SOCIOLOGY OF HEALTH & ILLNESS

Sociology of Health & Illness Vol. 36 No. 2 2014 ISSN 0141-9889, pp. 213–225
doi: 10.1111/1467-9566.12112

Why behavioural health promotion endures despite its failure to reduce health inequities

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https://onlinelibrary.wiley.com/doi/epdf/10.1111/1467-9566.12112

Abstract Increasing rates of chronic conditions have resulted in governments targeting health behaviour such as smoking, eating high-fat diets, or physical inactivity known to increase risk for these conditions. In the process, many have become preoccupied with disease prevention policies focused excessively and narrowly on behavioural health-promotion strategies. These aim to improve health status by persuading individuals to change their health behaviour. At the same time, health promotion policy often fails to incorporate an understanding of the social determinants of health, which recognises that health behaviour itself is greatly influenced by peoples' environmental, socioeconomic and cultural settings, and that chronic diseases and health behaviour such as smoking are more prevalent among the socially or economically disadvantaged. We identify several reasons why behavioural forms of health promotion are inadequate for addressing social inequities in health and point to a dilemma that, despite these inadequacies and increasing evidence of the social determinants of health, behavioural approaches and policies have strong appeal to governments. In conclusion, the article promotes strategies addressing social determinants that are likely to reduce health inequities. The article also concludes that evidence alone will not result in health policies aimed at equity and that political values and will, and the pressure of civil society are also crucial.

Keywords: social determinants, social inequalities, health promotion, health equity behavioural theories

Introduction

Although average life expectancy has doubled over the past two centuries (Williams 2004), people with a low health status, including those with chronic disease, are concentrated in disadvantaged areas and towards the lower end of the social gradient. Health inequities closely follow this gradient (Banks *et al.* 2006, Commission on the Social Determinants of Health 2008, Crombie *et al.* 2005, Mackenbach 2005, Turrell *et al.* 2006). There is also mounting evidence in developed nations that disparities in health status have begun to widen in response to changing social and economic conditions (Draper *et al.* 2004, Kroll and Lampert 2011, Stamatakis *et al.* 2010) and that inequities between rich and poor countries are also increasing (Labonté *et al.* 2007, Sanders *et al.* 2005). The persistence of health inequities has been the focus of policy concern for decades and most recently has been highlighted by the World Health Organization (WHO) Commission on the Social Determinants of Health (CSDH) which

concluded that 'social injustice is killing people on a grand scale' (2008: 26). The CSDH made a series of recommendations on ways in which health inequities could be reduced both between and within countries. However, it did not call for measures to directly change behaviour that is known to be risky to health. Instead it emphasised the need to change environments and introduce regulations.

The history of public health policy is characterised by a chasm between two central views of how population health may be improved through action to prevent ill health and promote health. On the one hand there is a focus on unhealthy behaviour (for example, the US Department of Health, Education and Welfare 1979*)* and on the other are the views that underlying social and economic factors are the primary determinant of health outcomes (CSDH 2008). This tension has existed since at least the 19th century, when public health reformers such as Virchow in Silesia, Engels and Chadwick in the UK, and Villermé in France pointed to the impact of industrialisation and urbanisation on health among the working class and promoted structural and political reforms accordingly, while others claimed that the poor health of the working class was the product of their own behaviour and 'immorality' (Porter 1999).

These differences foreshadowed tensions that are still evident in public health policy and policy debates today (Nutbeam and Boxall 2008). While public health advocates continue to call for healthy public policy to address the social factors shaping health and health behaviour, governments and international agencies are still inclined to direct their policy actions at changing risky behaviour directly through social marketing and other means of exhorting individuals to change (Alvaro *et al.* 2011, Bryant *et al.* 2010, Glass and McAtee 2006).

This article examines why behavioural forms of health promotion are an inadequate strategy for addressing social inequities in health and are unlikely to resolve social differences in risky health behaviour. It then considers why, despite these inadequacies and increasing evidence on the social determinants of health (SDH), behavioural approaches may be appealing to governments and thus come to dominate health promotion policy. The article concludes with a discussion of health promotion strategies consistent with addressing the SDH and health inequities, and why these are more likely to improve population health and health behaviour.

Behavioural health promotion and its limitations in reducing inequities in health and health behaviour

Behavioural health-promotion strategies are typically aimed at addressing widely recognised behaviour known to increase health risks, including tobacco smoking, excessive use of alcohol, consuming a high-fat diet or being physically inactive (Davies and Macdowall 2006). A basic example is disseminating information about health and lifestyle risks or benefits associated with different behaviour, on the assumption that this will motivate individuals to modify their behaviour (Lefebvre and Flora 1988).

Behavioural approaches to health promotion have drawn on theories of behavioural change and health behaviour stemming from social psychology, such as social cognitive theory (Bandura 2004), the health belief model (Becker 1974), reasoned action and planned behaviour theory (Ajzen 1991) and social marketing (Egger *et al.* 1990). While some such theories do take account of the potential influence of wider social factors, the main focus has been on individual action and choice as the key mechanisms for improving health behaviour (Nutbeam and Harris 2004). The idea that providing knowledge of health risks and benefits to people will lead them to change their unhealthy behaviour has an inherently logical appeal, and certainly in some circumstances behavioural strategies can influence individual health behaviour, especially among those with a high socioeconomic status (SES) (for example, Montague *et al.*

2001, Powles and Gifford 1993). There are, however, a range of reasons why this approach will have only a limited effect on the health status of a population, and why the more unfavourable the social and economic conditions of a population group, the less effective behavioural change strategies are likely to be.

Contemporary behavioural-health promotion strategies fall into two broad types; those applied across a large population (universal), and those implemented in a local area or in an identified at-risk group (targeted). Universal strategies such as social marketing campaigns tend to work best with people who have access to a range of social and economic resources, and they are therefore more likely to decrease prevalence of risky behaviour in high SES groups (Slama 2010). They may also help to decrease the overall rate of a form of behaviour in a population, especially when used with a mix of complementary strategies and sustained over time (Gordon *et al.* 2006, Lefebvre and Flora 1988, Randolph and Viswanath 2004). However, there is also evidence that they tend to generate significantly less or little improvement with low SES or other disadvantaged groups (Alvaro *et al.* 2011, Layte and Whelan 2009, Lee *et al.* 1991). The overall effect, therefore, may be to entrench or exacerbate inequality in health behaviour and so in health outcomes, as has been found with a number of tobacco control campaigns (Baum 2007, Layte and Whelan 2009, Slama 2010). This is despite the fact that most tobacco control involves both behavioural strategies and restrictive policies and regulations.

A similar pattern of outcomes has been found in the strongly behaviourally oriented US Healthy People 2010 strategy. A US Health and Human Services (2005) mid-course review of the strategy notes that health performance targets had been less successful for a number of disadvantaged groups, including those with a low income or education, than for more advantaged groups (p. 8).

Several large-scale, targeted behaviour-change interventions of the 1970s and 1980s, which sought to address smoking and other health behaviour, also failed to produce sufficient evidence to support their value (Glass 2000, Syme 2004). Evidence showing the limitations or failure of behavioural health-promotion strategies appears to inform policy rarely. If it did, then it would follow that there would be much less tendency to adopt behavioural strategies (See also Baum 2008: 460–5, Egger *et al.* 1983).

Small-scale targeted strategies such as intensive behaviour-change interventions with high-risk individuals have produced some limited positive results (for example, Laatikainen *et al.* 2007). These trials require significant resources and may produce benefits for a small group, usually those with other aspects of their life are going well. However, this form of evidence is not helpful in terms of changing risk factors across a whole population because even a large change in such a small proportion of the population will not have any significant effect on overall population health (Chapman 1985, Rose 1992), and the intensive intervention methods required are not feasible on a large scale.

Behavioural health-promotion strategies tend to assume that people are blank sheets ready to be receptive to health promotion messages. The reality is that people's lives reflect a range of factors, including their current social and economic resources, and risk factors are accumulated over the life span, with negative conditions in early life being particularly damaging (Lantz *et al.* 2007, Lindsay 2010). This means that peoples' abilities both to respond to health promotion messages and improve their health and risk factor status as a result of the messages vary significantly, and the overall impact is likely to be greater in economically advantaged groups (Link and Phelan 2005).

This point is illustrated by the experience of Aboriginal people in Australia who as a group face overwhelming structural impediments to their ability to act on health promotion messages, including poverty, a low education, high rates of incarceration, sub-standard or crowded

housing (Thomson *et al.* 2010), and racism (Ziersch *et al.* 2011). Thomas *et al.* (2008) report that Aboriginal people removed as children from their families under a previous government policy (Human Rights and Equal Opportunity Commission 1997) are twice as likely to be a current smoker as those who were not removed, indicating the powerful impact of social factors on health behaviour.

This example is consistent with evidence that exposure to psychosocial stressors can increase engagement in risky health behaviour as a form of seeking relief (Krueger and Chang 2008). These stressors often co-exist with a low SES and exposure to environments where risky health behaviour such as smoking are encouraged by social norms or corporate sales promotion (Smith *et al.* 2004). When people behave in ways that are not good for their health it is generally not because they are unaware of the risk but rather that the constraints of their life and accumulated dispositions over the life-course means they are unable or unwilling to change their behaviour (Anthony *et al.* 2004).

Bourdieu (1984) bridges the agency–structure divide with his theory that explains how individuals accumulate durable and transposable values and dispositions through socialisation and then adapt their ambitions and actions to the social circumstances and context of their lives. He maintains that values, beliefs and worldviews are created through the *habitus* (Bourdieu 1986), which reflects and helps to maintain class, gender or cultural position, and can be more or less supportive of health-promotion practices in everyday life. Bourdieu sees that economic capital is maintained and reproduced through cultural, social and symbolic capital and these capitals are crucial in determining opportunities to adopt healthy lifestyles over the life course.

What is the appeal of behavioural health promotion to governments and others?

Despite the limitations of behavioural health promotion, especially in relation to addressing inequities in health and health behaviour, it has come to dominate recent governments' health promotion policy in a number of Organisation for Economic Co-operation and Development countries including Canada (Bryant *et al.* 2010), the USA (Lantz, Lichtenstein, and Pollack 2007), the UK (Popay *et al.* 2010) and Australia (Baum 2011, Nutbeam and Boxall 2008).

In this section we suggest a variety of reasons why behavioural health promotion may be attractive to governments. Contemporary governments shape policies that privilege behavioural health promotion despite the considerable information available about SDH. Such information is evident in many background or policy papers on health promotion but is then often subject to lifestyle drift; namely a 'tendency for policy to start off recognising the need for action on upstream social determinants of health inequalities only to drift downstream to focus largely on individual lifestyle factors' (Popay *et al*. 2010: 148). Carter *et al.* studied the extent to which cancer control policies in six OECD countries incorporated information on SDH. They concluded that these documents 'foregrounded SDH as significant for cancer control in rhetoric but their recommendations for prevention centred almost entirely on generating individual behaviour change' (2009: 1454). We consider lifestyle drift as a by-product of the appeal of behavioural health promotion, particularly in relation to the several factors considered below.

Historical factors

The history of public health policy reviewed above that stresses the importance of improving living conditions in order to improve population health status (McKeown 1976) is usually overlooked in favour of accounts that stress medical and behavioural intervention, reflecting the power of medicine. Health education in high-income countries emerged in the early 20th century, firstly as part of efforts to control infectious diseases and later with a greater focus on

chronic disease and the health behaviour which increased the risk of these conditions (Nutbeam 2000). The dominant public discourse that has since developed has portrayed chronic diseases as an outcome of poor individual 'lifestyle' choices, from which it is an easy step to see them as preventable through lifestyle changes encouraged by behavioural messages. Thus programmes of health promotion that directly target behaviour linked to chronic conditions have been normalised and easily gain public acceptance. Also, the previous limited successes of some behavioural health-promotion campaigns (albeit, often in combination with other strategies) may lead to assumptions that more of the same is all that is required (Alvaro *et al.* 2011, de Leeuw 1993).

Ideological factors

From the early 1980s the political character of several Western countries underwent a marked shift from welfare liberalism to a neoliberal stance in favour of reduced government intervention in markets, privatisation, the deregulation of labour markets and trade, and reduced welfare programmes. Underlying these policy stances is an ideology that regards free markets as self-regulating systems, and differences in individual attributes and choices as the primary determinants of variation in economic status (Harvey 2005). The individualism of neoliberal theory offers little space to support a view that health is primarily created by the structures which powerfully shape peoples' lives, including the dominant economic structure. Tesh (1988) has described how neoliberal individualism underpins public health policy in the USA. Similar tendencies are evident in Australia (Baum 2008) and Canada (Bryant *et al.* 2010).

A strong ethos of individualism is likely to lead to blaming the victim (Crawford 1977) and the treatment of social inequalities in health behaviour as merely the cumulative result of individual choice (Levinson 1998); so paving the way for policies that exhort individuals to change their behaviour. The dominant biomedical model of disease and treatment that drives most health policy also reinforces individualism and directs the bulk of resources to medical services and research (Lantz, Lichtenstein, and Pollack 2007). Such policies are likely to be more acceptable to political actors sympathetic to a neoliberal worldview because they define health in terms of individual biology and risky health behaviour as primarily a product of individual choice. Navarro argues that the implications of neoliberal politics for the health sector include:

> [T]he need to reduce public responsibility for the health of populations … [to increase] individuals' personal responsibility for health improvements … [and] an understanding of health promotion as behavioral change. (Navarro 2009: 425)

The fact that changes in health promotion policies have often accompanied changes in the political orientation of governments in countries such as the USA, the UK, Australia and Canada also reinforces the view that underlying political beliefs and values are exerting a significant influence on public health and health promotion policy (Baum 2008, Bryant *et al.* 2010, Nutbeam and Boxall 2008).

A further consideration is on the ways in which class and its underlying power are maintained. Bourdieu (1984) argues that this happens through both institutional structures of social and economic power and the subjective structuring of beliefs and dispositions in systems of classification that serve to define and promote the acceptance of social position. He suggests (1997) this process is most effective when the correspondence between the objective and subjective elements of power engenders a tacit or explicit belief among people that the social structure they inhabit is just the natural way of things; a taken-for-granted 'reality' which he describes as the doxa (Bourdieu 1997). Furthermore, he suggests, a crucial part of the

effectiveness of this 'self-evident' reality lies in the fact that it can also, in effect, serve to maintain social silences about the perpetuation of power itself and about alternative ways of understanding the world (1997: 183–9).

From this perspective, the popular acceptance of individualised, biomedical or behavioural views of health and illness (Robert *et al.* 2008), and the ways these are institutionalised in health policies and systems, can be seen as elements of the dominant ideology of individualism in some high-income free market societies. Furthermore, individualised views of health may also, in effect, serve to protect certain power relations by helping to maintain a form of social silence around alternative views of health that challenge the normality of everyday social, economic and cultural inequalities in such societies; including the view that these inequalities cause and perpetuate inequities in health, and need not do so.

Practical factors

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 (see below) or require legislative change that will inevitably attract complaints about a nanny state. It is also true that Rose's prevention paradox (1992) is somewhat counter-intuitive, as on face value, changing the behaviour of high-risk individuals appears as if it will change the health status of the population (Baum 2007). Rose (1985) points out that treating high-risk or diseased individuals does not have much impact on population health, but changing a risk factor across a whole population by just a small amount (which may be clinically insignificant at the individual level) can have a great impact on the overall incidence of a disease or problem. For example, reducing salt content in manufactured food by a small proportion (at a level individuals would not notice) would reduce blood pressure levels across the population and in time reduce death rates from cardiovascular disease (Cobiac *et al.* 2010). This latter option is politically more problematic for politicians as it involves regulating the behaviour of corporations.

It is also true that most other approaches to health promotion call for action across sectors to achieve health goals. However, without strong leadership from above, competition or ideological differences between departments can make these inter-sectoral approaches difficult to implement (Alvaro *et al.* 2011, de Leeuw 1993). It is also easier to establish evaluation mechanisms for behaviour change and time-limited interventions with easily measurable outputs. These fit more easily with demands for evidence-based policy than the use of legislation and long-term community development health promotion, which are harder to measure (Baum 2010, Kavanagh *et al.* 2002).

Policymakers are also likely to be influenced by public perceptions of factors influencing health; which appear to favour both individual behavioural choices and access to medical treatment (Robert *et al.* 2008).

Corporations and health promotion

The power of corporations in shaping population health and wellbeing has been receiving greater attention (Hastings 2012, Korten 2006) as shown by the role of big tobacco companies in resisting the attempts by governments or international agencies to restrict the supply of tobacco (Saloojee and Dagli 2000, Ullrich *et al.* 2004). The industry's strategy was to portray smoking as a purely individual choice and so downplay the impact of their advertising and encourage governments to adopt behavioural change strategies, placing the onus on individuals rather than industry. Similarly, while it is extremely unlikely that the recent rise in overweight and obesity is merely a result of a spontaneous change in eating habits, a surprisingly large

number of policy responses promote individual behaviour change in eating and exercise habits. Such a response does not challenge the practices of multinational food corporations who make large profits from the sale of cheap, easily available high-fat and sugar content food (Egger and Swinburn 2010). Hawkes *et al.* (2009) have shown that the rapid increase in international trade has influenced a change in dietary patterns in India and the Pacific Islands from local, 'healthy' diets to the consumption of fattier diets. Corporations make large donations to political parties around the world (Saloojee and Dagli 2000) and can be expected to influence national health policies to shift attention away from the influence of food supply and marketing to that of consumption. There is increasing evidence that corporations invest directly in research and lobbying to persuade government and international organisations to adopt policies that do not threaten their interests. Ullrich *et al.* (2004) note that when the 2004 WHO resolution on diet, physical activity and health was being formulated, the food industry lobbied heavily to water down recommendations on maximum levels of dietary sugar and on the contribution of soft drinks to the obesity epidemic. They also noted that:

> [S]everal countries wanted to see the Global Strategy paying more attention to the roles of individuals in determining their lifestyle, and criticised the approach of seeking environmental changes as a key role for governments. (Ullrich *et al*. 2004: 254)

As Egger and Swinburn (2010: 8) note of the corporate food interests:

> there is little doubt that … it is in the best interests of governments… as well as big business … for individuals to see obesity as merely the product of sloth and gluttony, and hence as solely an individual responsibility.

This representation of individual responsibility is an example of the exertion of power through Bourdieu's social silences that we discussed earlier. It illustrates the political advantages involved in not talking about health in a structural way, because to do so presents a critical, de-normalising perspective on the socioeconomic status quo and on the actions of some powerful corporations (Hastings 2012).

Conclusions: implications for policy

WHO has produced a succession of initiatives leading up to the CSDH which emphasise the important of SDH, including the Alma Ata Declaration on Primary Health Care (WHO 1978) and the Ottawa Charter for Health Promotion (WHO 1986), leading to a settings approach to health promotion, including 'Healthy Cities' (WHO 1996). The SDH approach recognises that individual and population health outcomes are affected not only by behavioural and biological factors but by the environmental, social, cultural, economic and political settings in which people live (Baum 2008, Kickbusch 2009). There are central lessons that emerge from the accumulated WHO work to guide action to address the SDH and health behaviour.

Firstly, it is important for jurisdictions to adopt broad-based measures to improve overall population health within a 'healthy public policy' (International Union for Health Promotion and Education 2007: 200) or a 'health in all policies' framework (Kickbusch 2009: 1), where the health impact of each sector is considered and measures taken to minimise adverse effects and promote positive health benefits. There is also increasing evidence supporting the use of universal regulatory, taxation or planning measures to address structural factors influencing the prevalence of risky health behaviour or the degree of risk involved,

including price incentives, controls on advertising or sales or regulation of food standards; for example, in relation to alcohol use (Cobiac *et al.* 2009), physical exercise (Giles-Corti and Donovan 2002, MacDougall 2007), smoking (Levy *et al.* 2004) and salt intake (Cobiac, Vos, and Veerman 2010).

Such risk factor-specific initiatives need to be underpinned by measures that tackle the root causes of inequities. Three are vital: firstly, broad-based strategies to reduce socioeconomic disadvantage and introduce redistributive mechanisms in education, housing, employment and income and wealth; secondly, targeted interventions to address proximal structural factors disproportionately affecting disadvantaged groups – for example in Australia, the exploitative sale of alcohol in some Aboriginal communities; and thirdly, sustained community development strategies in disadvantaged areas to alleviate the effects of exposure to SDH and build local capabilities for wellbeing (Labonté *et al.* 2008, Tesoriero 2010).

These measures would also improve health for those often regarded as being hard to reach (Lefebvre 1992). In looking at overall population health gains achieved in different countries, Navarro has shown that socially and economically redistributive policies and full employment policies have led to greater health gains (Navarro and Shi 2001). An analysis by Lundberg *et al.* (2008) concluded that the universal nature of Nordic welfare systems had improved population health. Yet support for such welfare regimes has been under intensive attack since the days of Reagan in the USA and Thatcher in the UK, acting on the neoliberal principle of a smaller, non-interventionist government. The global financial crisis is now seeing such arguments intensify in Europe and the USA, where there is growing pressure to cut social spending despite the arguments by some economists for a return to expansionary growth budgets. Marmot (2012) notes, however, that the economic argument is always about a return to economic growth and not about the welfare of the population as the outcome measure. He points to the report of the Commission on the Measurement of Economic Performance and Social Progress (Stiglitz *et al.* 2009) that argues for broader measures of social and economic progress than simply gross domestic product. Gaining commitment to action on SDH to reduce health inequities will require the use of such social measures of progress (Baum and Fisher 2010, Hamilton and Saddler 1997, New Economics Foundation 2010) and the political will to drive policies that are based on achieving these measures. Evidence and arguments of the limits to growth, sustainability and climate change must also figure in how progress in society is defined and measured (Jackson 2009).

We have shown that there are strong incentives for governments to base their health-promotion policies on behaviourism. Yet the accumulating evidence on SDH is very clear that achieving health equity will require policies that change the conditions in which people make their unhealthy choices. Our review also indicates that ideology is a powerful driver of policy and political actors with a strong commitment to neoliberalism and individualism are very likely to be to drawn to behavioural solutions and to use power over the representation of social issues to maintain this stance. Evidence is not likely to change the ideology of these actors. While we acknowledge that evidence is a crucial part of the public health jigsaw, perhaps too little attention has been paid by public health actors to the importance of ideology in their efforts to translate evidence on the SDH into practical policy. The progressive 19th century public health activists were well aware that challenging the idea that the poor health of poor people resulted from their behaviour required direct attention to political will – Virchow became a politician and Engels co-authored *The Communist Manifesto* with Karl Marx. Political will, in significant part, draws on popular support and we conclude that public health researchers should pay more attention to ways of discussing their research evidence with people at the grassroots. As economic and health inequities grow, people's movements around the world are questioning the economic structures that have given rise to them. The

People's Health Movement, for example, has adopted a People's Health Charter (2000) which explicitly challenges existing power structures and the ideology of individualism and argues that achieving health equity will require a redistribution of power and resources and the adoption of structural reforms. It sees itself as speaking truth to power and opening up areas of social silence to critical examination. Public health, then, has a clear role to highlight the lack of evidence for much behavioural health promotion and promote the evidence that supports the value of action on the social and economic determinants of health in order to force the hand of governments to adopt effective means of promoting health equity.

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Acknowledgement

Fran Baum's time was supported by an Australian Research Council Federation Fellowship.

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