

For debate: the means/ends problem in health promotion

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There are several ways of evaluating mass-communication efforts in health promotion. Most are concerned with empirical questions of whether and how messages influence particular dependent variables such as knowledge, attitudes, intentions, behaviours and health status. In this tradition, there is much debate about the efficacy of different emphases, which concentrate on issues such as whether the use of fear can be effective^{1,2} or how the perception of risk might be improved.^{3,4} However, mass-mediated messages — the most public face of health promotion — are also evaluated against criteria that have nothing to do with their effects on health-related outcomes. These concern a-priori preconceptions about what health-promotional communications should or should not resemble. This paper is a critical examination of some of these preconceptions.

The impact of criticism

Any instance of mass communication, be it a film, poster, slogan or advertisement, will produce a range of reactions in different people; these reflect aesthetic, ideological and moral values, or often simply a boredom/arousal response. Health-promotional efforts in mass media are no different, and there are few campaigns that fail to attract critics who carry a range of ideological baggage. Recent large campaigns concerning the acquired immunodeficiency syndrome (AIDS) and heroin abuse have been both criticized and defended widely in Britain and Australia. Being by nature and intent conspicuous and attention-getting, health-promotional mass communications tend to be discussed inordinately relative to prevention's over-all standing and resource base within the total health-care system.

Being a political "good-news" area, health promotion's supportive rhetoric sporadically runs at fever pitch. Yet in spite of its

occasionally-celebrated high public profile, the discipline remains the Cinderella of health care; its poor funding turns it into metaphorical pumpkins with the regular midnights of health-system belt-tightening.

Health promotion universally is funded poorly relative to total health-care expenditure. There is an entrenched view in significant echelons of health systems that health promotion is a luxury: the fat on the lean of systems which fundamentally are concerned with cure and palliation. When health promotion addresses problems of chronic disease, when successes often ultimately are determined decades away, health-promotional efforts seldom have the potential for public alarm when pruned or postponed.

By contrast, the curative aspects of health care often are defined unquestioningly as urgent. Regardless of their efficacy to prolong life or to improve health status, the ready ability of curative fields to admit personalized argument in their support, places them at an enormous political advantage compared to the obtuse, population-based logic for prevention. The mere availability of a particular procedure, regardless of its efficacy, at least offers hope for a cure or a remission for individuals whose plight will draw a sympathetic response from the popular press in the face of threats of curative-budget cuts.

Sceptical critics of health promotion in curative areas of health care are able to wield here-and-now, pain-and-blood invocations to increase even further their slice of the resource cake. In the bear-pit of financial allocations during no-growth periods of health financing, the axeing of allegedly-expensive health-promotional campaigns can be cast in terms of a climate of restraint and an unquestioned commitment to continue curative services.

Unlike many areas of health and medicine, the high profile of health promotion makes it open continually for public inspection and comment. The frequent airing in public of critical "dirty

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laundry" by health-promotional circles has the potential for particularly serious consequences. When health-promotional efforts are criticized and their defence is ill-considered or feeble, the vulnerability of the field is increased.

This article was inspired by recent experience of the virtual dismantling of a high-profile and demonstrably-successful⁵ mass-mediated smoking-control campaign — the NSW "Quit. For Life" campaign — after a rising crescendo of criticism from those who did not "like" it. Many of the criticisms that were made of this campaign are common to those that are examined below.

This article has been written in a spirit of wishing to make explicit the principles that are central to most of the common criticisms that are made of health promotion, to examine their assumptions and to pose the dilemmas that remain for continuing debate. The means/ends dilemma concentrates many of these.

The means/ends dilemma

A recurrent ethical dilemma in health-promotional practice is the extent to which means can justify ends and the related problems of hegemony in the different values that are invoked in the arguments that characterize this problem. Obviously, the problem is not confined to health promotion, and is a classic preoccupation of political and moral philosophy. The four examples that are discussed below illustrate the horns of some of the characteristic dilemmas in health promotion. Some ethical principles that are involved are identified, and a series of questions are posed in invitation to debate in the correspondence columns of future issues of the Journal.

The following examples are Australian and British television advertisements in the smoking-control field. These have been chosen, not because I believe that the criticism in this area deservedly is high, but because its high priority in health promotion has caused an intensity and diversity of work to be produced, and has provided many examples for critics relative to other issues.

Case studies

"Pretty face" — Department of Health, Western Australia
Over 30 seconds, a young, smoking woman's face metamorphoses into that of an old witch-like woman, with the implication that smoking plays an important part in accelerating the ageing process, especially skin quality. As the transformation occurs, the narrator says, "When you don't smell all that pretty, you don't feel all that pretty [...] and somehow you don't look all that pretty. What good's a pretty face when you've got an ugly breath?"

Production rationale. Market research into the target group (young female smokers) revealed strong and widespread concern about the perceived cosmetic consequences of smoking. This concern appeared more likely to prove as motivational to smokers to quit than would be messages that concerned "orthodox", sex non-specific health consequences such as lung cancer, about which there exist considerable indifference and feelings of invincibility.

Concern that smoking might age the skin, make breath and hair smell unpleasant and generally look unattractive were beliefs that already were current in the target group. These suggestions held promise as motives that could be amplified through a campaign and lead to reductions in the prevalence of smoking. The view that smoking smells unpleasant is widespread and there is no concern that the sensitivities of those with halitosis should be protected: there is no lobby to criticize the breath-freshener industry as victim-blamers. The advertisement holds up a mirror to a widespread negative consensus about smoking.

Criticism. Of all the information and persuasive appeals that could be directed at female smokers, this one is trivial and is at the expense of the messages that have not run in its place. The issue of women and smoking, through this process of selection under advertising budgetary restraint (advertisements cannot be made about every "angle" on female smoking), becomes constructed publicly as "women who are smoking = ugly, smelly women"; this is different from smoking men who remain constructed as unhealthy and at risk

of serious diseases such lung cancer in most of the advertisements that are directed at them.

It is not disputed that significant numbers of the target group appear in market research to be more concerned about their appearance and smell than about their health. However, this finding reflects a prevalent consciousness in women that is a product of dominant patterns of female socialization and is fuelled by ideological-state apparatus,⁶ such as the educational system, the family and advertising. By accepting the logic and political assumptions of the view that dictates that advertising must always reflect subjective realities rather than attempt to change them, health promotion acts as a force to conserve and to reproduce these dominant (socially-constructed) subjectivities. Sexism is real, but health promotion should not appropriate it for its own ends.

Questions for debate. If we are committed to a research process that involves taking seriously the views of a community group about their motivations and interests in precampaign research, how do we justify the rejection of their views if they reflect views that are unpalatable to persons who are not part of the target community (such as health educators)? Who is to decide which consequences of a risk behaviour are the more serious in the day-to-day lives of a target group?

Accepting that bad breath is trivial compared to the serious health consequences of smoking, why, essentially, should this disqualify it from use if it is known or suspected to be a more powerful motivator? What principle dictates that focusing on the more serious consequences of a high-risk behaviour should take precedence over messages about less serious outcomes, if these allegedly-trivial consequences are (in fact) of more concern? What criteria ought to decide which aspects or consequences of a problem describe the ideologically-"correct" definitional parameters of the problem?

Would this advertisement be acceptable if it somehow depicted men who smoked as ugly and smelly too? More fundamentally, if a health problem is one that can affect both sexes, is it necessarily sexist to depict just one sex in an advertisement? Alternatively, should advertisements on such subjects be obliged always to show mixed-sex groups?

"Kathy" — Health Education Council, United Kingdom
A nine-year-old girl listens to her smoking father cough repeatedly. While secretly she is looking up "lung cancer" in the family medical encyclopaedia, her father interrupts her. She grasps his hand plaintively and gives him a pleading look. The narrator's voice says, "If you won't give up smoking for yourself, do it for your kids".

Production rationale. The advertisement attempts to appeal to the powerful and prevalent motivation in parents to keep healthy and alive in order to look after their children, and not to create anxiety in children. It targets the parent who is fatalistic about or indifferent to his or her own health, but is concerned to be a good parent. At base, the advertisement appeals positively to parents' sense of wanting to be giving, providing and sacrificing, or negatively, to their desire to avoid guilt by not fulfilling these roles.

Again, the advertisement is an example of a reflecting mirror on processes that are at work already: many parents do feel guilty about smoking and most children would be concerned that their smoking parents may die or become seriously ill.

Criticism. While some parents are likely to stop smoking after exposure to this advertisement, many more will not decide to stop. Therefore, the advertisement will produce anxiety in some children about their parents' health. Some of those parents who do not stop smoking may have severe dependence problems; they may smoke as a response to a stressful working or social environment; they are "victims" whom it is offensive to blame or to make feel guilty by invoking the concern of their children. Moreover, this is a good example of health promotion's frequent preoccupation with "negative" messages rather than the "positive" consequences of desired changes.

Questions for debate. Why, essentially, is it wrong for health promotion to amplify guilt with a view to having it motivate certain

changes in health practice? How can the relative values of two outcomes (success in persuading such parents to stop smoking, and anxiety in children of parents who do not succeed in stopping) be compared? If, empirically, such approaches can be shown to be effective, does this exempt them from this criticism, or is such a fate reserved only for those that fail?

Is the increasing insistence that health promotion should emphasize the "positive" a dogma that is based on empirical evidence that such appeals are more successful than are "negative" appeals? Or is it a statement of value masquerading as fact, which is bred out of a concern that to bring bad news is a more thankless task for health educators than to be harbingers of glad tidings? The evidence on the effects of fear-appeals is highly equivocal and hardly admits generalizations.¹

"Only dags need fags" — Health Department, Western Australia

This is a cartoon series of advertisements that feature anthropomorphic schoolchildren/animals. The character who smokes is shown as graceless, behind-the-times and somewhat outcast compared to his peers who are non-smokers. The advertisement ends with the slogan "Only dags need fags". (A "dag" is Australian school-yard vernacular for "a person who lacks style or panache" [*The Macquarie Dictionary*, 1983].)

Production rationale. Peer influence has long been identified as a critical vehicle for the adoption of both healthy and unhealthy behaviours. This advertisement appropriates current school-yard vernacular in the form of a slogan that is tailored to be used by non-smoking children as an affirmative anthem against their hitherto glamourless, underdog status as obedient non-risktakers, who are reviled in school cultures that place a high status on the symbolic defiance that smoking represents.

Criticism. This advertisement plays hopes for gains in one health issue off against potential losses in another. While it may make non-smokers feel better about themselves, this may be at the direct expense of smoking children, who may suffer the consequences of ridicule that is directed at them. If it is accepted — as often is expressed in health-promotional literature — that smokers use cigarettes instrumentally as social props against low self-esteem, stress and problems of identity, then to ridicule this prop in the manner of this advertisement is equivalent to kicking the crutches from beneath the disabled. Health promotion should seek to enhance self-esteem, not to undermine it. Equity considerations demand that the self-esteem of one group should not be at the expense of that of another.

Questions for debate. This advertisement, in attempting to subvert a dominant pattern of status, challenges the *status quo* of contemporary school culture. Notions of smokers as heroes, as glamorous and as embodying other aspirational qualities, are not inherent in the act of smoking. Rather, they are constructed by the appositions that are proposed in cigarette advertising and then are perpetuated by their reproduction in peer groups.⁷

Is not a decision to respect the social definitions of smoking that are provided by tobacco advertising, by sympathizing with smoking children who may feel affronted by having these definitions ridiculed, a decision that plays right into the hands of the tobacco industry? Is not a successful effort in persuading children to remain non-smokers and perhaps to convince smokers to quit, an example of a higher-ranking objective than the possibility that some sensitive children may be hurt by name-calling by others about their smoking? *"You could lose a leg" — Health Education Council, United Kingdom; and "Gangrene" — NSW Department of Health* These are two advertisements that show amputation as a consequence of the peripheral vascular disease that is caused by smoking. In one, a youth is seen in an artificial limb factory saying "some people think that smoking is attractive [. . .] I don't think artificial legs are very attractive". The other is a poster of a line of one-legged people which is captioned "Gangrene — one of the least attractive aspects of smoking".

Production rationale. The health consequences of smoking (heart disease, various cancers, and so on) lack "dramatic" potential in health education. Being chronic diseases, they may become evident only many years after regular smoking commences. Further, their development is internal and therefore hidden away — out of sight, out of mind. By contrast, gangrene, as a precursor to amputation, is highly dramatic. Precampaign research showed that amputation was viewed as highly undesirable; that it was understood mostly as a consequence of accidents; and that linking it with smoking constituted very new information to smokers, in an informational context that was characterized by feelings that "we've heard it all before".

Criticism. After the screening of this advertisement in Britain, the parents of a child with an artificial leg complained that the child was distressed that artificial legs were being described as unattractive. The advertisement subsequently was withdrawn from broadcasting. This understandable response was probably common in many amputees who saw the advertisement but did not complain. Again, this is an example of health promotion playing potential benefits to one defined group (smokers and potential smokers with limbs intact) off against another (amputees whose feelings might be hurt).

Questions for debate. Many diseases and behaviours result in consequences for their victims that are unpleasant (burns, injuries, obesity, infertility, and so on). Knowledge of these unpleasant consequences is the principal reason why many persons avoid behaviours or circumstances that increase the risk that these things would happen to them.

In the massive 1982 British Office of Population Censuses and Surveys' study of smoking attitudes and behaviour, 41% of ex-smokers named an episode of a current illness, and 22% of ex-smokers named fear of future illness, as the reasons that motivated them to quit.⁸ Without a full or reasonable appreciation of (for example) the distressing and fatal consequences of AIDS, it is unlikely that a desire to avoid the disease would develop with much conviction. Since no one is arguing that a policy of withholding information from the public about diseases and injuries is defensible, the question becomes one of the extent and manner in which information about consequences is presented.

Given that information always represents a process of selection — certain facts from the many that could be emphasized are deemed relevant — what criteria should motivate the selection of facts about the consequences of smoking? Given that the selection of facts and emphases unavoidably will be motivated by explicit or implicit criteria, how useful is it to speak of pristine "information" as opposed to motivated "persuasion"? If this distinction is artificial, and all information turns out to owe its selective existence to a motivated intent to persuade, then what criteria should place limits on persuasion in health promotion (aside, presumably, from a respect for the truth)? If the objective of health promotion is for it to succeed, then should health promotion not take heed of empirical research into the best way of doing this?

If research finds that people do find amputation unattractive, what is the difference between simply depicting amputation in health education — letting the facts speak for themselves; a picture says a thousand words, and so on — and captioning such a depiction with the words to the same effect?

If some amputees are offended by the depiction of their misfortune as a motivating warning to others, might not also AIDS victims be offended by descriptions of their disease in terms that suggest it should be avoided? Or quadriplegic persons by warnings about the outcomes of motor-cycle crashes?

Discussion: ends in health promotion

If means can ever be justified by ends, then the nature of such ends are worth examination. The criticisms that are instanced above concern various means to attain the ends (that is, the objectives) of smoking-control policy. The goals of smoking control are to reduce the prevalence of smoking in order to reduce the burden of disease,

the consequently-reduced quality of life and the premature mortality that is caused by smoking. The extent of this burden has caused smoking to be described as the single leading cause of death in Western countries, and for smoking control to be nominated by a number of important reviews as a leading priority for public health.

Other objects of health-promotional efforts are equally serious: stroke is often a devastatingly-debilitating disease; road crashes and burns can disfigure hideously and change lives utterly; pelvic inflammatory disease and other sexually-transmitted diseases can render women sterile. Many further examples could be instanced. However serious many of the criticisms of aspects of health promotion may be, sight should not be lost of the high moral imperative of the tasks that are set for it: to prevent the above serious and unwanted consequences of disease and injury.

Thus, prevention occupies a high moral ground if values such as the opportunity to live a long, fulfilling and disease-free life are accepted. The examples that are discussed above show that the ends that are sought by smoking control can conflict with many different and diverse values. Therefore, the ethical issues for policy about health-promotional practices include those of whether its particular ends can ever be achieved without such conflict; whom this conflict offends; and whether offending such persons really matters. Except in those rare circumstances when no one takes issue with any aspect of a persuasion, the resolution of means/ends dilemmas inevitably requires a choice among values. This resolution can be attained in several ways.

First, values can be ranked in terms of their importance. For example, trivial freedoms such as the freedom not to wear a car seat-belt often have been sacrificed in public-health policy for the sake of the prevention of serious injury and illness. The order of such rankings are not self-evident, and frequently will be different when undertaken by different interest groups. However, rankings and explanations for them at least declare the hands of critics and render argument possible.

Next, those who make particular criticisms can be rated as worthy of respect or otherwise. While criticism generally should

be met on its own terms rather than being deflected by ad-hominem responses, the intent behind criticism often is explanatory of its emphasis and omissions. For example, criticism of smoking-control efforts from the tobacco industry, its fellow travellers and tame scientists is motivated by a desire to protect investments and incomes, rather than from any genuine desire to correct the public record on matters of public health. Their criticism is opportunistic rather than principled and it is only the naïve who are moved to take it seriously.

Many of the objections that are levelled at health-promotional messages from within the health-promotional and the health-care fields concern criticisms that can be made of the vast majority of commercial advertising. These critics seldom have records of opposing advertising actively outside the health field. Therefore, the sincerity and motivation of their selective concern for advertising themes that are found in only some areas of advertising become a relevant question. In reply, such critics sometimes retort that standards in health promotion should be above those that are in evidence in the commercial world. This is a noble sentiment but, as is shown above, one that is more of a rhetorical flourish than a helpful principle in guiding the assessment of any given health-educational message.

Finally — and most often though — the resolution of criticism tends to be capricious or determined by extraneous factors such as when an advertisement has been made and screened no money is left for revisions and, therefore, the best must be made of what is available.

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