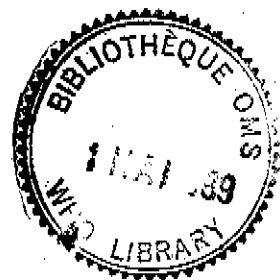


EUR/ICP/HSR 634

ETHICS AND HEALTH PROMOTION

A report from the  
Health Promotion programme



WORLD HEALTH ORGANIZATION  
Regional Office for Europe  
COPENHAGEN

## TARGET 13

### Healthy public policy

By 1990, national policies in all Member States should ensure that legislative, administrative and economic mechanisms provide broad intersectoral support and resources for the promotion of healthy lifestyles and ensure effective participation of the people at all levels of such policy-making.

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## Introduction

The Consultation on Ethics and Health Promotion was held at the UKK Institute in Tampere, Finland, from 7 to 9 December 1987, and was attended by 15 temporary advisers from 5 countries, 4 observers and representatives of WHO headquarters and the Regional Office for Europe. Professional interests in health education and health promotion were represented by specialists in a variety of fields, including child health, public health nursing, mental health, sports and rehabilitation medicine, education and training, mass media health promotion, and community development. They met with philosophers, social scientists and research workers with a developed interest in the field of applied ethics.

## Scope and purpose

Recognition of the ethical and political dimensions of health promotion is not a recent discovery of the World Health Organization or of those working in the field. Over the past three decades, WHO has encouraged the exploration of general ethical aspects of medicine, nursing and research involving human subjects. Since 1981, with greater emphasis being placed on health promotion, attention has been paid more specifically to ethical issues and dilemmas in this area.

The Consultation was preceded by two events that anticipated the need for a more systematic exploration of ethics in health promotion: the WHO-sponsored Meeting on Ethical Dilemmas in Health Promotion, held in Doxiadis in 1987, and the International Conference held in Ottawa in 1986, which produced the "Ottawa Charter". Thus, concern with protecting vulnerable individuals, redressing inequalities in health services and health status, and promoting greater respect for individual rights and

personal autonomy have been central to the WHO health promotion policy and philosophy.

## Topics

In the document "Health promotion: concepts and principles in action - a policy framework" issued in 1986, a number of principles are set out which may be summarized as follows:

- health promotion represents a mediating strategy between people and their environments, bringing together personal choice and social responsibility in health to create a healthier future;
- health promotion involves the population as a whole, in the context of everyday life, rather than focusing on people at risk of contracting disease;
- health promotion is directed towards action on the determinants or causes of health;
- health promotion combines diverse yet complementary methods or approaches;
- health promotion aims particularly at effective and concrete public participation; and
- health professionals, particularly in primary health care, have an important role to play in nurturing/enabling health promotion.

The Consultation was convened essentially to explore the interface between the scientific and moral grounds for these practical principles of health promotion, and to clarify the underlying ethical principles that apply to all activities in this field. There were several working sessions to explore the following topics:

- the context for discussion of ethics and health promotion;
- ethics and the meaning of the common good;
- the main dilemmas;
- responding to ethical concerns in a national strategy;
- guidelines for responding to ethical dilemmas in public policy, economic affairs, community action and individual and family behaviour;
- ethical aspects of research in health promotion; and
- organization of ethical control.

## General ethical considerations

In discussing health promotion there is a need to distinguish between three terms: *morals*, *ethics* and *meta-ethics*. The term *morals* relates to personal moral behaviour and moral judgement, whereas *ethics* is the reflective and critical study of the principles, practical criteria and decision-making procedures employed in making moral judgements. The term *meta-ethics* relates to the extra-moral criteria invoked when attempting to justify our moral principles or the decisions based on them.

In discussing ethics and health promotion, we are not concerned with passing moral judgement on the policies, behaviour or moral judgements of others, but rather with understanding which principles, practical criteria and decision-making procedures are appropriate to the exercise of professional responsibility in health care and in health promotion activities in particular.

In some contexts, it may be appropriate to consider aspects of meta-ethics, namely the different kinds of justification that people or politicians adduce to justify their policies or actions. Theological or ideological justifications, or arguments from duty or utility, or appeals to "natural law" or pragmatic considerations are, however, of more interest to academic moral philosophy than to practical or applied ethics.

Fundamental ethical principles in health care have been identified by various authorities and are traceable back to the Hippocratic tradition. In their most general form, these principles are those of beneficence (or non-maleficence), justice and respect for others.

It is evident that there is great diversity in personal values and social mores between different cultures and social systems. However, there are good logical grounds for asserting that these three principles are necessary for the coherence of any moral system, and in fact that they are common to almost all known moral systems. These principles are understood and formulated in a variety of ways in different human communities, and the priority given to one principle over another or the balance between them varies considerably from one system to another.

Furthermore, a number of other subordinate moral principles can and have been derived from each of these principles of beneficence, justice and respect for others. Thus, the principle of beneficence (to do good rather than harm) has been taken to imply several kinds of moral duty - the duty to protect the vulnerable, the duty of advocacy and a general duty to care. The principle of justice relates not only to punishment and compensation for harm done to individuals or the abuse of political power and public resources, but more fundamentally to distributive justice or the requirements of universal fairness, i.e. non-discrimination against and equal opportunity for individuals, and equality of

outcome for groups. Respect for others has been interpreted to mean not only respect for the life, dignity and bodily integrity of the individual, but also respect for the autonomy and rights of the individual, e.g. the right to know, the right to privacy and the right to adequate care and treatment.

In health care and health promotion, there is perhaps a particular need for attention to be paid to appropriate reflective and critical studies of moral principles, practical criteria and decision-making procedures in reaching informed and responsible moral judgements. There is also a case for more attention to be paid to theoretical teaching, supervised practical training and the review of developing skills and confidence in this area, as in management training.

## Some general moral issues raised in health promotion

Moral problems or "dilemmas" can be identified in relation to each of the principles of health promotion mentioned above. Who defines the content of health promotion policy? The state? Health professionals? Health promotion specialists? The public? Do we discriminate in favour or against "at risk" or "vulnerable" groups? Does the state adopt a proactive "healthist" ideology or adopt a laissez-faire and permissive policy?

In proposing "action on the determinants of health", it is true that disease factors are far better researched than health factors. Is it therefore moral to propose a major shift in approach based on limited data? How do we avoid victim-blaming - further isolating and stigmatizing those whose lifestyles or health behaviour we are attempting to change? Alternatively, giving priority to individual behavioural change, in the interests of protecting personal autonomy in choice of lifestyles, may result in ignoring structural factors affecting health

status and allow the state to opt out of its responsibility to influence change here.

Can the adoption of a "diversity of complementary approaches" really work? This may sound well in theory, but there is a risk that if health promotion is everybody's business it becomes nobody's responsibility. Health professionals may abrogate their responsibility for health promotion in the expectation that someone else will make it their specific responsibility, but nobody does. This relates to the problem of who coordinates interprofessional and intersectoral health promotion, and how integration is to be achieved in practice. There is both a practical and a moral responsibility on Member States to address these problems and to consider successful models elsewhere.

How is "effective and concrete public participation" to be achieved? Many forms of "consultation" may be inherently inhibiting and patronizing to lay people. Market research surveys may simply identify the lowest common denominator rather than the highest common factor of public opinion. Who is "the public"? How can they be persuaded to participate? Aggressive interventions may be counterproductive for vulnerable and disadvantaged groups, who lack the experience of participating in decision-making, management and control of their own affairs. The challenge of raising consciousness about health and health issues faces the same problems and challenges as community development in impoverished countries in the developing world. There may be a need for preliminary training in communication, assertiveness, decision-making and management.

The key role of health professionals in community health promotion may be obvious in theory but difficult in practice. Traditional medical education and training, like that in the other health professions, will need to be reorientated from preoccupation with the treatment and prevention of disease to health promotion. Differences

of theoretical mind-set, role definition and concepts of appropriate interventions frustrate interprofessional cooperation in primary health care and a fortiori in health promotion. Professionalism is about power and prestige, whereas community education and community development require a willingness on the part of professionals to share their power, knowledge and skills with lay people, even to work to make themselves redundant. How do we prepare established health and social services for the fact that successful community development and community action on health issues tends to create initial friction between community leaders and established providers of services? How do we persuade decision-makers, preoccupied with cost-benefit and cost-efficiency criteria, that the creation of supportive environments, or improved access and public acceptability of services, can be advantageous on both scientific and moral grounds?

## Conclusions and recommendations

### National strategy, policy and priorities

1. Developing a national strategy is not only a practical ideal on sound administrative and scientific grounds, but is a moral requirement of the principles of (social) justice and beneficence.
2. Public debate and political negotiation about the acceptable scope and limits of state intervention in health promotion, and the determination of policies and priorities, is demanded by the principle of respect for other people and for their rights and autonomy.
3. Adequately funded and scientifically rigorous basic and operational research in health promotion is required to ensure just and responsible use of public resources and objective accountability by politicians and agents of health promotion.

4. Health promotion practice should in general be subject to scrutiny in the light of the following ethical questions.

- Will the implementation of this policy/strategic plan do more harm than good (requirement of the principle of beneficence)?
- Will the implementation of this policy/strategic plan discriminate against the disadvantaged or increase their opportunities for choice and control of their own health (requirement of justice)?
- Will the implementation of this policy/strategic plan make adequate provision for public consultation/respect for individual rights (requirement of the principle of respect for others)?

#### Health planning and economics

5. Concern for the common good demands critical examination of the proportion of gross national product spent not only on health care but in particular on positive health promotion.

6. Similarly, the principles of justice and equity demand that there should be scientifically truthful and open debate about the relative costs and benefits, in both economic and human terms, of policies on the use of the environment, on industrial health and safety, and on the manufacturing, marketing and advertising of products damaging to health.

7. Policy-makers and politicians have a moral obligation to consider the impact on the health of society and of individuals of policies on employment, work and leisure.

### Community development

8. To avoid victim-blaming or discriminating against disadvantaged individuals or communities, the rhetoric of "empowerment", "skills sharing/transfer", "promotion of self-help" and "public participation" needs to become a reality through public commitment of the necessary resources. This would include easier access to information, services, learning opportunities, support staff and funding. Community development without the supportive political commitment would amount to double injustice and violation of the basic rights of individuals.

9. The theory of community development suggests that local communities should be allowed to determine their own priorities. Out of proper respect for their rights and dignity, however, and to avoid perpetuating dependency, realistic negotiation with funding agencies or agents of health promotion may be ultimately less patronizing than a protective beneficence that leaves disadvantaged people to their own devices and then blames them for the failure of the intended aid.

10. Knowledge/skills transfer requires not only respect for the client's own knowledge and skills, but a recognition of the profound reorientation and retraining that may be required for the "experts".

### Health professionals/health promotion specialists

11. Professional ethics are a means to an end, not an end in themselves.

12. Individual professionals have a duty to engage in the clarification of their own values, to avoid imposing their own values, to avoid discriminating against clients, and to ensure respect for their clients' rights.

13. The duties of a responsible profession - to research and maintain its knowledge base, to develop the skills and to assess and monitor the competence of its members, to regulate and discipline members who act to the detriment of clients or the profession, and to promote the good of the profession and the common good - should apply to specialists in health promotion.

14. Professionals have a duty to know and respect the rights of clients. Where clients are unable to defend their own rights, professionals have the duty of advocacy, namely to defend their clients' rights and promote their autonomy. These duties follow from both the general duty to care and the specific duties implied in the WHO definition of health.

#### Health promotion research and ethical control

15. Health promotion specialists have a fundamental duty to engage in rigorous basic and operational research, both for reasons of scientific integrity and, perhaps more fundamentally, for reasons of beneficence (i.e. to do good rather than harm by their interventions) and of justice (which requires responsible allocation and use of scarce public resources).

16. As with other research involving human beings, the requirements of the Declaration of Helsinki should be applied to health promotion research.

17. The researcher or health promotion specialist should be publicly accountable (e.g. for the publication of results) and should contribute in a responsible way to public debate on the costs and benefits of health promotion interventions.

18. As with the monitoring of clinical research involving human beings, there should be local and government bodies to consider and monitor the proposals for either health promotion research or specific

interventions. A variety of means would be desirable, including professional self-regulation, inter-party select committees to monitor developments at government level, and local bodies representing the public, local politicians, health professionals and health promotion specialists. In some areas, enabling legislation might strengthen the powers of such bodies to control activities detrimental to individuals or society.

## Annex 1

### WORKING PAPERS AND BACKGROUND DOCUMENTATION

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of Health and Welfare, 1986.

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Europe, 1986 (unpublished document).

## Annex 2

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