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Ethical issues in public health promotion

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Health promotion is a key element of public health practice. Among strategies aiming to deal with public health problems, health promotion purports to help people achieve better health. Health promotion can significantly alter people's lifestyles, and three main ethical issues relate to it: (*i*) what are the ultimate goals for public health practice, i.e. what 'good' should be achieved? (*ii*) how should this good be distributed in the population? and (*iii*) what means may we use to try to achieve and distribute this good? The last question is the subject of this article. Concerns raised about health promotion can be divided into two groups: (*i*) efficacy-based considerations – are they cost-effective or cost-ineffective? and (*ii*) autonomy-based concerns – (to what extent) do they interfere with free choice, i.e. do they attempt to direct social values and lifestyles? Ways in which an individual's autonomy may be compromised by means of influencing behaviour change are considered.

S Afr J BL 2014;7(1):30-33. DOI:10.7196/SAJBL.268

Health promotion is a key element of public health practice, but understanding of the concept is controversial. The World Health Organization defines health promotion as the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.[1] Among strategies that aim to deal with public health problems, health promotion purports to help people achieve better health.[2] Health promotion has significant potential to alter people's lifestyles. It aims to 'make the healthy choice the easy choice and the unhealthy choice the more difficult choice', and seeks to influence people to change their health-related behaviour, e.g. stop smoking, exercise more, eat healthy food, practise safe sex, wear helmets, etc.[3,4] Health promotion therefore aims to lead to better health by changing health-related behaviour or lifestyle.

Health promotion has three main ethical issues: (*i*) what are the ultimate goals for public health practice, i.e. what 'good' should be achieved? (*ii*) how should this good be distributed in the population? and (*iii*) what means may be used in trying to achieve and distribute this good?[5] The last question is the subject of this article. I focus on health promotion approaches supported by government (financially or otherwise), since these are often paid for by taxpayers and aimed at the wider public. Arguably, private funders can determine for themselves what they will or will not fund, and their approaches need not be aimed at the general public.

Approaches to health promotion

David Buchanan[3] mentions four kinds of more or less problematic strategies that health promotion uses to influence people to change their behaviour: (*i*) behaviourist conditioning, e.g. through rewards and punishment; (*ii*) communicative persuasion, e.g. through sub-liminal information or 'scare' campaigns; (*iii*) group pressure, e.g. through meeting strategies where people are influenced to abstain from certain kinds of behaviour; and (*iv*) direct instrumental power, e.g. through prohibitions or use of authority. Furthermore, different theories (or models) are used to underpin the various strategies to change behaviour or lifestyle.[3] To achieve their ends, many strategies use social psychological theory, e.g. the health belief model, the theory of reasoned action, or the social cognitive theory.[3] Other theories used are the trans-theoretical (stages of change) model, the diffusion of innovation theory, and the communication-behaviour change model.[6,7] These theories and models are used as tools for targeting specific kinds of behaviours to change them. They are therefore instrumental in influencing and changing the health-related behaviour of groups of people.[3,7] The primary aim is health-related behaviour change, but the immediate targets are typically psychological or cognitive factors, such as beliefs, attitudes and self-efficacy, and to an extent the social environment.[7]

Ethical issues raised by health promotion strategies

Concerns raised about health promotion can be divided into two groups: (*i*) efficacy-based considerations – are they cost-effective or ineffective? and (*ii*) autonomy-based concerns – (to what extent) do they interfere with free choice, i.e. attempt to direct social values and lifestyles?[8]

Health promotion raises many controversial ethical questions, including the question of the appropriate methods that might be used in seeking to promote health.[9] 'Appropriate' can be understood to mean the most (cost)-effective means of achieving the desired ends and/or the ethically acceptable means. Serious questions face the cost and effectiveness of health promotion, e.g. what should count as a successful strategy? What strategies count as health promotion for purposes of evaluation? What should be the criteria for measuring success? Should it be behaviour change or just attitude change? How much change must be achieved for the strategy to be called successful? Who can rightly claim success for the good outcome, or who can be blamed?

Many projects aiming to change people's behaviour and lifestyle to enhance health have been tried. Coercive, top-down, legislative interventions, such as the requirement to wear seatbelts and crash helmets, have often succeeded,[10] as have some fiscal policies, such as taxing alcohol highly, as in the Nordic countries.[11] But the results of lifestyle projects are mixed; some have succeeded, or partly succeeded,[6] while others have failed.[12]

Health promotion includes 'a range of interventions, ranging from providing information through education, persuasion, the construction of new norms, the shaping of existing norms, the manipulation of preferences, or even coercion'.[9] Often behaviour-change approaches have narrow lifestyle goals, such as smoking cessation or increased physical activity, and use various means to influence the target group, sometimes informing, persuading, coercing, or manipulating the individuals or groups targeted, to reach these goals. Because health promotion involves significant potential to changes people's lifestyles, it also raises questions about the values in health promotion. For example, suggesting that it is immoral and risky to have polygamous unions could lead to discrimination and stigmatisation of individuals who are, consensually, in such unions. It is also not clear why monogamy, despite its potential for good social consequences, should be the prized value. In the case of competent adults, does it make a difference if they voluntarily agree to the arrangement? Is it ethical to not separate the medical facts, i.e. that HIV is spread through unprotected sex with an infected person, from the underlying moral judgement that having multiple sexual partners is immoral? It is not obvious that the practice is harmful to or harms others. Health promotion involves a commitment to all kinds of activities to promote health, and this will inevitably touch on controversial political issues.[9]

Health promotion also raises concerns about the legitimacy of state interference in influencing or shaping individuals' choices. Liberal societies tend to think that lifestyle behaviour choices should be left to individuals. But it is also understood that a government is sometimes justified in infringing or limiting people's autonomy. Accepting that a government has a legitimate role to play in health promotion, i.e. 'making the healthy choice easier' for people, what health promotion strategies or government efforts to change behaviour are ethical?

Some health promotion strategies do not sufficiently respect the individual's right to autonomy (self-determination) and liberty, i.e. the right to make decisions about one's life, and about specific issues concerning that life. Others are less problematic and can be defended on other moral grounds. Some ways in which an individual's autonomy may be compromised by different means to influence behaviour change are considered.

Persuasion

Persuasion can be defined as the intentional and successful attempt to induce a person, through appeals to reason, to freely accept the beliefs, attitudes, values, intentions or actions advocated by the influencing agent.[8,13] A central feature of persuasion is that the reasons that compromise the persuasive appeal exist independent of the persuader and are conveyed by the use of structured argument or reasoning. In the words of Leroy Walters,[13] they simply 'appeal to the rational capacities of the hearer'. In persuasion, the influencing agent must therefore bring to the persuadee's attention reasons, whether conveyed verbally, in writing or through non-verbal mediums, for acceptance of the desired perspective. Alistair Campbell[14] argues that persuasion can respect people's autonomy if we make it clear that we are persuading, do not distort the facts, argue overtly rather than influence covertly, and remain independent of vested interests. If the influencing agent creates or controls the contingencies that the agent offers as 'reasons', the influence is not strictly persuasive, but rather manipulative or even coercive.

Health education or information sharing are not usually regarded as intrusive and are generally considered to be effective. Informing about health threats or health benefits appears not to involve major ethical problems, because if the strategy is successful, it is because the individuals or groups found it useful or persuasive and chose to act on it. Information sharing can therefore be defended because it seeks to facilitate informed decision making. However, it may be problematic in that it constitutes a potential infringement of people's right to autonomy if they receive information about lifestyle matters that they did not ask for, or if they are asked about their lifestyles, since such questions may cause embarrassment, shame or feelings of guilt.[3,4,15]

Persuasion, especially the use of authority, is a problem that might appear in face-to-face encounters, especially when the agenda is set by a professional with authority. Authoritative persuasion here means that a person with real or perceived high status,[16] e.g. a doctor, tries to persuade someone to change behaviour. It becomes an ethical question when the issue or problem, and how it should be dealt with, is wholly determined by the professional without taking into account what the individual (or group) wants, and pressure is put on them to comply with the advice given. In these situations, there is a mixture of paternalism, i.e. an imposition of limitations on an individual by someone else for that person's own good,[17] and that authority that puts the individual in a weak position. It therefore does not respect an individual's right to autonomy, and risks making the person feel offended, vulnerable and powerless.[3,4]

Manipulation and deception

Manipulation is a deliberate act that successfully influences people by non-persuasively altering their understanding of a situation, thereby modifying perceptions of the available options.[8] Manipulation of information compromises autonomy to the extent that it renders people ignorant, thereby causally constraining relevant aspects of their decisions. Informational manipulation affects what people believe. The influencing agent does not change the person's actual options; the person's perception is modified as a result of the manipulation. Deception includes such strategies as lying, withholding information, and misleading exaggeration where people are led to believe what is false.

Other ways in which information can be manipulated and people deceived include:[8]

- Intentionally overwhelming a person with excessive information to induce confusion and reduce understanding.
- Intentionally provoking or taking advantage of fear, anxiety, pain or other negative affective or cognitive states known to compromise a person's ability to process information effectively.
- Intentionally presenting information in a way that leads the manipulatee to draw predictable and misleading influences.

Questions concerning psychological and informational manipulation have been raised more frequently about commercial campaigns (advertising) than about social marketing campaigns. Social marketing is an intervention that uses commercial marketing tools to benefit the individual, group and society,[15] e.g. using gender and age stereotypes to 'sell' health behaviour.[18] In advertising the central issue seems to be deception. By contrast, health promotion is seldom seen as deceptive in any ordinary or straightforward, intentional sense.

In practice, it is often difficult to distinguish between persuasion and other forms of psychological and informational manipulation. Arguably, many social influence or change attempts contain elements of both persuasion and manipulation. If there are any autonomy-related problems with health promotion, they are likely to be more subtle than commercial advertising and to derive largely from the potential for skillful application of psychological theory.[8]

Coercion

Coercion is commonly understood as using power to gain advantages over others (including self-protection), punishing non-compliance with demands, and imposing one's will on the will of others.[19] Some kinds of coercion are morally unproblematic. It is generally accepted that public health strategies should use the least coercive means.[20] All governments act paternalistically, often for good reasons. Much of this is done by coercing people through legislation, e.g. to wear seatbelts and crash helmets. However, in liberal welfare societies there is a suspicion about too many restrictions.[4] For example, the use of sugar, or smoking (unless in public areas), is not prohibited, despite the fact that we know they are bad for people's health. There is a tension between the government's interest in intervening to protect the population from itself and people's right to do what they themselves find best.[4]

Using coercive means to change health-related behaviour is not always problematic. The less important, or the more trivial, the infringement and the greater the health gain, the less problematic the project, especially if it respects other important ethical principles, such as reciprocity, equality or social justice.[4,20] Another reason why coercion and manipulation are not always problematic relates to the idea that people voluntarily consent to coercion and/or manipulation. Sometimes individuals, or groups, targeted by health promotion accept being manipulated or coerced, e.g. in certain kinds of psychotherapy, where the therapist uses manipulative techniques that are (autonomously) accepted by the participant, such as accepting treatment with hypnosis for smoking cessation. Another example is where individuals ask to be committed to treatment, e.g. for drug abuse. This suggests that coercion and manipulation are acceptable strategies in such cases.

Strategies that are persuasive, manipulative or coercive do not respect the individual's right to autonomy. However, some strategies can be defended if they constitute minor rights infringements and the harms avoided are substantial, e.g. requiring people to wear seatbelts when driving. But what if a person is harmed in some other way? Are there behaviour change strategies that lead to situations that are worse than the problems they were designed to alleviate? Might improving a person's future health through reducing his or her (immediate) quality of life be an example? Health promotion might persuade, manipulate or coerce people to adopt behaviours that they may dislike, e.g. exercising more or giving up smoking.[4] Could a more serious harm be that of reducing a person's ability for autonomy, or similarly, that coercive interference might displace individual initiative? Manipulation risks leading to such a result.

Marketing strategies are in general manipulative, because they try to induce people to do, or buy, things that they did not originally want, and that they would not have bought or done, had they had more information or sufficient time to deliberate. Employing manipulative techniques in social marketing appears to be counter-productive, as the risk is that the more people are manipulated, the less autonomous they will become. Reasons for this include that manipulation reduces knowledge (a prerequisite for autonomous choices) through false, skewed or partial information, and that it makes the individual less inclined to reflect critically on the options that are available.[21]

Defenders of these strategies might claim that people are not very autonomous in the first place, since many forces in society influence us to want and do things,[22] and in this case we might as well 'counter-manipulate' individuals.[4] The ability for autonomy (self-determination) differs in the population. However, assuming that we are not fully determined by material or social structures, the answer to this problem should not be more paternalistic manipulation, but rather to strengthen or enhance the autonomy of those with less ability for it.

Conclusion

This article highlights some ways in which health promotion strategies can be ethically problematic. Reasons for why behaviour change projects can be morally problematic include that they do not sufficiently respect, or further, the autonomy of the individuals involved. However, some people participate in behaviour change projects that they have chosen, and in which the goals and means are determined beforehand.

Marketing tools are morally problematic if they influence the individual's wants and beliefs, i.e. if they try to make people do something that they have not chosen, for reasons they are not fully aware of. This creates inauthentic wants and instills false beliefs, and thus disregards the right to autonomy (self-determination). Health promotion strategies are not typically thought of as paternalistic, but when they go beyond the provision of information and systematically seek to transform the desires and preferences of those to whom they are directed, they assume a fundamentally different character. Health promotion approaches that rely on manipulative or deceptive techniques to induce people to (*i*) come to hold certain beliefs, and as a result (*ii*) change their unhealthy behaviour, even in the service of a good end (e.g. a long and healthy life), are problematic.

Although it would be a mistake to assume that respect for individual autonomy should always trump other considerations or values, e.g. general welfare, the violation of autonomy counts as a shortcoming in any approach to health promotion. Whether individual autonomy should be the deciding value in any particular case, however, depends upon what other values are at issue and the importance ascribed to them. Whether an approach is justified depends largely on the seriousness of the violation and the moral importance of the reason for conducting the approach. The questions can always be posed: Does the autonomy violation serve the approach well? Is it effective?

Acknowledgements. I would like to thank Prof. JP van Niekerk for valuable comments on an earlier draft of this article.

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