

Behaviour change and its per/inverse relationship with health equity

Centre for Health Equity Training, Research and Evaluation

The issue

Health equity has returned as a public policy and institutional priority. It joins a long tradition of behavioural interventions to improve health outcomes. However, questions remain about whether the two align, challenging health service providers and public policy makers. And, despite contrary statements from sources quoting high aggregate data, inequities between disadvantaged and better off groups are rising globally. The reflex to deploy behavioural interventions for better health (equity) can be challenged.

What we already knew

There are two 'laws' that impact on the potential of organisations and governments to effectively tackle (health) inequity:

1. The '[Inverse Care Law](#)': medical and social care availability varies inversely with population need.
2. The '[Least Coercion Law](#)': policy interventions that minimise coercive rules to the benefit of communicative action are preferred.

These 'laws' shape the conditions for [lifestyle drift](#) and an emphasis on individual behavioural attribution – even for phenomena like health equity that clearly have systemic origins.

New evidence suggests...

Lorenc's team, since the early 2010s^{1,2}, shows that behaviour change interventions do not reduce health inequities.

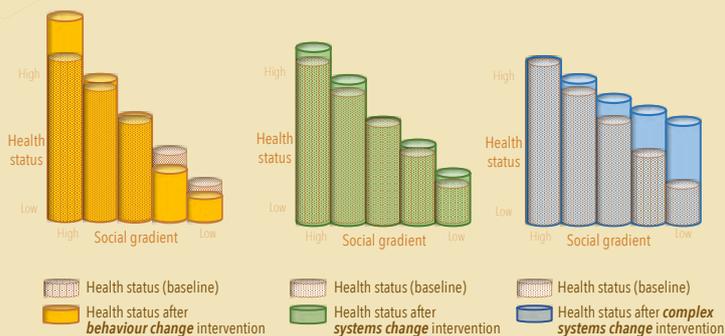


Figure 1: Three scenarios for intervention packaging and their impact on health inequities across the 'social gradient' (illustrative purposes only)

Worse: behaviour change exacerbates health inequities

with greater effect and lasting longer the further up the social gradient. Statistically, health behaviour change makes the most disadvantaged relatively, and sometimes absolutely, sicker.

But to attribute population health problems to individual choice is a socially attractive mechanism. Obesity and diabetes management becomes a matter of individual dietary choice, for instance. Addressing structural factors like food security is in the 'too hard' basket. Policy and organisational change are systems solutions to address the problem across large swathes of populations.

Complex systems solutions have the potential to more sustainably reduce (health) inequities than individual behavioural interventions.

The strength of the evidence in practice

Lorenc's work is a systematic review of copious intervention studies across the policy instrumentation spectrum. Evidence that behaviour change interventions worsen inequities, and adversely impact the most disadvantaged, is compelling. 'Simple' systems change, however, is insufficient. Designing complex and contextualised intervention packages is necessary³. However, evidence indicates that rhetoric and learned routines stand in the way of effective action.

Putting it into policy and action

Developing complex intervention packages and policies is not easy. Efforts to address obesity, diabetes, and other NCDs demonstrates the challenges. But individuals, communities, and institutions, must and can change. A first tangible step to the complexity task is to ask, whenever a disease prevention and health promotion issue is identified, 'what can we do, stepping away from health education and lifestyle drift?' Recent protocols indicate this is also imperative in health service delivery⁴. Institutional leadership should accept this responsibility.

References

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² Lorenc, T., & Oliver, K. (2014). Adverse effects of public health interventions: a conceptual framework. *J Epidemiol Community Health*, 68(3), 288-290

³ Naik, Y., Baker, P., Ismail, S.A., Tillmann, T., Bash, K., Quantz, D., Hillier-Brown, F., Jayatunga, W., Kelly, G., Black, M. and Gopfert, A., (2019). Going upstream—an umbrella review of the macroeconomic determinants of health and health inequalities. *BMC Public Health*, 19(1) pp.1-19

⁴ Sowden, S., Nezafat-Maldonado, B., Wildman, J., Cookson, R., Thomson, R., Lambert, M., Beyer, F. and Bamba, C., (2020). Protocol: Interventions to reduce inequalities in avoidable hospital admis-

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