Health Behaviour Change Qualitative Research July 2009

COI, on behalf of Department of Health

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Background

- COI, on behalf of Department of Health, has commissioned research to better understand how **best to influence healthier lifestyle choices** from fields such as behavioural economics, psychology and marketing

- This study aimed to determine in what ways – and to what degree – might the **government be capable of altering the public's attitude towards its general health?** Would people best respond to rational, scientific evidence or emotive scenarios? Conversely, might one (or both) be counter-productive, inducing the public to embrace a petulant rejection of such a prohibitive stance? If so, would this position be common across all socio-economic and age groups?

Research Objectives

- The **research objectives** were as follows:
  - understanding what **helps** with bringing about behaviour change
  - understanding what has, **in the past**, helped people to change their health behaviours and why?
  - what **specifically would help**, why and who should deliver it?
  - are **attitudes** based on rational thinking / decision-making?
  - are effective responses likely to be based on tapping into people's **emotional responses / instinct**? Do people tend to go for 'default' options?

Method and Sample

- **9 extended workshop groups** were conducted as follows:

1. Men: Freedom years 16-24: Balanced Risk Takers, IMD 4-6
2. Women: Freedom years 25+: Live for Today, IMD 1-3
3. Women: Younger settlers 16-44: Health Conscious Realists, IMD 3-6
4. Men: Older settlers 45-59: Unconfident Fatalists, IMD 1-2
5. Women: Younger Jugglers 16-44: Hedonistic Immortals, IMD 1-3
6. Men: Older jugglers 45-59: Live for Today, IMD 4-6
7. Men: Alone again: Unconfident Fatalists, IMD 6
8. Women: Active retirement 60-74 (with partner): Unconfident Fatalists, IMD 3-5
9. Men: Active retirement 60-74 (without partner): Live for Today, IMD 1-3

Method and Sample

- The sample reflected a **mix of geographical locations** across England, including urban, suburban and rural locations
- We also conducted **9 immersion depth interviews** in order to look at the personal, individual, components of behaviour change in relation to health and well-being, comprising:

1. Man: Freedom years 16-24: Balanced Risk Takers
2. Woman: Freedom years 25+: Live for Today
3. Woman: Younger settler 16-44: Health Conscious Realist
4. Man: Older settler 45-59: Unconfident Fatalist
5. Woman: Younger Juggler 16-44: Hedonistic Immortals
6. Man: Older juggler 45-59: Live for Today
7. Man: Alone again: Unconfident Fatalist
8. Woman: Active retirement 60-74 (with partner): Un. Fatalist
9. Man: Active retirement 60-74 (without partner): Live for Today

Method and Sample

- Also **3 workshop groups (2 hours duration) with healthcare professionals**
- **Group 1: HOSPITAL STAFF**:
  - Hospital doctors (mix of senior and junior doctors) and hospital nurses (mix of seniority and specialisms)
- **Groups 2 & 3. COMMUNITY STAFF**:
  - Practice, district and community nurses (mix of seniority and specialisms) and FNPs
  - GPs (mix of partners, salaried and locum)
  - Family Nurse Partnership Nurses
  - Other health Advocates: E.g. Community pharmacists, Teachers, Youth Workers, Community Workers, Weight Watchers leaders

Attitudes towards a Healthy Life

Attitudes towards a Healthy Life

- Responses to the idea of **quality of life over longevity** were very consistent – with most respondents preferring the option of a better quality, but shorter, life (although a long, healthy life is the real goal for most!!). The idea of spending an extended period as elderly and incapacitated was anathema to a majority

- There was a strong belief that a successful life is a **balance** between behaviour which both maintains **health and generates enjoyment**. A life solely dedicated to living healthily was widely seen as likely to be sterile and dull

- Equally, however, there was widespread disapproval of those who choose to live a **wholly indulgent lifestyle** and become ill as a consequence

Attitudes towards a Healthy Life

- Aspirations were, typically, to live to a healthy old age, but for many this is based more on **hope than real belief**

- Motivation for behaviour change was, as expected, strongly **influenced by HF segment**

- The influence of **peers and family** was evident – most of the respondents were well aware of what they should and should not be doing, but many felt unable to resist the call to ‘join in’ bad behaviour, especially where this can be seen as enjoyable and 'fun'

- **Children** are cited as a driver both for unhealthy behaviour (*“no time – always busy and tired”*) as well as healthy (*“I want to see them grow up and be well for them”*)

Attitudes towards a Healthy Life

- Some felt that there are **confusing messages** about healthy behaviour – fitness gurus die young of heart attacks while Keith Richards goes on forever!!

- Few believed that healthy behaviour now will **guarantee** a healthy future life (for example, developing cancer was seen by many as a 'lottery'). None could imagine their **own death** - so that mortality was, for most, a theoretical construct

- Overall, however, majority of the sample continued to believe that there must be a **strong element of personal choice** in terms of 'how you live your life' – even if some of those choices do not produce healthy outcomes

Thinking about Health

- Things that made the respondents **think about health:**
  - **Growing older**: feeling less bullet-proof, physical decline
  - **Death:** of people you know, as well as of celebrities (Michael Jackson, Jade Goody)
  - The presence of **loved ones**: influence of partners, watching grandchildren growing up
  - **Media stories and advertising** which focus on health issues
  - **Cosmetic considerations**: looking good for social events, holidays etc
  - **'Healthy options'** on display when shopping
  - **Good weather:** spending time outside, wearing less

Thinking about Health

- **Good health** is:
  - Physical vitality
  - Energy
  - Fitness
  - Looking good
  - Happiness
  - Stress-free
  - Positive thoughts
  - Clean pleasant environment
  - Absence from pain
  - Independence

Thinking about Health

- **Well-being** has a strong, holistic, spiritual dimension and typically comprises:

  - Good mental health
  - Feeling positive
  - Security
  - Affluence

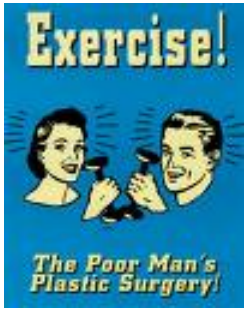
  - Satisfaction: ‘being in a good place’

Healthy Behaviour

- Typically, perceived ‘healthy behaviour’ is often rooted in **physical exercise** – either undertaken for itself (mostly as sport or leisure pursuits) or as part of lifestyle or work (walking, cycling or as a consequence of a ‘physical’ job)

- Exercise is often used as a **compensatory mechanism** for repairing what may be seen as ‘bad behaviour’ (drinking, smoking or eating poorly)

- Exercise also seems to deliver an **immediate feeling of benefit and satisfaction** – which is less obvious with other ‘healthy’ behaviours



Healthy Behaviour

- **Diet** is also seen as contributing to 'healthy' behaviour – drinking water; eating plenty of fruit and vegetables; cooking instead of eating takeaway/convenience food; cutting down on red meat, fatty foods, confectionary

- **Mental health** is also a significant component of perceived 'good health' – 'feeling good about yourself', avoiding stress and 'looking after yourself'. For many the state of their body is believed to be a reflection of the condition of their 'inner world'

- The principal **barriers to healthy behaviour** were felt to be time and opportunity: respondents were too busy, too tired and with too many opportunities to choose convenience over health
- The attitudes of **partners/family** were also seen as influential: support was seen as essential to the maintenance of healthy behaviour

Poor Health

- **Poor health** is:
  - Pain
  - Illness
  - Low self-esteem
  - Over-weight
  - Depression
  - Hardship
  - Unemployed
  - Purposeless
  - Cemeteries, hospitals
  - Medication
  - Poverty
  - Lethargy
  - Watching daytime TV








Unhealthy Behaviour

- The principal point of reference for an unhealthy lifestyle is the **body itself** with cues such as: lack of fitness, over-weight, unflattering comparisons with peers or the younger self

- There is also a consistent awareness of **day-to-day 'bad health behaviours'**: smoking, drinking to excess, eating unhealthy foods and a sedentary life-style

- The key **factors** which driving unhealthy behaviour were felt to be:
  - **excess** ('too much of anything') GLUTTONY
  - **stress**

  - and **local norms** in terms of health behaviour

Unhealthy Behaviour

- The use of **illegal drugs** was broadly believed to be wholly unhealthy – but this is an area of unhealthy behaviour typically seen as outside 'normal' parameters

- Also, a strong degree of **short-termism and fatalism** was evident across all sample segments

- **Few could imagine being old** (even those who are quite old!) and most prioritised 'good times now' over an uncertain, but potentially healthier, future

Behaviour Change

Behaviour Change: Specific

- For some groups change has been driven by **illness**
- For others by powerful personal experiences which have been extremely **motivating**
- However, some clearly feel that 'it is **too late** for them'

"I did smoke for years … I was always feeling bad and short of breath and knew that it was bad for me. But then I ended up in hospital and everything changed"

- Others have made **major changes**:
  - giving up: smoking, drugs, red meat, drinking, sun-beds and sun-bathing, unprotected sex
  - increasing: levels of physical activity; consumption of fruit and vegetables

Behaviour Change: Specific

- Level of effort required to make these changes varied significantly – those in the **'thriving' and 'fighting'** sectors of the HF model were clearly better psychologically equipped to make rapid behavioural changes and maintain healthy behaviours

"I don't drink water because it's good for me but because I like it. I can drink loads of it. I enjoy it and I do know it is healthy to have a certain amount of water within your body."

"I don't think at my age that I want to change very much. I can't actually see what I can do to lead a healthier life"

- Those in the **'surviving' and 'disengaged'** quadrants were often unable to properly contemplate ways in which changes might be made – and many found genuine action virtually impossible

Behaviour Change: Specific

- **Barriers** to being healthy:
  - **inactivity**: sitting in front of the TV 
  - **financial constraints** (not being able to afford gym membership)
  - **lack of energy** at the end of a day's work 
  - **lifestyle**: not having enough time: quicker to drive than to walk
  - lack of **will power** 
  - for some a sense that exercise **might not make a difference**: *"Is it worth the effort?"*

Behaviour Change: Specific

- **Barriers** to being healthy:
  - temptation of nice, **unhealthy foods** (e.g. in petrol stations)
  - **shop layout** (chocolate at checkouts)
  - **offers/promotions** on junk food

  - fruit and vegetables are frequently more **expensive** than junk foods
  - **convenience** of junk food

  - **shopping online** rather than walking to the shops

  - not feeling **safe** running in the park and streets (feeling vulnerable)
  - quality of **city air**: car fumes

Behaviour Change: Specific

- Overall, many respondents believed that the nature of, and priorities associated with, **modern lifestyles** mean that health often has to be sacrificed in order to fulfil critical objectives in areas such as Education, Work and Parenting

- Equally, many believed that **commercial interests** actively promote unhealthy products and services

- Alongside these concerns, there is also a powerful belief that **'you have to have some fun, otherwise life is not worth living'** – even if some of that 'fun' involves potentially unhealthy behaviours

Medication

- All those currently taking medication reported **no problems** in understanding how and when to take their medication
- Support and information was typically being provided by **pharmacists, nurses** and **GPs**
- While some admitted that they have occasionally forgotten to take medication at the correct time, none believed that this has had any **impact** on the quality of their lives or treatment outcomes
- All leave their medication somewhere **'where it can be seen**' and this eventually prompts use

Future Changes and the Role of the State

Future Changes

- For most, ideas about **future changes related to health** were focussed on three key areas for action:
  - taking more **exercise**

  - reducing existing **problem behaviours** smoking, drinking, drug use)

  - **eating** more healthily and **losing weight**

Future Changes

- In the main, respondents believed that **effective support** would comprise:
  - **positive, encouraging, communications from government** which focus on the benefits of changing behaviour (and are honest in terms of what can be achieved)
  - communications based on **case studies** and **real people** (no statistics)
  - **avoiding 'nagging'** or pejorative, judgemental approaches and recognising that 'health is a personal choice'

Future Changes

- In the main, respondents believed that **effective support** would comprise:
  - **avoiding shock tactics** (except where these may be really justified) – since these are believed to have lost their impact
  - **some practical support** – perhaps in terms of government funded gym places for less well-off people (but no rewards for unhealthy lifestyle choices)
  - a **focus upon parents**, who should be encouraged to promote healthy behaviours to their children (many believed that it harder to change adult behaviour: "*better to catch them young*")

Future Changes

- There was a consistent theme that 'healthy behaviour **costs money**' and that it is harder to be healthy if you are less well-off

"We have enquired about joining the local gym - but now we can't afford that kind of money."

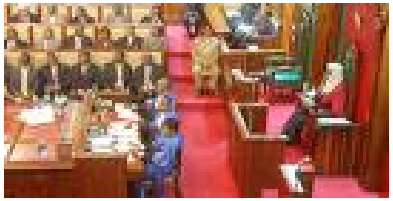
- All clearly expect a **cross-issue approach** (for example, diet and exercise seen as a natural combination) – this is seen as sensible and realistic

"If you're going to try and do one thing better you might as well do two things at the same time"

Changes made by the State

- The state is typically believed to comprise the **current government and associated machinery of state** (civil service, individual departments, the NHS - although **NHS bureaucracy** rather than clinicians)

- The **state 'runs the shop'** and is seen to be responsible for the condition of national infrastructure, the well-being of citizens and the overall 'success' of the nation



- Attitudes towards the state were **contradictory and largely emotional** in nature

Changes made by the State

- On one hand respondents wanted a **'hands-off' approach from government**, with personal freedoms and individual autonomy preserved – and direct interventions kept at a minimum

- Equally, respondents regularly **advocated draconian government action** in relation to behaviour which they saw as obviously unhealthy – for example, taxing unhealthy foods, raising the drinking age, banning the advertising of junk food, increasing taxation on cigarettes and alcohol

Changes made by the State

- It seemed that these reactions were shaped by a **clear attitudinal division between 'what is good for me' and 'what is good for everyone else'** – respondents were happy to advocate interventions which affect others whose behaviour was seen as unreasonable, while stridently defending their own freedom to act irresponsibly if they wish

- Views of the state/government were shaped by this **contradictory posture** – respondents clearly want to see the state act effectively, but were also afraid of the personal consequences of such action

Changes made by the State

- Equally the **agenda of the state** was believed to be unclear – while most assumed that the state is there to look after its citizens, many also pointed out that the state has something to gain from 'bad' health behaviours in terms of tax income

- Consequently, there was a certain level of **distrust of the motives of state policy** – which generally drove respondents towards a preferred 'light touch' approach and the preservation of personal freedoms. Certainly there was a consistently negative response to the idea of **'the nanny state'** (and the current government was seen as an exponent of this position)

Changes made by the State

- Changes enforced by **law, taxes or fines**:
  - broadly, respondents saw many of these ideas as **sensible and likely to prevent harm** – especially banning discrimination and tackling people who promote or indulge in obviously harmful behaviour
  - there was less interest in **constraining freedom of action** in private, domestic settings such as the home or car
  - however, many also felt that much of the probable enforcement action might fall upon the **poorer segments of society** who would be less able to comply and probably less able to respond to the punishment mechanisms

Changes made by the State

- Changes encouraged by **additional facilities or benefits**:
  - there was an almost **universal rejection** of these ideas – which were seen as rewarding people for their bad behaviour
  - all concepts were seen as a **poor use of taxpayers' cash**

- Changes encouraged by **changes to retail**:
  - there was broad agreement that **retailers** do little to promote healthy behaviour and seemingly take no responsibility for their customer's health
  - however, many of these ideas seemed either **silly** (spraying the smell of fresh oranges) or **unfairly punitive** for the ordinary, responsible consumer (making alcohol more expensive or less easily available)

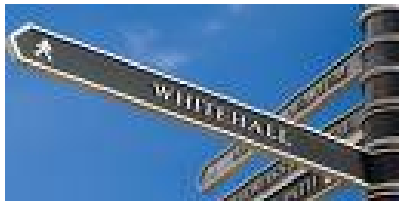
Changes made by the State

- Changes **encouraged by health services**:
  - While many respondents saw some of these ideas as sensible, there was an obvious disinclination to **promote state interference within the family** and particularly in relation to decisions about the **care of children**

- Changes encouraged through **education or campaigns**:
  - these were the most **enthusiastically-received** ideas
  - the idea of **promoting healthy options and choices** was endorsed and the concepts seen as appropriate, while leaving **personal freedoms** untouched: *"You've put the necessary information into people's hands…"*

Messages

- There was some scepticism about **messaging from the state,** with respondents typically feeling that health behaviour messages should come from 'people who have been there' and not politicians or spokespeople for government departments



- While some advocated 'shock tactic' messaging about health, others clearly stated that this type of communication has **largely lost its bite** (although there was consistent recall of the Think, Know your Limits and Frank campaigns)

- Respondents generally felt that **statistics and figures** have little impact and, in fact, can sometimes even be used as reassurance about the likely impacts of bad behaviour

Messages

- Some also wanted **proof** included as part of messaging – and clearly did not believe many of the statements made by government about health

- Interestingly, awareness of the **5 a day campaign** was consistently high – and this was seen as an example of a positive health message that can be accepted as sensible and realistic

"It makes sense and is pretty easy to achieve - also I understand it!!"

5 A DAY

Just Eat More
(fruit & veg)

The Healthy Foundations Segments

Unconfident Fatalists

- This is a group that feels **helpless in relation to health** and has lost its taste for change or challenge. Life is mostly a process of 'getting by' – often governed by unthinking routine

- Their views about health behaviour are shaped by inertia and **'what can't be done'** – change is too difficult or not worth attempting

- In the main, these respondents are **cynical and resentful** of any authority which attempts to encourage effort – most distrust the state

- All long for a **stress-free 'good life'** – but pessimistic about the future: *"it's all downhill from here"*

- Typically approve of **tough sanctions for health behaviour** – although these would be unlikely to touch their own lives

Live for Today

- Feel **OK about themselves** – carefree and keen to enjoy themselves
- Generally **can change behaviour if they decide to do so**
- Can be **encouraged to adopt more healthy behaviours** – but find it hard to see it this in broader terms: “life’s a lottery”
- Some positive influence for change from **partners/friends** – although peers can also be a powerful reinforcer for bad behaviour
- Generally **do not want to change** their current lifestyle and dislike being **dependent** on others
- Typically take little notice of **government communications** and are often sceptical about the veracity of many messages they encounter. Most support **control of retailers** in relation to healthy choices

Hedonistic Immortals

- **Health aware** (without being over-focussed) and feel good about themselves
- Believe that it is **enjoyable and easy to be healthy** – and feel positive about their current state of health
- Believe that, if they look after themselves, they can **live a long and healthy life**
- All have **made changes to their health behaviour** and reported no difficulties with this
- All believed that they state's attitude towards health should reflect **education and encouragement**, rather than coercion or threats

Balanced Risk Takers

- All see themselves as **active, healthy** and **image-conscious.** Healthy behaviour is seen as **easy and enjoyable**
- **Take few risks with their health** (although peer pressure sometimes drives a ‘session’) and take steps to re-dress potential damage
- All are **aware of health-related risks**, but this won’t stop them from following norms and ‘enjoying themselves’. Health is a **priority, but not an obsession**
- **Independent-minded regarding health** – typically believe that there is little that the state can do for them and feel that they **require little support** to ‘do the right thing’. Family/friends provide important input
- Sceptical about **direct interventions** and favour education

Health Conscious Realists

- Typically **feel good about themselves** and believe that they have control of their lives in most significant ways
- Take **few risks with their health** – in the main, this segment sins by doing nothing positive, rather than by overtly ‘bad’ health behaviour
- **Quality of life** – both now and in the future – is important to this group. Healthy behaviour reflects a strong aspiration towards quality
- **Changing health behaviour was seen as quite easy**
- While this group strongly believed in **individual freedom** and **personal control** over health decisions, it was happy to see the rest of society subjected to draconian measures to curtail 'bad' behaviour

NHS Staff

‘Unhealthy’ behaviour

- Health professionals agreed that there are a core set of interlinked ‘unhealthy behaviours’: **smoking, lack of exercise, excessive drinking and obesity**
- **All viewed health from a ‘holistic’ perspective** where ‘health’ is composed of a network of interlinked behaviours although views differed between settings
- **Secondary care professionals** focused on behaviour immediately affecting clinical outcomes and felt that their rc was to make people better – and then, recommend, rather than motivate, changes in behaviour
- Their view of their role **reflects a fairly interventionist posture in relation to their patients -** with the state, in this instance, as clearly in charge of directing treatment and appropriate behaviour

‘Unhealthy’ behaviour (2)

- **Primary care professionals** had considerable experience of attempting to motivate change and very much perceived improving future health prospects as part of their role

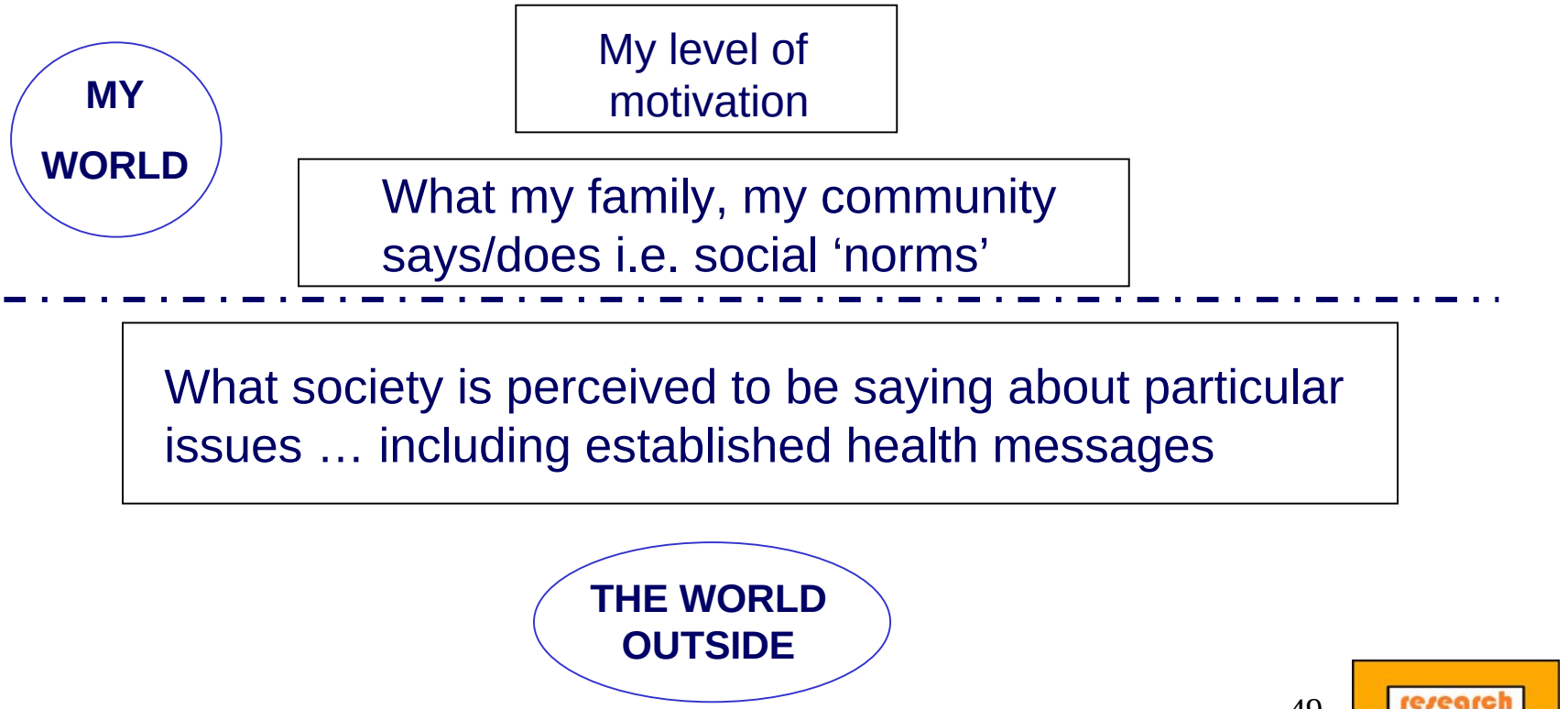
- This group typically reflected a more **'partnership-focussed'** approach to changing behaviour - relying on advice, persuasion and encouragement (rather than direction)

“People don’t like direct honesty, you have to be positive to even get them on board.”

“People need to take responsibility for their way of being.”

‘Unhealthy’ behaviour (2)

- Health professionals felt that **‘unhealthy behaviours’** had social roots, particularly for those from disadvantaged communities



‘Unhealthy’ behaviour (3)

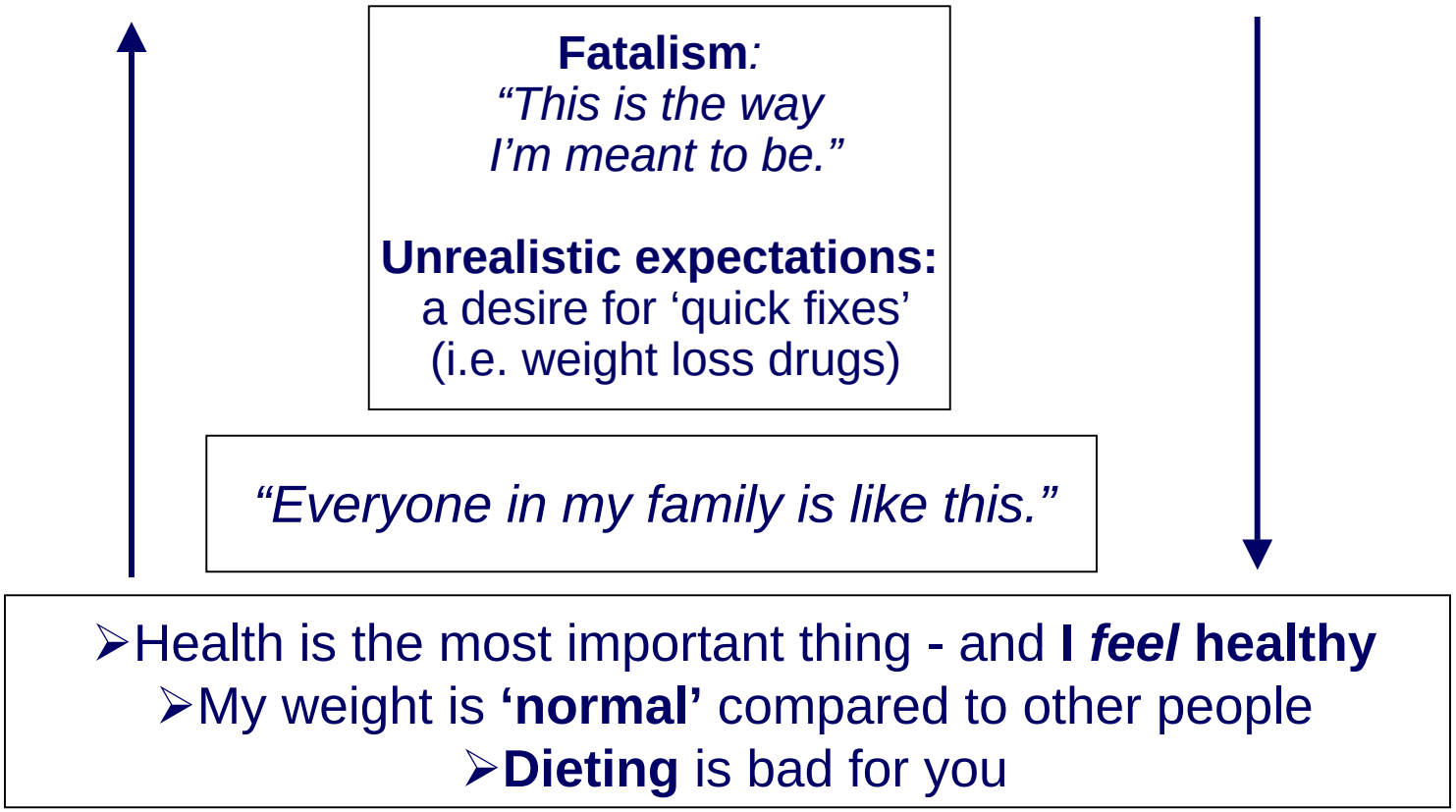
- In their view, **lack of personal motivation is a key barrier** to motivating positive changes
- Some even went so far as to suggest that:
  - a lack of willingness to accept personal responsibility and motivate oneself to change **was becoming more prevalent**
  - patients are moving towards *expecting* the NHS **to accept responsibility for changing ‘unhealthy behaviours’**

“There’s a whole generation without any motivation to change, without any belief that they can achieve the smallest goals.”

“You see people in the clinic with diabetes and they treat it like your problem, that the diabetes is the NHS’s to deal with, not theirs.”

‘Unhealthy’ weight

- **Health professionals reported that a lack of personal motivation** was a key factor for those maintaining an unhealthy weight

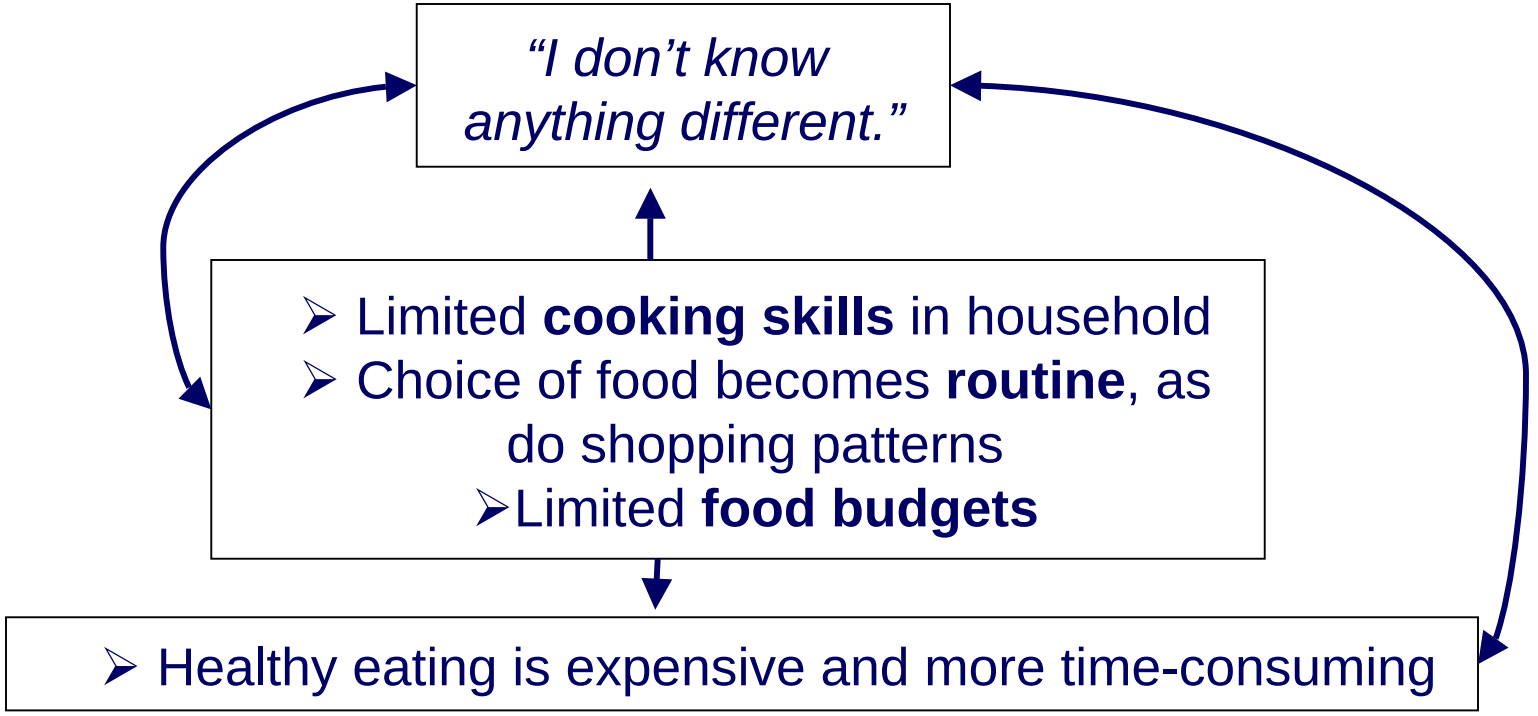


Exercise

- Health professionals also identified **lack of time as a powerful influence over the amount of exercise achieved by individuals**

Diet

- Health professionals identified that **poor diet was very much a product of lifestyle choices**



Smoking

- Health professionals identified that it is **usually a major health scare which inspires an attempt to quit**

"I enjoy smoking."

- Smoking breaks at work
- 'Everyone around here smokes'

Society is sending strong anti-smoking messages:

- Hard-hitting **advertising** (considered worthwhile)
- The **smoking ban** was also extremely well regarded

Alcohol

- Health professionals acknowledged **the UK has an attitude towards drinking as a culturally acceptable escape** – which, in some cases, becomes a refuge from difficulties

Motivating change

- Healthcare professionals felt that individuals **lack motivation to make positive changes to their health**

- **Opportunities to motivate behaviour change** were:
  - **focussed on lifestyles (i.e. people as people, not 'issues')**
  - **and from within their communities, for example:**
    - **Schools**: improving education in health (e.g. cooking skills), encouraging physical activity
    - **Employers**: promoting exercise during work (e.g. time, facilities)
    - **Transport**: improving transport links to facilities
    - **Environment**: more facilities for communities (e.g. opening up school facilities for wider use)

Motivating change (2)

- In future, there was **resistance to:**
  - **high levels of intervention by the NHS**
  - **unrealistic 'quick fixes'**

"She said 'oh, I'll just get a gastric band … the NHS will pay for that." No one wants to put any work in to being healthy any more."

- There was a concern that the NHS could be seen as **'rewarding' unhealthy behaviour**

"The British mentality is to put people on pills and give them free gym membership. What people need to do is learn to cook and walk a bit more. It's simple, but it takes longer to see results."

- **The worst case scenario was felt to be the idea of** paying people to stop smoking or lose weight

Motivating change (3)

- Health professionals were keen that any interventions should **reward positive behaviour - so:**

  ✗ taxation of junk foods

  ✓ subsidize healthy foods e.g fruit tokens, 2 for 1 deals

"Smokers always pay, regardless of how much tax is put on fags. It is the same for those who like junk food – they'll still pay because its convenient and cheap."

- **There was also support for initiatives where society expresses its views about more and less desirable behaviour** (inspired by the perceived success of the smoking ban and anti-smoking advertising)

"We all remember the tombstone ads in the 80s, but now it's very much seen as a disease that you just live with. Young people don't understand that the NHS doesn't have a pill for everything."

Staff - conclusions

- In short, staff believed that the State should encourage individuals to take responsibility for their own health **by both positively influencing lifestyle choices from within communities and from a broader cultural perspective**

- Staff strongly distinguished ‘the State’ from ‘the NHS’: there was resistance to the **NHS shouldering the responsibility** of addressing the ‘unhealthy’ behaviour of the nation

- Staff were sceptical about ‘quick fixes’ and emphasised the value of longer-term change. The respondents felt that the state has a **right (and for some a duty) to intervene** in life choices to create societal change in relation to health

Staff – conclusions (2)

- **Staff opinion** regarding appropriate levels of intervention differed in terms of the strength/authority of intervention

  - **Strong interventions are felt to be needed in relation to**: smoking and obesity- (exercise and healthy eating):

    - **Smoking:** there was strong support for a continued emphasis on expressing cultural disapproval via legislation (e.g. banning smoking in cars with under 18s present) and advertising

    - **Healthy eating:** was perceived as a question of education, complemented by encouraging healthy choices e.g. promotions on 'healthy' foods, banning of vending machines in schools

Staff – conclusions (3)

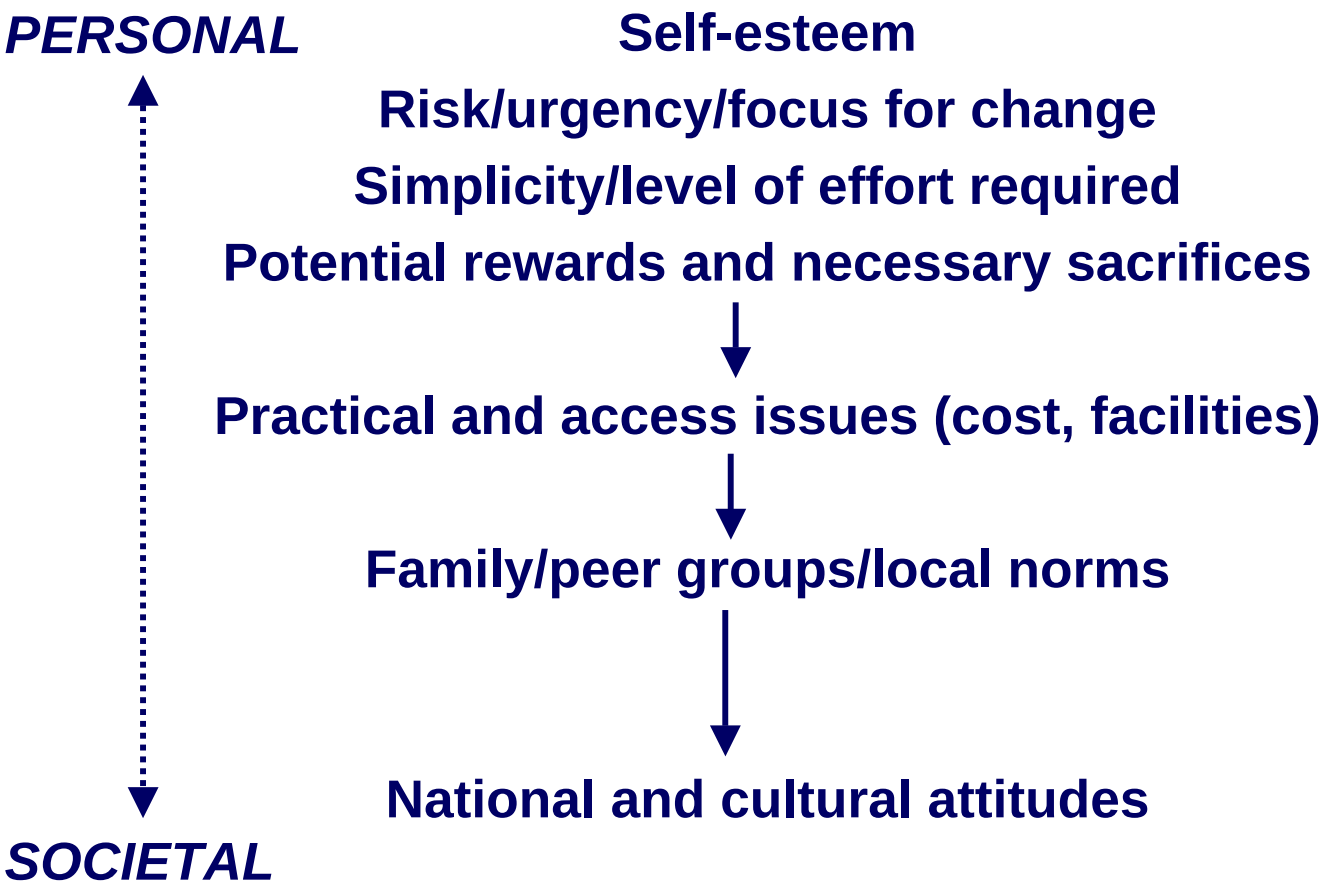
- **Strong interventions are needed in relation to**: smoking, weight management (exercise and healthy eating):
  - **Exercise**: those from primary care settings who had experience of prescribing exercise (e.g. gym memberships) reported poor results
  - Creating **opportunities** for people to include exercise in their busy lives was considered the most practical way forward

- More **collaborative interventions** are needed in relation to alcohol:
  - there was very little appetite for intervening in **drinking behaviour**, other than penalties for frequent A&E use

Conclusions and Observations

Conclusions

- Behaviour Change is influenced by a **set of factors**:



Conclusions

- However, the **behavioural status quo** is believed to be maintained by powerful influences:

COST →

COMMERCIAL PRESSURES →

NEED TO 'HAVE FUN'/LIVE NOW →

PEER NORMS →

LIFESTYLE CONSTRAINTS →

LACK OF GUARANTEES →

TIME PRESSURES/CONVENIENCE →

Conclusions

- Equally, **drivers for behaviour change** can also be powerful:

RESPONSIBILITIES AND FAMILY

SELF-ESTEEM/IMAGE

FEELING WELL/UNWELL

IMMEDIATE HEALTH CONCERNS

MEDIA MESSAGES

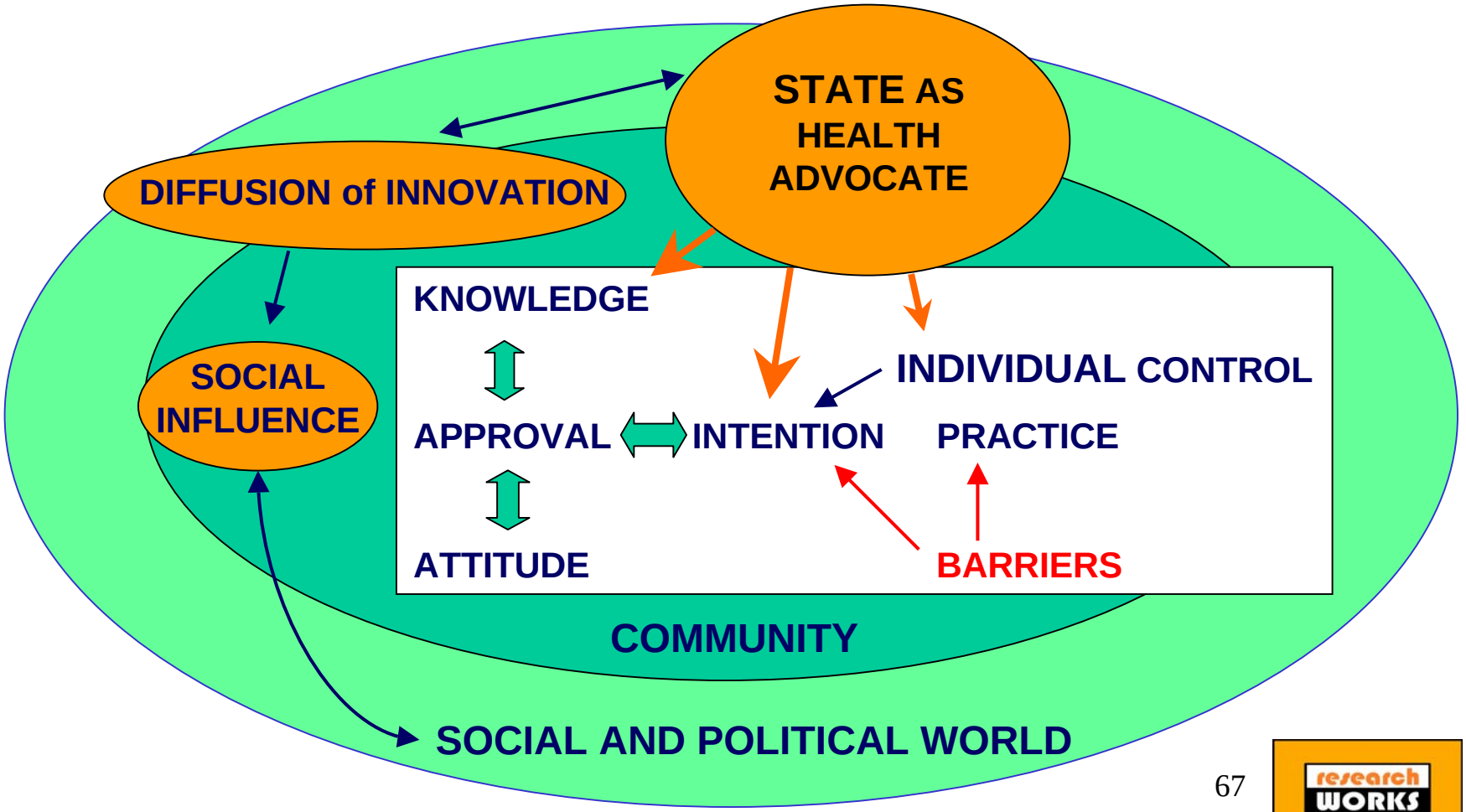
GOVERNMENT MESSAGES

Conclusions

- The **government**, it was generally felt, should be:
  - Respecting **individual choices and freedom** in relation to health behaviour
  - Providing **accurate information** about health issues
  - Offering **guidance** about positive, health-enhancing, choices and options: at both national and local level
  - But ***also***: directly controlling health choices/behaviours which have a **significantly negative impact on society as a whole** (for example, drink-driving, binge drinking, use of illegal drugs and deliberate lifestyle choices which cause harm and 'cost the taxpayer')
  - Otherwise: **'keeping a distance'**

Conclusions

- Overall, therefore, the state should be an **influencer and advocate** for health behaviour at both **local and national** level:



Conclusions

- So, the **state <u>should</u> be**:
  - generating **educational initiatives and information campaigns** at both a local and national level (and providing real practical support as part of this)
  - drafting **legislation** which protects society at large from the harmful impacts of those who live deliberately unhealthy lives
  - controlling **commercial organisations** (especially retailers) that might be seen as actively promoting unhealthy choices

- The **state <u>should not</u> be**:
  - interfering in **domestic lifestyle choices**
  - instigating **broad-brush health measures** which affect everyone without discrimination
  - trying to '**frighten us'** into behaviour change (does not work)
  - **rewarding bad behaviour** or unhealthy lifestyles