spectra

Public health and ethics

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International experts on substitution treatment meet in Geneva

Conferences on opioid dependence. Two conferences on the treatment of opioid dependence were held concurrently in Geneva on 18 and 19 October: NaSuKo (3rd national conference on substitution treatment) and TOD (3rd francophone international symposium on the treatment of opioid dependence). More than 450 experts from Switzerland and a number of other French-speaking countries attended the two conferences.

NaSuKo, the national conference on substitution treatment held every five years, takes stock of the situation of substitution treatment in Switzerland and discusses development opportunities. "Substitution treatment" is understood as the prescription of a legal drug (the substitution drug) by a physician as a substitute for an illegal opioid (usually heroin). The most important substitution drugs are currently methadone, buprenorphine und diacetylmorphine (pure heroin). Initial rudimentary recommendations for such substitution treatment were defined at the first NaSuKo, which was held in 2002. They were drawn up primarily for family doctors, who look after more than half of all patients receiving medical treatment for opioid dependence in Switzerland. This year the Swiss Society of Addiction Medicine (SSAM) presented revised, evidence-based clinical recommendations. Pascal Strupler, Director of the Federal Office of Public Health (FOPH), stressed the importance of this advance in his opening address, stating that one of the FOPH's oldest concerns in the drug policy field had been translated into action, i.e. providing a sound basis of empirical and clinical research for such treatment methods. What was taken for granted with every other disease had, he said, proved to be particularly difficult with regard to substitution-assisted treatment. Strong moral reservations about this form of treatment and widespread mistrust of the scientific rationale that stemmed from it still prevailed in many countries around the world – as indeed they had in Switzerland for many years.

Core topic: legal framework

The core topic of this year's francophone international symposium on the treatment of opioid dependence (TOD) was the legal and political framework of substitution treatment in various countries. TOD is held every two years, the first one having taken place in Montreal in 2008. The aim is to swap views on the benefits of this substitution method and discuss the progress made with it to date. Attending the conference for the first time were participants from Morocco, Tunisia, Algeria, Egypt, Lebanon and Cameroon, where substitution treatments have either just been established or are still viewed as possible options. A number of key presentations on the core topic of TOD were held in conjunction with NaSuKo. Among them was the address by former Swiss government minister Ruth Dreifuss who, as a member of the Global Commission on Drug Policy, talked about the criminalisation of dependent users and the effects on their health. She called for a pragmatic approach to the problem from politicians and for specific innovative projects. Professor Olivier Guillod from the University of Neuchâtel presented his FOPH-commissioned comparative study of the legislation on substitution treatment in France, Belgium, Canada, Tunisia and Switzerland. In this respect, Switzerland is one of the most progressive countries, in that diacetylmorphine can – though subject to stringent regulations – be prescribed by specialist doctors. But in France, for instance, only physicians in specialist clinics are allowed to prescribe methadone, while family doctors are restricted to the prescription of buprenorphine. In Lebanon, on the other hand, only psychiatrists may prescribe substitution drugs. These restrictive regulations can be interpreted as signalling mistrust of substitution treatment and substance-dependent patients on the part of legislators. This does nothing to make substitution treatment more attractive, and countries are familiar with the lack of

Prof. Olivier Guillod, former government minister Ruth Dreifuss and Prof. Jacques Besson on the podium during the opening.

physicians who are willing to take on opioid-dependent patients and to prescribe substitution drugs. Many of them are put off by the heavy administrative burden associated with substitution treatment and the difficulties that treating opioid-dependent patients can entail. In order to help family doctors with such patients, FOSUMOS (addiction-medicine forum Eastern Switzerland), FOSUMIS (addiction-medicine forum Central Switzerland), COROMA (the addiction-medicine network Collège romand de médecine de l'addiction) and Ticino Addiction joined forces to launch the website www.praxis-suchtmedizin.ch, where physicians can find detailed information on the treatment modalities of all addictive substances.

Switzerland as a model

Who is allowed to prescribe which substitution drugs, for whom and with what targets? How can we create broad access to substitution treatments? What kind of support do physicians need for this treatment? All the participating countries are currently addressing these questions. Drug experts from many of them envy Switzerland for its large degree of freedom in being able to try out new measures in the early 1990s and thus develop effective responses to the problems of the time. The experts assembled in Geneva accordingly called for such freedom to be granted to them by their own political decision-makers. But the trend in many places seems to be in the opposite direction. In Quebec, for instance, the government decided not to introduce heroin-assisted treatment despite the positive results obtained in a scientifically supported pilot study. In Switzerland, as a result of the difficulties many cities encounter in getting a grip on the drug trade on their streets, calls for a repressive approach are again attracting attention. However, hope is offered by France, where, in response to pressures exerted by large population centres, there are signs of a relaxation of the rigorous restrictions on the prescription of substitution drugs, and a similar development can be seen in Belgium. The key message of the experts at the end of the two conferences is: abandon rigid positions and retain and adapt any measures that are effective and relevant.

Links on the topic:
www.tdo3.org
www.nasuko3.ch

Contact: René Stamm,
Drugs Section,
rene.stamm@bag.admin.ch

Pascal Strupler, Director of the Federal Office of Public Health, expressed his satisfaction that substitution treatment in Switzerland is based on clinical and empirical studies.

More than 450 specialists from various French-speaking countries met in Geneva in October to share their knowledge and experience of substitution treatment.

Tobacco control is a human right

Tobacco control. WHO Director-General Margaret Chan calls for human rights concerns to play a greater role in the fight against the tobacco industry.

At the 15th World Congress on Tobacco or Health held in Singapore in March 2012, Margaret Chan strongly urged participants to base their arguments against the activities of the tobacco industry on concerns about human and children's rights and to enforce bans. The cultivation and use of tobacco often infringe human rights. The large number of children employed on tobacco plantations (which infringes the ban on hazardous child labour) and the lack of protection for non-smokers (which infringes their right to health) are two cases in point.

Enforcing agreements

Margaret Chan had already drawn attention at the WHO Global Forum in 2011 to the spread of chronic, non-communicable diseases of which smoking is a contributing factor, for instance cancer and cardiovascular conditions. These diseases, according to Chan, are an enormous challenge for all countries. The fight against non-communicable diseases is not comparable with efforts to combat infections such as HIV/AIDS. The former, she said, is above all a fight against powerful business interests that are pursuing exclusively commercial goals without any regard for health. In Chan's view, cooperation with the tobacco industry is not the way to go. The only tool to use against the tobacco industry is statutory pressure. Margaret Chan's call to action constitutes support for the efforts of organisations such as the international Human Rights and Tobacco Control Network (HRTCN), which supports the implementation of restrictions on smoking on the basis of human rights concerns. The cornerstones of this global network's approach are international agreements such as the WHO's Framework Convention on Tobacco Control (FCTC), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the International Pact on Economic, Social and Cultural Rights (Social Pact).

Six million deaths a year – and the trend is upward

According to the "Tobacco Atlas", just under six million people died as a result of tobacco use in 2011. One out of every two smokers dies as a result of tobacco use, half of them in middle age. The WHO expects the number of smokers, and thus the problems associated with smoking, to further increase in the next 20 years. The tobacco industry's marketing strategy particularly targets women living in developing and emerging countries.

The industry is responsible not only for illness and death but also for economic, social and ecological problems: many families lose their main breadwinner to premature death as a result of tobacco use; large numbers of tobacco plantations employ children and thus rob them not only of their health but also of their education and future prospects; and pesticide use and forest clearing by tobacco plantations cause serious damage to the environment and health.

Links:
Human Rights and Tobacco Control Network: www.hrtcn.net
World Conference on Tobacco or Health 2012: www.wctoh2012.org

Contact: Laure Curt, Tobacco Section, laure.curt@bag.admin.ch

When forgetting doesn't work

Posttraumatic stress disorders. A new publication from the Swiss Red Cross (SRC) provides clearly presented information on trauma and its consequences.

War, expulsion, torture or rape: people can be traumatised by many types of occurrence. Earthquakes and road accidents can also cause trauma, but human violence usually results in more profound psychological damage than natural disasters or accidents. Migrants are particularly subject to trauma. "It's estimated that one in four migrants in Switzerland is traumatised", says Thomas Hofer, from the Ambulatorium für Folter- und Kriegsopfer (SRC's outpatient clinic for the victims of torture and war), and author of the information brochure "Wenn das Vergessen nicht gelingt" [When forgetting doesn't work].

Recognising trauma and seeking help

The brochure has been funded by the Federal Office of Public Health (FOPH) in the framework of the National Programme Migration and Health and is aimed at traumatised individuals, particularly migrants, and their families. It furnishes clearly presented information on the origin, symptoms, consequences and management of trauma and posttraumatic stress disorders in adults and children. According to Hofer, "the brochure is designed to help traumatised people recognise their condition and accept help".

Permanent stress and sleep disorders

Constantly recurring memories of a painful event are characteristic of a posttraumatic stress disorder. At the same time, the victims try to suppress the experience and numb their feelings to reduce their suffering. They are in a state of permanent stress and constant hyperalertness. This can result in sleep disorders, depressions, anxiety states or even suicide. The psychological symptoms are often accompanied by somatic problems such as back and stomach pain and headache.

Good prognosis for treatment

Posttraumatic stress disorders generally respond well to treatment. "The most effective treatment is psychotherapy aimed at processing and accommodating the original experience", Hofer explains. Medication can also help relieve certain symptoms but is no substitute for psychotherapy. The brochure provides an overview of contact organisations and a list of bodies working specifically with migrants.

Contact: Martin Wälchli, National Programme Migration and Health, martin.waelchli@bag.admin.ch

Brochure in five languages

"Wenn das Vergessen nicht gelingt – Ein psychisches Trauma kann alle treffen" [When forgetting doesn't work – psychological trauma can affect anyone]. Published by the Swiss Red Cross (SRC), 32 pages, available in German, Albanian, French, Turkish, Croatian/Serbian/Bosnian. Download free of charge or order from www.migesplus.ch.

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Produced by: Pressebüro Christoph Hoigné Allmendstrasse 24, CH-3014 Berne christoph.hoigne@la-cappella.ch
Head of Editorial Board: Adrian Kammer, adrian.kammer@bag.admin.ch

Contributors: FOPH, Christoph Hoigné
Translation: BMP Translations AG, Basel
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At first hand

Unlike medical ethics, which are concerned with ethical dilemmas relating to the treatment of individual patients, public health ethics apply to the health sector as a whole. They constitute a basis for ethical judgements of measures taken by health authorities or private health institutions rather than on the actions of individuals such as doctors or nursing staff.

Public health ethics are predicated on the same four basic principles as medical ethics. The principle of autonomy requires that individuals give their consent to measures such as vaccination before these can be performed. This principle also seeks to strengthen personal responsibility (for instance in the areas of prevention and health promotion) and informed self-determination for the individual (for instance in how their own patient data are handled). The principle of doing no harm (non-maleficence) obliges us to weigh up the risk of harming individuals when undertaking measures to improve the well-being of the community (vaccinations, for instance). The principle of doing good (beneficence) is interpreted in various ways. One position is that the state is obliged to "do good" only under certain circumstances and may intervene only if individual behaviour represents a threat to others (for instance it can impose a smoking ban to protect non-smokers against second-hand smoke). Another interpretation calls for a stronger obligation on the part of the state to do good. This position seeks to create general conditions that enable individuals to assume responsibility for their health. The principle of justice also constitutes a frequent major challenge, since distributive equality and distributive inequality can both be regarded as just, depending on the resources to be distributed. Help in this dilemma can be found in the principle of justice advocated by John Rawls, which states that resources should be distributed in such a way that the worst off become better off. For example, awareness activities should target people whose health skills need to be improved rather than those who are already well informed.

Thus, we too bear the responsibility of judging what we do and what we omit to do from an ethical as well as from a health-policy viewpoint.

Salome von Greyerz
Head of Health Strategies Division
Federal Office of Public Health

Ethical check-up for public-health measures

Public-health ethics. Despite their community focus, public-health institutions must never lose sight of the needs of the individual. Measures that benefit society can harm the individual. There again, behaviour that is harmful to health can cause additional economic burdens that have to be borne by society as a whole. But which principles need to be respected when we are weighing up harm against benefit, community wellbeing against that of the individual? The answer has to lie in the ethics of public health.

Public-health interventions target the wellbeing of society as a whole or of sectors of the population, but ultimately affect the individual and can clash with the right to freedom of choice. Public-health decision-making is therefore constantly seeking a balance between the wellbeing of the community and that of the individual. Any such decisions need to weigh up carefully the benefits to society and possible harm to the individual. In their book entitled "Public Health Ethik" [Ethics of public health], Daniel Strech and Georg Marckmann discuss six criteria by which the ethics of health promotion and prevention measures can be appraised. Below is an overview of the criteria:

1. Potential benefits for the target population

> *Ethical principles of maximising benefits and of doing good (beneficence)*

Public-health measures should generate the greatest possible health benefits for society while respecting the autonomy of the individual. An ethical evaluation of a preventive intervention must therefore begin with an appraisal of the measure's potential benefits. Before any measure is launched, scientific studies must provide sufficient evidence that it will in all probability achieve an appropriately high measure of effectiveness. With regard to early identification measures, it is particularly important that they do not result in disease phases being prolonged.

2. Potential harm to participants

> *Ethical principles of doing no harm (non-maleficence) and of doing good (beneficence)*

Public-health interventions generally entail unavoidable negative effects. For instance, false-positive test results in the early diagnosis of cancer can lead to unnecessary treatment, or awareness-raising campaigns can result in stigmatisation of the target group (e.g. overweight children). The benefits and potential harm need to be compared and scientifically documented.

3. Right to self-determination

> *Ethical principles of respect for autonomy and of doing good*

In liberal societies, very great importance has come to be attached to the autonomy of the individual in recent years. According to this principle, health and protection against disease are essentially the responsibility of the individual. This principle of autonomy underlies two ethical criteria that can be applied to public-health institutions. On the one hand, public health interventions should strengthen the health skills of the individual so that they can adequately exercise responsibility for their own health. Health skills are the ability to make health-related decisions based on all relevant and available information. On the other hand, participation in any intervention should, wherever possible, be voluntary. Restrictions on freedom of choice are unavoidable in some situations, for instance quarantine-based measures. Essentially, the principle of proportionality applies: all less restrictive approaches should be exhausted before resorting to the law (see "Intervention ladder" below).

4. Justice

> *Ethical principle of distributive justice*

Social inequality is currently on the increase in all industrialised countries. There is thus a danger that health inequality will also rise. In Switzerland too, people with a low level of education, work status or income are already dying much earlier than the rest of the population. What is more, in the course of their shorter lives they suffer more frequently from health problems. A key criterion for judging public-health measures is therefore the extent to which they reduce health inequality. Every individual must have access to the same conditions and resources necessary for health, thus enabling them to realise their full health potential. In this respect, measures tailored to groups that are disenfranchised in terms of health are particularly valuable. But here, too, potential harm such as stigmatisation has to be taken into account. The principle of justice also means that a measure has to be accessible to all those who could benefit from it. Financial, geographical, linguistic and cultural barriers should be dismantled as far as possible.

5. Effectiveness

> *Ethical principles of maximising benefits and of justice*

Given the state of public resources, any public-health measure has to be carefully examined to determine its effectiveness. The scrutiny has to include an assessment of the "incremental cost-effectiveness ratio". This is the ratio between additional costs and additional benefits in comparison with any alternative interventions. Here, too, it is ultimately a question of proportionality and of whether specific goals cannot be achieved at less expense and with less restrictive measures and less potential for harm (see "Intervention ladder").

6. Legitimacy

> *Ethical principles of justice and respect for autonomy*

Complex ethical considerations rarely allow a single, definitive answer to be applied. Because there is no "super" ethical principle and no defined weightings, ethical differences of opinion on public health issues are difficult to resolve. The legitimacy not only of the decision-making authority, but also of the decision-making process has to be judged in such cases. The criteria governing a legitimate and fair decision-making process are transparency of the normative and empirical basis, consistency of individual decisions, rational reasons for decisions, involvement of the population groups affected, minimisation of conflicts of interest, readiness to review a decision in the light of changed circumstances, and state or voluntary regulation which ensures that these principles are actually respected. As experience shows, political discourse additionally involves criteria concerning benefits and harm to Switzerland's market economy and federalist set-up.

What should and must the state do?

It is uncontested that health is a responsibility not only of every individual, but also of the state, just like social security or education. Inequalities have to be reduced in all these areas. Equalisation can be achieved only from the bottom up, i.e. improving the position of the disenfranchised without impairing that of the better off. The extent to which this equalisation is an obligation of society and whether the state and civil society can be held to account for it beyond the limits of individual responsibility is a matter that will concern the next generation of public-health measures.

Contact: Regula Ricka,
Health Policy Directorate,
regula.ricka@bag.admin.ch

Book: Strech Daniel, Marckmann Georg (eds.). Public Health Ethik. Lit Verlag, 2010: Berlin

The intervention ladder

The intervention ladder is a model for selecting prevention or health promotion measures that are appropriate and proportionate to requirements. Only when an intervention has no effect or ceases to be effective should a measure from the next higher rung on the ladder be adopted. As a rule, the higher the rung on the ladder, the stronger the evidence has to be that the planned measure is appropriate, effective, necessary and acceptable to those who are subject to it. Virtually all statutory measures in the public health field aim to protect the population against objects or people that are harmful to health (endangerment of others). The Narcotics Act is one of the few federal laws that involve consumption bans and thus seek to stop adults of sound mind from putting their own health at risk.

Rung	Measure	Examples
1	**Do nothing** (apart from observing the epidemiological development)	– Monitoring of noroviruses (cause of acute gastroenteritis)
2	**Provide information**	– "LOVE LIFE – STOP AIDS" campaigns – Food pyramid, nutrition disk for children – "5 a day" campaign to promote the consumption of fruit and vegetables
3	**Enable choices**	– Building cycle lanes or playgrounds in densely populated conurbations – Improving public transport connections with local recreation areas and sports facilities – Providing free fruit at work
4	**Guide choice by changing the default policy**	– Lowering the salt content of convenience foods to allow individuals the "add salt" option – Improving the fat content of convenience foods – Reducing the sugar content of products without altering their sensory characteristics
5	**Guide choice by incentives** (financial or material)	– Having private insurers contribute to gym membership fees (through supplementary insurance) – Free administration of vaccines by the Confederation and/or cantons
6	**Guide choice by disincentives**	– Taxes on alcohol and tobacco – Reducing benefits from accident insurance if the mandatory seatbelt regulation is ignored – Fines for driving while under the influence of alcohol
7	**Restrict choice**	– Age-related restrictions on the sale of alcohol (Federal Food Act) or tobacco (cantons) – Smoking bans in public spaces (protection against passive smoking)
8	**Eliminate choice**	– Ban on absinthe (revoked) – Mandatory quarantine for people with a highly contagious disease – Ban on illegal narcotics

Eight-rung intervention ladder (Nuffield Council on Bioethics, www.nuffieldbioethics.org)