

**TO: Chair and Members  
Canterbury District Health Board**

**SOURCE: Community and Public Health**

**DATE: 12 February 2010**

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Report Status – For:      Decision          Noting          Information   

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## **1. ORIGIN OF THE REPORT**

The purpose of this report is to seek the support of the Board to the Canterbury DHB developing an Ethics of Association policy. This report has been developed by Community and Public Health and supported by the Executive Management Team and the Canterbury DHB Clinical Board.

## **2. RECOMMENDATION**

That the Board notes the report and:

- i. Supports the development of an Ethics of Association policy that recognises the Board's role in promoting and protecting the health of the community.
- ii. Agrees that the Canterbury DHB Clinical Board oversees the development of a draft Ethics of Association policy, for final approval by the Board, and undertakes the assessment of proposed associations (including offers of sponsorship and/or funding) to determine whether such associations are appropriate, and are in line with the Ethics of Association Policy.

## **3. BACKGROUND**

At the meeting of the Community & Public Health and Disability Support Advisory Committee (CPH&DSAC) held on 13 March 2008 that Committee considered a paper seeking feedback on a position statement on ethics of association to be presented to the Canterbury DHB Board.

The Committee resolved to:

- i. *note the content of the report; and*
- ii. *request a general paper on Ethics of Association, including ethical purchasing, naming rights and sponsorship issues be prepared for a future committee meeting and subsequent recommendation to the Board.*

Subsequent to this it was agreed with the Committee that this report would be presented direct to the Board for its consideration. The attached draft policy proposal was considered by the Executive Management Team who requested that this also be forwarded to the Canterbury DHB Clinical Board for input as well.

The draft document was considered by the Clinical Board in late 2009 and is now submitted to the Board for its support. The draft policy proposal defines a direction for an Ethics of Association Policy which would be brought back to the Board for final endorsement. Should the Board adopt

the recommendations as detailed above then it is envisaged that the final policy document would be submitted for approval by August 2010

Appendix 1: Draft Ethics of Association Policy Proposal

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Report approved for release by: David Meates, Chief Executive

**Canterbury**

District Health Board

Te Pōari Hauora o Waitaha

**THIS DOCUMENT HAS BEEN PREPARED BY  
PUBLIC HEALTH INFORMATION AND CAPACITY  
COMMUNITY AND PUBLIC HEALTH**

**PROPOSAL FOR AN  
ETHICS OF ASSOCIATION  
POLICY FOR THE CANTERBURY  
DISTRICT HEALTH BOARD**

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Released to Client	18 January 2010

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## **Executive Summary**

The Canterbury DHB Board requested that an Ethics of Association paper be prepared to provide information relevant to the Board about the implications of sponsorship/funding approaches from entities whose core activities potentially compromise health.

The findings of this report are:

- Enhancing commercial brand reputation and customer loyalty through association with reputable public institutions is a well-recognised and established marketing strategy (known as “image transfer”)
- The Canterbury DHB has been approached in the past and may again be approached by commercial agents or their affiliates who view the organisation as a useful means through which valuable publicity may be gained
- As a government health agency the Canterbury DHB has an ethical, social, and statutory responsibility to improve, promote and protect the health of the communities it serves. It follows from this that the Canterbury DHB also has a duty to provide visible leadership in demonstrating ethical practice
- Acceptance of sponsorship or funding from entities whose core activities potentially compromise health could inadvertently result in damage to the health of the population served by the the Canterbury DHB
- Acceptance of sponsorship by the Canterbury DHB may be interpreted as endorsement of the sponsor’s products and/or activities, and this is a potential risk to the Canterbury DHB.

This situation offers an opportunity for the Canterbury DHB to continue its strong leadership role among District Health Boards, by maintaining independence from potentially health compromising commercial influences.

## **Recommendations**

Community and Public Health recommends that:

1. The Canterbury DHB agrees to develop an Ethics of Association policy that recognises the Board’s role in promoting and protecting the health of the community.
2. The Canterbury DHB Clinical Board oversees the development of a draft Ethics of Association policy for approval by the Board, and undertakes the assessment of proposed associations (including offers of sponsorship and/or funding) to determine whether such associations are appropriate, and are in line with the Ethics of Association policy.

## **Introduction**

Sponsorship/funding/partnering agreements are becoming entrenched as normal business practices for a variety of sectors.

For health, this can be a double-edged sword – the value of funding to enhance the capacity/resource of an often stretched health service is obvious and superficially very attractive.

On the other hand, for an entity whose core focus is on “protecting, promoting and enhancing the health of our people” the duty of care extends well beyond the provision of health services.

In recognition of this the Canterbury DHB requested that a paper be prepared exploring the Ethics of Association issue from an “impact on health” perspective. This paper was written in response to that request.

## **Methods**

The international journal literature was systematically searched using MEDLINE, EMBASE, PsychINFO, Science & Social Science Citation Index, and CINAHL.

Search terms used included: public health, ethic\*, sponsor\*, fast food, marketing, naming rights, mixed messages, healthy eating, healthy diet, and “ethics of association”.

References of retrieved papers were scanned for additional relevant articles and a print and online search for textbook material was undertaken.

An Internet search was also undertaken of international review databases, resources of international ethics organisations, and commercial sector websites. In addition, relevant information was accessed from international health websites as well as the New Zealand Ministry of Health and District Health Board websites.

## **Background**

### **Public Health Ethics**

Ethics is a set of philosophical beliefs and practices concerned with questions of justice, fairness, equity, rights, and allocation of resources (Roemer and Roemer, 2002). Public health is concerned with preventing disease, prolonging life and promoting health through the organised efforts of society, and is also concerned with ethical mechanisms to improve health.

Public health interventions sometimes create tension between autonomy (individual rights) and utility (the greater good) since public health takes into consideration the interests of society as a whole (Wikler and Cash, 2003).

The contemporary practice of public health has developed from a diverse range of doctrines including clinical medicine, sociology, politics and economics. As a result, traditional biomedical ethical ideologies have been found insufficient. Economic concepts, such as that of economic freedom<sup>1</sup> are also unsatisfactory. Commentators such as Mann (1999) have noted that “a vocabulary of values which links directly with societal structure and function may be better adapted to the work of public health than a more individually oriented ethical framework”

More recent work on the matter of public health ethics by an expert Working Party in the United Kingdom noted that “The central issue in public health is the extent to which it is acceptable for the state to establish policies that will influence public health” (Nuffield Council on Bioethics, 2007). The Nuffield Council on Bioethics further expanded on this issue by proposing the notion of “stewardship” under which states have an obligation to provide conditions that allow people to be healthy<sup>2</sup>. The obvious benefits to the state that result from enabling higher levels of health in a nation include those of enhanced productivity and morale. Given the general similarities between the philosophies that underpin the United Kingdom’s national health system and the New Zealand health system, the “state-stewardship” concept is particularly relevant.

### **Ethics and Health Organisations**

Articles in the medical ethics literature have recently commented on issues relevant to health organisations, identifying that decisions in the managerial and health board arenas can be beset with ethical ramifications. Decisions can have effects at many levels, including for patients, staff, other organisational stakeholders and the wider community. Therefore it is in the best interests of all these groups that institutions have appropriate ethical and social standards (Biller-Andorno et al., 2004; Silva et al.,

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<sup>1</sup> Economic freedom is an ideal which the modern market attempts to personify with a large array of choices available independent of attached intrinsic values or constraints. This in theory leaves market participants free to pursue their individual interests without considering those of others. (Anderson, 1993).

<sup>2</sup> It should be noted that children are seen as requiring special consideration, given their increased susceptibility to external influences and reduced control and ability to make true choices. Society has always had an awareness of the need to protect children and it follows that there is an ethical duty to support parents in matters of their children’s health. (Nuffield Council on Bioethics, 2007).

2008). However, for those looking for guidance in this field Silva et al. (2008) point out that “empirical descriptions of organisational ethics are limited” with there being “a gap in the knowledge between what *is* being done and what *should* be done in addressing organisational ethical issues” (p320).

Given this gap, this report has drawn guidance and examples from various sources identified during the literature search for this report, with the aim of offering Canterbury DHB board members background knowledge on the topic. There follows a brief outline of the structure of the current New Zealand health system, to contextualise the ethical and social position that health boards occupy within it.

## **Ethics and the New Zealand Health System**

On 1 January 2001 the implementation of the New Zealand Public Health and Disability Act 2000 led to the formation of 21 District Health Boards (DHBs). The statutory objectives of DHBs include promoting the health of communities as well as the integration of health services (Ministry of Health, 2008a). Given their constitutional obligations to the public it follows that DHBs have duties to conduct their business in a way that reflects the public’s interests. Thus, as agents of the state DHBs inherit responsibility towards enabling people to be healthy.

The Ministry of Health has stated that “DHBs are expected to show a sense of social responsibility...and to uphold the ethical and quality standards commonly expected of providers of services and public sector organisations”(Ministry of Health, 2008a). This means that DHBs should be visible in undertaking their health responsibilities. Although it may not always be possible for government agencies to satisfy the public, they are obliged to ensure that issues are debated in public and that reasons for taking action are open to public inspection (Wall, 1989).

## **New Zealand Health Strategy, 2000**

Underpinning the current workings of the health system in New Zealand the New Zealand Health Strategy (Ministry of Health, 2000) outlines the framework of District Health Board structure and highlights the government’s priorities for health. The strategy incorporates a particular acknowledgement of the Crown’s obligations to Māori.

Health promotion is one of the seven fundamental principles upon which the New Zealand Health Strategy (NZHS) is based, reflecting the government’s desire to have a system that promotes ‘wellness’ and good health as well as treating illness. The NZHS cites the Ottawa Charter, a well-established health promotion tool, as a framework for action, with its five key actions; build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and re-orientate health services (WHO, 1986, in Ministry of Health, 2000).

## **Local Context – Canterbury**

The Canterbury District Health Board covers a large geographic area, and is the main funder for health service provision, health promotion, health protection, and other health and disability support activities in the region.

### **Mission Statement**

CDHB's mission statement is *“To improve, promote and protect the health of the people in the community and foster the well-being and independence of people with disabilities and reduce disparities”* (Canterbury District Health Board, 2005b). To this end, various documents outline the CDHB's plans for the region, including:

#### Towards a Healthier Canterbury: Directions 2006

This inaugural document summarises the Canterbury DHB's plans for the delivery of health care within the region, and was agreed with the Minister of Health. The introduction states the Board's intention to focus on keeping people well for longer by helping them lead healthy lifestyles. A clear opinion is voiced that “improving the health status of our community is as important as the provision of services for people who need care” (Canterbury District Health Board, 2002, p5).

### **CANTERBURY DHB and Public Health**

The Canterbury DHB has already taken a stewardship role on a variety of public health issues, including the following examples:

#### Fluoride Position Statement

Fluoridation of water is an issue that has received much public attention in the Canterbury region. Within its Oral Health Strategy, the Canterbury DHB included a public health oriented position statement that recognised water fluoridation as “the most cost-effective, practical and safe means for reducing and controlling the occurrence of tooth decay in communities of over 1,000 people”(Canterbury District Health Board, 2003, p4).

#### Gambling Position Statement

Following consideration of scientific evidence that showed the extent of and morbidity related to problem gambling, particularly in the New Zealand context, The Canterbury DHB adopted a policy that sought to limit the harm caused by gambling in its population and to support services that addressed the needs of problem gamblers (Currie, 2006).

#### City2Surf Sponsorship and Sugary Drinks

The Canterbury DHB took a public stand by deciding not to enter a corporate team into the City2Surf (a Christchurch fun run/walk event) in 2006. The reason for this decision was that the sponsorship of the event by sports drink “Powerade” contradicted key public health messages (Canterbury District Health Board, 2006).

Following this, the Canterbury DHB reviewed its provision of sugary drinks in hospital vending machines, a move that succeeded in removing almost two tonnes of sugar from hospital sites in one year (Canterbury District Health Board, 2007). This

initiative was taken under the Healthy Eating and Active Living Action Plan, which outlines the Canterbury DHB's scope of planned work to ensure effective promotion of healthy weight, healthy eating and active living in the Canterbury Region (Canterbury District Health Board, 2005a).

This particular example of public health leadership by the Canterbury DHB demonstrates ethical issues raised by a potential sponsorship relationship that conflicted with the health philosophies of the board. The adoption of a general "Ethics of Association" policy statement by the Canterbury DHB would provide a solid platform to inform debate on any similar dilemmas that present themselves to the board in future.

## **Commercial Perspective**

The aim of this section is to explore why the commercial sector participates in sponsorship and other such activities, with particular reference to marketing strategies. In this report corporate agents are defined as those whose products and services could either add to public health problems or help ease them. Examples include businesses such as food, drink, tobacco or pharmaceutical companies, as well as the hospitality industry (Nuffield Council on Bioethics, 2007).

### **Sponsorship**

Enhancing corporate reputation and building brand loyalty are essential activities for commercial survival. To this end corporate sponsorship has become an increasingly valuable strategic tool for many companies (Johar et al., 2006; Plummer, 2005). As opposed to advertising (which appears to work directly by improving the perception of a specific product) sponsorship seems to cause improvement in the perception of the sponsoring company, which has a resultant indirect effect on sales of the sponsor's product(s) (Harvey et al., 2006).

Sponsorship provides a recognised link between the sponsor and the event/activity/entity being sponsored. This means that commercial companies may seek to enhance their status through association with reputable public institutions, such as health entities or children's sport. Marketers now use the term "partnership" to describe such activities (Medcalf, 2005).

Fierce brand competition and increasing public exposure to all types of media have led to companies and advertisers developing increasingly sophisticated mechanisms to secure recognition. For example, the concept of "Love marks" has been developed, comprising a conscious marketing strategy which aims to engender a strong emotional bond between consumers and a particular brand (Pawle and Cooper, 2006). Such emotional bonds are thought to operate almost independent of conscious control to attach the consumer to a particular brand (Heath et al., 2006; Heath and Nairn, 2005).

Health institutions such as the Canterbury DHB need to be aware of such commercial manoeuvres and consider what, if any, true health benefits may be gained from an alliance with a corporate organisation. Acquisition of funding, goods or services may have an immediate and obvious appeal to budget-conscious board members, but the

overall fit with, and possible effect on board health objectives and the Board's reputation, must be considered.

## **Corporate Social Responsibility**

Given that a commercial company's primary duty is towards its shareholders or customers, it can be argued that as long as the company operates within the law it has fulfilled its role in society. However, a noteworthy trend in recent years has been the emergence of corporate social responsibility initiatives. Such projects become incorporated into the public image of the company. The Nuffield Council on Bioethics (2007) commented on this trend, surmising that whether or not the true motives behind social initiatives are altruistic or marketing-driven, they are nevertheless significant, and likely reflect a change in consumers' ethical expectations.

## **Example – Food Marketing, Non-communicable diseases and Obesity**

The prevalence of overweight and obesity in children and adults is increasing at an alarming rate worldwide, in both developed and developing countries (World Health Organisation, 2008). New Zealand statistics are in keeping with such overseas trends (Ministry of Health, 2008b). Epidemiological evidence shows that obesity is a notable risk factor for a broad range of non-communicable diseases, including cardiovascular disease, type-2 diabetes, hypertension and some cancers (Nuffield Council on Bioethics, 2007; World Health Organisation, 2004). The global burden of such diseases has increased substantially over the last decade.

## **WHO Technical Meeting on Marketing of Food and Non-alcoholic Beverages to Children, 2006**

This expert scientific meeting was convened in Oslo, Norway, to assess the available evidence regarding the influence of marketing on children's food choices (as well as to discuss the implications of marketing influences and review relevant national experiences). The forum identified that "a strong scientific rationale is available through robust science and research that links commercial promotion of food and beverages to poor diets in children" (World Health Organisation, 2006, p.28).

Marketing was defined as "an organisational function and a set of processes for creating, communicating, and delivering value to customers and for managing customer relationships in ways that benefit the organisation and its stakeholders" (American Marketing Association, 2005 in WHO (2006), p29). Marketing included promotion in child-specific settings (e.g. schools, children's hospitals, play areas).

Commercial promotion was identified as "all forms of communication activity designed to raise consumer awareness in order to encourage recognition and sales of a product" (WHO, 2006, p29). Of relevance to the current report is that examples of commercial promotion included: sponsorships and, activities designed to enhance brand recognition through image or lifestyle without specifically identifying food or drinks.

Major conclusions from this forum included that “the goal of any regulatory action should be to protect children from marketing which adversely affects their diets by substantially reducing the volume and impact of commercial promotion of energy-dense, micronutrient-poor food and beverages to children. Moderate increases in the promotion of better foods are judged to be insufficient” (WHO, 2006, p27).

On the basis of this and other evidence concerning the promotion of food to children, and with the agreement of Member States at the WHO’s 60<sup>th</sup> World Health Assembly in 2007, Consumers International and the International Obesity Taskforce agreed to develop (and have recently released) a set of recommendations on marketing of foods and non-alcoholic beverages to children (International Association for the Study of Obesity and International Obesity Task Force, 2008).

It should be noted that a New Zealand health strategy Healthy Eating Healthy Action (HEHA), 2007 was presented at the WHO 2006 Technical Meeting on the Marketing of Food and Non-alcoholic Beverages to Children as an international example of strategies being used in the area of promoting healthy food (World Health Organisation, 2006). The HEHA strategy (Ministry of Health, 2007) is consistent with the WHO’s recommendation for “governments to take strong actions to support improvements in nutrition, physical activity and, consequently a reduction in obesity and other non-communicable diseases” (WHO, 2002, in Ministry of Health, 2007).

### **Example – Health Professionals and the Pharmaceutical Industry**

Much interest has focused on the area of relationships between health professionals and the pharmaceutical industry (for example: Rothman and Chimonas (2008), Singapore Medical Association Centre for Medical Ethics and Professionalism (2000)). Opportunities arise for ‘conflicts of interest’ to occur. It seems that pharmaceutical industry influence on health professionals’ research and practice as well as health institutions’ core missions can occur, at both conscious and sub-conscious levels of awareness (Brennan et al., 2006; Coyle, 2002; Rothman and Chimonas, 2008; Sismondo, 2008).

It is becoming increasingly common for health institutions to adopt general principles to guide operations. Associations such as the American College of Physicians-American Society of Internal Medicine have recognised the potential threat to their reputation from financial and other associations with external organisations, and drawn up formal principles to guide their actions. Their principles include that “relationships with external organisations should promote the health and welfare of the public or patient care” and that “...instances in which a financial or other relationship might have the potential to influence...actual or perceived independence, credibility, and trustworthiness should undergo College review to minimise or eliminate such influence” (Coyle, 2002, p.406).

Closer to home, the Department of Public Health and General Practice at the University of Otago, Christchurch has adopted a “Conflict of Interest Policy” with regards to its teaching and research activities. The goal of this policy is to promote medical and public health practice in the best interests of patients and the wider community, and it consists of the following statements:

“1. Teaching.

We believe that education should be based on the best available evidence for the public interest rather than advertising or promotion for commercial gain.

Therefore, we do not accept any funding for undergraduate or postgraduate education from pharmaceutical companies or other outside institutions either directly or indirectly that may create a conflict of interest in our teaching. This includes lunches or other promotional ‘gifts’ and hospitality.

2. Research.

We aim to conduct research which will provide sound evidence for rational medical and public health practice. We believe it is important that such research should be, and be seen to be, impartial.

Our research is free of any funding which may prejudice these goals. We accept no funding for research from pharmaceutical companies or other for-profit organisations either directly or indirectly (as ‘unrestricted educational grants’ or fellowships) that may create a conflict of interest in our research. (Department of Public Health & General Practice, 2008)”

The large literature on the topic of health professionals and the pharmaceutical industry shall not be discussed in any further detail here, apart from to mention that the issues involved are receiving ongoing international attention. However the principles behind institutional conflict of interest policies are the same as the principles that Community and Public Health believes should form the basis of an “Ethics of Association Policy” for the Canterbury DHB, namely an explicit expression of independence from commercial influences that may compromise core board objectives.

Clearly the Canterbury DHB has good intentions to optimise the services it provides to the community it serves. This report does not oppose sponsorship *per se*, but sponsorship by organisations which have a negative (or potentially negative) impact on health.

## **Conclusions**

Community and Public Health reiterates its opinion that the Canterbury DHB should adopt a policy to guide its association with the commercial sector. Community and Public Health urges the board to fully consider all its statutory and ethical obligations on this matter with regards to protecting and promoting the health of the population it serves.

The adoption of an Ethics of Association policy offers a real opportunity for the Canterbury DHB to continue its strong health leadership role, and to be consistent with the aims of fundamental Canterbury DHB and Ministry of Health strategy documents. By distancing itself from organisations whose core business activities may compromise health, the Canterbury DHB would align itself with current international health initiatives such as those developed by the WHO. In addition the Canterbury DHB would maintain a consistent public health message to the general public.

If the Canterbury DHB adopts an Ethics of Association policy, a mechanism for review of proposed associations would need to be developed. Community and Public

Health suggests that the Canterbury DHB Clinical Board would be an appropriate body to assess whether proposed associations (for example sponsorship or funding) were consistent with the Ethics of Association policy.

## **Recommendations**

Community and Public Health recommends that

1. The Canterbury DHB agrees to develop an Ethics of Association policy that recognises the Board's role in promoting and protecting the health of the community.
2. The Canterbury DHB Clinical Board oversees the development of a draft Ethics of Association policy for approval by the Board, and undertakes the assessment of proposed associations (including offers of sponsorship and/or funding) to determine whether such associations are appropriate, and are in line with the Ethics of Association policy.

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