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The Politics of Nudge and Framing Behaviour Change in Health

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Abstract: This chapter examines how the political context impacts the use of behavioural insights in public policy. Specifically, we explore how the political context, which frames the use of nudges in matters of public health, has led to a mismatch between policy intent and implementation. This problem of mismatch is explored through two examples: health promotion and organ donation. In the first example, it is suggested that behavioural health promotion focuses too much on individual lifestyle preferences, with insufficient account being taken of the wider social determinants of health. The example of organ donation is used to show that the nudges may be an inadequate tool for addressing complex public policy problems. Drawing on such examples, the chapter concludes with a consideration of how this mismatch impacts upon broader questions concerning evidence-based policy and political legitimacy.

Keywords

Nudges, health promotion, social determinants of health, organ donation, evidence-based policy, legitimacy.

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Introduction

In recent years, behaviourally-inspired public policy has captured the political imagination. To a large extent, we can attribute this upsurge in political interest to Richard Thaler and Cass Sunstein's work on nudges. In order to bring about desired behavioural change in the citizenry, they argue that public policy-makers need to focus on altering the contexts in which individuals make decisions, through trying to harness or eliminate their cognitive biases (Thaler and Sunstein 2009). Although nudges have been employed in a range of policy sectors, one area of recent focus has been on promoting individual behaviour change in relation to 'lifestyle risks', with significant focus on tobacco, alcohol, and dietary factors (Alemanno and Garde 2015). In this chapter we critically examine this focus, asking whether we should be embracing the use of behaviourally-inspired public policy initiatives as a way of encouraging and enabling individuals to lead healthier lives (see also Tallacchini in this volume). Or conversely, should we be wary of the potential promise they hold, given the political context which frames their use?

In addressing these questions, we draw on the concept of framing in order to examine our key arguments. In doing so, we acknowledge that 'frames' and 'framing' analysis have been used in a diverse range of ways across a number of disciplinary literatures (see Goffman 1974; Tversky and Kahneman, 1981; Snow et al. 1986; Schön and Rein 1994). Drawing inspiration from the approach taken to frame analysis within the policy studies literature, we are specifically interested in examining how and why nudges, and behavioural insights more generally, have been framed as an innovative way forward in health promotion. This requires that we critically examine what set of problems nudges are designed to address in what is a highly contested area of public policy, as well as why they are preferred by those in political leadership (see Bacchi 2009). Adopting such an analytical framework also allows us to explore

any ‘mismatch’ between policy intent and outcomes and the reasons why this might be the case (van Hulst and Yanow 2016: 92).

Specifically, we argue that the political context which frames the use of nudges in the field of health promotion has led to a ‘mismatch’ between policy intent and implementation. For present purposes, we define policy ‘intent’ as the desire to bring about behaviour change to improve individuals’ health; whereas policy ‘outcomes’ refers to the evidentiary basis which shows that such change has been achieved. In order to make our case, we first examine nudge as a political project, which includes briefly tracing the international spread of behavioural insights in public policy-making. Thereafter, we illustrate the mismatch problem with reference to two case studies: health promotion and organ donation. Regarding the first of these, we argue that behavioural health promotion is focusing too much on individual lifestyle preferences, with insufficient account being taken of the wider social determinants of health. Organ donation is then used to show how nudges may be an inadequate tool for addressing complex public policy problems in health. Following this we broaden our critique to briefly look at some current difficulties regarding the evidence base for behavioural public policy. At the end of the chapter we return to the political context in which the design and implementation of behavioural health-related policies has taken place, and consider how the framing of such strategies affects their political legitimacy.

Nudge as a political project

The publication of *Nudge* provided the catalyst for renewed political interest in behavioural strategies (Thaler and Sunstein 2009). This has contributed to a recent upsurge in governmental or quasi-governmental units which seek to explicitly integrate findings from the behavioural sciences into public policy-making. Indeed, the use of nudges has been championed by those

on both the conservative and progressive sides of politics (John et al. 2013). This has much to do with the way in which the use of the behavioural sciences generally, and nudges specifically, have been framed in political terms (Quigley 2013; 2018). First, the very use of the term ‘nudge’ has been promoted as fairly innocuous and something that we need not be overly concerned about, thus adding to its political allure (Quigley 2018). Second, they are often promoted as offering a bipartisan way forward out of political gridlock. Third, they seemingly offer a ‘low cost’ approach in terms of design and implementation, as well as achieving ‘more for less’ in delivering public services. Fourth, it has been suggested that they are ‘easy to avoid’ (thus purportedly countering any concerns about the potential of nudges’ to infringe upon individuals’ freedom of choice). Finally, they are promoted as a viable alternative to what is presented as cumbersome and inflexible regulation (see Thaler and Sunstein 2009; Dolan et al 2010).

Given the growing propensity for cross-border policy transfer (Dolowitz and Marsh 2000), the positive political framing of nudges has led to the international spread of behavioural policy units (Behavioural Insights Team 2016a). Such framing has made nudge strategies a malleable policy tool (see Rein and Schön 1996), although this very malleability has meant that they are susceptible to a range of applications, informed by diverse political preferences and ideologies. In the UK, for example, a focus on ideas generation, which has its roots in translational academic research, has become a feature of the marketing of political messages in recent decades. For Blair’s New Labour government in the 1990s, it was the Third Way agenda, inspired by the work of leading sociologist, Anthony Giddens (Driver and Martell 2000). For former UK Prime Minister David Cameron in the mid 2000s, it was about the promotion of nudges, underpinned by the work of Thaler and Sunstein. This also melded well with his government’s neoliberal Big Society agenda, which championed greater individual initiative

and self-reliance at the expense of a more expansive welfare state (Burgess 2011, Quigley 2013: 9-10; Slocock 2015).

During his time in government, Cameron supported the establishment of Behavioural Insights Team (BIT) ('Nudge Unit'). In 2013, this became co-owned by its employees, the UK government, and NESTA, the UK's leading innovation charity (Plimmer 2014). The BIT describes itself as the 'world's first government institution dedicated to the application of behavioural sciences' (BIT 2016b; see also Dolan et al. 2010). The use of behavioural insights in public policy-making was also taken up with enthusiasm by the then Obama administration in the US. Buoyed by the success of the BIT in the UK, the Social and Behavioural Sciences Team (SBST) was established with the aim of translating 'findings and methods from the social and behavioral sciences into improvements in Federal policies and programs' (United States Government 2016). Specifically, this included the need for US federal agencies to 'identify policies, programs, and operations for which behavioral insights may yield substantial improvements in social welfare and program outcomes; develop strategies for implementing these insights and rigorously testing and evaluating their impacts; and to seek opportunities to strengthen agency relationships with the research community to better utilize findings from the social and behavioral sciences' (White House 2015).

At supranational level, the European Commission (Commission) also established the Framework Contract for the Provision of Behavioural Studies to EU policy-makers in order to 'facilitate the running of behavioural studies in support of EU policy-making' (van Bavel et al. 2013: 8). The commitment to this approach was also underlined by the EU Commissioner for Consumer Policy, who stated that '[b]ehavioural tools play a pivotal role in smarter regulation' (Mimica 2013). In 2016, the Joint Research Centre – the Commission's 'in-house science and

knowledge service’ – published an extensive report on the application of behavioural insights to policy in Europe (European Commission Joint Research Centre 2016). This initiative is seen as aligning with the Commission’s ongoing commitment to the use of evidence-based policy, which informs its Better Regulation agenda (see also Alemanno in this volume). This has informed the most recent iteration of the Commission’s Better Regulation Guidelines and the accompanying Better Regulation ‘Toolbox’, which explicitly feature behavioural approaches (European Commission 2015; 2018).

What the overview in this section highlights is both the alacrity and the enthusiasm with which insights from behavioural sciences research have been taken up in public policy-making at both national and supranational levels in recent years. It has crossed not only geographical, but also political, divides, albeit with differing emphases reflecting diverse political and bureaucratic cultures. Such developments also necessitate caution with respect to any claims about political neutrality with respect to the use of nudges. This is particularly so with respect to their application in politically sensitive sectors such as health promotion, which we consider in further detail next .

The politics of behaviour change in health promotion

There is a long tradition within health policy of drawing on a range of strategies to try to change citizens’ health behaviours. A particular focus has been on changing individual behaviour vis-à-vis lifestyle risks: alcohol, smoking, and diet and exercise (Alemanno and Garde 2015). This broadly fits with the view that an individual’s health is a question of personal responsibility, subject to lifestyle choice. This is underpinned by a commitment to upholding individual freedom and choice, in circumstances where state intervention in the lives of its citizens should be kept to a minimum (Quigley 2013: 591-92). Such commitment is often to be found as a core

political belief of a broader neoliberal worldview. In such circumstances, it may be resistant to change even in the face of evidence to the contrary (Sabatier 1998; Ayo 2012; Cahill et al. 2012).

One of the benefits of such a worldview is that health interventions (be they campaigns or direct interventions) which focus on individual lifestyle risks, such as the need to reduce alcohol intake, may be quicker and easier to implement than the sustained effort and investment that would be required to alleviate poverty in vulnerable populations (Wikler 1987; Minkler 1999). It also means that managing any adverse health consequences also becomes a matter of individual responsibility, even in the face of evidence that they are likely to be borne predominantly by those who are worse off in terms of socioeconomic and educational status (McKinlay and Marceau 2000; Glass and McAtee 2006; Karpin and O'Connell 2017).

This individualistic focus has continued with the new behavioural turn. For instance, in the UK, an early BIT report focused specifically on health. Whilst a range of interventions was discussed in the report, the focus on lifestyle risks comes through strongly. Indeed, half of the suggested interventions deal with smoking, alcohol, diet and weight, and physical activity (Behavioural Insights Team 2010). At EU level, smoking was a prominent health-related example in the JRC's first report (van Bavel et al. 2013: 4-6). Meanwhile, the majority of examples provided in the health section of the most recent JRC report are again related to lifestyle risks: the salt content of food in Estonia, healthy eating in Iceland, childhood obesity in Croatia, and numerous initiatives in different countries relating to smoking (European Commission JRC Report 2016: 23-27). Running through these reports is the clear expectation that insights from the behavioural sciences can be marshalled in order to 'nudge' people

towards making decisions (and taking actions) which are better for their health. The focus on risks associated with individual lifestyle factors is problematic for a number of reasons.

First, evidence regarding the success of strategies which target these types individual health behaviours can be described as mixed at best (Glass and McAtee 2006; Vallgård 2012; Baum and Fisher 2014). For example, targeting individual behaviours to address obesity through weight loss interventions, have largely been proven to be ineffective (Bombak 2014). Moreover, a focus on interventions which target individuals have ignored the complexity of the problems they are aimed at solving, overlooking vulnerabilities experienced by target populations. These include the differing resources available when trying to make dietary changes, as well as the need to make trade-offs (economic and otherwise) in order to do so (Ferrer et al. 2014; Woolf 2011).

Second, it has long been recognized that multiple social and other factors influence health outcomes (e.g. education, socio-economic status, and employment) (Independent Inquiry into Inequalities in Health 1998; Marmot Review 2010; World Health Organization 2016). Changing behaviour to improve health, therefore, is a complex and multi-faceted problem (Howlett and Mukherjee 2017; see also Weaver in this volume). It requires that policy-making for the purposes of health promotion needs to focus on prevention and protection, as well as structural health reform, to ensure access and equity for citizens. Adequately addressing these root causes of ill health requires political will and sustained financial and infrastructure investment (Commission on Social Determinants of Health 2008; Marmot Review 2010). It also requires accepting a greater role and responsibility (for failure to act) on the part of those in political leadership. Yet the framing of behavioural public health policy problems and the proposed interventions take place in almost complete isolation from these broader health

promotion debates and strategies. There is very little overlap between the literatures which deal with the use of behavioural sciences research in public health policy and those which focus on the social determinants of health (MacKay and Quigley 2018).

The risk with this is that we will continue to reinvent the wheel of past policy failures and perpetuate existing mismatches between policy intent and implementation with respect to health promotion. For instance, in health promotion policy-making in general there has been a propensity towards ‘lifestyle drift’. This is the ‘tendency for policy initiatives on tackling health inequalities to start off with a broad recognition of the need to take action on the wider social determinants of health (upstream), but which, in the course of implementation, drift downstream to focus largely on individual lifestyle factors’ (Marmot Review 2009: 3). Behavioural public health policy in the main has no scope for ‘drift’ per se, because the framing of the problems and the proposed interventions have a built in focus on individual lifestyle factors. The concern, therefore, is that this will continue to distract us from the fact that there are deeper socio-economic and educational factors which substantively influence health throughout people’s lives. If this occurs, then significant improvements in health at a population level are likely to remain elusive.

Third, for those who advocate for the use of nudges in health promotion, as well as behaviourally-informed public policy more generally, the tendency has been towards framing their use in opposition to the use of (what can only be presumed is ‘hard’) regulation to achieve desired individual behaviour change. In the UK, for example, this oppositional stance has more often than not been aligned with a neoliberal political agenda, expressed as a desire to cut ‘red tape’, avoid transactional costs, and promote flexibility associated with designing and implementing regulation (Behavioural Insights Team 2010; Quigley 2013). More recently, it

has been used for political positioning purposes in response to the UK's fraught relationship with the European Union (EU): 'wherever possible, the Government will argue for alternatives to regulation at European level, drawing on behavioural science insights (. . .) [and] (. . .) wherever possible, [it will] seek to implement EU policy and legal obligations through the use of alternatives to regulation' (HM Government 2013, General Principles, paras 2 and 5a). This oppositional stance is at odds with the more nuanced and complex view taken within the relevant regulatory studies literature. In this context, regulation is seen as being on a continuum – ranging from soft to hard measures – involving an increasingly diverse range of stakeholders and organized interests in regulatory governance, both within and beyond the state (Levi-Faur 2013). In health promotion, regulation in its varying forms has long been part of the governance toolbox, designed to increase state capacity to act, to provide incentives, to prohibit conduct, and to create environments in which desired change can take place (Gostin 2000; MacKay 2011; Alemanno 2012).

With this in mind, the oppositional framing of nudges and regulation in matters of health promotion should perhaps best be viewed as a heuristic device to serve a range of political ends, and which may coalesce at times with a neoliberal worldview depending on the health issue to be addressed. Current political enthusiasm for embracing behaviourally-inspired strategies, such as nudges, nevertheless warrants critical assessment in terms of their aims and objectives, as well as the evidence base for their effectiveness. It is these aspects which we consider in the next two sections.

Organ donation and complex public policy problems

An important, but underexplored question, is whether nudges and other behavioural techniques, which have been politically positioned as offering an innovative way forward in bringing about

such change, are suitable for addressing complex public policy problems. We focus on the example of organ donation in order to explore this question. This is because, while organ donation is viewed by some as fitting for the application of behavioural insights, deeper analysis highlights the complexities involved in health-related policy problems. By way of background, it is important to note that the need to increase organ donation rates is recognized as a pressing problem in both public health and political terms. There is a growing gap between demand and supply for organs to address the increasing incidence of end stage organ failure. This is related to an ageing population, with a higher incidence of co-morbidities, such as diabetes and hypertension. It has occurred in lockstep with medico-scientific and technological advances that have substantially increased the potential for successful organ transplantation outcomes in recent years and further fuelled demand for organs (Murphy and Smith 2012). Two ways in which nudges could be harnessed to this end are opt-out organ donation and increasing organ donor register numbers. For both of these we note some difficulties.

The majority of countries with developed organ donation and transplantation systems operate on an opt-in basis: that is, individuals (or their families after their death) must actively choose to become donors, usually by signing up to an organ donation register. A number of commentators, however, advocate for the use of opt-out systems of organ donation as the default position, as a way of increasing the number of organs available for transplantation (Saunders 2010; Rockloff 2014). In such a system, individuals are treated as agreeing to become organ donors unless they have actively opted out during their lifetimes (Farrell and Quigley 2012). The behavioural rationale behind this approach is that people tend to display *status quo* bias. They display inertia and tend not to move away from default option.

While changing defaults can be powerful, it is not clear how effective it is in the organ donation context. There is some debate as to whether changing the legal default in this particular area causes the desired increase in the numbers of organs available. A number of reviews of existing studies suggest that it does (Rithalia et al. 2009; Palmer 2012). In contrast, other commentators have argued that the question of whether it is the change in the legislative default which makes the difference remains unanswered. This is because studies that have been conducted thus far have not, and indeed cannot, control for confounding factors. These include national cultural and social change; concurrent changes to national transplantation infrastructure and organization; and advertising campaigns about organ donation conducted at the same time as the change in the default (Willis and Quigley 2014). As such, there is a need for caution regarding any claims made that changing the default is *causative*. What then about opt-in systems of donation?

One strategy is to try to increase the numbers of people who sign up to the national organ donor register, thus increasing the potential pool of organ donors. In this vein, the UK BIT conducted a Randomized Controlled Trial (RCT) to see if people could be nudged to do so. This involved comparing and contrasting various messages regarding organ donation that appeared on a UK government webpage, following completion of online renewal of their drivers' registration. Eight different messages were randomly assigned over a five-week period, which appeared on the webpage as people came to the end of their online renewal process. During this period, over one million people viewed the messages. Some of the messages had images and the others had text, and all drew on insights from behavioural sciences research to see what worked best in terms of encouraging organ donor registrations. The findings from the study showed that the message which relied on reciprocity – 'if you needed an organ transplant, would you have one? If so, please help others' – proved to be the most popular. BIT suggested that the findings

showed that if the reciprocity message was used over the course of a year, then it would be likely to generate a further 96 000 extra registrations for organ donation. Hailing the findings as ‘impressive’, BIT went on to state that the findings were already having an impact on the marketing messages used by the national transplant coordination agency (Behavioural Insights Team 2013).

The BIT study is focused on maximizing organ donation registration rates. But how should we measure policy success here? The study was experimental and of limited duration, therefore extrapolation claims with regard to the potential increase in organ donor registration rates over the course of a year are speculative and need to be treated with caution. If the ultimate policy objective is successful organ transplant outcomes, then this requires that a complex interplay of ethical, institutional, clinical and, regulatory factors be taken into account in policy design and implementation (Quigley and Stokes 2015: 64-65). Indeed, deciding to register as an organ donor can be ‘complicated and difficult’. A ‘one click’ (or ‘one tick’) nudge cannot deal with the complexity of such decisions, as other studies have demonstrated.

For instance, studies have been conducted in the UK to examine whether individuals could be ‘nudged’ towards registering as organ donors (John et al. 2013). One group of researchers found that using nudges in an information booklet, in the form of images and texts that promoted social norms supportive of organ donation, was effective in getting participants to register as organ donors. However, this proved not to be the case when the information booklet was combined with focus group discussion. This was because the discussion made participants more aware of the complex issues involved in deciding to become an organ donor and therefore made them uncertain about whether or not to register. The researchers concluded that there is a need for greater deliberation when complex issues such as freedom and informed consent are

at stake and this was necessary if nudges and other behavioural techniques were to be considered as legitimate policy tools (John et al. 2013: 101-108).

A further option increasing the rate of organ donation is a mandated choice model. Essentially, this is a required choice on the part of individuals as to whether to donate organs or not. This option is favoured by Thaler and Sunstein because individuals' views regarding donation would be known, thus making it easier for families to come to terms with the donation of a family member's organs after death. They also argue that it could be implemented at relatively low cost, with individuals required to tick a box at the time of renewal or registration of their drivers' licences (Thaler and Sunstein 2009: 169). To a large extent, they reach this conclusion because mandated choice is likely to be more politically acceptable than an opt-out system.

However, neither opt-out systems of donation nor the BIT RCT nor mandated choice models adequately engage with the complex and often fraught context in which family decision-making about organ donation takes place immediately following the loss of a loved one. Nor do they take account of the importance of professional duties and obligations impacting the doctor-patient relationship, as well as end of life care more generally in this context (Truog 2012). Studies such as the BIT one, which focus on effectiveness, also largely ignore what is a voluminous cross-disciplinary literature on the issue. These literatures explore the ethical, social and legal issues involved in the decision-making process to donate organs, as well as the significant support infrastructure required to facilitate successful transplant outcomes following organ donation (Farrell, Quigley and Price 2011; Farrell 2015: 268). By focusing on effectiveness we only see part of the picture, therefore, risk missing the complexity of the problem at issue.

The evidence base

As our discussion so far has illustrated, there are problems with the way that the behavioural sciences have been marshalled to health policy ends. One pressing issue, which has not yet been adequately addressed, is that of the evidence required to implement behavioural public policy. Some of the difficulties in this respect can be highlighted by considering the Commission's tripartite taxonomy for classifying behavioural policy initiatives which is set out in their most recent report (European Commission JRC Report 2016, see also Ciriolo et al. in this volume). The first category is behaviourally-*tested* initiatives. These are ones which are 'explicitly tested, or scaled out after an initial ad-hoc experiment' (16). The second, behaviourally-*informed* initiatives, are ones 'designed after an explicit review of previously existing behavioural evidence, although not benefiting from any specific prior ad-hoc experiment' (16). The third category consists of behaviourally-*aligned* initiatives. These draw on behavioural insights, although they 'do not rely explicitly on any behavioural evidence, be it available literature or evidence coming from an ad-hoc test' (16). The difference between these categories is the strength of the evidence behind each of them. Yet they all arguably rely on policy-makers too readily buying into questionable data.

For instance, even if real-world studies are done such as in category one, there may be problems of applicability and transferability between settings (e.g. between different countries or between the finance and health arenas, and so on). This is the case even if RCTs are used. These are a recent import from medical research into the policy arena and are widely viewed as representing an empirical gold standard (e.g. BIT 2012; Alemanno and Spina 2014: 442-443). Yet, all any particular RCT tells us is that an 'intervention worked somewhere, at some time, under certain conditions' (Quigley and Stokes 2015: 73-74; see generally Cartwright and Hardie 2012: 122-34). More is needed to get us from 'this policy worked there' to 'our

proposed policy will work here’ (Cartwright and Hardie 2012: 8). For instance, it cannot be taken as a given that a RCT conducted in one EU Member State will provide data that is applicable in another Member State. Heterogeneity exists along multiple dimensions within and across the EU: socially, economically, culturally, and so on. One or more such dimensions may impact on the transferability and applicability of behavioural policy studies as between EU Member States (Quigley and Stokes 2015). Moreover, as Deaton points out, RCTs are ‘unlikely to be helpful for policy unless they tell us something about *why it works*, something to which they are often neither targeted nor well-suited’ (emphasis added, Deaton 2009: 42; see also Deaton and Cartwright 2016).

There are also problems with the weaker types of evidence represented by JRC categories two and three. Category two ones, in drawing on existing research but not being specifically tested in the particular policy context, may not capture the complexity of the day-to-day reality of human behaviour. This is because they may be relying on studies from a wide array of laboratory-type experiments, rather than those tested in real-world settings (Berg and Gigerenzer 2010, Quigley and Stokes 2015). Category three initiatives do not rely ‘explicitly on behavioural evidence’. Given this, they seemingly amount to nothing more than best guesses, rather than providing a strong evidence base for effective public policy.

Leaving these aside, a further issue also compounds the empirical and methodological challenges regarding the use of the behavioural sciences in public policy-making. Behavioural psychology is undergoing what has been called a ‘replicability crisis’; that is, the replicability of some psychological research is poor, with suggestions that only up to 47 per cent of studies could be replicated (Open Science Collaboration 2015). Pressure to publish new empirical findings means that studies testing replicability are not given priority. The consequence is that

the replications needed to produce robust results are missing. Despite this, particular research in the field has gone on to become ‘canon’ and is frequently cited, including beyond its original disciplinary borders, such as in legal and philosophical scholarship (Gilbert et al. 2016). This is problematic because policy-makers are attempting to apply the findings from a body of research which does not yet have a stable and critical core which can just be applied in practice (Priaulx and Weinel 2014: 372).

Analyzing the political context in framing behaviour change in health

A critical analysis of how nudges, and behavioural strategies more generally, are framed in the political context is helpful in unpicking (some of) the reasons for the current political enthusiasm for their use. The surge in political interest in nudges occurred at a time of financial austerity brought about by the global financial crisis. Nudges were presented as low cost and easy to avoid, drawing on individual preferences and cognitive biases, whilst also preserving freedom of choice. It also coalesced with publics in many liberal democracies becoming increasingly disillusioned with traditional political parties, which precipitated the search for new ways of political thinking and action (Smith 2014; della Porta 2015). As mentioned earlier in this chapter, the use of nudges also focuses on individual behaviour change, rather than taking account of the social determinants of health. This chimes well with a neoliberal worldview which is concerned with market freedoms and individual responsibility for health and wellbeing. As a result, the recent behavioural turn in public policy on the part of national governments of different political persuasions (or ideologies) is not wholly unexpected.

The appeal of nudges in health promotion is likely to continue, despite the methodological and evidential flaws in the approach taken to the use of behavioural insights in the field (see Galizzi and Wiesen 2017). Their continuing appeal derives from a combination of historical and

biomedical factors favouring an individualized focus, and the fact that political leaders in many liberal democracies are wedded to a particular framing of policy problems which is rooted in a neoliberal worldview (see also Zuidhof and Tyers in this volume). This is likely to be resistant to change, notwithstanding evidence to the contrary. To do otherwise and to focus instead on the social determinants of health, for example, could be viewed as a direct challenge to existing structural and power asymmetries perpetuated by political, financial and corporate elites. This is something which the available evidence points to as having significantly contributed to growing health inequalities in liberal democracies (and beyond) (Commission on the Social Determinants of Health 2008; Hastings 2012; Baum and Fisher 2014).

If we accept that the neoliberal worldview largely informs the framing and use of nudges in health promotion, what might this mean for the political legitimacy of such strategies in the context of democratic politics? It is suggested that questions of legitimacy can be assessed by reference to constitutional, functional, values-based and democratic criteria (Casey and Scott 2011). It may also include taking account of whether particular policy strategies have infringed rights or caused harm to citizens (see Yeung 2012). For present purposes, it is the latter three criteria which are particularly relevant. Functional legitimacy goes to questions of efficiency and effectiveness in using nudges in health promotion. As highlighted earlier in the chapter, the evidence base regarding whether they are effective in bringing about desired policy outcomes has not yet been established, with some success noted with respect to limited, small-scale (experimental) interventions. The values-based criterion engages with the underlying principles that should inform the use of nudges in health promotion (see generally Farrell 2015: 277-281). As things currently stand, the predominant principle is one based on individual choice and responsibility for one's health and wellbeing, rather than a broader engagement with the social determinants of health at a population level.

The democratic criterion goes to participation, transparency and accountability. Participation invites deliberation, which is highly relevant for addressing complex policy problems (Lafont 2015). As was highlighted in the organ donation example discussed earlier, the complex interplay of values, culture and clinical issues at stake requires active deliberation on the part of those deciding to register as organ donors, as well as their families in the event of their death. ‘One click’ nudges are simply unable to engage with such issues, making them unsuitable for decision-making in this context (Truog 2012; see Powys White et al. 2012). On the question of transparency involved in the use of nudges, Thaler and Sunstein (2009) have argued that we should rely on the Rawlsian publicity principle, which recognizes information disclosure as the primary method by which transparency is achieved (244-5). It has been suggested that there may be policy areas where questions of transparency in the use of nudges do not loom large (Bovens 2008). However, this remains problematic in the context of democratic politics, given the reliance in designing nudges on unconscious cognitive biases in human decision-making. It also assumes that we can trust those policy-makers engaged in the design of nudges, and that they do not have their own political preferences or agendas in promoting the use of nudges and other behavioural techniques in health promotion (Farrell 2015: 278-280).

While conceptualizing the relationship between transparency and accountability in governance processes is not straightforward (Hood 2010), there is a necessary connectivity between the two concepts in the context of policy design involving nudges. In the circumstances, the need for political accountability looms large for a number of reasons. First, public policy-makers engaged in health promotion will need to deal with the clout of financial and corporate elites, such as those involved in the tobacco and food industries. It is therefore important that policy-makers are accountable with regards to any potential or real conflicts of interest they may have in their dealings with such elites. Second, it is important that the ethical probity of public

policy-makers is transparent. This is vital where public trust is integral to the continued success of public services, such as organ donation and transplantation programmes (Farrell 2015: 280). Finally, accountability on the part of policy-makers may be facilitated by the appropriate use of regulation, which was traditionally operated as a preferred technique of legitimation in the context of democratic politics (Brownsword 2008), redressing power asymmetries and socio-economic inequalities that adversely impact upon health promotion activities.

Conclusion

This chapter examined how the political context influences the framing of nudges, and other behavioural techniques, and their consequent impact on desired behaviour change in health promotion. Framing analysis calls attention to the dynamic process involved in constructing policy problems, which may result in a mismatch between policy intent and outcomes. We examined how the framing of nudge strategies as an innovative way forward in health promotion had resulted in insufficient account being taken of the inter-relationship between individual lifestyle preferences and social determinants impacting health. This occurred even where was little, if any, evidence that nudge strategies were effective in realizing desired behaviour change. What evidence was available pointed to limited success in relation to small scale interventions. Such strategies were also inadequate in addressing complex policy problems, particularly where there was a need to engage with the social, cultural, familial and clinical dynamics which impact the way in which health decision-making takes place.

Nevertheless, current political enthusiasm for nudges, and other behavioural techniques, which focus on changing individual behaviour with regard to identified risky lifestyle factors remains high. This can be attributed in large part to the fact that it fits within an overarching neoliberal worldview that holds fast to the idea of a limited role for the state in the lives of its citizens, as

well as support for individual choice and responsibility for one's health and wellbeing. Such political beliefs inform the framing of nudge strategies, and area likely to be resistant to change, even in the face of evidence of limited effectiveness in terms of desired policy outcomes. It is therefore important that the politics of nudge are taken into account in critically assessing their usefulness in health promotion. This is in addition to considering their broader political legitimacy in the context of democratic politics.

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