Health Promotion: Conceptual and Ethical Issues

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There is a large literature exploring the concept of ‘health promotion’. However, the meaning of the term remains unclear and contested. This is for at least two reasons. First, any definition of ‘health promotion’ is going to have to outline and defend an account of the notoriously controversial concept of ‘health’, and then suggest how (and why) we should promote it. Second, health promotion clearly has some overlap with ‘public health’, but it is far from clear how they are related. Is health promotion part of public health or is health promotion a radically different type of activity from public health? Answering this question requires engaging with tricky professional as well as contentious conceptual issues. Some advocates of health promotion talk as though public health is problematic: seen as medical, physiological in focus and reductionist in approach, whereas health promotion, on this view, is focused on the whole person in a social environment. However, to an outsider this looks more like an attempt to artificially (and rather crudely) define and protect professional boundaries, rather than a contribution to conceptual analysis. There seems no good reason why public health cannot take into account the role of social, political, economic and cultural factors and their impact on health. Indeed, much work in public health does precisely this, and uses a wide range of methodologies drawn from non-medical disciplines such as geography, sociology and psychology, not just epidemiology. It seems much more sensible to see health promotion as being one vitally important aspect of the work of public health, rather than something markedly distinct. We will assume here that this is the case and focus instead on the first issue: what is health promotion?

One place to start is with the official definition of ‘health promotion’ proposed as part of the World Health Organisation (WHO) sponsored and endorsed Ottawa Charter for Health Promotion produced in 1986. This document begins with the statement that ‘health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health’. Of course, this raises more questions than it answers. How are individuals and communities related? Are all health determinants ‘controllable’, if not are the uncontrollable determinants irrelevant to health promotion? Are actions that improve health through ‘non-enabling’ means just not part of health promotion? In addition, as the rest of the definition unfolds it becomes apparent that the account of health, and therefore what is to be ‘promoted’, is a version of the notorious WHO definition of health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease’ (WHO, 2005). This definition has been, rightly, subject to much criticism, perhaps most importantly for its apparent confusion of health with general welfare (Nordenfelt, 2007). However, despite its problems, this definition of health promotion remains the most influential and widely used.

Other accounts of ‘health promotion’ are even more explicitly ideological, often incorporating contentious normative commitments into the very definition of the term. Perhaps the best example of this is the increasingly common appeal to the idea of empowerment of the individual as central to health promotion (see Tengland, 2012). For example, in their recent textbook on health promotion, Tones and Green provide a formula for what they take health promotion to be, as follows: Health promotion = health education × healthy public (2004: 38). On their view, health promotion is defined as being an activity centrally concerned with empowering individuals through education, with the belief that this will also contribute to better (‘healthier’) public policy. There is, of course, no clear reason to assume that health will be promoted automatically as a result of education (although this is a common assumption in much health promotion activity). Neither does there seem good reason to exclude by definition the possibility that health promotion could improve people’s lives via some other route than empowerment.
A third approach to defining health promotion is more pragmatic in its focus. It gives up on seeking necessary and sufficient conditions for the application of the relevant concept, but instead seeks to describe the kind of features that seem visible in the practice of health promotion. For example, Macdonald and Bunton, suggest that, ‘[s]tated simply, health promotion is a strategy for promoting the health of whole populations’ (2002: 10). On this view health promotion needs to take a view on what counts as health, actively seeks to promote it, and is concerned with populations (not just individuals). Although vague, perhaps even tautologous, this kind of definition has the advantage of being open and flexible, but still managing to capture various reasons why health promotion may be considered controversial, and thereby, interesting in an ethical sense.

Public health very often involves seeking to prevent harm to health, not just reacting to cases of illness (Verweij and Dawson, 2007). As a result it is more likely to result in unsought interventions into people’s lives, because many suggested interventions are initiated by health providers rather than by the patients themselves. This raises the issue of the appropriate methods that might be used in seeking to promote health. ‘Appropriate’ here might mean only the most effective means to attaining the desired ends, but it may also mean, in addition, the ethically acceptable means. Health promotion will include a wide range of types of intervention, ranging from the provision of information through education, persuasion, the construction of new norms, the shaping of existing norms, the manipulation of preferences, or even coercion (see Rossi and Yudell, 2012). Are payments a legitimate means of seeking to change behaviour (see Gopichandran and Chetlapalli, 2012)? What are the possible consequences of such policies? What ought we to take into account? Health promotion involves significant potential to change the lifestyles of individuals. When is such change acceptable? In liberal societies it is often assumed that choices about legal lifestyle activities such as the consumption of tobacco, alcohol and food, as well as what type of exercise to engage in and how much, are decisions to be left to individuals. This assumption, however, should be made explicit and preferably be intelligibly defended. One problem for such a defence is that it is not clear whether lifestyle choices are truly free in the relevant sense. Are they not subject to strong influence by cultural, environmental and socioeconomic factors? If so, what difference, if any, does this make to thinking about attempts to change them? Are such attempts paternalistic? If so, does this automatically mean that they are unjustified (see Skipper, 2012; Grill and Nihlén Fahlquist, 2012)? How does the issue of paternalism relate to responsibility and concerns about harm to self and others (see Grill and Nihlén Fahlquist, 2012)? How should we think of health promotion activities that require the collective action of many people, often mediated via the action of the state (see van den Hoven, 2012; Awofeso, 2012)?

Health promotion involves a commitment to all kinds of activities to promote health, and this will inevitably touch on controversial political issues, such as the role of environmental and socioeconomic determinants of health. Health promoters are likely to be advocates for significant change not just in relation to our individual lives, but also our societies and our social and built environment. Issues such as urban planning, transport policy, the provision of public recreational space and parks, food regulation and agricultural policy will all be suitable (and politically controversial) issues for the health promoter. Is there a line to be drawn between ethics and politics in relation to health? If so, is it an important one?

Another set of ethical considerations relate to the place of values in health promotion. What do those involved in health promotion believe they are doing and why (see Carter et al., 2012)? These are relevant questions as it is surely important that there is some match between health promotion as a practice, the kinds of values instantiated in it, and the discussion of the legitimacy of actions carried out as part of that practice (Dawson, 2011). Taking seriously the practice of health promotion tends to avoid focussing too narrowly on a single value conflict, such as that between autonomy and health. Instead, it invites consideration of other values, such as equity and solidarity. For example, it seems apparent that if we are interested in promoting health within a population, we are forced to take equity considerations seriously, since it is not obvious how the health of the individual members of a population should be aggregated into population health. Furthermore, as we now know, any individual’s health is at least partly the consequence of their position in society (Marmot and Wilkinson, 2005; Goldberg, 2012). Health promotion will involve seeking to discover impediments to health and what makes lives go well, and we have good reason to see justice as being relevant to thinking about these issues (Voigt, 2010).

Health promotion raises many controversial ethical questions and the papers in this special issue aim to contribute to ongoing debates. This short editorial has merely outlined a series of conceptual and ethical issues that require further exploration. We look forward to
seeing further work on these topics in Public Health Ethics and elsewhere.

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References