say 2 to 3 days to enable further exploration of the issues raised in debate and to ensure all participants have opportunities for their views to be heard. It seems unlikely that consensus would ever be reached on values, but participants could at least aim to define more precisely where they agree and disagree and might be able to reach a consensus on a decision that most would be willing to accept

- the complexity of the debates around value trade-offs limits the usefulness of a survey to measure public opinion on these issues. As participants themselves argued, debates around value trade-offs require time for deliberation and review of evidence (section 4.2.4). Therefore the survey results only indicate what the public think now given what little they know, as opposed to how they might think in the future given more time and information.

5. Final conclusions: Why engage the public in debates around public values?

This debate about 'Public Health and Public Values' has provided some insight into how members of the public think decisions should be made on controversial issues in public health policy. They clearly support:

- public involvement through deliberative forums
- discussion of public values in addition to technical evidence
- unambiguous demonstration of how decisions made by government have addressed the issues raised by the public.

This exercise suggests there may be several advantages to policy-makers through involving the public in decision-making in this way:

(a) involving the public in decision-making could bring greater political legitimacy

Direct participation of the public was viewed by participants in this debate as an essential means of ensuring that 'the full range of opinions are heard', a necessary step to ensure political legitimacy. Without directly addressing the public's concerns, it can appear that decision-makers are biased or acting only in their self-interest. If the public's views are not visibly taken on board, people are more likely to become suspicious of the outcome and lose trust in those held responsible.

An important question remains as to which methods of engagement would engender widespread public support. The outcome of this debate suggests that a deliberative process matching the criteria outlined in section 4.2.4 might meet with wider public approval. Clearly any method of engagement will gain legitimacy only over time, through a gradual build up of public trust and awareness. In the meantime, every approach will need to be open and accessible if it is to be subject to public scrutiny and effectively judged by people other than the few directly involved.

Where there are no right or wrong answers, such as in areas of controversial public health policy, this question as to what constitutes a legitimate decision-making process takes on even more significance, since a large proportion of people are likely to disagree with any outcome. Again, it becomes essential that the process is demonstrably unbiased, open and transparent. Ham and

McIver make similar recommendations to strengthen the process of making decisions on priorities within the NHS.[23]

Decision-making must therefore be accessible to the public, both in terms of enabling the public to engage in the debate, and in being able to justify publicly the final decisions that are made. If the public's views have been given respectful consideration, people are more likely to be willing to accept policy decisions, even if those decisions go against their wishes. Open and honest dialogue between the public and policy-makers offers important opportunities for reaching mutual understanding. Through an explanation of the moral reasoning behind their decisions, decision-makers can become increasingly accountable to their public.

(b) involving the public in a values debate can *limit* conflict

Members of the public in this debate easily recognised that resolving value conflicts is a difficult and complex process. They were aware of contradictions in their own value trade-offs and of the difficulty of weighing-up opposing views that seem to have equal merit. While widening the debate may at first appear to heighten conflict by bringing in more contradictory opinions, there is much to be gained from understanding the exact nature of those disagreements. As Gutmann and Thompson argue,[24] 'a deliberative process can clarify exactly what is at stake, so that opponents can separate resolvable from irresolvable issues'. The debate can move forward if it then concentrates on the resolvable issues.

A public debate on values cannot therefore hope to eliminate conflict but it could help to limit conflict by identifying areas where agreement might be reached. In contrast, a lack of public engagement could create even greater public hostility. Processes that exclude the public are more likely to make people angry and resentful, and may further entrench individuals in their polarised positions.[25,26] Although public deliberation may bring deep disagreements to the surface, it offers the chance to modify people's views through access to new opinions and new information. Such changes can also help to move debate forward.

(c) engaging the public in a debate about public values encourages consideration of collective concerns

The public may be more willing to accept policies that act counter to their individual concerns if they are able to consider the wider moral arguments. However, they will only accept such policies if there is strong *evidence* to support the moral arguments and if the source of information can be *trusted*. Participants in this debate were strongly in favour of options that promoted the health of the population as a whole and promoted an equitable distribution of health care resources. However, they were aware that the persuasiveness of such arguments could be used to manipulate their views and so demanded proof of the effectiveness of the proposed measures.

In the interviews with policy-makers and practitioners, individuals reported experiences of strong public opposition to changes in health services proposed to promote efficiency and equity (better standards of care for all people affected by a particular condition). However, in these cases it seems that the public perceived that the moral arguments were being used to mask budget cuts. Rather than refusing to engage in a values debate, the public were rejecting what they perceived to be unreliable information. Mutual trust and respect are key to establishing a meaningful dialogue between the public and decision-makers.

In an honest exchange, discussion of moral arguments does appear to promote civic-mindedness. Through informed debate, the public could gain a collective understanding of what will best serve their fellow citizens, and move beyond consideration of their individual concerns. People easily distinguish self-interested claims from civic-minded or public-spirited ones. They place great emphasis on ensuring that decision-making processes are not biased towards any individual interest. If more people – ordinary citizens and decision-makers – were aware of the potential for widespread public support of decisions that promote ‘the good of all’, they may be less likely to judge their fellow citizens as incapable of constructive dialogue.

In conclusion, it appears that acknowledging and making explicit value trade-offs in policy decisions are essential if decisions are to be justifiable and acceptable to the public. However, this will be true only if decision-makers can be seen to be trusted to act morally themselves.

Appendix 1

Members of the steering group

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Jane Steele	Principal Research Fellow, Office of Public Management
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Appendix 2

The agenda for the public debate: five fictional scenarios reflecting 'live' public health policy issues in London

SCENARIO 1: The introduction of congestion charges in London

Issue: If there were less traffic in London, the health of Londoners would be greatly improved. The benefits for people's health include less air pollution, fewer traffic accidents, and more people using 'healthier' transport – walking, cycling, buses and the tube.

For buses to be a realistic alternative to cars traffic needs to be reduced. At the moment buses are unreliable and journey times are too long. Introducing congestion charges seems to be the only practical way of reducing the number of cars on the road. It would also provide extra money badly needed for improving public transport, both buses and the tube.

Congestion charges could take the form of having to buy an extra license to drive in the central London area, a flat fee of £5 a day and/or the introduction of a workplace parking charge.

The introduction of this charge could affect people in different ways.

Should the congestion charge be introduced?

Comments:

- Worked very well in provoking debate and easily understood by participants.

SCENARIO 2: Preventing heart disease in Greyton

Issue: North and South Greyton have similar sized populations, but many more people suffer from heart disease in North Greyton as the population is much poorer. The number of people who die from heart attacks in the North is much greater than the national average, while the number dying in the South is just below average. The health authority and local authority plan to start a Healthy Heart campaign to encourage people to eat a more healthy diet, exercise and quit smoking. They plan to put 80% of the resources into the north of the town where the problem is worse. *(*This will enable the North to trial a new package of measures to combat heart disease, which include 'exercise on prescription', free nicotine patches, and advice from nutritionists. These will not be available in the South.)* This suggestion has met with great resistance at public meetings. Most people at the public meetings are from the South. Local Southern groups have got together to campaign for more resources in their area. Local people expressed their views in a phone-in poll in a local newspaper. The results were that the majority (60 per cent) thought that resources should be split between North and South 50:50.

How should the resources be divided?

* changes introduced for the deliberative workshops are in italics.

Comments:

- In the discussion groups, the decision appeared to be very straightforward and therefore in order to make the decision more complex, the redistribution of services was included for the workshop discussion.
- In the workshops, some participants found it difficult to understand how an unequal distribution of resources would provide an equal level of support for each affected individual. Equity and equality are

hard to distinguish but this difference was made much clearer through diagrams with pie charts to show how the resources would be divided.
- Discussions of Northerners and Southerners in the fictional Greyton were sometimes confused with generalisations about the North–South divide in the UK. An east–west division of Greyton would have avoided this.

SCENARIO 3: English classes for Bosnians in Greyton

Issue: The local authority has housed a small community of Bosnian refugees in the centre of Greyton. Some of the Bosnians have had difficulty finding jobs and getting access to services because they don't speak English. The local authority would like to use some of its adult education budget to pay for English speaking classes for the Bosnians, to help them find work and get access to the health services they need. This will mean some of the existing adult education classes will have to be stopped. Local residents protest as they do not wish to lose resources from their existing adult education programme.

The local authority and health authority believe that alienation and stress amongst the Bosnian community could be solved by helping them to find employment and access to health and counseling services and with it improving life for everyone in Greyton.

Should the adult education resources be invested in English classes for the Bosnians?

Comments:

- This was the least effective of the scenarios – prejudices about refugees hindered reasonable debate.
- The health impact of the choice was not immediately obvious to participants and the links between education and health need to be made clearer.

SCENARIO 4: Drugs versus alcohol

Issue: The health and local authorities in Greyton have found that alcohol is a significant cause of crime and ill health in their area. The number of people involved in fights outside local pubs as well as cases of domestic violence linked to alcohol are far greater than the numbers of people committing street crime to obtain hard drugs. The far greater number of injuries that result from fights, alcohol poisoning and accidents involving drunks cost the health authority a lot more money than the treatment of heroin addicts. The health authority would like to take resources away from their methadone treatment programme and work with the local authority to launch a campaign to reduce alcohol consumption in their area. Such a policy might for example encourage health promotion in workplaces tackling drinking after work, step up measures to prevent illegal sales of alcohol to minors and measures to prevent drink-driving.

Should the health authority spend money on a drug programme or on an alcohol programme?

Comments:

- The choice presented in this scenario was perhaps too complex. Participants were asked to choose between two policies addressing different public health issues, to choose between a treatment and preventative measure and to choose to withdraw resources from an existing service to start a new campaign. This scenario may have benefited from simplifying the choice along one or two dimensions.

SCENARIO 5: Testing for gonorrhoea

Issue: In Greyton, the number of heterosexual adults infected by gonorrhoea is increasing. A voluntary and confidential screening programme has been in place but there has been little take up of screening. The heterosexual population mistakenly thinks that it is not at risk and need not practice safe sex. The health authority has limited funds but urgently wants to reduce the number of new cases. They are concerned that as people with sexually transmitted diseases are far more vulnerable to HIV infection, the rising level of gonorrhoea will also increase the transmission of HIV.

Two proposals have been suggested:

(1) The health authority should contact the previous partners of newly infected people to offer testing, without mentioning the name of the infected individual, but with their consent;

(2) The health authority should raise awareness of the increase in gonorrhoea through postal campaigns in the area, giving people increased options to be screened through all GPs, family planning clinics and hospitals.

Should resources be given to proposal 1 or proposal 2?

Comments:

- This scenario could have been improved by providing supporting information about the effectiveness and take up of testing under the different options. This would have prevented participants from debating this issue at length and from making decisions based on their beliefs about the effectiveness.

Appendix 3

Guide for the discussion groups

Composition of discussion groups

Location	Gender	Age	Socio-economic grouping	No. of attendees	No. from ethnic minorities	Scenarios
North London	Male	18–30	AB	8	2	Scenario 1 Scenario 3
South London	Female	18–30	C1C2	6	5	Scenario 5 Scenario 4
Central London	Male	31–55	C1C2	8	2	Scenario 4 Scenario 2
North London	Female	31–55	DE	7	2	Scenario 3 Scenario 4
South London	Male	56+*	DE	7	4	Scenario 2 Scenario 1
Central London	Female	56+*	AB	7	2	Scenario 1

**In each group of those aged 56+, there were at least 2 participants aged over 70*

Discussion guide

1. Introduction – 5 minutes

- assure confidentiality
- ask permission to tape
- respondents introduce themselves

2. Warm up – 15 minutes

Questions: What are the factors that affect your health? Who is responsible for your health? Why?

Brainstorm and record suggestions on a flip chart

3. Scenario study – 65 minutes

Distribute appropriate scenario

Questions:
What do you think should happen? Why?
How do you think this should happen? Why?
Who do you think should be responsible for making this decision? Why?
Are there winners and losers? Why?
What are the good things and bad things about this for London?
Distribute next scenario if necessary (i.e. if discussion has been exhausted on this scenario).

4. Questionnaires – 5 minutes

Appendix 4

Post-discussion group questionnaire

1) What are the 3 most important things that affect your health and well-being?

1)……...

2)……...

3)……...

2) Who do you think is responsible for your health and well-being and why?

…….

3) Who do you think should be responsible for your health and well-being and why?

…….

…….

4) What do you think should happen in the example you looked at?

…….

…….

…….

…….

…….

…….

Thank you for filling in this questionnaire.

Appendix 5

Agenda for deliberative workshops

Scenario 1: Congestion charges – facts and figures

Transport in London

- just over 1 million people enter Central London every weekday morning – 13% by car
- 40% of all car journeys in London are under two miles but car owners are least likely to walk
- the number of trips by car increased by 45% between 1981 and 1991
- cycling accounted for 25% of all road traffic in 1951 – it now accounts for just 1%. Only 1.6% of trips in London are taken by bicycle (a total of 330,000), and 24% are taken by public transport
- 40% of London households (60% in some boroughs) do not have cars.

Health impact

- physical activity is an important factor in combating heart disease
- half an hour a day of walking or cycling can halve the risk of developing heart disease and diabetes, and can also reduce blood pressure (equivalent to the effects of not smoking)
- pollution makes respiratory symptoms, including wheezing and shortness of breath, worse in asthmatic children
- car users breathe more air pollutants than walkers, cyclists or people using public transport on the same road
- in the UK, air pollution is associated with 14,000–24,000 hospital admissions and re-admissions per year, and does most harm to people who are already ill
- the health benefit of cycling outweighs the risk of accidents in the UK at present, but the risk of road accidents must not get greater – so safety is an important part of promoting cycling.

Environmental impact

- road traffic contributes to climate change – it accounts for 25% of CO_2 emissions in Europe
- levels of pollution in London regularly exceed national safety limits, particularly during hot weather and fog.

Combating congestion

- the most effective measures are thought to be road user charging and parking controls
- a proposed charge of £5 per day in Central London and a parking levy of £1500 per year, to rise to £7.50 per day in Central London and £3.75 in Inner London in 2 to 3 years
- the projected high growth of car use in Outer London means that the greatest effort to reduce dependence on the car needs to be focused there.

Scenario 1: Congestion charges – Value statements

1. I'm on the minimum wage but I have to use my car to get to work – what's going to happen to me when I can't afford the congestion charges?

2. If the money from congestion charges goes to improve public transport, then I think it would be good for London

3. I'm not that bothered if they introduce congestion charges – I'll be able to afford them so there's no reason for me to stop using my car

4. Even if driving is bad for my health, I don't think that anyone should be able to force me out of my car – it's my decision after all

5. I'm just one person in one car – I won't make a difference on my own, so why stop using my car?

6. It's not just about each single driver, it's about them all contributing to the traffic problem and to pollution – of course they should be made to leave their cars at home if it's for the good of everyone

7. People shouldn't be allowed to be so selfish and still use their cars, when it's so obviously bad for everyone's health

8. I reckon that most Londoners would be against congestion charges, so how can they still introduce them when they're so clearly unpopular?

9. It's the responsibility of decision-makers to introduce congestion charges if they're the best way of reducing traffic and improving health – even if the charges are unpopular

Scenario 2: Preventing heart disease – facts and figures

Heart disease in the UK

- the UK has one of the highest heart disease rates in the world – many deaths could be prevented
- one British adult dies of heart disease every three minutes
- 80% of people in Britain believe themselves to be fit, but 60% of men and 70% of women are not actually active enough to benefit their health.

Heart disease in London

- in a comparison of 14 European capital cities, London had the highest proportion of obese people (13%)
- the number of deaths of people under 65 from heart disease in one of the poorest boroughs in London is 67 out of every 100,000 people. In richer boroughs this number is reduced to 25 in every 100,000 people
- the number of people smoking in London has been falling steadily, but levels of smokers are still high amongst the poorest sections of the population.

Combating heart disease

- the risk of heart disease can be reduced by taking plenty of exercise, not smoking, losing weight, reducing salt and alcohol intake, reducing stress and eating healthily – low fat, high fibre, lots of fruit and vegetables
- exercise on prescription involves GPs prescribing discount rates at the local gym or swimming pool. Each patient is given a fitness assessment and an individualised exercise programme for a ten-week course. 25–30% of patients continue with the exercise after the course is over, reporting an overall improvement in their sense of well-being.

Scenario 2: Preventing heart disease – Value statements

1. It's only fair if everyone gets the same – half for the North and half for the South

2. It makes sense that the money goes where it's needed the most

3. They should ignore the poll – the people that rang in don't represent everyone, most of them were from the South anyway

4. The phone-in poll shows that most people want it 50:50 so that's what it should be

5. You've got to get the most for your money – pound for pound you'd have more effect in the North

6. The people in the South shouldn't suffer just because the people in the North lead unhealthy lives

7. The money should be spent on having more heart surgeons rather than a health campaign

8. It's better and cheaper to try to prevent heart problems rather than spend lots of money on treatment

9. It's the responsibility of decision-makers to do what the majority of people want

10. It's the responsibility of decision-makers to make sure our taxes are spent in the best way to improve health even if it is unpopular

Appendix 6

Post-workshop questionnaire

(Spaces for participants' responses have been omitted)

1) To what extent do you agree or disagree with the following statements?

	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Don't know
If the money from congestion charges goes to improve public transport it would be good for London					
Even if driving is bad for my health, no-one should be able to force me out of my car – it's my decision					
It's not just about each single driver, it's about them all contributing to the traffic problem and to pollution – drivers should be made to leave their cars at home if it's for the good of everyone					
People shouldn't be allowed to be selfish and still use their cars, when it's so bad for everyone's health					
Most Londoners would be against congestion charges, so they shouldn't introduce them					
It's the responsibility of decision-makers to introduce congestion charges if they're the best way of reducing traffic and improving health – even if the charges are unpopular					

2) What do you think should happen in Scenario 1 (congestion charges)?

3) Why?

4) Who should be involved in making this decision? (Please tick all that apply)

National politicians ☐
Local politicians ☐
Local council officers ☐
Experts (academics, medical professionals) ☐
General public ☐
Other (please specify) _____

5) Why?

6) Who do you trust to make this decision? (Please tick all that apply)

National politicians	☐
Local politicians	☐
Local council officers	☐
Experts (academics, medical professionals)	☐
General public	☐
Other (please specify)	_____

7) Why?

8) Who should have the final say?

9) To what extent do you agree or disagree with the following statements?

	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Don't know
Everyone should get the same – half for the North and half for the South					
They should ignore the poll – the people that rang in don't represent everyone (most of them were from the South)					
The phone-in poll shows that most people want it 50:50 so that's what it should be					
Pound for pound you'd have more effect in the North, so that's what they should do					
The people in the South shouldn't suffer just because the people in the North lead unhealthy lives					
The money should be spent on having more heart surgeons rather than a health campaign					
It's better and cheaper to try to prevent heart problems rather than spend lots of money on treatment					
It's the responsibility of decision-makers to do what the majority of people want					
It's the responsibility of decision-makers to make sure our taxes are spent in the best way to improve health even if it is unpopular					

10) What do you think should happen in Scenario 2 (heart disease)?

11) Why?

12) Who should be involved in making this decision? (Please tick all that apply)

National politicians	☐
Local politicians	☐
Local council officers	☐
Experts (academics, medical professionals)	☐
General public	☐
Other (please specify)	_____

13) Why?

14) Who do you trust to make this decision? (Please tick all that apply)

National politicians	☐
Local politicians	☐
Local council officers	☐
Experts (academics, medical professionals)	☐
General public	☐
Other (please specify)	_____

15) Why?

16) Who should have the final say?

17) Do you think events like today are an effective way of involving the public in decision-making?

Yes	
No	
Don't know	

18) Why/why not?

19) Do you have any other comments about today's workshop?

Thank you for filling in this questionnaire.

Appendix 7

Questionnaire for the opinion survey

Good morning/afternoon/evening. My name is …… and I'm calling from ……..., an independent Market research fieldwork company. We have been commissioned by the King's Fund and the London Coalition for Health to talk to Londoners about how they feel about health in London. I would like to ask you if you could spare 10 minutes to answer a few questions about a particular health issue. This is part of a programme of consultation with people in London, the results of which will be given directly to the policy-makers including the Mayor of London.

The issue I would like to ask you about is the introduction of congestion charges in London.
Before I ask you any questions, I am going to read you a short statement about the issues.

The London Mayor is planning to introduce congestion charges in the form of a flat fee of £5 a day, with some exceptions. Introducing the congestion charge appears to be the best way of reducing the number of cars on the road, and would also provide extra money for improving public transport. If there is less traffic, there are likely to be benefits to Londoner's health through less air pollution, fewer accidents and more people using 'healthier' forms of transport – walking, cycling, buses and the tube.

I am now going to ask you some questions about what you think about congestion charges.

Q1
Do you think the introduction of congestion charges will improve, reduce, or have no impact on the health of Londoners?

Improve	
Reduce	
Have no impact	
DK/NS	

Q2
Do you think it's fair or unfair if everyone pays the same congestion charge?

Fair	
Unfair	
DK/NS	

Q3
Do you think congestion charges will restrict people's freedom to choose to drive their car, or have no impact on it?

Restrict	
Have no impact	
DK/NS	

Q4
Do you think congestion charges will increase, reduce, or have no impact on the amount of traffic on the road?

Increase	
Reduce	
Have no impact	
DK/NS	

Q5
Do you think car drivers in London are in some way responsible for the health of Londoners or not?

Yes	
No	
DK/NS	

Q6
Do you think that the majority of Londoners would be for, against, or indifferent to the introduction of congestion charges?

For	
Against	
Indifferent	
DK/NS	

I'm now going to ask you a series of questions about what you think the Mayor should take into account when planning to introduce congestion charges.

When the Mayor is planning to introduce congestion charges, is it more important that he thinks about:

Q7
a) Whether the charges are fair?
b) Whether the charges can help to improve health?

a)	
b)	

Q8
a) Whether the charges will reduce traffic in London?
b) Whether the charges are fair?

a)	
b)	

Q9

a) Whether the charges can help to improve health?
b) Whether charges will restrict people's freedom to drive a car?

a)	
b)	

Q10

a) Whether Londoners will oppose congestion charges?
b) Whether charges can help to improve health?

a)	
b)	

Q11

a) Whether car drivers have some responsibility for other people's health?
b) Whether charges will restrict people's freedom to drive a car?

a)	
b)	

Q12

On a scale of 1 to 4, where 1 is not at all important, 2 is not very important, 3 is quite important, and 4 is very important, how important is it to **involve** the following people in decision-making on this issue?
[READ OUT & ROTATE]

	1	**2**	**3**	**4**	**DK/NS**
National politicians					
Local politicians					
Health professionals/experts					
General public					
Community groups/voluntary groups					

Other (please specify): _____

Q13

On a scale of 1 to 4, where 1 is not at all, 2 is not very much, 3 is quite a lot, and 4 is a lot, how much do you **trust** the following people to make decisions on this issue?
[READ OUT & ROTATE]

	1	**2**	**3**	**4**	**DK/NS**
National politicians					
Local politicians					
Health professionals/experts					
General public					
Community groups/voluntary groups					

Other (please specify): _____

I'd now like to read out a list of arguments *for* the introduction of congestion charges.

Q14
a) Which of the following do you find convincing arguments *for* the introduction of congestion charges? **[READ OUT IN ROTATION – tick as many as apply]**

Better health through less pollution	
Better health through more exercise	
Reduction in pollution	
Reduction in traffic	
Safer roads	
Money for public transport	

Other (please specify): _____

b) Which one argument do you find the **most** convincing? **[READ OUT ARGUMENTS AGAIN IF NECESSARY]**

Better health through less pollution	
Better health through more exercise	
Reduction in pollution	
Reduction in traffic	
Safer roads	
Money for public transport	

Other (please specify): _____

I'd now like to read out a list of arguments *against* the introduction of congestion charges.

Q15
a) Which of the following do you find convincing arguments *against* the introduction of congestion charges? **[READ OUT IN ROTATION – tick as many as apply]**

Cost to individual of congestion charges	
Congestion charges will not be an effective way of reducing congestion	
Takes freedom of choice away from individual	
Unfair system	

Other (please specify): _____

b) Which one argument do you find the **most** convincing? **[READ OUT ARGUMENTS AGAIN IF NECESSARY]**

Cost to individual of congestion charges	
Congestion charges will not be an effective way of reducing congestion	
Takes freedom of choice away from individual	
Unfair system	

Other (please specify): _____

Q16
Taking everything into consideration, do you think that congestion charges should be introduced?

Yes	
No	
DK/NS	

Q17
Why do you say that? **[PROBE FULLY]**

Thank you for taking part in this survey.

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