

Does health promotion need a code of ethics?

One recent landmark in the maturity and achievement of the health promotion movement has been the International Union for Health Promotion and Education (IUHPE) report to the European Commission on the Evidence of Health Promotion Effectiveness (European Commission, 1999). This report, and many recent papers on the nature of evidence in health promotion, demonstrate that health promotion has come a long way in establishing its credentials as an effective, and technically and conceptually sophisticated player in the health arena and beyond.

Less progress has been made, apparently, in the development of a similar level of sophistication in articulating health promotion's moral and ethical credentials. A recent editorial in this journal noted that younger practitioners are developing high levels of technical efficiency. However, the author commented, technical excellence is not always accompanied by equally important competencies in theoretical development, understanding of broader social issues and reflection on health promotion's 'reason for being' (St Leger, 2001).

Is there a risk that health promotion might mirror a wider problem in modern society, where advances in science and technology constantly serve to highlight the many things that *can* be done, yet there is often little opportunity to reflect on what *should* be done? In other words, will our technical capacity overtake and outgrow our moral imagination?

Several recent developments, all but one originating from North America, give grounds for reflection on these matters. The first was the drafting, following wide consultation, of a Public Health Code of Ethics by members of the Public Health Leadership Society in the United States (American Public Health Association, 2001a). The rationale given for the development of the Code can be summarized as follows. The mandate of public health is an inherently moral one. Society is increasingly demanding explicit

attention to ethics, as in an increasingly pluralistic society the values from a single culture, religion or disciplinary perspective cannot be assumed, and it is necessary to work out our common values in the midst of diversity. Historically, medical institutions have been explicit about the ethical elements of their practice, but the ethical nature of public health has been implicitly assumed rather than explicitly stated (American Public Health Association, 2001b).

The second development was the publication, towards the end of 2000, of the report of a 2-year collaborative research project on the ethical and social dilemmas of health promotion and disease prevention, conducted by the Hastings Centre and the Stanford University Centre for Medical Bioethics (Callahan, 2000).

The third development was the recent commentary by Cheryl Easley and her colleagues (Easley *et al.*, 2001), documenting the growing literature arising out of the dialogue taking place between public health and the international human rights movement. This dialogue has been advanced by several international coalitions and networks such as the Consortium on Health and Human Rights, the International Federation of Health and Human Rights Organisations, and the International Student Association for Health and Human Rights.

Finally, there is the ongoing policy debate on health equity and distributive justice set in motion by the World Health Organization's *World Health Report, 2000*. This report took a significant step beyond the utilitarian philosophy that has traditionally dominated thinking in health economics and health policy. The report stated that the objective of good health really has two dimensions: the best attainable average level (goodness) and the smallest feasible differences among individuals and groups (fairness). Thus, it is 'not sufficient to protect or improve the average health of the population, if—at the same time—inequality worsens or remains high

because the gain accrues disproportionately to those already enjoying better health' [(World Health Organization, 2000), p. 26].

The theme linking all these developments is an increasing interest among a wide range of actors in making explicit the ethical dimensions of health policy and public health practice. Health promotion needs to have a significant presence in these debates and in the interdisciplinary conversations that are occurring. The involvement in the Hastings Centre project (referred to above) of several leading contributors to the health promotion literature is a valuable start. Ron Labonte, Ann Robertson and Meredith Minkler were among the contributors to the book edited by Daniel Callahan (Callahan, 2000).

With some exceptions, however, health promotion has had relatively little to say in relation to its moral foundations. This is not to say that health promotion has lacked moral imagination or vision—the Ottawa Charter for Health Promotion can be read as a statement of values and ethical commitment, with an explicit acknowledgment of peace, social justice and equity as prerequisites for health.

Where in the broader health promotion literature is the considered explication of the meaning of these ideas, and their moral and political implications? Writing recently in the *Health Promotion Journal of Australia*, David Seedhouse commented that while 'there are isolated islands of debate about the ethics of health promotion ... ethical matters are rarely considered seriously in mainstream health promotion training and practice' [(Seedhouse, 2001), p. 135].

Does this reflect the comment made some years ago by John Last, that public health lacks a defined statement of ethics, compared with the well developed codes of ethical conduct in clinical practice, because 'public health workers take it for granted that their activities are always morally and ethically impeccable' [(Last, 1987), p. 367]? Is this the case for health promotion?

There is a wide range of ethical dilemmas that health promotion needs to address, although they may not always be perceived as such by those engaged in health promotion activities. Yet in the wider health system, in government, in the media and in the community, one often finds these issues being raised. Some groups are uneasy about issues such as paternalism, 'social engineering', the 'nanny state', privacy, and interference with rights and freedoms. Others

raise concerns in relation to the role of health promotion in widening the health gap between rich and poor, in victim blaming, or of failing to engage with the social determinants of health.

Many bioethicists take as their starting point in assessing a problem or situation, a well established analytical framework based on the principles of autonomy (respect for persons and individual rights), beneficence (doing good, optimizing benefits over burdens), non-maleficence (not doing harm) and justice (a group of norms for distributing benefits, risks and costs fairly) (Beauchamp and Childress, 1994).

There are many limitations to this approach; the principles, for example, may and do conflict. But they provide a useful starting point for considering a response to issues such as those suggested above. Under what circumstances, for example, would a health promotion perspective suggest that autonomy should be overridden in the interest of the greater good? What is health promotion's response when considerations of social justice conflict with rights or the maximization of health gain?

To some extent we are now seeing these and related principles and discussions being incorporated into introductory ethics chapters in health promotion textbooks (Katz and Peberdy, 1997; Naidoo and Wills, 2000). This is a promising start, but much more is required. Change in many of the broader, social determinants of health requires action in the political arena. As a consequence, many commentators suggest that a broader 'macro-ethical' framework is needed, which moves beyond principles derived from bioethics, to incorporate theories from social and political philosophy. Communitarianism is a theory of this type, which emphasizes social connectedness, and sees individuals as members of a community, embedded in community norms and history, and not as the atomised individuals of classical liberalism. Communitarianism appears intuitively to accord with health promotion values, and it has been suggested that communitarianism is a moral theory 'particularly appropriate ... for public health' (Beauchamp and Steinbock, 1999). But what if community values conflict with other values, such as upholding the interests of minority groups?

A further set of ethical questions is raised in focusing on health inequalities and social disadvantage. For example, what trade-offs are we prepared to make in relation to other social goods in order to ensure a fairer distribution of

health? And what does a fair distribution of health imply? If all people's health cannot be the same, as it obviously cannot, what is an acceptable range of deviation from an agreed 'level of health' such that it can be said that equity has been achieved? It has been argued that among the wide range of health issues needing attention, the reduction of health inequalities has a special moral urgency. But if health promotion is to take a leading role in responding to health inequalities, clarity in relation to the ethical issues to be faced is sorely needed.

Health promotion can no longer take its own moral credentials for granted. For health promotion to effectively establish its moral credibility a number of steps are required. The following recommendations are based on those proposed by Callahan and Jennings (Callahan and Jennings, 2002).

Those who play a leadership role in health promotion need to recognize the need for the articulation of a coherent moral framework on which health promotion practice is based. A first step might be the development of conferences, discussion groups and other forums on the theme of health promotion and ethics. Health promotion leaders and academics should encourage an ongoing conversation between health promotion, bioethics, human rights and social philosophy. Health promotion journals should call for papers on ethical topics and actively seek input from other disciplines. At the same time, health promotion should begin to test its ideas in the wider bioethics literature.

Ethics courses should be incorporated into the health promotion curriculum, and into in-service programmes for the current workforce. Case studies and materials should be developed to support these courses. Finally, the health promotion field as a whole needs to consider whether there would be value in developing a code of ethics similar to that developed by the Public Health Leadership Society in the United States, referred to above. This could also build on other initiatives, such as the code of practice developed by the Society of Health Education and Promotion Specialists (SHEPS) in the UK (Naidoo and Wills, 2000). To ensure an international debate, reflecting the views of many

different cultures, this process could possibly be led by the International Union for Health Promotion and Education.

An energetic debate about health promotion's ethics and values would demonstrate a 'coming of age', and enable those in the wider community to see that health promotion is founded on well argued principles. It should also open the way for new ideas and a revitalization of health promotion's moral vision. *Health Promotion International* invites papers and contributions to launch this debate.

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