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Healthy nations: behavioural approaches in public health policy

Jessica Pykett

Abstract This chapter explores the rise of behavioural approaches to public health policies in different nation-states, exploring these in the context of contrasting efforts to address the social and spatial determinants of health and wellbeing. It examines how moral and political arguments for health promotion have given way to 'simpler' health strategies, albeit those which are based on increasingly sophisticated evidence and data relating to human behaviour and decision-making. In highlighting place-based and geographically variable understandings of health inequalities, the chapter considers how behavioural public health policies, which are growing in global significance, recast notions of health citizenship and governance towards behavioural, universal and marketised ideals. Using case studies from Singapore, the UK and USA, the chapter explores the wider ethics of the behavioural turn in terms of its unintended consequences, its long-term sustainability and its capacity to transform health inequalities in different geographical contexts.
Keywords: Global public policy; urban health; social determinants of health; lifestyles; practices; human geography

Introduction: behavioural approaches in public health policy

> "Although the conditions in which people are born, live and work are very important for their health, around half of the global burden of disease arises from behavioural and lifestyle factors." (Hallsworth et al., 2016)

The application of behavioural science research findings in global health governance has a long history which can sometimes be overlooked in the rush to declare as novel the solutions proposed by behavioural insights approaches to public health. Since the 1980s, the World Health Organisation has promoted behavioural change interventions including social marketing techniques. These techniques set out to address disease prevention and transmission, nutrition, hygiene and birth control, in response to calls from healthcare workers to address these seemingly intractable problems (WHO 1993a). In 1993, the WHO published learning modules for medical students on behavioural science evidence, with a focus on the "prevention of disease by reducing unhealthy behaviours, improving treatment by changing a patient's behaviour, community diagnosis to identify high risk groups and areas, as well as behaviour change in health workers for greater effectiveness" (WHO, 1993b, 2). It is no coincidence that the pioneers of the application of behavioural insights in

public health have been in the global development sector, given both the valued status of anthropological expertise within international NGOs. So too, these approaches fit historically with the socially paternalistic, and yet often economically liberalising frames of international development initiatives in general, which are found by some to be infantilising (Berndt and Boeckler, 2017). Until recently, the focus of health policy in the Global South has been on communicable diseases such as Malaria, HIV/AIDS and TB. But since the early 2000s, there has been a worldwide emphasis on tackling Non-Communicable Diseases (NCDs) (cancer, cardiovascular disease, diabetes and chronic respiratory disease) and their associated risk factors (tobacco, diet, physical activity, alcohol) (Herrick, 2014, provides an overview of recent global public health policy trajectories)[1].

The rise of behavioural-insight-based approaches to public health, as justified in this chapter's opening quotation from a UK Behavioural Insights Team report, could thus be considered as a continuation of a gradual shift towards 'lifestyle' factors in public health policy. This is part of a long-term move towards health promotion and addressing the behaviour of the citizen as a matter of consumer choice. Indeed, it has been well established by historians of public health (Porter 1998; Rosen 2015 [1958]) that post-industrial nations in particular have witnessed a wholesale shift away from social policies aimed at reducing the effects of structural deprivation, for instance 19th-century public hygiene and sanitation infrastructures: tackling air pollution; providing clean water; sewerage and refuse collection. In the UK, the post-war establishment of the National Health Service, sickness benefits and the welfare state continued the state's strong role in the provision of conditions for basic health. These provisions have been replaced by what historian, Dorothy Porter (1999, 298) has described polemically as "[p]ropaganda campaigning now aimed to influence social behaviour and to educate citizens into adopting healthy lifestyles". Post-industrial public health policies reveal a particular vision of healthful citizenship and demonstrate a specific social contract between citizen and state, shifting the locus of responsibility squarely onto the individual.

Notwithstanding these continuities, three features of current behavioural insights for public health policies indicate a shift in emphasis. The first is that moral and political arguments for the promotion of healthy lifestyles have given way to behavioural evidence which is used to justify an avowedly 'simple' public health strategy. Secondly, these behavioural explanations are said to be universal human qualities (deficiencies in cognition, behavioural biases) and are thus placed somewhat beyond the scope of political argumentation or geographical variability. Thirdly, where behavioural insights are prioritised above place-based accounts of health and disease, the social and structural aspects of health inequality, not least the failure of marketised public health agendas to address health inequalities, are side-lined. This chapter explores the significance of these shifts for understanding the relationship between health and governance, using case studies from three countries. It considers how

[1] The exception here is Tobacco use and its role in causing cancer, which was identified in the 1950s and put on the global health agenda in 1964 (see Herrick, 2014, 186; Porter, 1999, 299)

behavioural, universal and market-driven solutions are dependent on an intentionally simplistic and naïve account of the politics of public health, a narrowing of the contextual or spatial drivers of health inequalities, and a blinkered view of the types of evidence and disciplinary resources which could be marshalled to provide a more realistic diagnosis of ill-health and health inequalities and to shape more effective and sustainable public health policies in the future.

Healthful nations, healthful citizens: geographical variation in behavioural public health policies

Some of the public health initiatives which have been informed by behavioural science and/or tested using behavioural science methods such as Randomised Controlled Trials (RCTs) are highly morally or politically controversial in their specific national contexts. One example is the use of default 'opt-out' procedures for organ donation, which have thus far not been implemented in the UK (except in Wales, where presumed consent was legislated for in 2013), but which several other countries worldwide have already put in place. A second example is the failed proposal of former New York Mayor, Michael Bloomberg, to restrict the sale of super-sized soda drinks (he was later successful in introducing a sugar tax in Cook County, Illinois – which became the subject of a political battle and multi-million dollar advertising campaign (Jaspen, 2017). Despite clear evidence that these behaviourally-informed public policies save lives and do not ultimately restrict individual freedom (people can still choose to withdraw consent, or buy several 'regular' sized sugary drinks), these examples have thus far fallen short of the level of public acceptability that would be required for their introduction in specific countries. However, the majority of health initiatives supported by behavioural insights units around the world are in fact relatively benign: the placement of fruit at eye level in supermarkets; the increased prominence of healthy meal options in schools; the use of social norm prompts in reducing missed hospital appointments. There is a rapidly expanding repertoire of contemporary behavioural techniques used for health promotion, many examples of which are pragmatic, sensible and measured options for public health policy (see chapter 3).

It is only when we take a longer-term perspective on these techniques that we can begin to consider their political and historical significance. These apparently small, detailed and context-specific initiatives can be said to have a significant cumulative effect. David Halpern, Chief Executive of the UK's Behavioural Insights Team refers to this as a 'radical incrementalism' (2015, 291), of which he argues: "…we can be pretty confident that each of these incremental improvements can lead to an overall performance that is transformative in its cost-effectiveness and impact". This chapter focuses on the connection between these politically-neutral narratives of cost-effectiveness, an evidential base, real-world relevance and simplicity, and the cumulative impact of behaviourally informed public health policies on the practices of health governance and healthful citizenship. It examines the way in which policy-makers in different countries are drawing on these narratives to address complex health problems, and outlines some of the public controversies that have followed. The

chapter thus explores the political claims-making and broader ethical effects that are indicated by behavioural forms of health governance. In so doing, we can begin to think afresh about whether place and practice-based approaches are a fitting response to the urgent public health challenges that we collectively face.

Doing 'what works' in the UK: charges of the nannystate

The UK is often considered as the front-runner in terms of developing behavioural approaches to public policy in general, and behavioural health policies in particular. Since the early 2000s, there has been an open debate about the potential benefit of 'behaviour change' approaches to policy, with influential policy strategists advising a shift towards personal responsibility (Halpern et al., 2004). During this time, within public health, social marketing experts were employed by the National Health Service (NHS), and 'NHS Choices' (the public-facing health information website of the NHS) incorporated many behavioural insights, such as targeting segmented audiences in its anti-obesity communications strategies, highlighting social norms to reduce alcohol use, and designing interventions which took advantage of key life stages, timeframes and pre-stated commitments to promote new healthy habits or lifestyle changes such as quitting smoking (DoH, 2011). By 2010, the Behavioural Insights Team (BIT) had been set up within the Cabinet Office, in order to promote and co-ordinate behavioural science approaches across government departments and to trial policy initiatives and interventions which experimented with administrative procedures, communications techniques and existing regulations in order to change policy outcomes. In short, the BIT used what behavioural economists and psychologists knew about the biases, frames and cues for human behaviour, rejecting the rationality assumption of traditional economic thinking, to make public policy more effective, and – crucially at a time of government spending cuts – less costly (see Jones et al., 2013; Halpern, 2015 for accounts of the institutional history of the BIT and behavioural economics).

With the increasing momentum that was derived from positive evidence gained through many of the BIT's trials, and the growing influence of the BIT and behavioural forms of governance around the world (Lourenço et al., 2016; OECDa, 2017; Whitehead et al, 2014; World Bank, 2015), the UK's public health sector has embraced nudges, as evidenced by the commitment of the UK's second largest public health charity, the Health Foundation to fund a Behavioural Insights Research Programme of over £3 million since 2015. In government too, in the context of what most see as the chronic underfunding of the NHS, the Conservative government's NHS Five Year Forward Review (2014) advances a particularly 'experimental' approach, for instance by investing in new health technologies, supporting "'test bed' sites for world innovators", "new 'green field' sites where completely new NHS services will be designed from scratch" (NHS, 2014, 5), and work on "behavioural 'nudge' type policies in health care" (NHS, 2014, 35). In the absence of significant clinical evidence on the efficacy of nudges in healthcare (Marteau et al 2011; McDaid, 2016), the latter may seem a risky strategy. One might also question just how novel and experimental the Five

Year Forward Review is, given commitments long associated with Conservative governments in the UK to open up the NHS to global healthcare companies ("world innovators"), and to apportion responsibility for ill-health to individuals themselves in a manner which has long been criticised by legal scholars and bioethicists (Brown, 2013; Crawshaw, 2013). As the Review clearly sets out:

> "we live longer, with complex health issues, sometimes of our own making. One in five adults still smoke. A third of us drink too much alcohol. Just under two thirds of us are overweight or obese." (NHS, 2014, 2)

This emphasis on prevention and personal responsibility has been a well-established feature of successive UK government's approaches to public health since at least the 1970s (Kelly and Russo, 2017, 3), so it is difficult to discern anything of a step-change here. What is most significant about the most recent calls for the application of behavioural insights to health may rather be the way in which they propose new sources of evidence for justifying behavioural solutions, whilst rehearsing older narratives about the 'lifestyle' drivers of ill-health. Thus a set of intractable political-economic problems which affect deeply and systematically the provision of healthcare and the persistence of health inequalities are re-framed in terms of the behaviour of individuals. It has been argued that this "simple narrative" is attractive to policy makers who seek short-term simple solutions without confronting the vested interests of the industries involved in producing risky conditions for health, and that such a narrative is dependent on a fundamentally mistaken conflation of disease causation and prevention, and an absence of policy designed to address the social determinants of health (Kelly and Russo, 2017, 3). In the UK, at least, the consequence of these narratives is often that public and political debate focuses on critiquing a perceived loss of autonomy; bemoaning the 'nanny' state (Jochelson, 2006; Lansley, 2010) which is telling us to stop drinking, smoking and eating tasty foods. This consideration of autonomy is not, however, sufficient in assessing the ethics of behavioural insights in public health (Blumenthal-Barby and Burroughs, 2012; Verweij and van den Hoven, 2012; Oliver, 2015).

If we are to consider the ethics of *responsibility* rather than autonomy, we get a more accurate account of issues of substantive freedoms, capability and culpability. As such, we can consider lifestyle factors alongside the underfunding of public health services and other sources of contemporary ill-health. These might include over-consumption encouraged by a deregulated and highly industrialised food and drink industry, the over-availability and advertising of health-harming products (Rayner and Lang, 2011), and overworking, including long hours and workplace stress (Carter et al., 2013; Sparks et al., 1997). That these kinds of structural, contextual and demographically uneven issues are rarely tackled by behaviourally informed health policies has led public health critics to argue that "nudge becomes collusion between the state and corporations to hoodwink consumers" (Rayner and Lang, 2011, 899). The voluntary 'responsibility deals' struck between government and the food and drink industry in the UK are an infamous example of weak and ineffective policy in this area. In this

sense, even if behavioural public health policies draw on the best available evidence about what works in health promotion and prevention (though even this is strongly disputed (Baum and Fisher, 2014; Kelly and Russo, 2017), wider democratic and moral arguments about the locus of responsibility for public health remain outside of the parameters of discussion.

Changing Singaporean habits: lifestyle approaches in context

Singapore – as city-state often noted for its innovation – was quick to adopt behavioural insights in public policy. Institutions such as the Civil Service College (CSC), Singapore Management University, the Lee Kuan Yew School of Public Policy (LKY), the Design Thinking Unit and The Human Experience Lab in the Prime Minister's Public Service Division, Behavioural Insights units within various government ministries, and a cadre of social enterprises and policy-focused start-ups have been exploring the value of behavioural approaches since 2011. The UK's Behavioural Insights Team provided direct advice to government agencies, and launched its own branch office in Singapore in 2016. The head of the Singaporean Civil Service, Peter Ong praised nudge approaches at the global 'Behavioural Exchange' conference held in Singapore, 2017. All this signifies a concerted effort and a high-level enthusiasm to explore the potential for integrating behavioural insights into government policy, although there is currently no central office at the executive level whose primary purpose has been to coordinate a behavioural approach.

Within Singapore's health sector, there have been default opt-out settings for health insurance plans (Medishield) since the 1980s, and there is opt-out for organ donation, following public consultation. This suggests that Singapore was an early adopter of behavioural insights in healthcare, although these measures were not necessarily informed by behavioural economics. Indeed, in this one-party state, the government does not shy away from strong mandatory regulation, and in 2015 legislation was passed to make Medishield compulsory, with action taken against those who fail to sign up. In this sense, whilst enthusiastic about nudges, the Singaporean state is not necessarily committed to the *politically libertarian* paternalistic values which are said to underpin nudges. A more explicit example of behavioural insights in health is found in the work of the Health Promotion Board, which has played a key role in preventative, lifestyle-based health campaigns. One such example is the Million KG Challenge, a weight-loss initiative that supports participants in getting started with healthy eating and physical activity, using the principles of gamification to reward them with vouchers and prizes, and buddying up participants with friends to keep them motivated. As Peter Ong (2015) described it: "the Million KG Challenge nudges each participant towards their weight-loss goal by making goals salient and achievable at each stage". Similarly to the UK's emphasis on lifestyle health factors, lack of willpower is identified as one of the key drivers of the unwarranted financial burden on the health system. The Million KG Challenge is one of several initiatives undertaken by the Health Promotion Board which recognise the inadequacy of information to ensure behavioural changes. Rather, the emphasis is now on 'influencing', taking account of

"behavioural traits such as how Singaporeans think, decide and form new habits." (Tan et al, 2017).

In Singapore, as elsewhere, this includes attention to the environmental cues which shape healthy and unhealthy decisions, such as the availability of unhealthy options when dining out. The Healthier Dining Programme, for instance, worked with food and beverage providers, mapping where Singaporeans were most likely to eat out, and working in partnership with these companies to market healthier choices, promotions and point-of-sale prompts (Tan et al., 2017, 47). As such, the external context is said to be as important as the inner workings of the mind in shaping everyday decisions, a prevalent notion in behavioural approaches to health (Hollands et al., 2016). This may include the size of portions or serving plates, the way that information is displayed, the design of canteens and cafes, the attractiveness of taking the stairs instead of the lift; in short, the 'choice architectures' which are already infused in the contexts in which we think, decide and act. However, when we start to expand our definition of 'context' away from the immediate perceptual environment and towards the political, economic, social and cultural context in which nudges are offered as health policy solutions in the first place, it is possible to take a more geographically-specific view of the significance of behavioural insights in health. In doing so, we can begin to generate new questions about the ethics and politics of health nudges, not in simple terms of interference - or otherwise - by a nannying state, but in terms of the potential effects on the ground of cumulative interventions in the lives and environs of citizens.

Ironically, it is within the "flawed democracy" of Singapore (The Economist 2016 Democracy Index[2]), famed for its sometimes authoritarian state interference in the 'graciousness', littering and personal behaviour of its citizens, that some of the limitations and dangers of health nudges are increasingly the focus of public debate. It might be considered somewhat incongruent that the Singapore Government has embraced potentially liberalising nudges conceived in the context of the USA, where citizens are inherently suspicious of 'big government', and trialled in the UK, during an unprecedented period of state retrenchment – issues which are largely anathema to a Singaporean context. Policy strategists, academics and young policy entrepreneurs alike have commented on this irony, noting for instance that the high levels of trust placed in government agencies to operate efficiently, the stereotyped social compliance of Singaporean citizens, the size and manageability of the city-state and the lack of political alternatives, might all suggest that nudges and RCTs might not be necessary; the Singapore state will effectively do what it wants (Whitehead et al., 2017, 102). All the more surprising, therefore, that Singaporean social scientists have begun to question whether all these small nudges in health policy and elsewhere are really good for society. In a recent article in the magazine of Singapore's Civil Service College, Walter Theseira and Ong Qiyan (2017) consider the 'hidden costs' of nudging, highlighting the need to weigh up the welfare benefits of nudging with the unintended costs of potentially leading

[2] https://www.eiu.com/public/topical_report.aspx?campaignid=DemocracyIndex2016

"people to make choices that are inconsistent with their own preferences or interests". This may include universal approaches to health promotion which may inadvertently cause harm or emotionally impact those who are not at fault:

> "negative messaging is increasingly being considered to address other health-related issues, such as sedentary lifestyles, obesity, and the consumption of sugar, meat, and fat. Those who have no serious health problems will likely resent being made to feel guilty or shameful at the occasional indulgence. Others, who are trying hard to improve their habits, may likewise feel shame and stigma" (Theseira and Qiyan, 2017, 71).

Indeed, their broader point is that the 'radical incrementalism' of small nudges described by Halpern above can indeed have transformative impacts, and that these have not been considered or understood to the same evidential standards as those prescribed by the behavioural science on which they are based. They caution that:

> "Every behavioural intervention that is narrowly focused on a specific policy goal may impose a small, but cumulative, cognitive tax on members of the public. A barrage of such nudges may gradually deplete our capacity to plan and make good decisions" (Theseira and Qiyan, 2017, 73).

As others have already argued (Jones et al., 2010; Jones et al., 2013; Hausman and Welsh 2010), the fundamental basis of behavioural insights for health is the inadequacy of informational/educational approaches to change behaviour. This inadequacy is related to a plethora of psychological biases inherent to human decision-making and the pervasive influence of human ecologies which promote unhealthy living. Yet bypassing people's irrationalities, susceptibilities to influence and the drowning out of health lifestyle information in a world full of harmful corporate nudges may not empower citizens to act in healthier ways in the future. Therefore an ethical approach to behavioural public health must necessarily consider more deeply the effects of health nudges on the empowerment, education and capabilities of individuals and societies to make better decisions in the future (Tengland, 2012). In this context, we must take a closer look at the dominant framings and drivers of public (ill) health and decide whether we are asking the right questions and developing the most effective solutions.

Nudging America: a failure to address market failure

Part of the reason for the global success of behavioural public policy, according to Richard Thaler, co-author of *Nudge* (Thaler and Sunstein, 2008), was the coincidence that Barak Obama was elected as President of the United States in 2008, later appointing his former colleague, and *Nudge's* co-author Cass Sunstein, as head of the White House Office of Information and Regulatory Affairs (Thaler, 2015). In this position, Sunstein (2011) encouraged government agencies to incorporate behavioural insights into their policies, and a Social and Behavioural Sciences Team (SBST) was established in 2014 – re-instating a sub-committee of the White House National Science and Technology Council originally chartered in 2004 (White House, 2015). A year on, an Executive Order on "Using Behavioral Science Insights to Better Serve the American People" was passed by the Obama administration. This

order, amongst other things, was to enable "Americans to lead longer, healthier lives", by simplifying administrative processes, improving the presentation of information for public programmes, including how choices could be arranged or defaulted to support and enhance welfare, and generally make desirable citizen action easier while also reducing regulatory burdens[3].

Whilst it is not yet clear how widespread the policy ramifications of this Order have been, there have been a number of health intervention research trials in the USA in which nudges have been evident. The New York Times, for instance, recently reported on trials in Pennsylvania for smoking cessation and weight loss programmes which have used the behavioural economic principle of loss aversion to shape interventions involving people pledging their own money and getting it back only if they complete the programme (Khullar, 2017). So too, new companies which combine behavioural insights with self-tracking health and fitness technologies have emerged to capitalise on the way in which healthful behaviour has become a lifestyle issue. One such company, NudgeCoach, has a mobile app which enables users to "take back control of your health"[4]. Other companies such as those involved in the 'Blue Zones Project' have invited comparisons between nudges and place-based health promotion programmes. The Blue Zones Project began in Iowa in 2011, and is a community and place-based public health promotion initiative based on the work of author, Dan Buettner (Carter, 2015). Buettner travelled the globe in search of places where people lived longer, in order to identify the lifestyle and environmental conditions necessary for improving health. Online lifestyle quizzes and calculators, group seminars and events, advice on diet, relationships and personal fulfilment, and working with city authorities to develop environmental nudges to 'deconvenience' people's lives (getting people walking, having healthier restaurant options) are all combined to inspire Iowans to "improve their health and happiness" (Healthiest State Initiative, 2014, cited in Carter, 2015, 378). It is not just health responsibility that is emphasised in these examples, but a promise of self-empowerment. Yet whilst the Blue Zones Project may seem a welcome intervention to promote community and individual action for health, Carter argues that its discourse, practices and funding regimes (healthcare insurance providers and wellness companies) are suggestive of the neoliberalization of health promotion and the narrowing of political discussion of the social and structural determinants of health inequalities, and is almost entirely silent on the organisation, funding and infrastructure of hospitals and medical care (Carter, 2015, 378).

In contrast to this apparently de-politicised programme of healthy lifestyle nudges, the highly politically contested *Affordable Care Act* (ACA, known as Obamacare), is evidence of the limitations of the public acceptability of behaviourally-informed policies in a manner which is quite specific to the US context – a context which appears (from a European perspective at least) to involve a rather self-defeating cultural loyalty to the 'freedom' to

[3] https://obamawhitehouse.archives.gov/the-press-office/2015/09/15/executive-order-using-behavioral-science-insights-better-serve-american

[4] https://nudgecoach.com/nudgeapp/

reject healthcare, and thus – put crudely – to run the risk of being ill without recourse to treatment except at great individual cost. The ACA aimed to increase health insurance coverage across the US whilst also reducing premiums, in light of the ongoing lack of access to medical care experienced particularly among low-income and non-white population groups (Chen et al, 2016). The ACA is not a nudge itself, since it clearly mandates people to purchase (now more highly subsidised) health insurance, and mandates providers to accept all applications for such insurance. Yet it is behaviourally-informed, in the sense that it has tried to support and guide consumer decisions using the principles of choice architecture. First, the new default compulsory nature of the Act recognises that people tend to discount the future when making financial decisions in the present. Secondly, since people must choose from a large number of options, the ACA developed categories of plans (Bronze, Silver, Gold) to cover different eventualities. It has already been demonstrated that the Act has increased health insurance cover and reduced racial inequalities in such cover (Chen et al., 2016), but behavioural economists have highlighted that consumers are still not making the most cost-effective choices for them (Bhargava et al., 2017). The evidence they provide is consistent, they note, with the tendency of insurance providers to over-complicate products in ways which increase profits and decrease consumer welfare (Bhargava et al., 2017, 10).

The ACA thus offers a rather contradictory example of behaviourally-informed health policy (both involving mandates and supporting choice), but it also highlights a key difference between countries in which the private sector dominates healthcare financing and those which are based on public infrastructures. On the one hand, the ACA – whilst ending the freedom to choose to be *not* insured – still operates within a largely liberal health insurance market. The behavioural 'tweaks' which have been embedded within the Act, whilst welcomed by consumer rights advocates, have arguably not addressed the key issue, which is the failure of the market to increase competition, drive down prices, drive up quality and ensure the health and welfare of citizens. This is indicative of the prioritisation of individual consumer choice over the goal of 'Better Serving the American People'. It is in part a result of the effective lack of collectivised responsibility for health, and in part a misidentification of the root causes of ill-health, as epitomised in the following quote from Harvard Medical School doctor, Dhruv Khullar, writing in the New York Times:

> "Health is fundamentally the product of myriad daily decisions made by doctors and patients, and by uncovering what truly motivates us, we may be able to nudge one another toward wiser decisions and healthier lives."

Health is, of course, related to what doctors and patients do and how they act, but these actions cannot be properly evaluated and addressed out of context (Kelly and Russo, 2017; Cohn and Lynch, 2017). It is thus worth questioning whether nudging can offer anything but a sticking plaster to issues of public health in the context of the enduring ideological battleground over healthcare markets and affordability in the USA.

While the Trump administration may prove the death knell for both the White House Social and Behavioural Sciences Team[5] and Obamacare, what these examples provide is an indication of the importance of national context – in terms of politics, economics and culture – to the shaping of behavioural public health policies, their likely long-term effects and the level of public acceptance of such policies, which will vary between nations (see Reisch et al., 2017). By focusing on national rather than personal differences, we can begin to unpick some of the simplifying logics of behavioural health policies and their relative silence on the social determinants of health inequality. Indeed, although the opening quote to this chapter maintains that behavioural factors account for half of global disease, others have found that these factors only determine 30% of health outcomes (Dubb, 2017). For some there is a clear political rationale for emphasising the behavioural determinants of health as explained by Baum and Fisher (2014, 218):

> "There is a strong inherent logic to behavioural change strategies. If the problem of smoking is seen as one of people choosing to smoke and obesity as one of people over-eating, then telling them not to do this seems to make sense. This is a powerful, simple logic for politicians and does not involve upsetting corporate donors to political parties […] or require legislative change that will inevitably attract complaints about a nanny state."

Conclusion: *place* and *practice* approaches to public health promotion

This chapter has explored the increasing focus on lifestyle and behavioural approaches in public health policy emerging globally, considering the antecedents of this shift, and the emerging differences in the application of behavioural insights in health in different countries. It has highlighted that there is a tendency, where 'nudge' or behavioural public policies are promoted, to downplay other significant drivers of public health and health inequalities, and thus to simplify health problems as deserving of individual, administrative, (proximate) environmental and behavioural solutions – even though proponents of nudge are careful to point out that such policies are just one strand among a suite of policy tools available to governments.

Meanwhile, supranational bodies, amongst others, have recently called for further research on the ethics and effects of behavioural public policies, for an exploration of the potential for more empowering forms of behavioural governance, for a more pluralistic set of methodologies for evaluating policy impact, and for discussion on the regulatory architectures required to check the power and function of behavioural public policies (Jones et al., 2013; Lourenço et al., 2016; OECDb, 2017). Bioethics, social science, medical sociology and histories of the human and psychological sciences could be usefully drawn on to set out future research agendas to meet these challenges, and yet it is predominantly behavioural scientists who are called upon to set the parameters of such endeavours.

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[5] Since 2017: https://oes.gsa.gov.

In concluding, I want to outline an alternative approach to analysing behavioural public health policies which addresses the geographical variation in the drivers and effects of such policies, and to consider the active role of *place* and *practices* in shaping public health. In her discussion of global public health policies, Claire Herrick (2014) notes the renewal of the field of urban public health and urban political ecology as positive moves towards a more sophisticated analysis of the governance of health and health disparities. Herrick's call for a revival of a place-based approach to public health seeks to provide insight into "the mechanisms linking urbanisation processes, urban management, the provision of basic infrastructure and services, planning, healthcare services, informality, employment, education, consumption and health outcomes" (Herrick, 2014, 187). She argues that there is an ethical imperative for the field of public health to develop appropriate ways to study how global health funding, structures of governance, intervention techniques and local experience are connected – reflecting the call from urban political ecologists to investigate how apparently natural biophysical properties such as health have been commodified (Herrick, 2014, 187). One way in which this might be done is through the engagement of behavioural scientists with critical policy scholars who have analysed public health policy discursively or anthropologically. A complementary route is to involve epidemiologists and geographers who have modelled *neighbourhood effects* on public health – to show how place-based structural and demographic factors shape health decisions and outcomes, in relation to smoking for instance (e.g. Duncan, Jones and Moon, 1999), or life-expectancy (Thomas et al., 2010).

Another approach is to consider *practice-based* and sociological accounts of health, in order to specify the conceptual and methodological assumptions underpinning the behavioural approach. In their evaluation of a nudge-based public health RCT in Cambridgeshire, UK, medical sociologists, Cohn and Lynch (2017, 3) argue that habits and automatic behaviours have come to dominate health psychology at the expense of wider considerations of context-based practices. Whilst this fits well with a government commitment to autonomy preserving nudges, in effect, what they have found in their empirical research is evidence that people themselves adopt a rather different conception of habits, based more on everyday mundane routines and the contextual opportunities afforded to them to change or sustain particular socially-embedded practices (Cohn and Lynch, 2017, 8; see also Thompson et al., 2007). The "simple experimental logic" of the RCT, by which all variables except for the intervention must be kept stable, thus has the perverse effect of 'designing out' context, separating the internal and external drivers of practices, and treating the experimental body as a static entity (Cohn and Lynch, 2017, 2). In other words, the behavioural findings used to justify behavioural public health policies can be guilty of producing the artefacts of their own research assumptions. The combined contribution of these medical sociologists and health geographers is to highlight how place and context are more than a back-drop to behaviour, more than a set of environmental cues. Rather they are constitutive of health practices. To ignore this dynamic relation between place and people's health is likely to foreclose the

development of public health policies which are effective and sustainable over the long term. Simple narratives, simplified experimental logics and simple solutions are rarely adequate in tackling the complex, multi-causal pathways of non-communicative diseases and the dynamic and unequal lives of individuals and social groups in different national contexts. Relying on the power of the market, through the modification of choice architectures and behavioural prompts will not radically transform global health outcomes and inequalities. Evaluating the long-term effectiveness, ethics and impact on the empowerment of diverse citizens of behavioural health policies is therefore an urgent priority for public health researchers.

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