Sytnik-Czetwertyński Janusz, Cianciara Dorota. The individual face to face with public health: a conflict of interests or a conflict of conditions? Journal of Education, Health and Sport. 2016;6(2):223-237. eISSN 2391-8306. DOI http://dx.doi.org/10.5281/zenodo.46590
http://ojs.ukw.edu.pl/index.php/johs/article/view/3394
https://pbn.nauka.gov.pl/works/716770

The journal has had 7 points in Ministry of Science and Higher Education parametric evaluation. Part B item 755 (23.12.2015).
755 Journal of Education, Health and Sport eISSN 2391-8306 7

The authors declare that there is no conflict of interests regarding the publication of this paper.
Received: 05.01.2016. Revised 12.02.2016. Accepted: 21.02.2016.

The individual face to face with public health: a conflict of interests or a conflict of conditions?

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Abstract

The freedom of man and the freedom of the citizen are two entirely different domains. By nature, man is created for freedom, yet he does not possess the ability to effectively provide himself with a feeling of security. Man is therefore forced to negotiate, and in exchange for the abandonment of certain rights to freedom, receives a guarantee of relative peace. In order to enforce its obligations, the state is sometimes forced, in the name of the public good, to pacify the intentions of the individual and enforce pro-social actions. The issue discussed here is therefore reduced to the following: is the domain of public health one of those which should remain under the complete, or merely partial, control of the state (such as defence for instance), or should it remain open to the rights and demands of citizens?

The conclusion seems to be the following: the public health perspective is a social one and there is therefore little room for a wide-ranging dialogue with the individual. On the other hand, the system cannot close itself entirely to the reactions of society, since it is supposed to serve people and not its own ideals. It must possess the capacity to not lose sight of people and their problems, so often defying any prognoses and expectations, within the process of enacting public health policy.

Key words: face to face, public health.

INTRODUCTION

Each commonwealth is created based on a social contract, which consists in individuals renouncing part of their freedoms, in exchange for a guarantee of relative peace and security. This should be understood as the fact that the loss of certain prerogatives by citizens, which could be enjoyed by entirely free men, is recompensed by the feeling of security which individuals could not otherwise guarantee themselves on their own. This principle has been the basis for all civilisations in the history of mankind. This arrangement lasts while the relationship between freedom and security remains more or less balanced.

This entails that a too great interference by the state in the lives of its citizens, or too small a capacity on the part of the state to defend itself, against both internal and external threats, both lead to its disintegration. The stabilisation of this equilibrium should therefore be guaranteed by law. This is more or less the axis on which all political and state systems exist.

The state implements its obligations to its citizens within the domains, fulfilling appropriate functions, and defined by law. The segmentation of these domains is related to human needs, the fields in which man can fulfil himself as well as the preservation of public order. Finally, there are fields with special significance. For instance, the function of culture and art is to promote mental exaltation, and through this, to raise the level of satisfaction of citizens and provide spiritual recreation. Art which does not contain a kernel of social exaltation is, in principle, of no use to the state. Mental recreation is in fact indispensable to the functioning of the individual, especially an individual performing hard physical labour.

Basically, all the domains of the state have a role in relation to global social functions. Thus, commerce (fulfilment of needs), administration (organisation of public life), education (raising the level of knowledge and social consciousness), all play different roles. To this, we should also add those services which inspect the correct functioning of the system.

In each state system, a specific role is played by the public health system, whose goal – from the point of view of the community – is to protect the health of society as such. Two entirely different points of view and different interests meet here. The right of the individual to self-determination clashes with what is termed social interest, the interest of the community. Taking the previously enounced definition of statehood at face value, according to which the state is a system of exchange of defined values (freedom for security) between citizens and their dominion, we can state that the right of citizens to self-determination is, by its very nature, limited. It therefore cannot be, that within the domain of public health, citizens have anything to decide on universal issues, even when they themselves are subjected to

them. A good example is the duty to save those who attempt suicide, when the state deprives them of their right to self-determination, in the name of the common good.

However, the question which arises is of course that of the limits of this oppression, the place where the care of the state for the individual starts to turn into pacification? Quite obviously, a precise answer is impossible here and the public sentiment in this regard is based more on public sensitivity.

And it is precisely within this context that certain questions should be asked of the significant issues, from the point of view of the friction between the individual and the state, witnessed within the domain of public health. We shall carry out this analysis from the point of view of this dispute between the sphere of freedom of the individual and the ability of the system to reform itself and develop creatively. To start with, we shall base ourselves on specific examples. In the second part, we shall strive to show the substance of the conflict between the interests of the individual and those of the collective, from the point of view of the bioethics of public health. This shall therefore be a dialogue between philosophy and public health.

PHILOSOPHICAL PERSPECTIVE

Preventive vaccination. The issue of preventive vaccination returns from time to time in the form of a political dispute for the right to self-determination of individuals. However, the limitation of these rights proceeds directly from the nature of statehood itself. Besides which, on the one hand we have an individual, not necessarily highly educated, and on the other a system, whose decisions are supported by expert knowledge. Within this context, the argument that "a parent always knows what is best for their child" seems quite empty. No one can guarantee that the decisions taken by parents, who vary in terms of social consciousness, education, character etc., will always be correct and adequately thought through. On the other hand, the system is also not exempt of faults. For one, it is as least possible to decry its inability to understand the specific situation of individuals. By its very nature, the system is usually reductive, devoid of empathy and inorganic. How to resolve this dispute?

In essence, the problem of preventive vaccination boils down to the following: how much can the system, which has no direct contact with the patient, be elastic enough to take into account the specific conditions of a particular child and not treat all of them schematically; and how much can parents, who have the ability to understand a specific situation, be expected to conform to the rigours of factual knowledge, opposing fashions, gossip or even their own fancy?

The choice here is therefore between the capacity of the system to be personalised, and the capacity of the parents to take responsibility upon themselves.

It is worth noting however, that there is no rational basis to believe that the decisions of parents, taken on a reasonable basis, are in any way different from systemic decisions, even though based on expert knowledge. It seems therefore that the legislative effort in this domain should rather be concentrated on allowing the system – in those situations that require it – to take individualised decisions, than empowering parents with the legal tools allowing them to make discretionary decisions. By the same, education becomes more important.

The real threat then becomes solely the lack of elasticity of the system, where actions taken in the name of an incorrectly understood letter of the law, constitute a danger to the health and life of those persons whose circumstances escape the image of reality as perceived by the system.

Food safety. In many aspects, sanitary and epidemiological policy is similar to preventive vaccination policy. But it also has its own specificity, in particular when it applies to such domains of public life as for instance food production, distribution and inspection. Food production is probably the domain most susceptible to this dispute between the freedom of choice of the individual and the interests of healthcare. The question is the following: is the preservation of the culture of production, and this perfectly in line with tradition (e.g. home production of *oscypek* cheese in Podhale), compatible with the current interests of the state? Which is more important: culture and tradition or conforming to the regulations integrated with modern requirements of industrial production? Should traditional production, exempt from current standards, be allowed? Or should it be developed in such a way that not only the product becomes a legacy of a bygone era, but also its production process?

The truth is that ancient ways of producing food were adapted to the realities of that day. This being said, we should keep in mind not only the technological, industrial, social or infrastructural realities but also the communicational, logistical and organisational ones. Through which epidemiological threats, provoked by defective food, were decidedly lower (e.g. the distance between producers and consumers was different). Within this context, it would therefore seem that traditions should be strictly adapted to modern health requirements, taking into account new modes of existence and new threats to health. Let us remember that the pasteurisation of milk once led to many controversies.

Prevention. In Poland, prevention is one of the most neglected issues within healthcare. Furthermore, it is exclusively limited – entirely incorrectly – to direct factors. Meanwhile, the future health of the individual depends not only on direct physical activity for instance, but in equal measure on indirect factors such as the availability of healthy food, or the formation of adequate eating habits etc. The food industry, geared towards profit, has long been forming eating habits by manipulating portion sizes or through the availability of easily marketable, highly processed foods.

Prevention should therefore also include the sanctioning of the availability and sale of food products which are detrimental to health.

A health-promoting policy is therefore the basis, the cornerstone of a healthcare system. It should educate, show man's place within the organism of the state, teach how to maintain a capacity for life at the level necessary for man to face the challenges incumbent upon him, teach how to minimise the risks of illness and define realistic life choices for the individual.

Prevention understood this way verifies the abilities of individuals, their inclinations and the ability of the system to manage them. It classifies abilities and directs a given person to choose a role within the system. It is only citizens formed in this way who are able to fully answer the needs of the state within a given domain, selected by them according to their own choices. Professional aspirations are correlated with physical predispositions.

A wisely run prevention system therefore solves a series of problems not only within the domain of healthcare, but also allows to avoid political and worldview suggestions, as well as informing as to the possibility of achieving personal goals. Such a prophylaxis brings about social development and allows to satisfy personal aspirations.

The key to this is the ability of the system to take initiatives, in a much wider sense than derives from the form of the meeting between the individual and the system. However, this has nothing to do with an imposition of will. It is a showing of the way, the possibility of choice. A health-promoting policy should be a guide, that which introduces the citizen into the world of social relationships, and not a censor nor a guardian of the one true way.

The problem of systemic utopias. Any solutions within the domain of public health are of an objective and systemic nature, and through this are exposed to potential utopianism. The error of every utopia is the conviction that human actions can be foreseen and planned. That everyone does that which is incumbent upon them and does not meddle in the affairs of others. The belief in the predictability of human behaviour entails that man is seen as a sort of

inorganic automaton, while social phenomena are explained according to the principles of mechanics. Meanwhile, life tends towards spontaneity, which mechanics and the utopia built upon it, does not understand and even actively combats. This happens because the task set before every system (and an utopia is a type of system, be it political or a public healthcare system for instance), is the fullest possible ordering of reality. We are dealing with an utopia when a system is of a closed nature and does not allow exceptions, since it believes it is the final end-product of thought, normalising the largest possible spectrum of reality.

Utopias do not serve man, they swallow him up and use him. They direct everything towards their own power. Which is why when constructing any system relating to social problems (be it from a political, economic or health perspective), we must remember that it should be of an open nature and susceptible to reforms. The point here is precisely the elasticity mentioned earlier during our discussion on preventive vaccination policies. Public health must be a system capable of change and allowing to take decisions which have not been foreseen by any procedure. And an excess of procedures reduces common sense. While the latter is the last instance in the fight for the freedom of the individual within a system veering towards totalitarianism.

THE PUBLIC HEALTH PERSPECTIVE

Development of bioethics. Although the links between ethics and medicine and healing date back to the times of Hippocrates (460-370 BCE), Sun Simiao (581-618 CE) and Ibn Sina (aka Avicenna, 980-1037 CE), bioethics emerged only after World War II. Its development was the result of the condemnation of genocide and medical experiments performed on people during the war, as well as the rapid development of medicine, including reproductive treatments, transplants and the use of numerous modern technologies. Their use created new questions and dilemmas. Besides which, the post-war liberation movements, starting in the 1960s, raised the question of the asymmetric power relationships between institution-individual and doctor-patient. Biomedical ethics started to be developed and the summary of this tendency can be seen in the Oviedo Convention[1] and its additional protocols. Poland did not ratify this convention. [2]

[1] *Rada Europy. Konwencja o ochronie praw człowieka i godności ludzkiej wobec zastosowań biologii i medycyny: Konwencja o prawach człowieka i biomedycynie*. Komitet Ministrów, 19 listopada 1996 r. http://www.coe.int/t/dg3/healthbioethic/texts_and_documents/ETS164Polish.pdf

[2] Dharmananda S. Sun Simiao. Author of the Earliest Chinese Encyclopedia for Clinical Practice. http://www.itmonline.org/arts/sunsimiao.htm

Recent years, in particular at the end of the 1990s, brought about an interest in the ethics of public health (understood as the science and art of improving the health of human collectivities). An example could be the study on the lack of premises for the introduction of compulsory immunisation of children in Great Britain[3].

During the next decade, attempts were made to formulate ethical codes in the domains of public health, health promotion, health education and a wider discussion of ethical issues in those activities which are aimed towards the collective[4]

At the same time, the issue of the lack of bioethical reflection within the domain of public health was raised[5], as well as the urgent need for "weighing up alternatives", anticipating consequences and balancing the benefits and harms resulting from interventions by public health[6].

In 2003, the US *Association of Schools of Public Health* published a set of case studies for the analysis of the scope of action and responsibility of public health[7].

However this was appreciated, it was decided that the responsibility for the protection of human rights was not featured prominently enough[8].

Attention was also brought to the necessity of including these issues in the teaching programmes intended for public health professionals[9].

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3 Bradley P. *Should childhood immunisation be compulsory?* Journal of Medical Ethics 1999;25:330-334 http://jme.bmj.com/content/25/4/330.full.pdf+html

4 *Public Health Leadership Society. Principles of the Ethical Practice of Public Health*. 2002 http://phls.org/CMSuploads/PHLSposter-68526.pdf
Public Health Leadership Society. *Skills for the Ethical Practice of Public Health*.2004 http://phls.org/CMSuploads/Skills-for-the-Ethical-Practice-of-Public-Health-68547.pdf
Thomas JC, Sage M, Dillenberg J, Guillory VJ. *A Code of Ethics for Public Health. Am I Public Health*. 2002 July; 92(7): 1057–1059. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447186/
Coalition of National Health Education Organizations. Code of ethics for health education profession. February 2011. http://www.cnheo.org/files/coe_full_2011.pdf. Dostęp z: http://www.cnheo.org/ethics.html
Sindall C. *Does health promotion need a code of ethics?* Health Promotion International (2002);17(3):201-203. http://heapro.oxfordjournals.org/content/17/3/201.long
Petrini C, Gainotti S. *A personalist approach to public-health ethics. Bull World Health Organ*. Aug 2008; 86(8): 624–629. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2649469/

5 Krebs J. *The importance of public-health ethics.* Bull World Health Organ. Aug 2008; 86(8): 579.

6 Rothstein MA. *The Future of Public Health Ethics.* Public Health Reviews 2012, 34(1):1-2.

7 Jennings B, Kahn J, Mastroianni A. Parker LS. *Ethics and Public Health: Model Curriculum*. ASPH, July 2003. http://www.aspph.org/wp-content/uploads/2014/02/EthicsCurriculum.pdf

8 Tulchinsky TH, Flahault A. Editorial: *Why a Theme Issue on Public Health Ethics?* Public Health Reviews 2012, 34(1): 7-17. http://www.publichealthreviews.eu/upload/pdf_files/11/01_Ethics_Editorial.pdf
http://www.publichealthreviews.eu/upload/pdf_files/11/00_Rothstein.pdf

9 Tulchinsky TH, Flahault A. Editorial: *Why a Theme*… wyd. Cyt. 7-17.

Most of the references to the ethics of public health derived from experience and the belief that the health of individuals (the domain of clinical medicine) and the health of society (the domain of public health) are implicitly independent constructs[10], and therefore also require a different mode of action[11]. However, this dichotomy is sometimes questioned. It is argued that the health of the individual depends on socio-economic context and many interdependencies between the person, the environment and all of society. Therefore, this distinction between two factions of ethics is, at best, inexpedient[12].

This position, which accepts the substantial dynamics within the relationship between the health of the individual and that of the group, possesses a strong epidemiological basis. In parallel, there are those approaches to the ethics of public health which derive from theoretical philosophical foundations[13] and which emphasise precisely this relationship between the individual and the group. Here, we should mention contemporary ethical theories based on the pragmatism of Pierce and James.

Difficult choices. Within the domain of public health, and from a global perspective, particularly important ethical questions concern the following:

- Differentiation between the health situation of the population on a socio-economic basis (disparities in health), including a differentiation in access to services (e.g. lack of access for women and migrants);
- Reaction to health threats resulting from infectious diseases;
- Cooperation (including international) for the needs of monitoring diseases and managing them (e.g. IHR 2005);
- Research conditions, the risks of using people for experiments, the risks resulting from a lack of protection of personal data in medical records, overloading select populations with various studies;

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http://www.publichealthreviews.eu/upload/pdf_files/11/01_Ethics_Editorial.pdf

[10] Dawson A. Resetting the parameters. *Public health as the foundation for public health ethics*. W: Dawson A. (red.). *Public Health Ethics. Key Concepts and Issues in Policy and Practice*. Cambridge University Press, Cambridge 2011: 1-19.
http://sgh.org.sa/Portals/0/Articles/Public%20Health%20Ethics%20Key%20%20Concepts%20and%20Issues% 20in%20Policy%20and%20Practice.pdf

[11] Lee LM. *Public Health Ethics Theory: Review and Path to Convergence*. Public Health Reviews 2012, 34(1): 1-26.
http://www.publichealthreviews.eu/upload/pdf_files/11/00_Lee.pdf

[12] Onyebuchi AA. *On the relationship between individual and population health*. *Medicine, health care, and philosophy*, 2009; 12(3): 235-44.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2698967/

[13] Lee LM. *Public Health Ethics Theory*… wyd. cyt. 1-26.
http://www.publichealthreviews.eu/upload/pdf_files/11/00_Lee.pdf

- Health promotion, including compulsory health-promoting behaviour, independently of choices and personal possibilities, including "blaming the victim";
- Transparency in decision-making and the responsibility of the healthcare system for the resultant health effects[14].

Obvious dilemmas appear in these domains: what is more important, the person or the collective, the rights of the individual or the common good? Another question is equally pertinent, what is more important: the customs of national or ethnic minorities or the aspirations and views of the majority stemming from academic medicine[15]?

Thus, what are the limits of state paternalism and coercive medicine[16]?

Questions also arise for which we have no universal answers, such as what is good. For instance, when patients visit clinicians with a specific health problem, the doctors are then obliged, both legally and ethically, to provide them with the best possible medical care. However, they are not obligated to guarantee the success of this correct procedure. Yet the situation of a healthy person, not asking for help, that is supposed to be a participant in a mass screening is entirely different. In that case, the doctor has a duty to demonstrate that the benefits of taking part in such a study outweigh any possible detrimental health effects (unnecessary further diagnostics and treatment) as well as other losses (time, money, fear and effect on social ties). The principle of weighing benefits and harms in screening studies forms the basis for the recommendation for implementing them. The latest example of this are studies on mass mammography screening[17].

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[14] Coleman CH, Marie-Charlotte Bouësseau M-C, Reis A. *The contribution of ethics to public health*. Bulletin of the World Health Organization 2008, 86 (8): 578-9.
http://www.who.int/bulletin/volumes/86/8/08-055954.pdf
Coleman CH, Marie-Charlotte Bouësseau M-C, Reis A. *The contribution of ethics to public health*. Public Health Reviews 2012, 34(1):1-4.
http://www.publichealthreviews.eu/upload/pdf_files/11/00_Coleman.pdf
Kass NE. *An Ethics Framework for Public Health. Am I Public Health*. 2001 November; 91(11): 1776–1782.
Całość: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446875/

[15] Razum O, Stronks K. *The health of migrants and ethnic minorities in Europe: where do we go from here? Am I Public Health* 2014, 24 (5): 701-702.

[16] Erika Blacksher. *Public Health Ethics. Ethics in medicine*. University of Washington School of Medicine 2014.
http://depts.washington.edu/bioethx/topics/public.html
Skrabanek P. *The death of human medicine and the rise of coercive healthism*. The Social Affairs Unit 1994.
https://bradtaylor.files.wordpress.com/2009/06/death-of-humane-medicine.pdf

[17] Woloshin S; Schwartz LM. *The Benefits and Harms of Mammography Screening: Understanding the Trade-offs*. JAMA. 2010;303(2):164-165.
http://weinsteinimaging.net/userfiles/The%20Benefits%20and%20Harms%20of%20mammography%20Screening.pdf

It would currently seem that the best solutions have been devised within the domain of health-related scientific research which is carried out among people and with their participation[18].

Education. In various countries, there are different principles relating to the duty to submit to preventive vaccination and in the US for instance, it is possible to be exempted from vaccination not only on the basis of medical contraindications, but also also due to philosophical or religious convictions. With the caveat however that the practical obtention of such an exemption can be extremely variable[19].

With the whole spectrum of diverse positions on mandatory vaccination, the literature underlines the role of education and voluntary vaccination but also that of mandatory vaccination in situations of epidemiological threats[20].

In Poland currently, anti-vaccination movements evoke the most emotional response among public health professionals. Opponents of vaccination raise various arguments (post-immunisation side-effects, neurotoxicity of thiomersal, overloading of the child's immune system, lack of epidemiological threats, freedom of the individual) while public health professionals attempt to correct views which they hold to be retrograde or harmful[21].

Marmot MG, Altman DG, Cameron DA, Dewar JA, Thompson SG, Wilcox M. *The Independent UK Panel on Breast Cancer Screening. The benefits and harms of breast cancer screening: an independent review. A report jointly commissioned by Cancer Research UK and the Department of Health (England)* October 2012. British Journal of Cancer 2013, 108, 2205–2240.
http://www.nature.com/bjc/journal/v108/n11/full/bjc2013177a.html

18 *World Health Organization. Standards and Operational Guidance for Ethics Review of Health-Related Research with Human Participants*. WHO, Geneva 2011.
http://whqlibdoc.who.int/publications/2011/9789241502948_eng.pdf?ua=1

19 Malone KM, Hinman AR. *Vaccination mandates: the public health imperative and individual rights*, in: Goodman RA, Rothstein M, Hoffman RE, Lopez W, Matthews GW, Foster K. *Law in public health practice*. Oxfrod University Press, New York 2003: 262-284.
http://www.cdc.gov/vaccines/imz-managers/guides-pubs/downloads/vacc_mandates_chptr13.pdf

20 Moodley K, Hardie K, Selgelid MJ, Waldman RJ, Strebel P, Rees H, Durrheim DN. *Ethical considerations for vaccination programmes in acute humanitarian emergencies*. Bulletin of the World Health Organization 2013;91:290-297
http://www.who.int/bulletin/volumes/91/4/12-113480.pdf
http://www.who.int/bulletin/volumes/91/4/12-113480/en/
Isaacs D, Kilham H, Leask J, Tobin B. *Ethical issues in immunisation*. Vaccine.2009, 27(5):615-8.
Abstract: http://www.ncbi.nlm.nih.gov/pubmed/19026706
El Amin AN, Parra MT, Farley RK, Fielding JE. *Ethical Issues Concerning Vaccination Requirements Public Health Reviews* 2012, Vol. 34 (1): 1-20.
http://www.publichealthreviews.eu/upload/pdf_files/11/00_El_Amin.pdf

21 Magdzik W, Zieliński A. *Szczepienia przeciwko wirusowemu zapaleniu wątroby typu B a domniemany związek z występowaniem stwardnienia rozsianego*. Przegląd Epidemiologiczny 2005, 59(1): 11-19.
http://www.pzh.gov.pl/przeglad_epimed/59-1/591_03.pdf
Oświadczenie Narodowego Instytutu Zdrowia Publicznego - Państwowego Zakładu Higieny na temat bezpieczeństwa szczepionek i szczepień. Przegląd Epidemiologiczny 2010, 64(1): 105-107.
http://www.pzh.gov.pl/przeglad_epimed/2010/Przeglad_PZH_1-2010.pdf
Bucholc B, Górska P, Janaszek-Seydlitz W. *Liczba wykonanych szczepień a układ odpornościowy*. Przegląd Epidemiologiczny 2011, 65(4): 629 – 634.

Within this dialogue, health professionals are on the defensive, despite an intensive educational programme called *"Zaszczep w sobie chęć zaszczepienia"* (Inoculate a desire for inoculation). Scientific articles on the harmfulness of vaccines[22], as well as the amendment of the law on infectious diseases, which states that persons residing on Polish territory are obliged to subject themselves to mandatory preventive vaccinations, per the principles defined in the law (Art. 5 par. 1), add oil to the fire[23].

Meanwhile parents, and not only in Poland, are faced with a difficult decision, to vaccinate their children or not, and expect a factual discussion on the subject of vaccination[24].

It should be noted, that while preventive vaccinations can (very rarely) provoke side-effects, they have without any doubt provoked a radical reduction in the incidence of those infectious diseases they were introduced to combat. In the case of smallpox, they have allowed to eradicate it. Community immunity works in the favour of those who have not been vaccinated and immunised: the less persons are sick (because vaccinated), the lower the risk of transmission to healthy persons. In effect currently, the risk of infection is lower than it has ever been, while the risk of post-vaccination side-effects remains the same. In summary, the general population has less contact with the illness, but can exaggeratedly perceive the negative side-effects of vaccination[25].

In such a situation, current means of persuading and educating parents fail, since they are based mostly on an insistence on the negative effects for the child exposed to a given illness and emphasis on the possibility of avoiding them through vaccination. Most of the communications aimed at parents until now have relied on the acceptance of a health belief model. In its initial version in the 1950s, it took into account four basic factors in the acceptance of health-promoting behaviour: (a) perception of personal susceptibility to a given illness, (b) perception of the gravity of the illness, (c) perception of benefits from the

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http://www.pzh.gov.pl/przeglad_epimed/65/Przeg_epidem_4-2011.pdf

[22] Sienkiewicz D, Kułak W. *Powikłania neurologiczne po szczepieniach.* Klinika Pediatryczna 2010, 18(1): 60-64.
http://zdrowedzieci.blox.pl/resource/dr_Sienkiewicz__Powiklania_neurologiczne_po_szczepieniach.pdf

[23] *Obwieszczenie Marszałka Sejmu Rzeczypospolitej Polskiej z dnia 19 kwietnia 2013 r. w sprawie ogłoszenia jednolitego tekstu of the act of o zapobieganiu oraz zwalczaniu zakażeń i chorób zakaźnych u ludzi.* Dz. U. 2013 poz. 947.
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[24] Gawlik K, Woś H, Waksmańska W, Łukasik R. *Opinie rodziców na temat szczepień ochronnych u dzieci.* Medycyna Ogólna i Nauki o Zdrowiu, 2014, Tom 20, Nr 4, 360–364.
file:///C:/Users/Dorota/Downloads/fulltext496.pdf
Evans M, Stoddart H,Condon L,Freeman E, Grizzell M, R Mullen R. *Parents' perspectives on the MMR immunisation: a focus group study*. Br J Gen Pract. Nov 2001; 51(472): 904–910.

[25] King S. *Vaccination policies: individual rights v community health*. BMJ. Dec 4, 1999; 319(7223): 1448–1449.
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1117187/

prescribed behaviour (d) perception of obstacles to implementing prescribed behaviour. In later years, additional factors were added: (e) incentives for action, (f) sense of own effectiveness[26].

Currently, preventive vaccination programmes for children are the victims of their own success and confirm the paradox of prevention described by Rose[27].

Motivating factors, such as susceptibility, gravity and benefits (a, b, c) have completely lost their meaning and unnaturally exaggerated the question of obstacles, that is the unfavourable balance of beneficial and detrimental effects, including side-effects. In such a situation, it is necessary to employ different theories of behaviour modification, in particular those deriving from interpersonal theories. The theory of planned behaviour is particularly promising, as is the concept of subjective norms, that is the normative beliefs in what other persons of importance to the individual think[28].

The increase in flu vaccination coverage among medical professionals in Poland, also recommended in other countries[29], requires a much better examination of the reasons for the failure of this programme[30].

CONCLUSION

Interests and conditions. The freedom of man and the freedom of the citizen are two entirely different domains. By nature, man is created for freedom, yet he does not possess the ability to effectively provide himself with a feeling of security. Man is therefore forced to

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[26] Rimer BK, Glanz K. *Theory at a glance. A guide for health promotion practice.* National cancer Institute. US Department of health and Human Services. 2005.
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negotiate, and in exchange for the abandonment of certain rights to freedom, receives a guarantee of relative peace. In order to enforce its obligations, the state is sometimes forced, in the name of the public good, to enforce pro-social actions. The issue discussed here is therefore reduced to the following: is the domain of public health one of those which should remain under the complete, or merely partial, control of the state (such as defence for instance), or should it remain open to the rights and demands of citizens?

The conclusion seems to be the following: the public health perspective is a social one and there is therefore little room for a wide-ranging dialogue with the individual. On the other hand, the system cannot close itself entirely to the reactions of society, it is supposed to serve man, and not its own ideals. It must therefore possess the capacity to not lose sight of people and their problems, so often escaping any prognoses and expectations, within the process of enacting public health policy. The system must learn!

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