(Social) Marketing and Ethics: Should we, and can we, help people change?

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Introduction

Whilst the benefits accrued from living a 'healthy lifestyle' are numerous, including overall positive health and wellbeing, the extent to which diseases such as obesity are currently increasing within the UK highlights the growing numbers of 'unhealthy lifestyles' being followed. In particular young adults, principally those aged 19-26 years, are exhibiting erratic lifestyle choices, such as binge drinking, lack of physical activity and poor diets. These three factors alone contribute significantly to weight gain and increasing obesity levels. The author's PhD research provides a basis for the arguments presented in this paper concerning ethics, (social) marketing, and consumer behaviour change. The research aims to identify the attitudes and perceptions of a group of these young adults living in the North East of England, concerning their lifestyle choices. It aims to: 1) profile the typical lifestyles of these young adults; 2) seek to explore barriers to living healthily, and 3) make recommendations to help overcome unhealthy lifestyle behaviours. Underpinning this is the utilisation of a social marketing framework. Ethical arguments put forward in this paper concern the utilisation of social marketing techniques which seek to change individual behaviours in the area of lifestyle-related behaviours. The specifics of how social marketing can help people change will not be covered. Rather a more general view of the use of social marketing and the implications of using such an approach in relation to behaviour change ethics will be considered.

To be clear about the terms of reference in this paper a brief definition of 'health' and 'healthy behaviour' will be made here. The World Health Organisation (1998: 1) (see also Nutbeam, 1998; Green and Raeburn, 1988, Yeo, 1993) defines health as "a state of complete, physical, social and mental wellbeing, and not merely the absence of disease or infirmity". Healthy behaviour is further defined as "any activity undertaken by an individual…for the purpose of promoting, protecting or maintaining health" (World Health Organisation, 1998: 8). This paper discusses whether we ('we' includes all actors who have some part in individual and community behaviour change initiatives) *should* attempt to help people change their health behaviours; and if so, *how* we can help people change, with a particular emphasis on social marketing.

Should we help people change?

Individuals want greater personal control over their lifestyle behaviours and decisions. The Department of Health (2004) recognise that individuals increasingly see their lifestyle decisions as a personal matter, and for which they value *less* government involvement and coercion. That is not to say that they do not want support from the government in making these decisions, just that they would like the choice to be able to make these decisions for themselves. Thus, they value personal and voluntary behavioural decisions, as opposed to being told what to do, or having little manoeuvre in what they are able to do (Cabinet Office, 2004; Department of Health, 2004). In order for individuals to possess this individual autonomy and freedom in their decision making, it could be argued that they must also accept

the “causal responsibility” that comes from this “free will” (Yeo, 1993: 231). Thus individuals must accept that their behaviours in the present will be responsible for their health outcomes in the future. Some may argue that this allows individuals empowerment over their health and lifestyle behaviours (Yeo, 1993). However, this view may also be flawed. Duncan and Cribb (1996) argue that individuals may not possess the (both intellectual and wider resource) capacity to determine their lifestyle behaviours in the best possible way. Hence, should individuals be granted total responsibility for their health behaviours, given their decision-making constraints, or should others (e.g. government) intervene?

In terms of whether there should be intervention in public health behaviours, it is perhaps important to distinguish between the areas in which these interventions would impact. Beauchamp (1983) acknowledges that individuals operate within both public and private life spheres. In these terms individuals and their actions will impact not only upon themselves, i.e. within their private sphere, but on others, i.e. within their public sphere. It is concern with this public sphere impact that is of relevance. As this public sphere encompasses others, respect to the ‘common good’ is important (Beauchamp, 1983). However, due to the presence of a private sphere, it is also important to respect individual autonomy and privacy rights, and to only enter this sphere when absolutely necessary (Beauchamp, 1983). Thus, in terms of influencing consumer behaviours, practitioners should be mindful of individual rights. However, it is asserted that health promotion techniques have some way to go to infringe these private rights (Beauchamp, 1983). Taking such a stance would seemingly advocate the use of health promotion and behavioural change techniques as being of both public and private benefit (or at the very least, not harmful to individuals).

Mindful of these public and private spheres in which individuals operate and the view that individuals want to make their own personal choices with respect to food and alcohol consumption, and levels of physical activity, the element of risk is a further concept worthy of attention. Whilst health promotion and behavioural change techniques may impact on individuals’ sense of personal responsibility and autonomy, not taking any action is argued to be more harmful to individuals, in that “intervening is always justified because not doing so will always lead to greater eventual harm” (Duncan and Cribb, 1996: 342). With respect to healthy lifestyles, allowing individuals complete personal responsibility over their food, alcohol and physical activity behaviours is seemingly, and currently, only leading to negative health, economic and wider outcomes, including rising levels of obesity. Thus action, whether in the form of policy, legislative measures, or behaviour change initiatives would appear to be worthy, given that they may help in improving such negative externalities arising from these lifestyle behaviours.

This element of risk associated with the lifestyle decisions that individuals make is relevant. This risk, for instance whether unhealthy lifestyle behaviours are linked to ill-health, or whether ill-health in one person risks negatively impacting other people, indicates a multifaceted context in which to implement behaviour change initiatives (Bayer and Fairchild, 2004). Of course, there are those who argue for, and also against, the view that unhealthy lifestyle (food, alcohol, and exercise) behaviours impact on others and not just the person who follows them (Bayer and Fairchild, 2004). However, considering the need to manage this potential risk and taking the values underpinning the precautionary principle, it is deemed appropriate for the management of risks to adopt a precautionary, rather than a reactive stance (Bayer and Fairchild, 2004; see also Kriebel and Tickner, 2001).

Adopting such an approach would mean that failure to act in the face of risk could potentially

be more costly in the long term (Bayer and Fairchild, 2004). A cautionary word is appropriate however. Some argue that there needs to be clear and specific identification of cause and effect in terms of any risks proposed. Thus, in terms of lifestyles and public health, there would need to be a clearly identifiable link between unhealthy lifestyles of one person and the associated impacts and risks for that person and the wider population, before action is deemed necessary (Jamieson and Wartenberg, 2001). On the other hand, it is just as relevant to say that even if it is difficult to clearly identify such links, it may be just as reasonable to regulate behaviours/products/systems, given *potential* risks (Jamieson and Wartenberg, 2001). Thus, one (paternalistic) viewpoint would be that interventions are justified when lifestyle behaviours impact on the wellbeing of that individual and common others (Yeo, 1993). Pellegrino (in Yeo, 1993: 229) accepts the use of health promotion interventions, which account for the "principle of proportionality". This implies that any coercive aspects of intervention must be proportionate to the expected gains, and for which the gains must increase as the coerciveness of interventions increase (Yeo, 1993). Thus, overall intervention is useful (and necessary), but should be carefully managed.

Problems arising from behaviour change initiatives include whether the behavioural change outcomes are viewed of benefit to both the public health practitioners overseeing the behaviour change initiative(s), and those individuals directly involved and affected by it. Additionally, the values that underpin these initiatives, such as better health and wellbeing from leading healthier lifestyles, may not be similarly viewed by both the health professionals and individuals. Individuals may not just "want the health that is being offered to them" (Duncan and Cribb, 1996: 343). In this respect, invasion of personal autonomy could be argued (Duncan and Cribb, 1996). However, as Bayer and Fairchild (2004) assert, the challenge is not to 'squabble' over issues such as invasion of personal responsibility, or the degree of coerciveness of change interventions, but to be able to better define the times where intervention/regulation is needed and how best to implement this, whilst preserving overall individual free choice.

Can we help people change, whilst best accounting for ethical considerations?

Given that it would seem reasonable to assert that health promotion interventions can be ethically justified, the question now arising is how best can health promoters help people change their behaviours, given such ethical considerations? As Yeo (1993) highlights, health promotion and behaviour change techniques can be plotted on a continuum from voluntary, to more coercive initiatives. The issue arising from such a metaphorical continuum is where these health promotion initiatives should sit, given values such as "health, freedom, responsibility, and the common good" (Yeo, 1993: 226). Considering the individual-versus-the-system debate, health promotion techniques can be further divided into those that are more 'individual', and those that are more 'system' based. The individual approach would focus on individual behaviours determining overall lifestyles, and thus target individuals rather than mass groups (Yeo, 1993). Such measures will be less coercive, and more voluntary. On the other hand there is the systems view. This standpoint accounts for wider behaviour determinants outwith of the individual, such as the "social, economic, political, institutional, cultural, legislative, [and] industrial environments in which behaviour takes place" (Green and Raeburn, 1988: 152-153). It could be argued that implicit within this system's view is the assumption that individual behaviours are, as a consequence of wider determinants, not wholly based on individual choices, personal responsibility and individual freedom (Green and Raeburn, 1988). Indeed Yeo (1993: 228) argues that "the power of free

will" is erroneous, given that risks (such as health risks from leading an unhealthy lifestyle) are often imposed by the environment in which individuals are situated. The example of advertising pressures is used, where unhealthy lifestyles are often a product of "systemic pressures", and as such "are not so much chosen as they are programmed" (Yeo, 1993: 228).

One such approach for behaviour change, which the author argues encompasses both individual and system-based values, is that of social marketing. Social marketing in this respect aims to assist individuals to modify the behaviours themselves, in a voluntary and highly-participative manner (Yeo, 1993). Social marketing acknowledges individual attitudes, perceptions and behaviours; but also investigates and accounts for wider behavioural determinants stemming from the environments, cultures, and social situations in which individuals find themselves (National Social Marketing Centre, 2006; 2007). Green and Raeburn (1988) would perhaps class social marketing as part of an 'ecological view' of the world. This view prioritises both individual and environmental factors.

So then, if it has been distinguished that at times health promotion interventions are appropriate in respect to changing lifestyle behaviours, and if ecological viewpoints are considered, can techniques such as social marketing be advantageous? What benefits of adopting such an approach can be accrued, and can this approach help to overcome aforementioned ethical issues? Thinking about the risks involved in health promotion and behaviour change as identified above, Kriebel and Tickner (2001) suggest that if there is any uncertainty, then the best solution would be to involve individuals *and* communities within any health promotion initiatives. In doing so, both 'experts', individuals and communities are active participants in behaviour change for health (Green and Raeburn, 1988). This is one advantage of using social marketing. Social marketing places the individual at the very centre of all it aims to achieve. Thus, the individual is involved in: 1) identifying behaviours to be addressed/changed, and 2) the gathering of insight and understanding of these behaviours (given research methods such as focus groups and interviews). In addition the individual is involved through mutual communication exchanges between the social marketer(s) and the individual/community. They can suggest and evaluate the behaviour change interventions that *they* think will help and work for them, rather than simply being told what to do. This process of "enabling" (Yeo, 1993: 233), or empowering individuals in their own health care, helps to overcome disconnections between individual and system determinants of health.

Social marketing, and other approaches like it, will thus offer a more even platform for behaviour change and health promotion, where health professionals and individuals are not arranged in a hierarchical way, but in a more equal and participative way (Green and Raeburn, 1988). By overcoming 'totalitarian' approaches to health care, and by involving individuals, as social marketing does, people can be involved throughout all policy and behaviour change initiatives, from conception to end[1]. Duncan and Cribb (1996: 345) argue that such behaviour change approaches (of which social marketing could be included) inherently acknowledge ethical issues, with "empowerment" and "self-determination" being built into the techniques. Answering the dilemma of whether we, as health professionals, can help people change; there are current health promotion and behavioural change techniques that consider individual rights, responsibilities and freedom. Techniques, such as social marketing, aim to involve individuals and communities at each and every stage of the process,

[1] Of course, there are arguments which highlight shortcomings of social marketing, but this paper does not seek to offer a critical review of social marketing concerning both its benefits and limitations.

in ways which they agree to, and see the benefits of. Those involved will only do what they want to do. In this sense, how can techniques such as social marketing impact on individual feelings of freedom and choice, *if* they are carried out correctly, effectively and in the best possible manner?

Such health promotion and behaviour change initiatives, such as social marketing, use both the expert resources of both the health professionals, i.e. the social marketers, and input from the community or individuals of focus. One aspect of tension which Green and Raeburn (1988) highlight considers where the control of power sits, whether that is with the health professionals or the individuals. With social marketing this power is more evenly distributed between both parties, as it is recognised that individual input and insight is crucial to the success of social marketing-based, behaviour change interventions. This effectively means that "power, knowledge, skills and other resources" are not taken away from the individuals involved (Green and Raeburn, 1988: 156). Again, it could be said that if individuals retain a degree of power and control over their health behaviours, when adopting such an approach as social marketing, then they are not losing aspects such as freedom and choice when it concerns their health behaviours.

Conclusion

Indeed "because the discourse of health is so powerful, and because so much of our economy is health-based, different groups and institutions have different interests in how health and health promotion are conceptualized" (Yeo, 1993: 227). Thus, for one group they would see such health behaviour change techniques as invasions of their personal privacy, freedom and control, whereas for others they may see such interventions as empowering, and self-enabling. Thus, no intervention will be unanimously and positively viewed by all those it seeks to help. It is proposed that interventions such as social marketing may help to ease feelings of discontent where ethical issues of freedom and privacy are concerned.

Indeed marketing and social marketing are both forms of "voluntary exchange" (Brenkert, 2008: 17). Voluntary exchange thus implies that individuals have, to a degree (given variables such as income, education, social class) unimpeded options when it comes to the behaviours and choices they make. Additionally, competency and informed choice must be prevalent given that a certain degree of knowledge is required to enter into such exchanges (Brenkert, 2008). Certainly Brenkert (2008: 4) argues that we should not be debating "whether freedom is required, but how much and what kind(s) of freedom" is needed; whilst Yeo (1993) advocates that this debate needs to be refocused, such that notions of freedom no longer provoke tension, but act as a foundation for community involvement in public health issues, helping to then support personal freedom. It is then up to both the health promotion professionals, working *with* individuals to best decide how much, and what type of intervention is required, not whether such health promotion should be used at all. Indeed the ethics of marketing is a volatile and complex area, particularly that if you think that 'commercial' marketing often seeks to persuade individuals to buy/eat/do certain things, and approaches such as social marketing seek to undo/change these, or get us to do the opposite. It is no wonder that the individual members of the public (and professionals) become confused, and that such ethical arguments surrounding (social) marketing and health promotion become tricky to navigate.

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