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Published in:
International Journal of Marketing

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Recommended citation(APA):
Holden, G., & Cox, D. (2013). Public health marketing: Is it good and is it good for everyone? *International Journal of Marketing*, 52, 17-26.

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1-1-2013

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Recommended Citation

Stephen S. Holden and Damian Cox. (2013) "Public health marketing: Is it good and is it good for everyone?" *International Journal of Marketing*, : ISSN 2306-7217.

http://epublications.bond.edu.au/business_pubs/785

Public Health Marketing – is it good and is it good for everyone?

Stephen S. Holden · Damian Cox

Abstract We define public health marketing broadly as the use of marketing tools (segmentation, targeting, positioning, and the four Ps) to encourage behaviour change that will deliver the social good defined as public health. We explore the ethical challenges and risks that confront public health and social marketers. In particular, we note that public health marketers with a self-defined goal of delivering a social good face two major ethical challenges: the first is establishing the ethicality of the social good itself; the second is distributing the social good in an ethically defensible way. In particular, we draw attention to the central conflict of balancing the utilitarian benefits of public health with the rights and needs of individuals. This in turn leads to consideration of the issues of paternalism and the degree of influence that might be deemed appropriate for public health marketing.

Keywords Ethics · morality · public health marketing · utilitarianism · autonomy · justice · liberty

What are the key ethical challenges facing public health marketers? How do these challenges differ from those confronting commercial marketing? We argue that public health marketers confront a number of important ethical challenges beyond those facing commercial marketers. Our discussion is framed in terms of the ethical issues in public health marketing. As public health marketing is a form of social marketing, much of what we say also applies to social marketing generally.

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The claim that public health and social marketers face unique ethical challenges is different from the frequent assertion that social marketers should be held to higher ethical standards than commercial marketers. Murphy and Bloom (1992) suggest that social marketers need to be more ethical because they are promoting a social good. Pragmatically, Andreassen and colleagues (Kirby and Andreassen 2001; Kotler and Andreassen 2007) suggest that the ethics of social marketers should be beyond reproach as they are likely to be in the glare of publicity and unethical behaviour may threaten future funding. As Kirby and Andreassen state, “it would be hypocritical for social marketers to urge ‘good’ behavior while at the same time behaving ‘badly’ themselves” (Kirby and Andreassen 2001, p.162).

We acknowledge these calls for social marketers to be ethical, but note that they do not draw attention to the nature of the ethical challenges confronting public health marketers, and particularly those that are unique to social versus commercial marketers. Specifically, we contend that promotion of a social good is ethical only if the putative social good is genuinely good, and is properly and justly distributed. We acknowledge that public health and social marketers assume this to be the case, but we argue that this is not sufficient. The goals of public health marketing like “the goals of public health are too often assumed or simply asserted, rather than cogently explained or justified” (Gostin et al. 2007, p. 57). The examination of such assumptions is especially important as the social good promoted by public health marketing is established independently of the public whose well-being is allegedly being served.

Commercial marketers do not encounter these ethical challenges. The ethical challenges for commercial marketing principally revolve around the means employed to satisfy corporate goals. For example, commercial marketers may engage in manipulative or dishonest practices to achieve their ends (Barksdale et al. 1976; Murphy and Bloom 1992; Murphy 2010). Of course, public health marketers may do so as well as has been noted for instance, in deceptive reporting of statistics relating to the ill-effects of

tobacco consumption (Donovan and Henley 2010; Hatton 1994; Johnstone and Ulyatt 1991). However, both commercial and public health marketing confront similar challenges in this regard.

In this paper, we focus on the special set of ethical challenges facing public health and social marketers. We note that the approach taken in this paper is conceptual rather than empirical, analytical rather than descriptive, philosophical rather than research-based. We pose questions that might cause public health and social marketers to pause and reflect on the ethics of their domain. We do not offer solutions. There are no off-the-shelf solutions to complex ethical problems. Solutions must be developed on a case-by-case basis. What we offer is an overview of the ethical issues in public health marketing. We use examples that are deliberately chosen to illustrate points being made; they are not chosen randomly and accordingly, are in no way intended to be interpreted as representative. As Radcliffe-Richards has observed, "philosophical questions, in contrast with ... questions about matters of fact, can be classified roughly as those whose solution has nothing to do with empirical matters, but depends on reasoning; on techniques like finding contradictions, showing what follows from what, exposing ambiguities, working out presuppositions, clarifying confusions, and so forth" (Radcliffe-Richards 1980, p.5).

Our objective is to initiate an examination of the special ethical risks facing public health marketers. We do this by addressing a set of four questions (see Table 1 which outlines the structure of our paper). Before we can address the important ethical issues, we begin by (#1) defining public health marketing, and addressing the issue of (#2) whether public health marketing is intrinsically ethical. We then identify and discuss two key ethical challenges and risks for public health marketers. The first is (#3) how public health and social marketers defend the ethical value of their goal which we call 'social good.' As we pose it, "What is good about 'social good'?" The second is (#4) how public health and social marketers defend the social good against competing interests, especially in circumstances in which the distribution of risks and benefits is likely to be uneven. We frame this question as "Is the 'social good' good for everyone?"

Table 1 The questions addressed

#1. What is public health marketing?
#2. Are public health marketers ethical?
#3. What is good about 'social good'?
Are public health marketers obliged to consider the ethicality of the social good?
How is the social good assessed?
How is uncertainty of outcomes accommodated?
How is allocation of resources justified?
#4. Is the 'social good' good for everyone?
Are individual rights accommodated?
Is paternalism permissible?
How much influence is permissible?

What is public health marketing?

Public health marketing is generally presented as a part of or an application of the broader field of social marketing (Donovan 2011; Grier and Bryant 2005; Lefebvre and Flora 1988). Grier and Bryant (2005) describe public health marketing as the application of social marketing principles to public health issues and characterise social marketing as "the use of marketing to design and implement programs to promote socially beneficial behavior change." Donovan (2011) suggests that social marketing provides a framework for implementing behaviour change which he argues is lacking in the public health approach.

Public health marketing has long made up a major part of social marketing (Goldberg 1995; Kotler and Lee 2011). Some of the earliest social marketing efforts include efforts to educate the public about health in the ancient Greek and Roman civilisations (Kotler and Roberto 1989). Other early public health marketing efforts include the promotion of vaccination in 19th century England (Holden 2012) and condoms in the Asian sub-continent to limit population growth in the mid-1900s (Andreasen 2006; Rangan et al. 1996).

A central and unifying feature of public health and social marketing is the goal of social good (Dann 2010; Kotler and Zaltman 1971; Smith 2000). The idea is so central that a recent social marketing text is subtitled "Influencing behaviors for good" (Lee and Kotler 2011). Another social marketing text states that "If the well-being of the community is not the goal, then it isn't social marketing" (Donovan and Henley 2010, p.1).

However, commercial marketers can also be involved in promoting a social good. For instance, marketers of vaccines, seat belts, or quit-smoking programs may be said to be promoting a social good that aligns with those advanced by public health marketers. Corporate philanthropy in the forms of social corporate responsibility (Lichtenstein et al. 2004) and cause-related marketing (Varadarajan and Menon 1988) also serve a social good. Social marketers, however, tend to distinguish themselves from these commercial marketers by arguing that the commercial goals of profit override any social good (Donovan and Henley 2010; Gordon et al. 2006; Smith 2000). As Donovan (2011, p. 9) states, "Where the primary, if not only motivation, is to enhance the public good, then it is social marketing. Where the primary motivation is to turn a profit, even where this contributes to the public good, it is not social marketing – simple."

However, determining the primary goal of a marketing effort presents both conceptual and epistemological difficulties. It is clearly conceivable that a public health marketer may have motivations aside from the social good. For instance, public health marketers are likely to have set targets and budgets to be met. Moreover, employees working in public health marketing may have a personal interest in preserving their ongoing employment. And a public health

marketer, like a commercial marketer, serves multiple stakeholders reflecting various interests (e.g., Bouckaert and Vandenhove 1998). Finally, it is generally acknowledged that public health and social marketers exist in an environment where they are obliged to compete for government, philanthropic and public support and attention (Andreasen 2002).

While not denying the good intentions of social marketers, social marketers have multiple objectives, as do commercial marketers. Instead of profit, the social marketer's corporate objective may be more difficult to define, but at some level of analysis, it begins to look like 'meeting budget' and providing a 'return on investment' (e.g., Lingane and Olsen 2004). Accordingly, we argue that while having a commercial objective can be used in practice to distinguish commercial from social marketers, this is not sufficient to prove the social marketer's claim that their primary objective is to provide a social good.

Social marketers may have mixed motivations reflecting individual, corporate and stakeholder goals. Hence, the interrogation of the bona fides of putative social goods and the ethics of their promotion by social marketers is essential. In particular, two questions may be asked: 'Are we promoting a genuine social good?', and 'Are we doing so in an ethically defensible way?' A social marketer is someone who has good, positive answers to these questions.

Are public health marketers ethical?

Marketing in general has never enjoyed much of a reputation for ethical behaviour. Even within the marketing literature, it is admitted that consumer sentiment towards marketing has been reliably poor for decades (Barksdale and Darden 1972; Barksdale et al. 1976; Gaski and Etzel 1986; Gaski and Etzel 2005; Gaski 2008; Lundstrom and Lamont 1976). Gaski (2008, p.212) observes that "the field of consumer marketing has long suffered a negative public image in some quarters as a borderline unsavory undertaking." Gaski rejects this extreme view but does admit that his own two decades of empirical measurement show that "consumers' affective reaction to the performance of marketing is rather subdued. Over the period of the project, marketing has been consistently viewed slightly negatively" (2008, p.212).

Customers are not confident about marketing messages; in particular, they tend to believe that marketing messages are unreliable or untrue or both (Barksdale and Darden 1972). Generically, marketers are criticized for being intrusive, manipulative, wasteful, and treating people unevenly (Murphy and Bloom 1992).

In annual surveys of the standing of various professions in terms of ethics and honesty, only about one in ten people (11%) rates the standards of advertising practitioners as 'high' or 'very high' (Gallup 2011). By contrast, nurses,

pharmacists and doctors are rated as 'high' or 'very high' by 70% or more, while other marketing professions such as telemarketers and car salespeople are rated as 'high' or 'very high' by just 8% and 7% respectively. In sum, the ethics of the medical professions are some of the most highly rated while the ethics of the marketing profession are some of the lowest.

Are public health marketers regarded as more ethical than commercial marketers? We are not aware of any data that address this specific issue, but our suspicion is that both the general public and marketers themselves probably view public health marketing as more ethical than other forms of marketing. There are at least two reasons why this might be so. First, public health marketing represents a blend of the highly rated medical profession and the poorly rated marketing profession. Accordingly, there may be a tendency to rate its ethical standing as being between the two. Second, public health marketers may win kudos from the focus of their efforts on the promotion of a social good. Commercial marketers are likely to be evaluated more negatively because their ultimate objective is normally taken to be profit even if they are customer-oriented. The public health marketer is presumed to operate without such conflicting objectives. We again note that presumption is untested, but it is a plausible supposition.

What is good about a 'social good'?

Obligations

Before examining the nature of social good, it is necessary to address the question of whether social marketers are even obliged to examine the putative contribution of the social good. At least some social marketers think not. Kirby and Andreasen argue that it is not for "social marketers to define what is 'good' for society" (2001, p.162), rather this should be handled by others, e.g., governments and foundations. Donovan and Henley (2010, p.196) similarly state: "As we consider that social marketing is, by definition, concerned with 'ethical' goals, the primary concerns for social marketers are whether their methods are ethical and whether the relative allocation of resources is ethical." Lee and Kotler (2011) cite a view advanced by Andreasen in a discussion on the Social Marketing listserver in 2006 that social marketers are simply "hired guns" and that "the decision about which behaviors ought to be influenced is not ours to make" (2011, p.53).

Other social marketers do not dismiss the issue so explicitly, but nevertheless give scant attention to whether the social good is in fact good. For instance, Rothschild (2001) notes that a discussion of the ethics of social marketing can take place at three levels and that the first and broadest level "considers the ethicality of the policy or goal itself" (p.18). While this is not the focus of his paper, Rothschild does not

provide any references or suggestions as to where the issue is discussed in the social marketing literature.

Explicitly or implicitly, then, it seems that public health and social marketers leave the social good, the goal of their efforts, largely unexamined. However, this apparent unwillingness to deal with the challenges of public health ethics is to engage in what Cribb (2010, p.17) calls "ethics avoidance". That is, social marketers may be displaying moral myopia and muteness as has been observed among advertising practitioners (Drumwright and Murphy 2004). In describing ethics avoidance, Cribb even notes that one strategy used to defend such a position is the view that "It's not up to me to decide what ought to be done" (Cribb 2010, p.18).

The view that social marketers are not obliged to examine their goals is untenable. It is inadequate to defend our ethics by saying we simply do what we are told; the comfort offered by saying it is someone else's issue is illusory. Social marketers' claim to be "hired guns" but are likely unwilling to act for unhealthy products such as tobacco, alcohol, and fast-foods. Indeed, marketers of these unhealthy products are criticised publicly and by social marketers as acting against the public interest. If acting against the social good is a legitimate object of ethical assessment, then the claim of acting for the social good is also a legitimate object of ethical assessment.

So, social marketers are ethically obliged to assess the quality and character of the goods they promote, and to bear some responsibility for their decisions to promote them. As Brenkert (2001) puts the point, "Social marketers must be convinced that the ends they seek to promote are themselves justified. They may not, simply as agents for a client, undertake projects that reason suggests are morally impermissible, wrong or harmful" (p.50).

Assessment

How is social good to be assessed? Both the definition and the measurement of social good are extremely difficult (Bayer et al. 2007). There are many terms that refer to something like social good, e.g., common good, community benefit, or the quaint and old-fashioned term, common weal. Despite all these terms, there is less clarity about exactly what they mean and how it may be assessed.

What are the components that make up social good? For instance, at one level the social good of public health sometimes refers to public goods that are shared and held communally like herd immunity and clean air. These kinds of goods are indivisible, non-excludable (shared by all), and cooperation dependent (Cribb 2010). However, public health can also encompass individual outcomes such as longevity and quality-of-life. Obviously, both components need to be included in the assessment of the social good that is public health.

What assurance is there that all components are included in the calculation? 'Unintended consequences' refer to out-

comes that were overlooked in the assessment of the social good after a public health intervention. For instance, a public health program recommending increased consumption of fish and fish oil may put pressure on the sustainability of marine ecologies and might also weaken the market for producers of foods cultivated and raised on the land. The problem of unintended consequences highlights the difficulty of capturing all the components of the social good.

Once the components that make the social good of public health have been identified, the next problem is to measure and quantify them. Some specific health outcomes such as a reduction in morbidity may be readily amenable to measurement, but others such as happiness and other hedonic outcomes are more subjective. That is, how do we assess 'quality-of-life' or 'well-being' relative to more objective medical measures?

A related problem is that assessing a social good may require valuation of two competing outcomes. While some valuations may be universally agreed (health is better than illness; happiness is better than unhappiness; social engagement is better than isolation), limited resources force choices or trade-offs, and these will be based on subjective preferences. For example, a determination of the social good of public health often requires a judgment (even if implicit) about the value of longevity versus quality-of-life. Both are of course valuable, but sometimes choices need to be made between them. At least some people may prefer quality-of-life over longevity, e.g., smokers, extreme-sportspeople and people with terminal illnesses. However, these individual preferences may be opposed by public health initiatives such as those which respectively encourage people to quit smoking, discourage engagement in dangerous activities, and oppose euthanasia.

Uncertainty

To add further to the already difficult task, public health marketers must also be able to make claims about how their interventions will contribute to advancing or improving a social good. What will be the cost and what will be the benefits, and what is the overall net gain? The problem is that this relies on correctly predicting the effect of an intervention. However, inferring causal relations is notoriously challenging epistemologically (Cook and Campbell 1979).

Public health marketers promote a social good based on their beliefs about what causes sub-optimal public health (i.e., epidemiology) and how interventions may improve public health. Their claims may be undermined if the concept of social good is inadequately defined or measured (construct validity), the cause is not correctly isolated (internal validity), the results are erroneous (statistical validity), and the results do not generalise (external validity) (Cook and Campbell 1979).

One perennial temptation is to mistake decision under uncertainty, a situation in which we can make no secure

probability judgment, for decision under risk, in which we can play the odds in a controlled and rational way. Decisions under uncertainty are very difficult to manage rationally. Acknowledging the uncertainty does not appear to resolve the problem. In risk situations, expected outcomes can be expressed in terms of probabilities. For instance, the probability and likely consequence of a vaccine-preventable disease may be compared with the probability and likely consequence of a vaccination. Balancing differing probabilities and differing consequences returns us to the problem of value-judgments about trade-offs. The difficulty of resolving these trade-offs is seen in differing views of what constitutes best public health practice.

As concerns vaccination for instance, Voltaire (2001/1909–14) in his *Lettres Philosophiques* famously reflects on the differing views of Europeans and the English as regards smallpox inoculation: “[Europeans consider] the English are fools and madmen. Fools, because they give their children the small-pox to prevent their catching it; and madmen, because they wantonly communicate a certain and dreadful distemper to their children, merely to prevent an uncertain evil. The English, on the other side, call the rest of the Europeans cowardly and unnatural. Cowardly, because they are afraid of putting their children to a little pain; unnatural, because they expose them to die one time or other of the small-pox.”

The problem of establishing social interventions that clearly serve the social good is reflected in the variation of public health policies across time and across geographies. For example, Japan bans the use of the MMR (measles, mumps, rubella) vaccine and has done so since 1993 (Hope 2001). However, the same vaccine is actively promoted in health programs in many other Western countries. The Japanese concern is thought to be due to observed adverse reactions to the mumps component used in the MMR vaccine as reported in systematic reviews (Demicheli et al. 2012). These adverse reactions are apparently considered to be an acceptable risk by most public health agencies but not by the Japanese.

There are of course other debates that highlight uncertainty about what is best for public health. While much public health marketing may encourage people to avoid infections, the “hygiene hypothesis” challenges this social good by suggesting that childhood allergies are rising due to an overly hygienic childhood experience linked with smaller families and higher personal cleanliness standards (Strachan 2000). Uncertainty is also evident in the debates around the value of various screening diagnostics such as prostate screening (McSweeney 2011).

Resource allocation

Notwithstanding the conceptualisation, measurement, and causality problems, public health and social marketers have

a pragmatic reason for wanting to be able to evaluate various public health marketing campaigns. As Donovan and Henley (2010) note, social marketers ought to be concerned with the allocation of resources to different programs. As funding for public health and other social causes is limited, the question of how much good is delivered by different marketing efforts is important for the reason that decisions must be made about which projects are to be supported and prioritised. It is necessary, therefore, to examine the question of how social good should be determined and how public health marketers should respond to, and contribute to, this process. For this to happen, there must be a system of evaluating each program on one standard, but it is clear that such a standard is lacking.

How do public marketers compare the value of different campaigns without an assessment tool? For instance, while it is acknowledged that smoking is considered to cause more deaths than most other preventable fatalities, it typically kills its victims after they have finished their useful working life. Motor-related fatalities are the largest cause of death among young children and more likely to kill people of working age than smoking. Similarly, activities such as skiing, cycling, skateboarding, and other active outdoor activities are more likely to incapacitate able-bodied working people temporarily or permanently, but we do not discourage these activities. In fact, we tend to encourage them. How do public health marketers determine which public health initiatives to support?

Despite the difficulties and intractability of the issue, we note that a number of researchers have endeavoured to create measures assessing the value of a social good – e.g., “social value” of charitable organisations (Polonsky and Grau 2008; Polonsky and Grau 2011) and “social return (on investment)” for corporates (Lingane and Olsen 2004). As might be expected from our discussion, these efforts are plagued with difficulties as the authors themselves acknowledge. Polonsky and Grau (2008) conclude their effort by admitting that their measures of social good are highly subjective and can be influenced by irrelevant factors such as political motivations and competition for resources and competing stakeholder objectives. Lingane and Olsen (2004) remark that “social return on investment analyses often involve subjective value judgments regarding the measured outcomes” (p.127). To this we can add the problem of multiple stakeholders served by any given public health marketing campaign. As a consequence, what might be perceived to maximise value to society is likely to differ from stakeholder to stakeholder (Bouckaert and Vandenhove 1998; Harrington 1996; Polonsky and Grau 2008).

Realistically, and perhaps reasonably in view of these difficulties, it is unclear that public health and social marketing activities are fully assessable in terms of their contribution to the social good. Social marketers are therefore obliged to presume that the social good is served. However,

the presumption thereby undermines the opportunity for showing how a marketing program is helping the social good. Accordingly, a systematic review of the effectiveness of 54 public health marketing interventions measured the effect of interventions in terms of changed behaviour, not contribution to the social good (Gordon et al. 2006). Public health marketing may well be effective in changing behaviour, but the extent of its contribution to the social good is much less clear.

So, the question of how much social good is moved by a given public health marketing effort remains at best subjective and at worst unknown. The accounting for social good is far removed from the level of cost-benefit analysis that takes place in the commercial world in the calculation of profit. The assessment of social good is clearly very difficult and, therefore, any public health marketing aimed at a social good can be difficult to justify. This is not a reason for social marketers and public health professionals to abandon the task of justifying public health programs or to abandon the struggle to continually improve marketing efforts. It is a reason for public health marketers to be actively engaged in complex, value-laden discussions of what the goals of public health campaigns should be. It is a reason to participate in these discussions at a conceptually, epistemologically, and ethically sophisticated level.

Is the 'social good' good for everyone?

Individual rights

As has already been noted, attention to the benefits of a public health marketing campaign must often consider the possibility of conflict between what is best for the community as a whole, and what might be best for the individuals themselves. The promotion of a social good by public health marketers has the potential to conflict with at least some individual's personal preferences.

The issue of how individual rights might be balanced with public health objectives has generated much debate in public health circles. The Nuffield Council on Bioethics recently published a report on public health ethics that addressed precisely this issue (Nuffield Council on Bioethics 2007). The report developed a "stewardship model" laying out the conditions of when and how the state might intervene and override individual liberties. Despite the work, the issue is not simple as reflected in numerous responses to the Nuffield Council's report. In particular, not everyone agrees with the recommendations of the report. An editorial in *The Lancet* (2007, p.1801) acknowledges that under the proposed stewardship model, "some of the recommendations might make the supporters of individualism uncomfortable." Peckham & Hann (2010) note that the report has attracted some criticism and in their view, reflects more traditional rather than contemporary ethical and philosophical debate about public health.

The public health agenda is largely derived from a utilitarian conception. As Holland puts it: "The moral theory at the heart of public health [is] utilitarianism" (Holland 2007, p.16). The utilitarian approach aims to treat all those affected by a public health intervention in an equal and impartial way. However, utilitarian judgment of the distributions of harms and benefits of social programs is strongly contested. Political philosophy in particular draws attention to issues of justice as we discuss here.

If a social program harms one group in order to benefit another, the question arises as to the justice of the exchange. Is it fair to harm one group in order to advance the condition of another? Might the harmed group have a right of veto over the imposition of the harm? Under what conditions might they possess such a right? The ethical challenge here emerges from the fact that what is good for the community as a whole may not be good for each and every individual. Hence, as Smith (2001) notes "Conceivably, social marketers might attempt to influence the behavior of target individuals because it is in the best interests of society (at least in their opinion), though not necessarily in the best interests of the individuals targeted" (p.134).

Public health marketing is by its nature a population-based practice. Medical clinical practice generally emphasizes individual rights; public health emphasizes social good (Cribb 2010; Dandoy 1988; Nuffield Council on Bioethics 2007). As these two outcomes can be in conflict, public health practitioners are confronted by a tension between community interests as reflected in the social good and individual interests as reflected in individual rights (Holland 2007; Sheridan 2008; Smith 2001). Holland (2007) considers this tension or conflict to be the "central dilemma" of public health.

The key question then is "Which value – the reduction of disease or respect for autonomy – should take precedence? The answer is not obvious" (Beauchamp and Steinbock 1999, p.6). Public health marketers face an ethical challenge arising from the idea that individuals have rights and interests that are not fully accommodated by impartial, utilitarian aggregation of harms and benefits (Holland 2007; Miles and Loughlin 2009). The challenge is to accommodate such rights and interests within public health marketing practice.

The depth of the dilemma is that a strictly utilitarian view based on the maximisation of community welfare may be pursued at the expense of one or more individuals. That is, even while the social good is greater, it may require a greater than acceptable cost at the individual level. To illustrate this risk, philosophers use a thought-experiment called the Transplant Case.

"Imagine that each of five patients in a hospital will die without an organ transplant. The patient in Room 1 needs a heart, the patient in Room 2 needs a liver, the patient in Room 3 needs a kidney, and so on. The person in Room 6 is in the hospital for routine tests. Luckily (for them, not for him!), his tissue is compatible with the other five patients,

and a specialist is available to transplant his organs into the other five. This operation would save their lives, while killing the ‘donor’. There is no other way to save any of the other five patients” (Sinnott-Armstrong 2012). It appears intuitively clear that acting to save the five threatened lives in this example violates fundamental rights of the ‘donor’ and that these rights trump concerns for the greater good.

In a more realistic example, immunisation programs may be understood as giving an unjust distribution of costs and benefits. Non-vaccinators may argue that the majority who suffer no complications from vaccination gain the benefits of immunisation at the expense of the few who suffer adverse effects. While a vaccine “might expose a few, rare, susceptible individuals to vaccine-related damage or even death... [t]he idea that the good of the majority cancel out the welfare of the few has led to the criticism that utilitarianism devalues individuals and individual rights” (Beauchamp and Steinbock 1999, p.15). The small minority adversely affected by an immunisation program are being asked to sacrifice their health for the benefit of the community. Under what conditions is this an ethically legitimate request to make?

One might argue that if the risk of an adverse event is distributed equally, then no person is being asked to take an unfair burden of risk. However, if a particular vaccination program is known to expose one part of the population to greater risk than another and also to benefit the lower-risk group more than the higher-risk group, then the higher-risk group takes on a disproportionate share of the harms while the lower-risk group takes on a disproportionate share of the benefits. Are the interests of those in the higher-risk group being sacrificed for those in the lower-risk group? Should individuals in the higher-risk group have rights of veto in this situation?

It is beyond the scope of this paper to develop answers to these questions and to the more central question of how to balance the social good against individual rights. However, we believe that what we can do by asking these questions is highlight an important ethical challenge that confronts public health marketers. The act of promoting vaccination programs and other public health programs can predictably generate winners and losers. The risk of treating people unfairly is then an ethical issue that confronts public health marketers.

Paternalism

From the conflict of individual rights and social good emerges the related issue of paternalism, the promotion of a public health goal over the individual’s preferences on the basis that it is ‘for their own good.’ In this context, the public health marketer steps beyond the tension to an action, and by so doing, imposes his will over others.

In many matters, including even complex health matters with major outcomes, people tend to prefer to choose for

themselves (Botti and Iyengar 2006; Botti et al. 2009; Botti and Hsee 2010). Justifying the intervention is problematic then because it overrides individual preferences to choose for themselves rather than delegate the choice to others, even if we tend to make poorer decisions than those made by others.

The rights that are potentially violated by paternalism are the rights of autonomy famously advocated by John Stuart Mill in his essay *On Liberty* (1991 / 1859). As Mill puts the case: “[...] the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinions of others, to do so would be wise, or even right [...]. The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part of which merely governs himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.”

Mill’s conception is that individual rights are unassailable, but public health often calls for interventions that limit or restrict individual freedoms. Under what conditions are such interventions ethically permissible? While paternalism is often viewed pejoratively, it can be viewed as permissible in certain contexts. For instance, it is generally agreed that parents have the right to make decisions for their children in view of the limited capacity of children to decide for themselves. So, in at least some contexts, we appear to be willing to accept, and indeed support paternalism. The issue is under what conditions are paternalistic interventions ethically warranted?

One basis for such intervention is to invoke Mill’s harm principle; that is that individual rights can be curtailed if an individual’s actions affect others. The difficulty this raises is in the definition of how much our choices and actions affect others. A person who steals money to buy drugs and a smoker who exposes others to their smoke are clearly having an impact on others. A motorcycle rider who refuses to wear a helmet makes a more personal decision. But still their choices can be cast as affecting others such as family, friends and society at large if they are in an accident causing injury or death. The extent of the harm principle is clearly critical and its role in public ethics has been the subject of many studies (Feinberg 1984; Lyons 1994; Raz 1986).

Can public health practitioners intervene if an individual behaviour causes no harm to others? One important exception to the sovereignty of the individual in matters primarily affecting only themselves is the provision that paternalism may be warranted in cases where individuals are clearly incompetent judges of their own good and agents of their own decisions. That is, it can be ethically permissible to deny individual rights under conditions in which individuals clearly do not competently make decisions for themselves.

For example, public health marketers might target drug addiction on the grounds that the addicts are not in a position to competently judge their own good.

Even granted the general point, the issue of agent competence is problematic. Who decides, for instance, whether a person's consumption of a substance like alcohol is excessive? When can the notion of agent incompetence be invoked? The ethical risk, here, is that standards of agent competence are simply set too high and that they make permissible any number of interventions. While drug addiction may be a fairly clear indication of agent incompetence, every person is a less than fully ideal judge of their own good and every person is prey to self-deception and weakness of will that undermines the conditions of ideal agency.

Finally, the legitimacy of paternalism may also be questioned from the point of view of whether the public health agency does in fact know what is best for an individual. This returns us to the earlier mentioned problem of uncertain knowledge. As was mentioned, policy reversals over time and policy differences between countries suggest that what is right is less certain than may be portrayed, and this leads to questions about the legitimacy of paternalism.

Influence

If public health marketers are prepared to bite the paternalism bullet and proceed, how much influence are they prepared to wield? The challenge faced is that "[b]y their very nature, public health interventions require the 'orchestration' of, or some degree of 'interference' in, social life and social practices" (Cribb 2010, p.23). So if we take the case of a drug addict where it is reasoned that paternalism is justified, the question now is what degree of influence is justified. Is it legitimate for the public health marketer to act manipulatively or coercively in an attempt to get drug addicts to give up drugs?

While public health and social marketers do not appear to have dealt very directly with the paternalism issue, they have nonetheless considered at some length the issue of how much influence is appropriate. Influence is generally conceived of as varying across some continuum. Rothschild (1999; 2001) for instance, articulates a view that the influence of marketing stands somewhere between education and regulation (or "law" as he calls it). While education is informative, regulation is coercive. Marketing meanwhile is based on the notion of an exchange between marketer and customer.

The issue of the proper degree of influence of marketing has also been explored at length in the public health ethics domain (Faden and Faden 1978; Pellegrino 1981). Faden and Faden grade influence from facilitation to persuasion to manipulation to coercion. Pellegrino suggests influence ranges from health education to opinion manipulation through mass media to tax and insurance incentives / disincentives to legal prohibition.

Social marketers appear to have acknowledged the ethical risk surrounding influence by defining public health and social marketing efforts as being restricted to voluntary behaviours only (Andreassen 1995; Grier and Bryant 2005; Rothschild 1999; Smith 2000). More recently, Dann (2010) has reaffirmed the centrality of voluntary, non-coercive efforts in an empirical analysis of a selection of definitions of social marketing definitions.

However, at least some think the exclusion of coercion is artificial and that coercion is within the range of influence tools available to social marketers. Donovan and Henley (2010) offer two arguments in support of this view. First, they note that social marketing efforts aimed at having manufacturers change a product formulation for the 'good' of consumers (e.g., reducing sugar or fat content) may be voluntary at the manufacturer level, but result in an involuntary behaviour change for the consumer. That is, an "upstream influence" can result in changes that are essentially imposed on customers. Thus, the fine line between whether social marketers engage in coercion or not is unclear and contestable. In addition, Donovan and Henley (2010) point out that marketing in general does not limit itself to only voluntary behaviour change. Commercial marketers are quite willing to use coercion where they can such as by securing exclusive (monopoly) distribution rights for sporting events, airports, shopping centres, etc.

Even if coercion is excluded from social marketing practice, public health marketers must nonetheless examine the degree of influence that is appropriate as voluntary behaviour can still be motivated by ethically dubious means. For instance, an advertising campaign that endeavours to make people feel foolish, embarrassed or ashamed may not be coercive, but is nevertheless manipulative. Donovan and colleagues for instance have questioned the ethicality of an advertising campaign against domestic violence that targeted and shamed men (Donovan et al. 2008; 2009).

Tangentially, we note that many social marketing definitions make the claim that the exchange concept is as central to social marketing as it is for commercial marketing (Dann 2010; Lee and Kotler 2011). However, if exchange and voluntary behaviour change are both central, then the notion of 'influence' for social good, particularly if it crosses individual desires, leads to a question about whether this is strictly a matter of exchange and voluntary behaviour. The issue is not an easy one to resolve. Rothschild (1999) who suggests that marketing sits between education and regulation concludes his paper by saying that "Because all societies attempt to manage the behavior of their citizens at some level, the question now is not whether to manage public health and social issue behavior but rather how to do so appropriately" (p.36).

We suggest that one resolution to the problem of the proper degree of influence may be to think of the matter more in terms of the conditions under which certain degrees of influence are acceptable. Specifically, the notion of pro-

portionality might be considered which attempts to balance the ‘cost’ with the ‘benefits’. Initiatives offering lesser benefits might justify only educational approaches, and coercion would be justified only if the benefits were unequivocal (Kass 2004). Of course, this returns us to the issue identified in the first part of this paper, how do we assess social good of a public health marketing program?

Conclusion

We have argued that public health marketers should take seriously the ethical challenges and ethical risks of public health marketing. There are two principle areas of ethical challenge and risk relevant to public health marketing. The first revolves around the determination of the social good. What constitutes the social good? What are the components of the social good and how are they related to each other? What priorities ought to be in place when comparing different social goods? Who gets to decide these questions and on what basis are decisions made? Public health marketing is a cooperative enterprise, involving many facets of the public health industry. The ethical challenge of arriving at strongly justified accounts of the social good is shared by everyone in the public health industry and marketers have a responsibility to help meet this challenge.

The second area of ethical challenge and risk encountered by public health marketers concerns distributive questions. Whenever risks, benefits and costs are distributed unevenly by a public health initiative, questions of justice and fairness arise. These questions involve clashes between utilitarian concern to advance the greater good and rights-based concern to protect individual interests. The difficulty of finding a strongly justified balance between these contrasting ethical perspectives challenges all those involved in the public health industry. The ethical risks of unjustified paternalism and undue or inappropriate influence confront public health marketers in many situations. It is vital that public health marketers remain keenly aware of these challenges and risks and respond to them in a considered and informed way.

Public health and social marketers are, we contend, obliged to consider these ethical challenges and risks. We reject the explicit claims to the contrary made by some academic social marketers. To not address these issues might be characterised as ethics avoidance; this is not ethically defensible. Moreover, public health marketers have an important perspective and contribution to make to the debate. Just as they may examine and critique the ethics of marketers of unhealthy products and services, so they too must be prepared to examine and defend their own goals. We are not suggesting that public health marketers ought to be philosophers, but that reflective attention to ethical issues is vital. As Cribb (2010, p.19) notes, “What is needed from public health practitioners... [is] simply an acknowledgement of

this philosophical dimension, and a willingness, in dialogue with others, to take it seriously” (p.19).

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