HEALTH PROMOTION AS PUBLIC POLICY:
THE NEED FOR MORAL GROUNDINGS

I) Context of the Debate

The promotion of health was a central tenet of Hippocratic medicine and of Paideia, the Greek educational ideal. (1) Today, in the midst of the golden age of curative medicine, the time of this ancient ideal seems to have come again. There are mounting pleas for extensive national programs of prevention and health promotion. They promise to compete for expenditures with curative medicine. A public debate over the allocation of funds is in the offing.

The debate will focus on the choice between several good things - cure and prevention, personal freedoms and social and economic welfare of the nation. It will turn on such questions as the allocation of scarce resources, the potential conflict of individual and social good and the extent to which even the most benign government may intervene in our personal lives to improve our health habits. (2)

These are moral questions not to be settled on economic and political grounds alone. They involve our conceptions of the good life. Their resolution requires some moral principles against which to measure conflicting goals and obligations. An ethics of preventive medicine and health promotion is part of the expansion of ethical concerns to include a broad range of health-related public policy decisions. (3) (4)
No formal ethics of prevention is currently at hand to set the normative guidelines for the forthcoming debate. This essay offers some tentative principles that might ground the choices. It is tentative and sketchily developed. I hope only to underscore the need for a more formal and fully developed ethics of prevention.

Dr. Henderson's paper today, and the Surgeon General's report of July 1979, (5) urge us to take action as a nation to modify drastically our personal behavior. They point out, as did the the Lalonde report of a few years ago, (6) that billions of dollars could be saved if we eliminate smoking, control obesity, curb alcohol and drug use, modify work and living environments, drive safely, exercise regularly, and cope reasonably with emotional stress. They confirm, too, that the cumulative effects of medical cures on national health are small compared to what could be accomplished by more hygienic living. (7)

Aristotle's conviction that the good society is not possible without healthy citizens seems to be capturing human imagination once again. Unlike the ancients, however, we are motivated by the enormous economic burdens of unhygienic life styles rather than the inherent good of a healthy life or its necessity for the good society. We live in a more organized and interdependent society in which individual actions may quickly touch the lives and pocketbooks of others. Our solutions must be on a national, and ultimately, an international scale. They must go beyond the obvious measures of sanitation, quarantine and immunization. Their success depends upon massive changes in personal behavior - and on an energetic pursuit of the public health.
Our national experiences, however, with the energy and environmental crises, with gun control, and crime show all too painfully our collective proclivity for short-term satisfactions over long-term social benefits. To modify personal health habits, therefore, implies not only some effective form of persuasion but even some coercion in selected instances. The proposed measures range from the mildest kinds of coercion - like education and opinion manipulation through the mass media - to the more forceful, like tax and insurance dollar incentives and disincentives - to the most coercive - legal prohibition.

The social and moral implications of these proposed measures are of the utmost significance in a democratic and pluralistic society. They touch on the kind of life we think worth living, on the things we are willing to trade for good health and economic security, on the balance between libertarian autonomy and government dictates. There is unlikely to be universal consensus on these matters in a democratic society that promises a maximal degree of personal choice. Yet we must define what constraints, if any, we can accept to enhance the common good which promises to elude us unless we do alter our deleterious life styles.

The debate promises to be as difficult as it is indispensable. There are true believers on all sides of the question - some who see health as a new salvation theme for mankind; others who would willingly run the risks of bodily damage and economic disaster so they can pursue their own version of the good life, however deleterious it may be. Still
others place fiscal and economic health as the first needs of a good society and convert economics into ideology. (8)

The line of argument that is, and will be, debated is simple enough: certain life styles result in disease, disability and death with economic consequences damaging to the whole of society. There is therefore a social mandate to encourage healthier life styles in all citizens. But completely voluntary measures promise to be ineffective. Therefore, for the good of all, measures to enforce personal compliance are justified.

This line of argument is customarily advanced or attacked on economic and political grounds because these aspects are more familiar and urgent to decision makers than moral discourse. Granting their obvious importance, economic and political philosophies are themselves grounded in more fundamental human values and these must be more explicitly examined if moral choices are to be made among policy alternatives.

If the forthcoming debates about health promotion are to be better grounded, two things are required at a minimum: 1) Whatever measures are selected for universal application must be demonstrably effective. This is to say, the probability of success is high enough to warrant making difficult choices among competing good things, and 2) the choices themselves must be grounded in some set of explicit moral principles.

In the time allotted me, today, I cannot do more than outline what I mean by these two conditions for a morally grounded public policy debate.
II) Moral Implications of Effectiveness

Debates about the ethical use of new knowledge or techniques often go awry because of unrecognized uncertainties in the data supporting their application. To distinguish what is known with certainty, what is unknown and what is problematic is admittedly difficult but it is the first step in any debate. Experts who are the guardians of "the facts" all too often are "true believers." They are easily tempted to screen out uncertainties in their favored technique or to confuse technical with moral authority.

But experts have no special prerogatives entitling them to make value judgments for the rest of humankind. Their discretionary space is necessarily limited.9 Their unique responsibility is to provide valid fact statements and to outline alternatives. Only in this way can the moral implications of different decisions be properly weighed. Policy makers and moralists working with uncertain facts can go dangerously and foolishly astray.

With respect to health promotion there are two preeminent fact questions in deciding whether a proposed modification of personal behavior is morally defensible. 1) How good is the causal connection between the suspect behavior and disease? And 2) Does the method proposed to modify deleterious behavior actually do so? Decisions about the justifiability of a preventive measure or a method of changing behavior must start with reliable facts about causal connection and effectiveness.
The effectiveness of preventive measures and advisability of widespread promotion depends on the strength of the evidence linking certain personal habits to specific illnesses. Some of the relationships are firmly established; others are suggestive but not proven; and others merely speculative. (10)

For example, there is no doubt now that smoking causes cancer of the lung, larynx, esophagus, tongue, lip, coronary disease, emphysema; that alcohol is linked to cirrhosis, automobile and airplane accidents, and coupled with smoking, increases the incidence of laryngeal and esophageal cancers; that caries is linked to carbohydrates in the diet; that salt and hypertension, obesity and increased morbidity go hand in hand; that asbestos, radiation, and certain industrial chemicals are linked to cancer; that early multiple sexual contacts and herpes simplex viruses are linked to cancer of the cervix; that higher auto speeds, and driving without seat belts or a motorcyclist without a helmet are associated with fatal accidents. In these instances the evidence is direct and obtained from observations in man.

In other examples the evidence is suggestive but not well substantiated in man, limited to subsets of the population, or obtained in test systems whose congruence with human diseases is uncertain. Here we might cite saturated fat and cholesterol in the diet, the utility of vigorous exercise, the damaging effects of stress, the relation to cancer of the nitrites, cyclamates, the cost benefits of multiple screening,
the importance of dietary fibre content, or the relationships of hard water to coronary disease - to mention a few.

In still other examples the relationships are speculative and in need of much more study before preventive measures can reasonably be prescribed. Here we might include the evidence linking a wide variety of food additives, chemicals and drugs, to human cancer, or the epidemiological evidence for higher or lower incidences of cancer, coronary disease or longevity in certain populations where the interactions of genetic, environmental, social and cultural factors have yet to be separated, or the relationship of certain emotional and attitudinal states to morbidity and mortality - or the highly debatable status of high doses of vitamins C, E in human disease, to mention a few relationships hotly contested.

Where the evidence is very strong as in the first group, concerted governmental and public programs would seem justifiable to urge voluntary compliance and even to apply coercive measures of varying types. Where the evidence is suggestive but not fully established, public programs should be undertaken with great caution. Involuntary measures would be difficult to defend morally. Prudent advice through education to individuals might be more in order allowing each person to decide whether he wishes to err on the side of safety and in how many situations. When the evidence is merely speculative only information underscoring the uncertainties would be justified. Even this must be done with caution because if too many common practices or substances are condemned, the
public becomes cynical, throws up its hands, and says "everything causes cancer." This becomes an easy excuse for not changing personal habits, even when such changes would be truly effective.

Even if causal relationships are established personal behavior must be modified accordingly if health is to be promoted. However the same questions must arise about the effectiveness of the methods proposed to bring about a given change in life style.

Education is the most widely used means for eliciting voluntary compliance with recommendations that promote health. Its effectiveness is difficult to assess and often dubious. There are few studies with controls that would show that behavioral change is actually the result of educational intervention. Health habits are tightly woven into the fabric of a person's entire life - his emotional needs, self image, social, family and peer pressures, changing public opinion about what is chic, sophisticated or "macho." Movements like the current fashion in jogging and running, the increase of smoking in young girls, the cult of leanness, the vegetarian trend, the one-a-day vitamin craze, arise in complex matrices in which education may play a major, minor or insignificant role. Changes in smoking habits among the educated may be an exception. But the precise role of education is still difficult to ascertain in determining most life style changes.

Nor is the formal transfer of information about health sufficient. Complementary measures are usually necessary - group discussions, clubs,
buddy systems, individual and group psychotherapy, follow-up visits, hypnosis, bio-feedback, social group reenforcement, medication to mention a few. How much of these measures contribute alone and in combination is still extremely difficult to assess.

Finally some of the most important factors correlating with health habits are insusceptible to education or behavior modification, like marital status, sex, income, social class, family size, geography, race, culture and ethnic identification, or personality type. These are more powerful determinants of response and relapse rates than modifiable factors like information. They are changed only with difficulty and at considerable risk to personal freedom and the character of our entire society.

None of this is to suggest that sophisticated, multi-media educational methods should not be used. It does suggest that selected combinations of methods are usually necessary. But more significantly, we must critically assess the effectiveness of causal connections of deleterious habits and the methods proposed to alter them before undertaking expensive national programs. Moreover, it is on these judgments of effectiveness that the more difficult questions of moral justification of coercive measures must depend.

These admonitions are especially pertinent when we recognize that some of the most effective preventive measures have been less than voluntary - dropping the speed limit to 55 miles per hour, immunization,
fluoridation, childproof medicine bottles, flame proof pajamas, package labelling, to mention a few. Before committing ourselves to even the mildest coercive measures we must have reliable data demonstrating their unequivocal effectiveness. Voluntary measures can legitimately be initiated as experiments when the data are ambiguous but this is scarcely justifiable with involuntary measures.

Involuntary and coercive measures will continue to be needed in specified areas of health promotion. They must be undertaken with a clear perception of the dangers they pose to a democratic society—loss of personal freedom to choose a life style, dependence upon governments to define values and concepts of the good life, and the imposition of cultural homogeneity. Involuntary measures also assume a benign, wise and responsive government—something history finds singularly rare.

Each time we partition resources for specific ends—let us say health promotion versus curative medicine, or versus housing, security, crime, protection of environment—we necessarily limit personal choices about what constitutes a good life. There is the additional question of injustice to those who want and need other good things—like curative medicine, life support measures, and rehabilitation. The poor are at special risk for they cannot pay the costs of surtaxes, increased insurance premiums and of other "disincentives." They cannot enjoy the "luxury" of the wealthy persons to choose health damaging habits. Nor must we forget that one person's prudent, healthy diet and exercise are another person's version of hell—or at least purgatory.
Again, these observations are not meant to argue against health promotion or against morally justifiable coercive measures. They do frame the pertinent questions that need debate if we seek a national policy based on moral as well as economic and political considerations.

III) Some Tentative Moral Guidelines for Health Promotion

There is yet no formally developed ethic of prevention and health promotion which might resolve the moral dilemmas raised in this essay or in Wikler's excellent paper. Yet some guidelines are needed if the Surgeon General's recommendations are to be applied on a national scale. Without them, health promotion is easily susceptible to the extremes of overzealous application by enthusiasts on the one hand and overprompt rejection by libertarians on the other. This is especially so when involuntary measures must be considered. Since I believe the social economic benefits or prevention and promotion will require some involuntary measures, I will close this essay with some tentative guidelines for the morally justifiable use of coercive measures.

The first principle to be observed is that of proportionality. Coercive measures are to be considered only when their effectiveness is unequivocal for large numbers of people and when affecting control extends over a limited sector of life. "The game must be worth the candle." Examples would be such things as immunization, sanitation, limiting carcinogenic food additives, speed limits, helmets for motorcyclists,
nutrition of the newborn, fluoridation, built-in seat belts. The inconvenience of such measures is small, their social benefit is high and their economic advantages considerable.

Even if a measure meets the test of proportionality it must accommodate as closely as possible the democratic principle of self-determination. Voluntary measures must be clearly inadequate at the outset or have failed before coercive measures are contemplated. But even when justified, coercion should be of the mildest sort, compatible with achieving the desired change in behavior. To forestall the imposition of involuntary measures, individuals should be assisted to analyze the consequences of deleterious habits so they can see the value choices they must make and make those choices on the basis of valid information. This is a new realm of moral obligations for health professionals, especially as we move into programs of self care and personal promotion of health.

There are several corollaries of the obligations to optimize self-determination. Inducements, for example, should be favored over disincentives, like tax surcharges or increased premiums. Such disincentives put the poor at a disadvantage. Remediable conditions that make choices less than free must be ameliorated as much as possible through education, by restraints on misleading advertisements, reducing peer and group pressures and treating emotional problems. True education aimed at providing information to enable free choice must be distinguished from subtle use of the media covertly to manipulate decisions even for good purposes.
When involuntary and/or coercive measures are unavoidable, they should be limited severely in matters that are almost personal and private, like sex, family and personal amusements. Regulation should be confined to actions with direct public impact lest moralizing take the place of morality. Restrictions likewise should be placed on those who take deleterious actions and not on the victims of another's unhygienic habits. Those who wish the freedom to choose unhygienic habits like smoking should be restrained by social quarantine from imposing its unesthetic or unhealthy effects upon others in public places, restaurants, in the presence of infants, or in the work place. Social quarantines place the restriction where it belongs - on the source of the socially unacceptable behavior. The same would apply to noisemaking and other forms of non-industrial pollution of the local social environment.

Regulations should always presume in favor of those whose consent cannot be obtained - infants, children, the retarded, and the senile, or those who must work, let us say, in noisy or chemically polluted environments. In general, those who cannot decide should be given the benefit of doubt by legislating effective measures to promote health in their behalf.

These examples are all simply corollaries of the rule in a civilized and democratic society that freedom must be optimized and is to be limited only when it violates the freedoms of others. In an interdependent society, free acts which, taken cumulatively, have undesirable effects on the national economy or quality of life are subject to justifiable restriction. However, no civilized society can abandon those who have
chosen unwisely and fall victim to the physical and emotional disorders that result from their damaging life styles. They must be treated humanely even though at public expense and even when resources are scarce.

The guidelines suggested here in the most preliminary way illustrate how decisions about health promotion might be morally grounded. They obviously do not, in themselves, constitute an ethic of the promotion of health on a national scale. The need for some such guidelines will become more urgent as the nation faces implementation of broad and important recommendations like those in the Surgeon General's report.

What is suggested here in the most preliminary way are some moral groundings for public policies in health promotion. They obviously do not in themselves constitute an ethic of public health or preventive medicine. But the need for some such ethic will become urgent as the nation faces implementation of broad and important recommendations like those in the recent Surgeon General's report.

Today's debates about national policies in health care are urgent enough and universal enough in their effects to become paradigms of the value choices we must make in all policy decisions in a democratic and professedly humane society. Our task is a continuous one – to balance equality and efficiency, personal freedom and social good but to do so in morally defensible ways.
An ethic of health promotion and prevention is but part of an ethic of health care, and both are steps toward a larger enterprise - an ethics of responsible citizenship and moral governance. It is a mark of a civilized society that its citizens can perceive the tensions that conflicting good things may engender and yet balance them in reasonable and moral ways that avoid the easy seductions and evils of the extremes.
REFERENCES


References - Continued


10) No attempt is made here to cite the voluminous literature supporting these statements. Nor is a special case being made for the classification. What is essential is that there are varying degrees of certitude as to causation and in each instance that degree must be ascertained as precisely as possible or moral implications cannot be correctly weighed.
