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The ethical commitments of health promotion practitioners: an empirical study from New South Wales, Australia

Describing the good in health promotion

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ABSTRACT

In this article, we provide a description of the good in health promotion. This description comes from an empirical study of health promotion practices in New South Wales, the most populous state in Australia. Through analysis of interviews and observations, we found that practitioners were unified by a vision of the good in health promotion that had substantive and procedural dimensions. Substantively, the good in health promotion was teleological: the good inhered in meliorism, an intention to promote health, which was understood holistically and situated in places and environments, a commitment to primary rather than secondary prevention, and engagement with communities more than individuals. Procedurally, the good in health promotion arose from qualities of practices: that they developed over time in respectful relationships, were flexible and responsive to communities, built capabilities in communities, and were sustainable. We discuss our findings with reference to Martha Nussbaum's normative list of functional capabilities for a good human life, David Buchanan's vision for health promotion ethics, and common concerns in health promotion ethics regarding the relationship between paternalism and freedom. Our thick, vague conception of the good in health promotion, founded in the values and practical reason of people engaged daily in health promotion work, makes an important contribution to the development of a more complete theory of health promotion ethics.

INTRODUCTION

Although the public health ethics literature has expanded rapidly in the last decade, only a small proportion of this work has focused on the ethics of health promotion. It is reasonable to expect that a distinct ethics of health promotion might be useful and necessary, given that health promotion is often distinguished from, and seen as a subset of, public health practice. Public health, the broader category, includes a wide range of disease prevention, health protection and health promotion activities; within this, health promotion is defined as 'the process of enabling people to increase control over, and to improve, their health,' (First International Conference on Health Promotion 1986). One significant contribution to health promotion ethics has been the work of David Buchanan, whose writing develops a broad vision for health promotion based on a teleological ethic (Buchanan 2000).[1] Buchanan argues that health promotion practitioners require practical reason and that revitalisation of civic engagement is needed for health promotion to flourish. For Buchanan, the ultimate purpose of health promotion is the development of a broad, eudaimonic form of wellbeing in citizens.[2] This wellbeing is a multidimensional virtue that can be achieved only within just social arrangements, focused on 'living one's life in accordance with values that matter' (Buchanan 2000 p103). Although other contributions to health promotion ethics have been less explicitly teleological than Buchanan, the issue of defining health has been central, as reflected in the call for papers for this issue. There has also been considerable exploration of potential tensions between paternalism or coercion and freedom or liberty in health promotion (Bayer and Moreno 1986; Jones and Bayer 2007 ; Jennings et al. 2003; Nilstun 1994), ongoing debate between practitioners regarding values in health promotion, and some advocacy by practitioners for the importance and value of ethics (e.g. Sindall 2002; Tannahill 2008; Views on health promotion online 2008).

As Buchanan's analysis makes clear, health promotion is a practice. This is reinforced by iconic statements like the Ottawa Charter (First International Conference on Health Promotion 1986) and in the health promotion literature, which has a strong practice focus (e.g. *Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals* 1990ff). This practice orientation in health promotion motivated the contribution we make in this article. Believing that any theorising about health promotion must remain rooted in practice, we approached health promotion ethics via a qualitative empirical study of the work of health promotion practitioners in New South Wales, the most populous state in Australia. We used qualitative methods because they allow us to develop detailed,

emic understandings of the perspectives of social actors, the meanings they share, and the social processes they are engaged in; this provides a sound basis for moral evaluation (Flyvbjerg 2001; Frith 2012). We collected data about health promotion in general and especially about the prevention of overweight and obesity. We had two main goals: first to develop a detailed empirical account of health promotion practice, particularly the values and ethical commitments of health promotion practitioners; and second to use this knowledge to extend existing theories of health promotion ethics.

Through our initial inductive analysis of the resulting empirical data, we concluded that health promotion practitioners were largely unified by a vision of the good in health promotion: we thus use this article to extend theorisation of the good in health promotion. We will situate this analysis in theories developed by Martha Nussbaum and David Buchanan. We seek to bring together the practical reason of health promotion workers – not often heard in the ethics literature – with concepts from ethical theory – which do not often appear in the health promotion literature – and thus to extend the theory of health promotion ethics.

METHODS

This study is part of a larger project which critically examined the nature and role of values, ethics and evidence in current health promotion interventions in New South Wales, Australia. We particularly focused on interventions in overweight and obesity because this issue dominates health promotion policy and funding in Australia at time of writing. The study methodology combined grounded theory (Charmaz 2006) and ethnography (Hammersley and Atkinson 2007). We selected three regions as research sites. These varied in levels of urbanisation, socioeconomic status and degree of research activity. The regions were defined using the borders of the corresponding health administration jurisdictions. The largest of these was approximately 60,000 km^2 and each contained several health promotion teams spread across urban centres and regional towns.

We conducted 58 semi-structured interviews with 54 participants. All practitioners who were implementing or overseeing overweight and obesity related health promotion activities were invited to participate; most agreed. The practitioner-participants came from diverse levels of experience and/or seniority (ranging from 6 months to over 30 years), roles including research & evaluation, media & communications, and project implementation, and responsibilities including junior project officers, senior management and unit directors. Per site, 20, 21 and 13 practitioners respectively participated; interviews lasted from 30 to 150 minutes. We kept the introductory interview questions as broad as possible; interviews gradually became more focused on the informant's core values, moral intuitions and ethical reasoning. The interview questions were revised twice as the study progressed. The relevant questions from the final interview route are presented in Box 1. Both interviewers had training or experience in public health or health promotion. Interviewers focused on encouraging lengthy explanations and probing meaning. Interviews occurred in the participants' workplaces, and during work hours so it is possible that participants may sometimes have felt constrained either by time or the location, although there was little evidence of this in the data. Interviews were transcribed verbatim by a professional transcriber. We also engaged in participant and non-participant observation and collected relevant organisational program and policy documents: these data complemented and contextualised the interviews. Data collection commenced in May 2010 and was completed in June 2011.

Box 1: Sections of the interview route relevant to this analysis

Introductory questions:

Can you please tell me the story of your career so far?

What have been the best things in your career in health promotion?

What have been the worst things in your career in health promotion?

What has been the most rewarding project? What has made it rewarding?

What has been the most frustrating project? What has made it frustrating?

What values drive you personally in health promotion? [Probe if difficult: What really matters to you as a health promotion professional?]

Values in overweight and obesity prevention:

If you made the decisions, what kinds of programs would you develop and fund in overweight and obesity prevention? [Probe: What is it about those programs?]

Are there programs that you wouldn't fund? [Probe: What is it about those programs?]

What effect has the increased focus on overweight and obesity had on your work? [Probe: What effect has it had on health promotion resources?] [Note: adjust question depending on participants' seniority to ask instead about their team's work or the work of health promotion in the Area Health Service]

Ethics:

Do you think there are right and wrong ways to do health promotion? [Probe: how did you come to that point of view?]

Have there been times when colleagues have disagreed about what was the right or wrong thing to do? [Probes: what was it about that issue? why did people feel so strongly about it?]

Finishing questions:

If you had the freedom to determine the role of a health promotion service, what should it do? [Probe: what is it about those ideas / directions that is important?]

You've been in health promotion for x years. [For experienced people:] What's kept you there? [For less experienced people:] Do you think you will stay? What guides your intentions?

In an ideal world, what would the next 10 years of your career in health promotion look like? How would you like them to look?

We commenced data analysis soon after interviewing began. Early inductive data analysis involved detailed coding, extensive memo writing and team discussion; later analysis became more focused, combining codes, exploring relationships and developing analytic categories (Charmaz, 2006a). We were not seeking to replicate any specific ethical theory, although we were sensitised to existing theories. The central categories presented in our analysis were developed from the data rather than being imposed. When these categories had been developed and related to one another, we observed an unexpected resonance between them and the list of basic human functional capabilities proposed by

Martha Nussbaum (Nussbaum 1999). This led us, in our normative deliberations, to compare our findings not only with the existing health promotion ethics literature but also with Nussbaum's analysis.

Ethics approvals were obtained from the Sydney South West Area Health Service Human Research Ethics Committee under the Model for Single Ethical and Scientific Review of Multi-Centre Research; student involvement was ratified by the Human Research Ethics Committee of the University of Sydney. All participants gave individual consent to be interviewed or observed; unit managers consented to release documents. All participants were free to withdraw from the study or parts of it at any time. All data used has been de-identified by replacing names with alphanumeric codes.

FINDINGS

Participants shared a multi-dimensional definition of the good. While participants did not engage in an explicit discussion of 'the good' in health promotion, notions of the good ran through all of the evaluative accounts provided.

This description of the good had two dimensions: a substantive dimension, which was teleological, and a procedural dimension which described qualities of practices. Substantively, health promotion practitioners valued actions that were melioristic, that sought to improve health, defined holistically and positively, that were intended to prevent disease from developing in healthy people rather than reducing risk in already at-risk or sick people, and that engaged more at a collective than an individual level. Procedurally, health promotion practitioners thought that the good in practice came from a particular kind of relationship-building, which was responsive, capability enhancing, developed over a long time, and oriented to sustainability. These dimensions of the good are summarised in Figure 1.

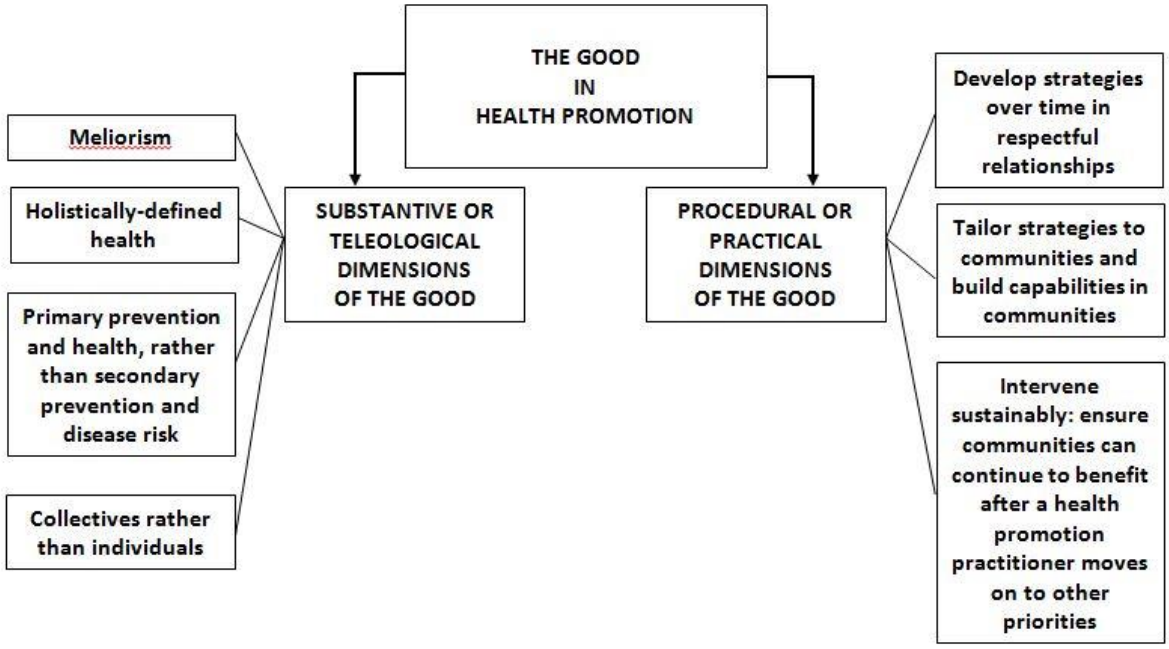

FIGURE 1: Dimensions of the 'good' in Health Promotion Practice

SUBSTANTIVE DIMENSIONS OF THE GOOD IN HEALTH PROMOTION

Meliorism as a teleological good

Health promotion practitioners valued melioristic goals: that is, they thought it was good to be committed to making the world a better place through human effort. Practitioners were dedicated to 'making a difference,' a phrase used frequently in interviews, and expressed a desire to initiate, drive and facilitate change 'for the better.' Participants understood themselves to be members of a group with common values, who were altruistically, and often at some personal cost, drawn to a career that offered the satisfaction of contributing to change.

… there's probably a sense of wanting to make a big difference and wanting to be part of something big […] most people come into [health promotion] with this understanding, the idea that we can really make a big difference to the population in a good way, in the long term. B8 841-869

...people that work in health promotion want to change things for the better... [to] change ... the health of the population that we work with and that's why people work here. It's not for the money. Most people that work in health promotion could probably get jobs elsewhere with ... a lot more money. But people really believe in what they do... A15 653

A holistic conceptualisation of health as a teleological good

Most participants said that health promotion should aim to achieve health, defined holistically. Thus, a holistic conception of health was part of the good in health promotion. Health was conceptualised holistically in two senses. First: most participants emphasised that people were embedded in social environments and places, and needed to be understood in those contexts. Defining health in this way supported broad goals such as decreasing social and economic inequity, working on root causes of ill health in places or social contexts, or improving the social determinants of health, rather than narrow, biomedically defined goals:

'the holistic nature of health promotion in terms of the holistic view of health ... that health is not just about the absence of disease ...It's so clichéd, I know, but the whole social determinants thing and the way that all that contributes to health ... [there is a]... shared vision that people in health promotion seem to have about that.' C11 68

Definitions of health were also holistic in a second sense: for many participants, health was not just physical, but to do with the whole person – particularly the emotions – which for some participants produced a responsibility to care:

For me health promotion is helping and supporting people, to be able to look at the sorts of things that [are] within their control and power to do for themselves in terms of their health. It's about maintaining wellbeing ... certainly not only physical wellbeing but mental and psychological wellbeing. It involves, for me, as a practitioner ... trying to set up supports and strategies that can facilitate or enable the community to do that. B2 504

Primary prevention as a teleological good

A standard distinction in public health is between primary prevention, which aims to prevent the onset of disease, and secondary prevention, which occurs after disease has commenced but aims to minimize resulting morbidity or illness, generally through early detection and management. This distinction was important to participants, who saw a commitment to prevention rather than cure, and

primary rather than secondary prevention, as goods in health promotion. While health promotion practitioners may sometimes be expected to undertake secondary prevention, most participants thought this should not be their role:

[Health promotion is] more about the proactive and the preventing illness and injury and that sort of thing rather than fixing it up at the end. B16 867-9

..[my] interest in health promotion developed because I thought primary was better than secondary. So let's start even earlier. C11 12

You don't try and treat overweight people and get them to lose weight; you treat people before they get overweight. C1 1300-1304

Participants were not opposed to secondary prevention. Rather, they did not see secondary prevention as part of what was good in health promotion. In fact, secondary prevention was sometimes characterised as a distraction from 'real' health promotion – as misdirection of the scarce resources available for primary prevention and loss of a fundamental good:

I actually think [health promotion] is so worthwhile and can have a big impact and I would hate to see anything happen to make it any less valuable or important than it is now. ...We keep talking about it but prevention... all the money goes into all the whoopee doopee machines, when people have got something, but prevention, if you prevented the problems as much as you can, in the first place, we wouldn't need all that money going into the health dollar. B10 1802

We have a very clear commitment to primary prevention, and any time we've been asked as a health promotion service to get engaged around secondary or treatment programs […] I don't want to be distracted by that. It muddies the water. As soon as we start dabbling in treatment we've lost our focus of what we want to be, which is physical activity, healthy eating, broad environmental support. A1 1080-5

There was some concern amongst the workforce that there was growing pressure for health promotion practitioners to engage in secondary prevention, particularly regarding overweight and obesity. Some participants worried that because overweight and obese people – by some definitions at least – already had a disease, being required to focus on overweight and obesity diverted health promotion resources from primary to secondary prevention. Others were more comfortable with a health promotion focus on preventing overweight and obesity if the strategies addressed root causes such as available opportunities to eat well and to be physically active, not only individual knowledge and behaviours.

Practitioners' evaluations of the place of primary versus secondary prevention in health promotion were clearly moral evaluations. An emphasis on secondary prevention was contrary to the essence of health promotion; it both undermined the good in health promotion and risked negative consequences. It undermined the good through:

1. A focus on biomedical goals (i.e. disease reduction) rather than health promotion goals (i.e. increasing health in the community);
2. Being reactive or curative (when it should be proactive and preventive);
3. Taking negative goals such as 'reducing overweight and obesity' instead of positive goals such as 'increase healthy weight' or 'increase healthy eating';
4. Excluding those without identified risk factors, when health promotion should be for everyone;
5. Ignoring social context and failing to confront root causes; and
6. Being unresponsive to the self-identified needs of communities.

An emphasis on secondary prevention in health promotion would also have morally problematic consequences:

1. misdirection of the limited resources available for primary prevention;

2. negative community self-understanding because of negative goal or problem framing;
3. missed opportunities for positive health improvement, especially in people who are deemed 'low risk';
4. greater victim blaming; and
5. specific harms of interventions – for example, a focus on overweight may encourage anorexia.

The 2 or 300 people that are exposed to [secondary prevention programs] will benefit hugely, but it won't do much for the rest of us. A3a 332-336

...the narrower view that the health department would like to focus on, that's driven by hospital costs. What are people coming into hospital for and taking up beds that cost us $3,000 a day? Oh they've fallen, they're smoking, they're obese and overweight [...] it seems to me that health promotion is being used in the last 10 years to more or less reduce hospital costs rather than necessarily focus on priorities for communities. C8 744-5

Despite the majority of practitioners arguing that positive primary prevention was essential to the good in health promotion, many acknowledged that framing problems in disease prevention terms was more attractive to politicians and decision-makers and more likely to be funded. This sometimes resulted in a perceived strategic need to communicate in this language with partner agencies, powerful clinicians and funders.

The collective as a teleological good

Participants generally believed that health promotion action should engage at a collective more than an individual level: that is, that it should engage with communities or populations. This community focus signified a distinctive way of conceptualising individuals: as embedded in social, geographic and institutional environments and relationships, consistent with the holistic definition of health discussed earlier. Communities contained identifiable people, located in identifiable local places and contexts. This was – at least in part – a matter of scale: communities were conceptualised at a scale which allowed practitioners to identify the beneficiaries of their work. Communities were generally seen as the best informants about their own needs and working with communities provided job satisfaction for practitioners, many of whom found grass-roots work and having a local impact especially enjoyable:

I think [health promotion as a whole has] lost a little bit of those local connections, I actually would have to say that. But I haven't. I feel that that's the only way that you can work with communities, is actually connect at the local levels. And so I've stubbornly fought and stayed involved in a lot of things... A16 70

I enjoyed doing that sort of grass roots community work... they've been among the most ... satisfying sorts of work. C8 301

PROCEDURAL DIMENSIONS OF THE GOOD IN HEALTH PROMOTION

The good in health promotion did not inhere only in the substance and purpose of health promotion – its goals, objectives and working concepts. The good also inhered in the process or practice of health promotion: developing a particular kind of relationship, being responsive to communities and building their capabilities, taking time, and working sustainably, so that when the practitioner withdrew from a program, the community would still be able to experience its benefits. We note that these procedural goods had both instrumental and intrinsic value. They were instrumentally valued because by acting in this way, substantive goods would be more likely to be achieved (particularly, actions would be more effective in delivering improvement in health, defined holistically, at a community level). However these procedural goods also had intrinsic moral value.

Developing respectful relationships over time as a procedural good

A particular kind of relationship was a good in health promotion. Relationship-building was *intrinsically* valued as an expression of interest and care and *instrumentally* valued for creating relevant, useful, acceptable, feasible and interactive programs and making a difference in people's lives. These good relationships required being present in the community – described by one participant as '*professional loitering.'* This involved listening and learning from people, developing understanding, trust and credibility, being open-minded and learning from mistakes. There was sometimes tension over the resources that should be devoted to such generalised relationship-building – in particular, this sometimes conflicted with the goals of politicians, funders and agenda-setters in the bureaucratic hierarchy. However it was seen as critical by many practitioners, particularly when communities were especially vulnerable.

...that's actually being respectful, taking cue from learning, walking alongside, letting them lead, you leading a bit. That sort of relationship stuff that's really important, where's that written in a plan? ... who am I to decide what works for a community that I have really no understanding [of]? ... It's about actually involving the community in the decision-making. It's not that difficult. It's difficult because it requires process. It's difficult because it requires investment, respectful dialogue, conversation, engagement around various means, and you can't talk to everybody. …It's about taking on board the right way to do things so you actually involve and inform the group ... that you're supposed to be working with. A16 389-391/1249-53

So it's only when you actually sit next to people in the community, and talk to them and hear what it's like for them, do you really start to understand some of the issues around people's view of themselves, and their health, and the world that they live in. A1 385-388

The good of relationship-building was time consuming; practitioners got to know communities over years, and committed to long-term goals. Time was needed because of the complex systemic nature of health promotion. It took time to build trust and form partnerships, shift social norms, address social determinants of health or coordinate the agendas of multiple and diverse stakeholders. This long time commitment contributed to the conflicts over relationship-building already described. It could also make it difficult to produce evidence of the value of health promotion, because – in contrast with clinical work – health promotion goals could take many years to achieve:

...I guess the other frustrating thing is really short term funded projects. So projects that go for 6 weeks and you're expected to make changes in peoples' health behaviours. It's just madness; it's just a huge waste of money... you can't just run in and do something and then run away again. C1 203-210

...sometimes it takes five years to get a project sustainable; it can take up to 10 years. Whereas it's always like, 'Okay, you've got a year to do this.' The timeframes are unrealistic... A7 508-10

Tailoring intervention to particular communities and building the capabilities of those communities as a procedural good

We have already noted that conceiving of persons as existing in social contexts and focusing on the collective were teleological goods. There was a parallel procedural good: being responsive to the specifics of communities, and focusing on developing capabilities in community members. This had instrumental value – it ensured effective communication – and intrinsic value, as a form of respect, truthfulness, care and reciprocity. This responsiveness and capability-building was predicated on the quality of relationships already discussed. It involved recognising the existing strengths of communities and individuals, increasing transferable skills, and enabling communities to solve self-defined problems and to develop and evolve in their own way by building on their own strengths. It was good to make participation in health enhancing activities attractive and easy, and to understand that there were many

competing priorities in human lives. This flexibility also made health promotion work rewarding and interesting for practitioners.

People participating in a process and managing it themselves; those things are critical. A3a 152-3

So I think it's very good for a health promotion worker ... to be flexible and change quickly towards the people's needs... I don't like personally the top-down [approaches], which many traditional health services follow, like, we understand better, we are the experts – bullshit, you are not. The grass roots up is the better way of working, this is what Ottawa Charter says, this is what the Jakarta Charter says, we know that they say all that. ... best practice means you have to be open, to listen to people, what's the best way to work for them. How ... could they improve their lives ... only they can tell you that … [only] they can improve their lifestyle, not us ... you sit back and give the credit to the people. Because they do this, it's about their lives; it's about their health, about their stories. A18 247, 272-3, 437-8, 1012, 1042

As a result of this flexible, capability-building way of working, health promotion could achieve a range of benefits for participating communities: increased opportunities to live healthy lives, changed social norms, enhanced local environments and improved socio-economic conditions, increased resilience, independence, dignity and skills, heightened awareness of the underlying causes of ill-health or barriers to good health, and increased opportunities for communities to act to achieve their own wellbeing.

Sustainability as a procedural good

Finally – with the exception of people whose roles included clinical as well as health promotion responsibilities – most participants said working sustainably was an important good. When a practitioner eventually left a program, the community concerned should still experience the benefits of that program. This expressed the logical consequence of building capabilities and focusing on communities. After a certain period of time, a health promotion program should have developed community capabilities such that community members could take full ownership of the work and the practitioner's role would become less central:

… then we can have all these projects running that are hopefully more sustainable because they are run by local people for local people, with our guidance. So the investment isn't that great, but the outcome is amazing... C6 242-4

'And I guess the other big difference is that we didn't go into preschools doing it to preschools, we went into preschools and formed management teams, which was a staff member, a parent, and a health person. So the three of us together […] would decide on the strategies and how it was going to work, so there would be some sustainability. So when health pulled out there was still this project management team who'd keep the program on after a year. And we've just done some research on the sustainability of that; we've gone back after two and three years and […] most of the strategies are still happening.' C1 399-409

DISCUSSION

We found that health promotion practitioners shared a multidimensional understanding of the good in health promotion practice. This included both substantive, teleological dimensions, reflected in how the goals and objectives of health promotion were defined, and procedural dimensions, related to the way that health promotion strategies were carried out. We begin by reflecting on our description of the good in health promotion.

First, a particular 'holistic' conception of health – that is, health as physical, social and emotional and embedded in environments – was central to practitioners' definitions of the good. As discussed, in the health promotion ethics literature there has been a tendency to focus on improved health as the main good offered by health promotion, and thus to focus on defining health. These practitioners certainly valued holistically-conceptualised health as a central good in health promotion. But their definition of the good included several other substantive and procedural dimensions. This both demonstrates the potential usefulness of a teleological approach for practitioners and expands the scope of the good that inheres in health promotion beyond health alone.

Second, the good inhered in communities, rather than individuals. This suggests the potential to extend recent work regarding the importance of concepts of community in public health ethics to our thinking about health promotion ethics (Hunter and Leveridge 2011). Third, practitioners strongly valued primary prevention over secondary prevention and gave a series of both categorical and consequentialist reasons for this value. This suggests a need for future investigation of the validity and the moral significance of the distinction between primary and secondary prevention in an ethic of health promotion. Fourth, practitioners were strongly committed to meliorism, and saw themselves as part of a progressive societal project. Some forms of meliorism can be readily criticised for naiveté regarding the possibility of progress, or for imposing the values of dominant cultural groups onto less dominant groups. However the melioristic commitments of these practitioners need to be understood in relation to their equally strong commitments to processes that were just and inclusive. These practitioners explicitly spoke against forcing change onto vulnerable citizens, and they valued community self-determination. Good health promotion was seen as relational, responsive and capability-building, thus allowing the practitioner to become less important in a program over time.

These findings have particular resonance with Martha Nussbaum's empirically derived, normative list of central human functional capabilities (Nussbaum 1990, 1999, 1993). Nussbaum's work contributes to the capabilities approach in moral and political philosophy. This approach builds on a liberal foundation, and thus foregrounds the moral importance of freedom. However capabilities scholars value a particular kind of freedom – the freedom to achieve wellbeing – and understand this freedom in terms of capabilities. Capabilities are opportunities for people to be and to do what they themselves value (Robeyns 2005). In this approach, having access to such opportunities – that is, possessing capabilities – is the most important freedom. These moral claims have been applied theoretically in various ways, particularly to argue in support of development and against oppression.

One of Nussbaum's major contributions to the capabilities approach has been a list of central human functional capabilities. These are the opportunities that she argues are necessary for a good human life. These are the opportunity for: life, bodily health, bodily integrity, senses, imagination and thought, emotions, practical reason, affiliation, living with concern for other species, play and control over one's environment (Nussbaum 1999). A key difference between Martha Nussbaum and her close colleague Amyarta Sen is that Sen pursues an even more radically underspecified notion of the good, resisting even listing the broad categories in which people should be able to pursue what they value (Sen and Nussbaum 1993).

Nussbaum and Sen are both committed to liberalism and development, but Nussbaum argues that this is best pursued by agreement on a 'human core' of goods that all people should have access to. Her list, developed empirically, is not offered as a prescriptive ideal. Rather, it is a 'thick vague notion of the good' (Nussbaum 1990), that is, it is rich, comprehensive and empirically founded ('thick'), but is open enough to allow it to be specified in particular local contexts ('vague'). Nussbaum's intention in producing the list is at least partly political: to create a locus for consensus between people from widely different cultures about what is needed to pursue a good human life, and thus to assert a moral claim to at least a threshold of opportunity for all people (Nussbaum 1999). We see parallels between Nussbaum's list and the list developed in our project.

First, our list was also empirically derived, and also leaves considerable room for local specification.[3] Second, some key commitments of capabilities scholars parallel the commitments of the practitioners who participated in this study. Most obviously, practitioners talked about building the capabilities of community members, facilitating opportunities for them to enhance their health, very broadly defined. Practitioners were also melioristic, similar to the valuing of human development that has been important in the capabilities approach. Third, there are overlaps between the content of our list and Nussbaum's list. The substantive goods of primary prevention and a holistic, situated conceptualisation of health resonate with Nussbaum's listing of life, bodily health, bodily integrity and emotions as central capabilities. The procedural goods of respectful relationship-building and the support of skill development and independent health improvement resonate with Nussbaum's inclusion of practical reason – being able to form a conception of the good and plan one's own life based on critical reflection – and affiliation – being able to live in relationship and social contact with others – as central capabilities.

This said, there are differences between the two lists, most obviously that Nussbaum's is a list of the goods that make a human life worth living, while the list we have generated is of the good in health promotion. This difference can be usefully considered via the issue of moral obligation in the capabilities approach. Both Nussbaum and Sen assume that there is a moral obligation to ensure that people have access to capabilities. However these obligations are underspecified theoretically, including in relation to whose obligations they might be (Robeyns 2005; Sen and Nussbaum 1993). It is beyond the scope of this paper to attempt to theorise these obligations directly. We note, however, that Nussbaum intends her list of capabilities to offer 'real guidance to policymakers, and far more accurate guidance than that offered by the focus on utility, or even on resources' (Nussbaum 1999 p 14-15). This implies that policymakers ought to provide opportunities to develop these capabilities. Health promotion, particularly when publicly funded, is one means by which public policy could meet this underspecified obligation to support capabilities. The practitioners in this study, like all health promotion practitioners, were obliged to 'promote health' by virtue of their employment. The key issue this raises for theory and practice is: what does this obligation entail? We propose that the normative assessment developed here is a first attempt at a 'thick, vague notion' of both substantive and procedural good in health promotion. This, we argue, like Nussbaum's list of capabilities, implies a set of obligations: obligations to be committed to or work towards certain substantive goods, and obligations to implement a particular form of procedural justice in doing so. Like Nussbaum's list, it could function both as a normative agenda implying obligations to act and as a focus for further moral deliberation.

How does our capability-oriented approach compare with David Buchanan's ethic for health promotion (Buchanan 2000)? Buchanan, like Nussbaum, draws extensively on Aristotle,[4] and his vision is founded on two Aristotelian concepts. The first is phronesis or practical reason: this is what health promotion practitioners require. The second is eudaimonia, the wellbeing that arises from being able to reflect on one's values and live in accordance with them: this is what citizens require (Buchanan 2000). Buchanan argues that health promotion practitioners should exercise practical reason so as to facilitate the development, in citizens, of a disposition that is oriented towards achieving eudaimonia. Buchanan presents this as an alternative to what he argues is the contemporary malaise of health promotion: an instrumental, scientifically rational striving to improve physical health.

Our work is in some senses compatible with Buchanan's vision. Both presume plurality of values in communities, both emphasise that health promotion should provide a locus for community engagement, both value supporting communities to improve their lives in self-defined and self-sustaining ways, and both reject simple biomedical definitions of health. Buchanan advocates that practitioners require practical reason: we argue that the account we provide here is evidence of such practical reason, being founded in practitioners' experience, their understanding of the communities they work with, and their commitment to reflection on what the correct function of health promotion should be. The phronesis

in practitioners that Buchanan advocates would provide the necessary link in health promotion between appreciation of the teleological good and practice of the procedural good.

However there are important differences between our work and Buchanan's. First, although these practitioners defined health very broadly (as not just physical, but social, emotional, environmental and situated), they were clear that they should be providing opportunities for health improvement, through primary prevention, with attention to procedural justice. This seems to us to be both more restricted and more justifiable than Buchanan's extremely demanding eudaimonic purpose for health promotion. Second, although Buchanan's analysis was richly informed by his experience and understanding of health promotion, his task was ambitious: to justify a completely new theoretical foundation for health promotion practice and ethics. In many ways, the resulting work is an ideal theory of health promotion. Our contribution, in contrast, is a practical theory, with a less ambitious goal – to describe a thick, vague notion of the good in health promotion. While we admire and agree with much of Buchanan's reasoning, we believe that our contribution may provide more concrete and detailed criteria for evaluating both the substance and the process of health promotion.

Our analysis is also relevant to the debate in health promotion ethics regarding paternalism and freedom. Recent work in public health ethics has emphasised that valuing positive freedoms can reduce concerns about paternalism – in fact, can potentially create obligations for states to provide health-enhancing conditions for living (Wilson and Dawson 2010; Gostin and Gostin 2009).[5] Capability arguments are one way of thinking about these obligations and their moral significance. The goods described here are striking for their contrast with the paternalistic health promotion critiqued in the literature. Rather than being coercive, the health promotion valued here is respectful, responsive, tailored, capability-developing and relational, and seeks sustainable benefit in communities. We believe this thick, vague conception of the good in health promotion, founded in the values of practitioners themselves, makes an important contribution to the development of a more complete theory of health promotion ethics.

Footnotes:

[1] That is, an ethic which emphasises the importance of ends or purposes in determining what one ought to do: in Buchanan's case, the purpose of health promotion is to facilitate the development of a particular kind of wellbeing in citizens.

[2] That is, drawing on Aristotelian notions of wellbeing that emphasise the development of practical reason.

[3] Nussbaum's list has been subject to much debate since its publication, including over whether such a list can be developed at all, whether Nussbaum's list has content validity, and whether Nussbaum's list expresses a 'human core', as she intends it to do, or is instead a well-meaning form of cultural imperialism. It is beyond the scope of this paper to enter into these extensive debates, or into the debates about the potential universalisability of empirical findings such as these. We suggest, however, that it is reasonable to propose that our findings might be theoretically generalisable. By this we mean that, given that these findings are based on rigorous analysis across diverse and informative practitioners and settings, the concepts produced are likely to also be relevant for health promotion in other settings (Mason 2007).[4] In fact Buchanan makes considerable use of Nussbaum's classical scholarship when discussing Aristotle.

[5] The difference between positive and negative freedom has its origins in the work of John Stuart Mill. Negative freedom is the freedom not to be interfered with; positive freedom here refers to opportunity freedom – freedom to be or to do. Such positive freedom relies on the availability of conditions and opportunities that allow citizens to be and to do. For example, freedom to be healthy relies significantly

on the provision of basic sanitation, immunisation and health care, and such complex and collective tasks are unlikely to be provided – or at least, unlikely to be provided equitably – without some intervention by the state. There are clear resonances between positive freedom and capabilities.

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