Health promotion: an ethical analysis

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Abstract

Thinking and practising ethically requires reasoning systematically about the right thing to do. Health promotion ethics – a form of applied ethics – includes analysis of health promotion practice and how this can be ethically justified. Existing frameworks can assist in such evaluation. These acknowledge the moral value of delivering benefits. But benefits need to be weighed against burdens, harms or wrongs, and these should be minimised: they include invading privacy, breaking confidentiality, restraining liberty, undermining self-determination or people's own values, or perpetuating injustice. Thinking about the ethics of health promotion also means recognising health promotion as a normative ideal: a vision of the good society. This ideal society values health, sees citizens as active and includes them in decisions that affect them, and makes the state responsible for providing all of its citizens, no matter how advantaged or disadvantaged, with the conditions and resources they need to be healthy. Ethicists writing about health promotion have focused on this relationship between the citizen and the state. Comparing existing frameworks, theories and the expressed values of practitioners themselves, we can see common patterns. All oppose pursuing an instrumental, individualistic, health-at-all-costs vision of health promotion. And all defend the moral significance of just processes: those that engage with citizens in a transparent, inclusive and open way. In recent years, some Australian governments have sought to delegitimise health promotion, defining it as extraneous to the role of the state. Good evidence is not enough to counter this trend, because it is founded in competing visions of a good society. For this reason, the most pressing agenda for health promotion ethics is to engage with communities, in a procedurally just way, about the role and responsibilities of the citizen and the state in promoting and maintaining good health.

Introduction

In this article I present a way of thinking about ethics for contemporary health promotion. Anyone concerned with the future of health promotion faces two important ethical challenges. The first challenge is to engage with the ethics of everyday health promotion practice. A range of ethical frameworks and principles from the literature can help with this task. The second challenge is to engage with health promotion as a normative ideal. This is a political challenge: it requires re-engagement with the foundations of health promotion, and careful consideration of what constitutes a good, or a just, society. I will first introduce ethics, and then will consider these two challenges in turn.

What is ethics?

Thinking and practicing ethically requires reasoning systematically about what it means to be a 'good person', or about the right thing to do.[1] Health promotion practitioners and policymakers regularly face ethical dilemmas, although they may not think of them in these terms. If for example professionals discuss how persuasive a health promotion campaign should be, how to treat citizens with respect, the equity implications of a strategy, or how participants in research or evaluation should be treated, they are considering practical ethical issues. Often the relevant health promotion literature – including in this journal – has focused on values rather than ethics.[2,3] A value connotes something of importance: to say that something is valued is to say that it is good, or worthwhile. Health promotion values include a commitment to equity, empowerment and social justice.[2] But it is easy for such statements to be empty or imprecise: they mean little without careful explication and thoughtful analysis of how they should make a difference in our actions and way of being. Ethics is focused on such systematic analysis, with a particular attention to normative implications: that is, to what we should do and why.

Bioethics, established in the 1960s, is an area of applied ethics focused mostly on the biological sciences and medicine. Although some early bioethicists considered the ethics of health education,[4] most focused on the ethics of medical technologies and doctor–patient relationships, including end-of-life care, euthanasia and abortion. However, since ~2000 there has been a rapid increase in journals, books and articles focused on another area of applied ethics: public health ethics, including health promotion ethics.[5] Box 1 provides a reference list for those interested in pursuing this exciting and rapidly growing literature.

Box 1. Reference works in public health and health promotion ethics

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Health promotion as a practice and as a normative ideal

This brings us to the question of what, exactly, health promotion ethics might be. To consider this, I will return to a distinction I have made previously between health promotion as a practice and health promotion as a normative ideal.[5]

Health promotion is a form of practice: health promotion practitioners implement a wide variety of strategies and projects. Their day-to-day decisions about who to target, what to implement and how to evaluate all have ethical implications. Much writing on the ethics of health promotion, and of public health more broadly, has aimed to provide practical tools that can guide decision-making in these contexts. These tools are generally presented as frameworks or sets of principles. Reasoning from principles is a common approach in bioethics, because it provides heuristics to support practical problem solving under time pressure. The best-known set of ethical principles is that for medical ethics: beneficence (doing good), non-maleficence (avoiding harm), respect for autonomy and justice.[6] Another is the list of principles underpinning the Australian National Statement on Ethical Conduct in Human Research, familiar to health promotion practitioners who need to obtain ethical oversight for their research. This framework suggests that a study should: have merit and integrity (be well designed), be just (for example, fair in how participants are included or excluded), be beneficent and non-maleficent (minimise risk to participants) and be conducted with respect for participants (for example, by ensuring that they give valid consent).[7] Such lists of principles can provide useful guidance. Most – including the examples above – are built on more extensive reasoning for those who wish to pursue it. This is because lists of principles alone cannot be detailed enough to support thorough ethical reasoning about a situation: to fully understand the principles requires familiarity with the complex concepts that underpin them. Several frameworks, or sets of principles, have been proposed for public health ethics: I will review the best known of these in the next section.

Health promotion is not simply a practice: it is also a normative ideal. That is, health promotion is a vision of how society should be arranged, a set of political and moral commitments. These commitments include: to health as a resource for living rather than an end in itself, health as the product of social, environmental and economic living conditions, egalitarianism, and working in collaboration with citizens. This vision was set out in early health promotion documents[8–10] and is still deeply held by many practitioners. It is a commitment to a particular idea of the good society, and of the relationship between the state and its citizens. Following the discussion of ethical frameworks, I will review different authors' positions on the good society and health promotion's place in it. I will conclude by considering implications for the future of health promotion.

The ethics of health promotion practice: existing ethical frameworks

To date, ethical frameworks have been constructed for public health in general, rather than health promotion in particular. I will briefly review four of the best known, described in Table 1. They present lists of principles, considerations, forms of justification or questions to sensitise the user to ethical concerns, and provide basic guidance for how the principles should be applied.

Table 1. A selection of frameworks for considering public health ethics

Short summary of principles*

Kass NE. An ethics framework for public health. Am J Public Health2001; 91(11): 1776–82.	Suggested six concerns when evaluating a proposed program: (1) Should have clear goals related to decreasing mortality or morbidity. (2) Should be effective, and the greater the burdens imposed, the stronger the evidence of effectiveness required. (3) Burdens that should be considered include risks to privacy/confidentiality, liberty/self-determination, and justice. (4) Burdens should be minimised: consider alternatives and balance against effectiveness. (5) Should be implemented fairly, considering broad social determinants of health. (6) Institute open, deliberative processes to consider benefits and burdens.
Childress JF, Faden RR, Gaare RD, Gostin LO, Kahn J, Bonnie RJ,et al. Public health ethics: Mapping the terrain. J Law, Med & Ethics2002; 30(2): 170–8.	Suggested a set of moral concerns: seek (health) benefit, avoid harms, maximise utility; distribute benefits and burdens fairly; ensure public participation; respect autonomous choices and actions; protect privacy and confidentiality; keep promises and commitments; disclose information; speak honestly and truthfully; and build and maintain trust. However, these are likely to conflict. When conflict arises, apply five 'justificatory conditions': (1) Effectiveness (prefer more effective strategies). (2) Proportionality (prefer solutions that are in proportion to the problem). (3) Prefer necessary actions over unnecessary actions. (4) Prefer least infringement (choose the action that infringes least on any of the moral concerns above). (5) Ensure public justification (be transparent and trustworthy in dealing with the public).
Upshur REG. Principles for the justification of public health intervention. Can J Public Health 2002; 93(2): 101–3.	Suggested four principles to justify public health intervention: (1) A citizen's liberty should only be limited to prevent harm to others. (2) If several strategies are available, use the one that is least restrictive or coercive. (3) Public health should help individuals and communities fulfil expectations by offering something in return (reciprocity). (4) Decision-making should be inclusive and transparent.
Nuffield Council on Bioethics. Public health: ethical issues. London: Nuffield Council on Bioethics; 2007.	Proposed a 'stewardship model' of public health. This entailed aiming to: prevent people imposing health risks on one other, minimise causes of ill health,

	prioritise children and other vulnerable people, support behaviour change, provide health opportunities, ensure access to care, reduce health inequalities. And also entailed avoiding: coercion, intervening without consent, or adequate mandate, intrusiveness and conflict with important personal values. Also proposed an 'intervention ladder' from least to most coercive: • Do nothing or simply monitor the current situation • Provide information • Enable choice • Guide choices through changing the default policy • Guide choices through incentives • Guide choice through disincentives • Restrict choice • Eliminate choice

*Note that these are severely truncated: for precise wording and full justification please refer to the original article or report.

The four frameworks in Table 1 share a common set of concerns. They all prioritise outcomes. In ethics, this characterises the consequentialist or utilitarian tradition. Very simply put, utilitarianism is the doctrine that the right course of action is that which maximises total utility, however that is defined (for example, total happiness, total satisfaction, total wellbeing, or total wealth). Utilitarian reasoning would suggest that interventions should be reasonably expected to improve mental and/or bodily health or longevity, and that in general the most effective strategies should be preferred. However they also emphasise the need to balance these benefits against the possibility of producing burdens, harms or wrongs. Relevant harms or wrongs include invading privacy, breaking confidentiality, restraining liberty, undermining self-determination or people's own values, or perpetuating injustice. Even a very effective strategy may be considered unjustifiable if it engendered serious burdens: for example, if it required that people were to have their movements or finances controlled, if it forced people to change their lives in ways that were completely foreign and unacceptable to them, if it saved some by allowing others to die, or if it made the already-privileged better off while making the already-disadvantaged even less well off.

These frameworks assume the need for complex trade-offs between moral concerns. There is rarely a clear right or wrong answer in ethics: rather, there are degrees of justifiability that depend on the moral commitments of the person doing the evaluating. Several strategies for trading off have been suggested by framework authors. These include:

- Ensure that action is necessary and in proportion to the problem.[11]
- The greater the risk of harm, the stronger the evidence required to justify action.[12]
- Consider all alternatives, choose the least burdensome or potentially harmful strategy; in particular, recognise that strategies range from least to most coercive and prefer less coercive strategies.[11–14]
- It is more justifiable to prevent people from imposing harms on one another than to prevent people harming themselves (although in health that distinction is often not entirely clear).[13–15]

- Prioritise fairness in distribution of burdens and benefits.11,12
- Work on causes of ill health or the social determinants of health.12,14
- Be transparent and open in decision-making, include everyone likely to be affected by a strategy, seek a mandate for intervention.11–13
- Communicate honestly and build trust.11,13
- Establish reciprocal relationships with citizens: if citizens are expected to act to improve community or public health, then they should be provided with the support or assistance they need to be able to fulfil that expectation.13

How might these strategies appear in the everyday work of health promotion? Imagine, for example, a practitioner instituting a workplace health promotion strategy. She is concerned to ensure that her practice is ethical. This will include being concerned about effectiveness, but that is only the beginning. She will need to consider the burdens and harms that she might cause. If employees are individually assessed for health risks, for example, might that information become known to the employer and influence the employee's insurance status or threaten their job? How can this be protected against? The practitioner's own performance will be evaluated partly on participation rates, so she has an incentive to maximise participation. How then will she ensure that she does not – even unwittingly – coerce unwilling employees to join the program? If the practitioner is concerned about transparency and openness, she will need time to give all staff an opportunity to participate in its planning, rather than simply imposing a standardised program, and will communicate honestly with workers about what is being offered. This will require the support of both the workplace and her own employer, as the time required is an opportunity cost. And if the practitioner is concerned about fairness and justice, she will ask how the benefits and burdens of the program are distributed. Who decided on the criteria for participation? Was the program open to all interested workers? What about those on casual or shift work contracts, or other low-status workers, who may be less visible but may also need more help? These are just some examples of the ways in which ethical considerations might shape a workplace health promotion program in a practical sense.

The normative ideal of health promotion

Thinking well about the ethics of health promotion requires more than choosing the most ethically justifiable strategy from alternatives using principles or frameworks. It requires engagement with politics and with philosophical ideas about the state and the citizen.

This is, in part, because health promotion is founded on a political idea: a vision of the good society articulated in the Declaration of Alma-Ata, the World Health Organization 'Global Strategy for Health for All by the Year 2000' and the Ottawa Charter for Health Promotion.8–10 These documents – particularly the Ottawa Charter – still define the identities of many working in health promotion. I have argued elsewhere that they articulate a normative ideal of health promotion that has two central characteristics.5 First, it envisages citizens as active, as having a say in how health promotion is conducted and as the creators – to some extent – of their own health. Second, it imagines a society that fairly distributes the conditions and resources that improve health, including through structural change and advocacy. This society values health, includes citizens in health-related decisions that affect them, and makes the state responsible for providing all of its citizens, no matter how advantaged or disadvantaged, with the conditions and resources they need to be healthy.

If this is accepted, it seems little wonder that many authors who have developed theories about the ethics of health promotion have focused on deep questions about the meaning of health, the nature of a good society, and the place of health promotion in that society.16–20 Theories of health promotion ethics are systems for reasoning about what is morally and politically important in health promotion. Authors have taken different views on these questions. For example, David Seedhouse has argued that every citizen has a different concept of health and should be able to live their lives in accordance with their own values: in a good society, the state would not impose particular ways of being healthy on its citizens.19 In David Buchanan's view, health promotion in a good society would promote the development of wellbeing (broadly defined) in its citizens, by supporting their ability to make wise decisions that would allow them to live flourishing lives.20 Alan Cribb contends that health should be defined in a restricted way: as physical or mental health as typically understood in the health system. This allows clearer analysis of outcomes – that is, it allows us to identify when strategies might offer a health benefit and when they might not – and so prevents health promotion from doing anything it chooses in the name of 'health'. In Cribb's vision, health promotion should be especially concerned with the root causes of ill health and their distribution in society, and should avoid making individual citizens unduly responsible for their health when the responsibility is in fact diffuse. This would mean, for example, not implying that citizens are entirely responsible for their weight or the food they eat, or for obesity- or nutrition-related diseases they might experience, because the responsibility for these is in fact shared between individual citizens, their networks of relationships, the state, and industry.16

These theorists show how different views of the good society can produce different understandings of what health promotion is and what it should do. But there is also something that they share: they all make arguments against what we might call an instrumental, individualistic, health-at-all-costs vision of health promotion. This is a vision other commentators have suggested is ascendant and problematic.2,21,22 It is often linked to implicitly utilitarian reasoning. This can be operationalised in many ways, but in public health – and increasingly health promotion – generally translates as 'maximise aggregated health for the available budget'. In this approach, interventions that target individuals and have outcomes measurable at an individual level tend to be prioritised, because this allows counting and aggregation of health improvement.22 Effective interventions are scaled up, implemented, and evaluated rigorously to determine their effect on individuals' health. They are often (although not always) social marketing, educational or behavioural interventions, and often imply that the individual has a responsibility to change. Burdens or harms are not often measured. The outcomes that matter tend to be defined by the state (health promotion service or policymaker), with a focus on health states or behaviours such as Body Mass Index or fruit and vegetable intake. Such outcomes may or may not be important to any given individual, despite their importance to a health policymaker. An individual may have more compelling priorities: they may, for example, be more concerned that they are homeless, poor or unemployed (or even that they have a stressful life, or are about to get divorced, or feel lonely, or have a sick child) than about their weight or their vegetable intake. They may have tried countless times to lose weight without success. They may be healthy despite their weight or diet. And their weight or choice of foods will be partly but not entirely their responsibility, arising and taking its meaning from their relationships, their culture and the market.

We recently published an empirical analysis of health promotion practitioners' understandings of what was good about health promotion.23 We found that they shared a commitment to making the

world a better place by improving health (understood holistically and in the context of place and environments), primary rather than secondary prevention, and engaging with communities rather than individuals. They also valued a particular kind of process. For these practitioners, the way things were done was as important as goals and outcomes. They said that health promotion strategies should be developed over time in respectful relationships, that practitioners should be flexible and responsive to communities, that interventions should build capabilities in communities, and that health promotion work should be sustainable. This reflected the long tradition in health promotion of community engagement and a participatory approach. It was also consistent with traditions in ethics and philosophy that emphasise the importance of public deliberation and accountability. Daniels and Sabin, for example, have argued that for public decisions to be considered just, four conditions should be met.24 The reasons for the decision must be fully transparent, stakeholders must be able to agree that these reasons are relevant, the decision should be open to change if new evidence or arguments emerge, and these conditions should be enforced.

There are various reasons to object to the instrumental vision of health promotion described above. The practitioners in our study would object if health was divorced from its context, if individuals and their diseases were targeted instead of communities and shared opportunities to be healthy, and if proper processes – relationship-building, flexibility, respect, responsiveness, sustainability, capability-building – were not valued. Seedhouse may object to the instrumental vision because it imposes a definition of health on citizens and requires that they achieve it. Buchanan may object because it focuses on bodily health, instrumentally defined, instead of flourishing, and rarely aims to develop wisdom in citizens. Cribb may note that instrumental strategies often locate all responsibility – unjustifiably – with the individual, and are insufficiently attentive to the fair distribution of benefits and burdens. It could be argued that the instrumental, individualistic, health-at-all-costs vision of health promotion also contrasts with the normative ideal of health promotion: it arguably imagines citizens as passive, defining health problems for them, prioritising aggregated health improvement over fair distribution, and focusing more on individual behaviour change than on provision of the conditions for good health through structural change.

Of course the instrumental vision and the normative ideal are oversimplifications, and many health promotion actions will combine elements of both. In fact the practitioners in our study found ways – even when tightly constrained – to put their values into practice: for example, maintaining a commitment to proper process even when required to work toward individualistic, disease-oriented targets. But the contrast between the individualistic vision and the normative ideal, the concerns of practitioners, and the health promotion ethics literature all show that it is not enough simply to ask, as a utilitarian would, 'what strategy will give us the biggest health gain for our dollar?' The ethics of health promotion is much broader. Health outcomes are important, but need to be complemented by other concerns, including possible burdens, the importance of good processes, reciprocity, the need for justice in distribution and, most broadly, the proper relationship between the citizen and the state.

The normative ideal of health promotion in practice

2012 was a difficult year for health promotion in Australia, especially in Queensland. Substantial cuts in that state included the defunding of a wide range of preventive and health promotion programs, including those targeting the most disenfranchised: Aboriginal and Torres Strait Islander people,

prison inmates, people with disabilities and homeless youth. A committed disregard for the most disadvantaged seemed evident. Most people in the health promotion sector lost their jobs, demolishing years of relationship-building.[25] The cuts suggest that health promotion was seen as peripheral to the responsibilities of the state. The rationale given was that only 'front-line' services – acute care in hospitals – would be retained: everything else was an unnecessary expense. It was something of a return to the 1960s, before Alma-Ata and the Ottawa Charter, before broad agreement was reached that health is not primarily made in hospitals, but rather is produced by the social, environmental and economic conditions in which we live, such that promoting health requires intervening in these conditions. It remains to be seen the extent to which this will also come to characterise the national policy environment.

It is tempting to believe that such cuts occur because health promotion lacks an evidence base. If only outcomes had been more robustly defined, if only we had more randomised controlled trials, if only we were better able to prove the effectiveness of health promotion, then the cuts would not be happening. There may be some truth in this. But a robust evidence base, however important, is not sufficient for the justification of public policy. Many interventions on the clinical 'front line' are incompletely or insufficiently evidence based, and they continue to be supported for reasons beyond evidence. For example, some support for acute care is underpinned by the rule of rescue: the idea that we should not abandon or ignore identifiable individuals who are in extremis. This impulse is not without problems, including its effect on resource allocation.[26] But for our purposes, it is enough to notice that upholding the rule of rescue means having a vision of a good society: in this case, one that does not turn its back on desperate people who need help.

So what vision of a good society would provide robust support for health promotion? Evidence – the bedrock of utilitarian reasoning – is important but not enough. We need also to find ways of communicating honestly, openly and inclusively with citizens about what health promotion is, and to meaningfully include citizens in defining and updating our vision of health promotion. This is consistent with the normative ideal of health promotion outlined in the Ottawa Charter, which sees citizens as active contributors to their own health and the health of the public. It also reflects an idea that unifies all of the authors and practitioners that I have discussed in this article: all of them argue that due process has moral importance. This attention to process is lacking from the instrumental, individualistic vision. Rather than asking citizens, it tells, rather than including citizens, it makes them responsible for improving their own health, rather than building relationships, it rolls out standardised projects and measures whether individuals live up to a pre-determined idea of the good (healthy) citizen. It is perhaps these very characteristics that have made the instrumental vision acceptable to some conservative regimes. But if citizens do not have a stake in the future and contribution of health promotion, if they don't see health promotion as essential to a good society, if they don't see themselves as co-authors in its creation, why would they object when it is shut down?

Health promotion was always a vision for how society should be: that we should care about the least well off, that the state has a real responsibility to provide conditions necessary for good health, that citizens should be actively involved in building the health of their communities. Perhaps in serving the important goal of demonstrating effectiveness, it has been too easy to lose sight of this vision. Reviving it and including citizens in its re-invigoration, I would argue, is the most pressing agenda for an ethic of health promotion in the 21st Century.

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