

Applying Behavioural Insights to Policy: From Evidence to Practice



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Executive Summary

Evidence from the behavioural sciences is increasingly used to inform and improve policy around the world across many domains. These *behavioural insights* can be used for a number of purposes, such as improving communication to the public, encouraging healthier behaviour, and increasing the uptake of social services that improve life outcomes. However, not all evidence can be equally applied to any policy; the strength of the evidence and suitability for the situation at hand should be assessed case by case and ideally more evidence within the new context should be established. This report presents an approach to incorporating behavioural insights into policy using a number of examples while leveraging original work on mental health, trust, and decision-making in Lebanon. The aim is not to present a specific recipe or set of recommendations, but to share general concepts and examples for consideration in establishing a behavioural policy framework.

This report complements our workshop on evidence-based policy and provides basic information to participants in advance.

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Introduction

What are behavioural insights?

The success of a policy largely depends on the assumptions it is built on. This includes tailoring a policy to the environment where it is applied as well as anticipating how the target population will react to it. While policies for decades relied on economic models assuming that people think rationally and want to maximize their outcomes, research from behavioural and decision sciences has shown that decisions are dependent on a number of internal motivators and external factors. Accounting for such factors based on reliable evidence can therefore improve policy outcomes and acceptance.

What are the advantages of behavioural insights?

Behavioural policy is typically implemented through small changes in the environment (see next page) with positive effects and without coercion ('nudging'). For example, having found that surgeons are often under stress and can forget minor but crucial checks, the WHO developed a checklist that was associated with an error reduction from 23% to 6%¹. Instead of assuming that people will behave in a fully rational and error-free way, by incorporating behavioural insights, we can account for actual behaviour.

Why build on behavioural insights in Lebanon?

For this report, we will predominantly focus on the interplay of behaviour and health: The behaviours and habits of non-clinical populations may increase or decrease the risk of subsequent health problems. This includes habits relating to diet, exercise, smoking, driving, and more. At the point of service delivery, doctors make decisions relating to diagnoses and treatment, patients make decisions with regards to when to seek aid, whether to keep appointments, whether to follow the doctor's prescriptions, etc. Therefore, behavioural science can be used to inform proactive interventions, designed to increase the overall health of the population and reduce pressure on healthcare providers as well as set up interventions that makes the service delivery itself more efficient and effective. This report aims to provide guidance on translating behavioural and mental health research into policy, building on a practice previously successful in Lebanon².

Common behavioural interventions

Choice architecture

We face numerous decisions every day. Some of these decisions may be conscious and deliberate (such as buying a car), while others are less thought out, such as selecting a beverage for lunch, or deciding on which side of the road to walk. Choice architecture is a way of designing the environment in which decisions are made in a way that the more beneficial option is more likely to be chosen. As a result, we ideally make more directly beneficial decisions – for ourselves or for society – without giving away our freedom of choice. Two common ways to do this are **nudges** and **boosts**.

Nudges

Nudges are low-cost, easy-to-implement interventions that alter the environment of a decision in a way that **highlights a more beneficial option**³.

If the goal was to have people eat healthier, one example of a nudge would be placing healthy food options more visibly or salient. This preserves a person's free choice of meal, but still increases the number of people who choose healthy nutrition.



Boosts

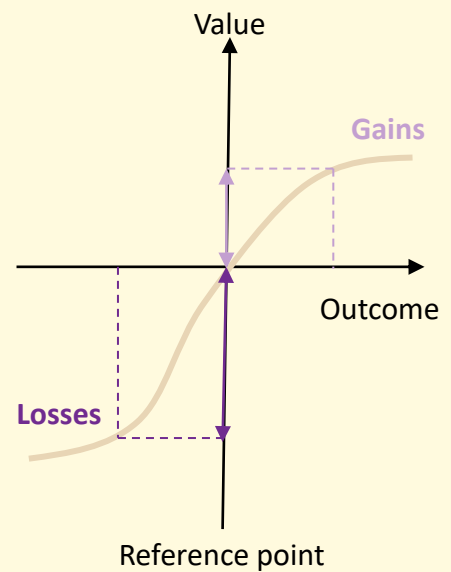
Boosts aim to foster a decision-makers **competence** or build new competence regarding the choice at hand, often by encouraging a more informed, deliberate process⁴.

Boosts can involve simple tools such as calculators for determining budget allocations or interactive apps from grocery stores that help consumers estimate health value of their choices as they shop.



Consider what influences decisions

In classic economic models, humans are assumed to always act rationally and gain-oriented - that is, choosing to their highest benefit. This is often the case in **decisions with certainty**, where the outcome is clear: we would prefer \$120 over \$100 if given the choice. When it comes to **decisions under risk**, humans do not always choose the option with the highest potential value – this is because **gains and losses are not perceived equally**⁵. In other words: the prospect of losing \$100 often appears more dangerous than the prospect of winning \$100 seems appealing. This is not only limited to decisions regarding money.

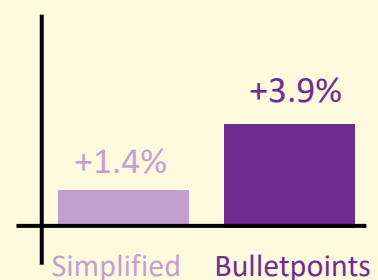


Based on an individual's reference point, they may make different decisions, which is why **framing** a message or situation⁶ is important to consider: telling a patient that 90% of people survive an operation is much more comforting than being told that there is a 10% chance to die.

Communicating effectively

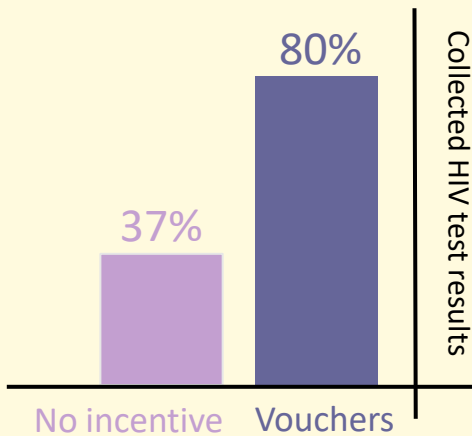
Not only the reference point is important when communicating with the public: People engage with information more if it is **salient** and **simple**. One large-scale study showed that letters simplifying their content, or using short bullet points receive more responses, than a standard text⁷.

Simply not being aware of available public services is a crucial **structural barrier to the uptake of healthcare services**. Evidence suggests large differences in education between the Lebanese population and refugees⁸, and also the generally low healthcare service uptake of Syrian refugees⁹:



These findings alone may not give clear indications for policy but indicate that **further testing of simplifying messages may reveal how uptake could be increased** through small changes in communication.

Addressing stigma with behavioural insights



Only 6% of Lebanese adolescents affected by mental disorders report to have sought help¹⁰. Social stigma is a common barrier for people all over the world to access mental health services¹¹. Behavioural insights can be used to support people in their **choice to seek help**. One example of engaging people affected by a stigma-heavy disorder is the successful use of **financial incentives** for HIV testing in Malawi. Participants collected test results more often when given a small financial incentive¹².

Reducing mental health stigma

Mental health literacy has been identified as one of the crucial aspects in reducing barriers to mental healthcare¹¹. While reducing stigma on a wider level is a complex and complicated task, it can be achieved through **education**, as well as through **contact with stigmatized groups**^{13,14}.



Education

Replacing stereotypes with facts



Contact

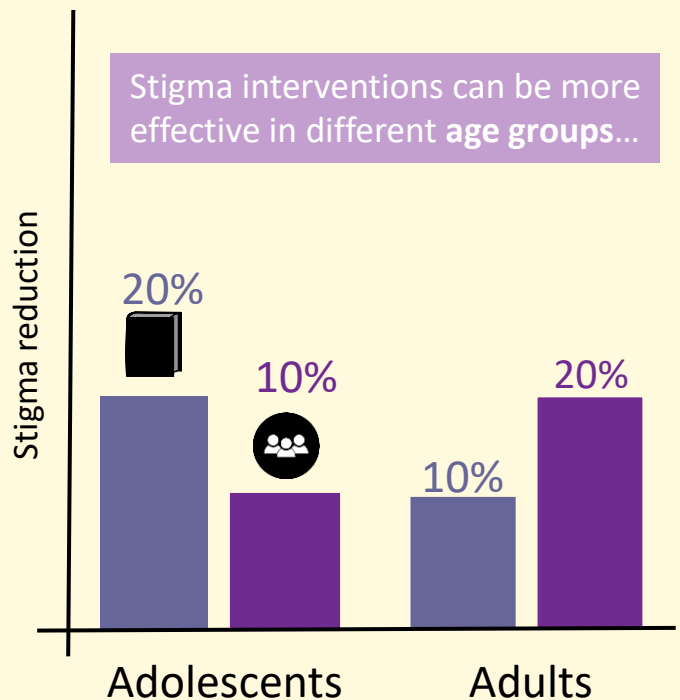
Interacting with members of stigmatized groups



24%



10%

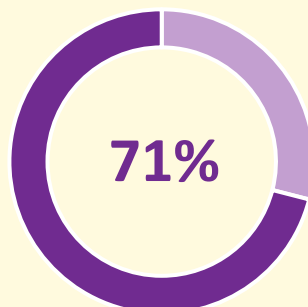
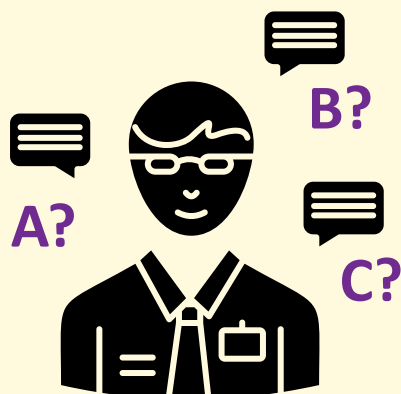


Face-to-face contact has larger impact than by **video**.

Providing patients an active role in their treatment

Trust plays a large role in the decision to start treatment and choosing a physician or provider.

Which Treatment?



of patients prefer to have an active role in treatment decisions¹⁶

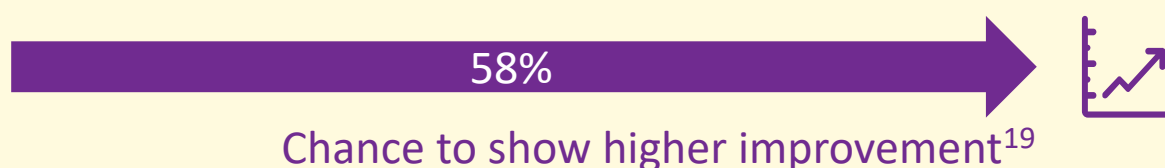
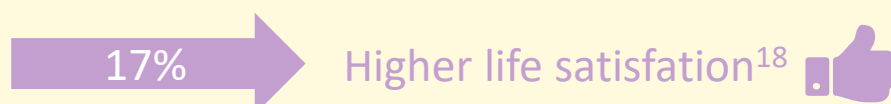
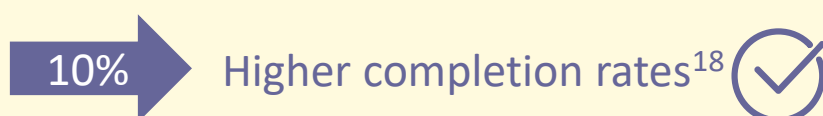
Increases trust



Increases uptake?

Lebanese and refugees report very low trust towards others but put much higher trust in family members⁸, which may also explain some successes of former Syrian healthcare workers in refugee camps¹⁵. More and more patients prefer to make active decisions in their own healthcare¹⁶. Evidence also indicates that patient involvement is often related to an increase in trust into the healthcare system¹⁷.

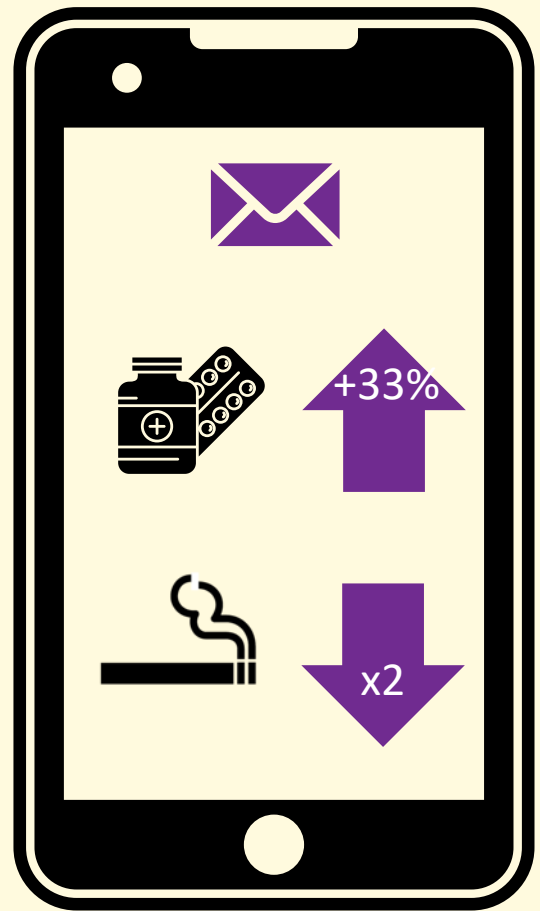
Potential benefits of involving patients in decision-making



Reminding people to carry out daily healthy behaviours

Despite knowing about many health outcomes, people often neglect simple beneficial behaviours such as taking their medication as scheduled or showing up to healthcare appointments.

Brief text-message **reminder messages** can improve various kinds of health behaviours, such as medicine adherence²⁰ or support smokers in quitting²¹.



E-Mental Health interventions

The use of digital applications in mental healthcare **remove the barrier of requiring patients to be physically present** at a care facility or provider. This has been particularly helpful since the start of the COVID-19 pandemic²². However, clear **ethical guidelines are still missing**.

High satisfaction as well as positive attitudes towards apps among refugees and immigrants²²



Symptoms improve in...

Anxiety

Depression

Post-Traumatic Stress Disorder



However...

Poor implementation and reporting of ethical standards so far



Preliminary results exist regarding one WHO guided **E-Mental health intervention in Lebanon**²³. The intervention is a brief self-help programme with minimal guidance.

While the intervention shows potential effects on **depression** and **anxiety**, the study also found that it needs to be **better tailored to younger people and singles, made more motivating, and easier to use**.

Example: Behavioural insights and mental health in Lebanon

Exploring traits of the population

When using evidence to inform policy, it is always crucial to remember that **populations often differ from another**. It is reasonable to assume that refugees—who have left their homes and are more likely to have recently gone through other traumatic events—feel and behave differently from the average population of the host country. If the goal is to develop inclusive policies, a first step could be to capture and compare levels of well-being.

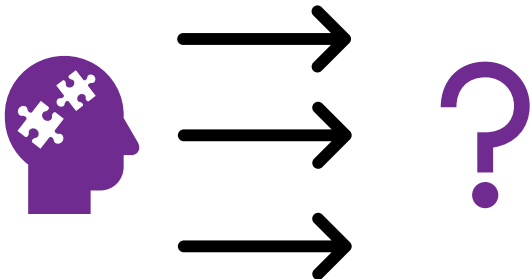


Well-being in Lebanese nationals and refugees

Researchers tried to find out how strongly refugee well-being may differ from local populations. Surprisingly, there were **no significant differences** in any dimension in a sample of over 600 people in Lebanon⁸.

Can policy be derived from these findings alone?

Will refugees with low or high well-being behave like Lebanese with low or high mental health?



The role of mental health in risk-taking: Example from Lebanon

Lebanese



**No differences in
risk-taking on average**

Refugees



While both are in a very different situation, researchers found that refugees in Lebanon make about the same amount of risky financial decisions as the general population. Both groups take **more risk** when choices involve **losses**⁸.

Does mental health play a role in decision-making?

If well-being is...

Data shows...



**Poor to
moderate**



**Lebanese and
Refugees make
similar decisions**



High



**Refugees make
more risky
choices**

How could we encourage more risky decisions, when they are beneficial, especially in those with poor mental health?

What are the *reasons* for poor/good mental health?

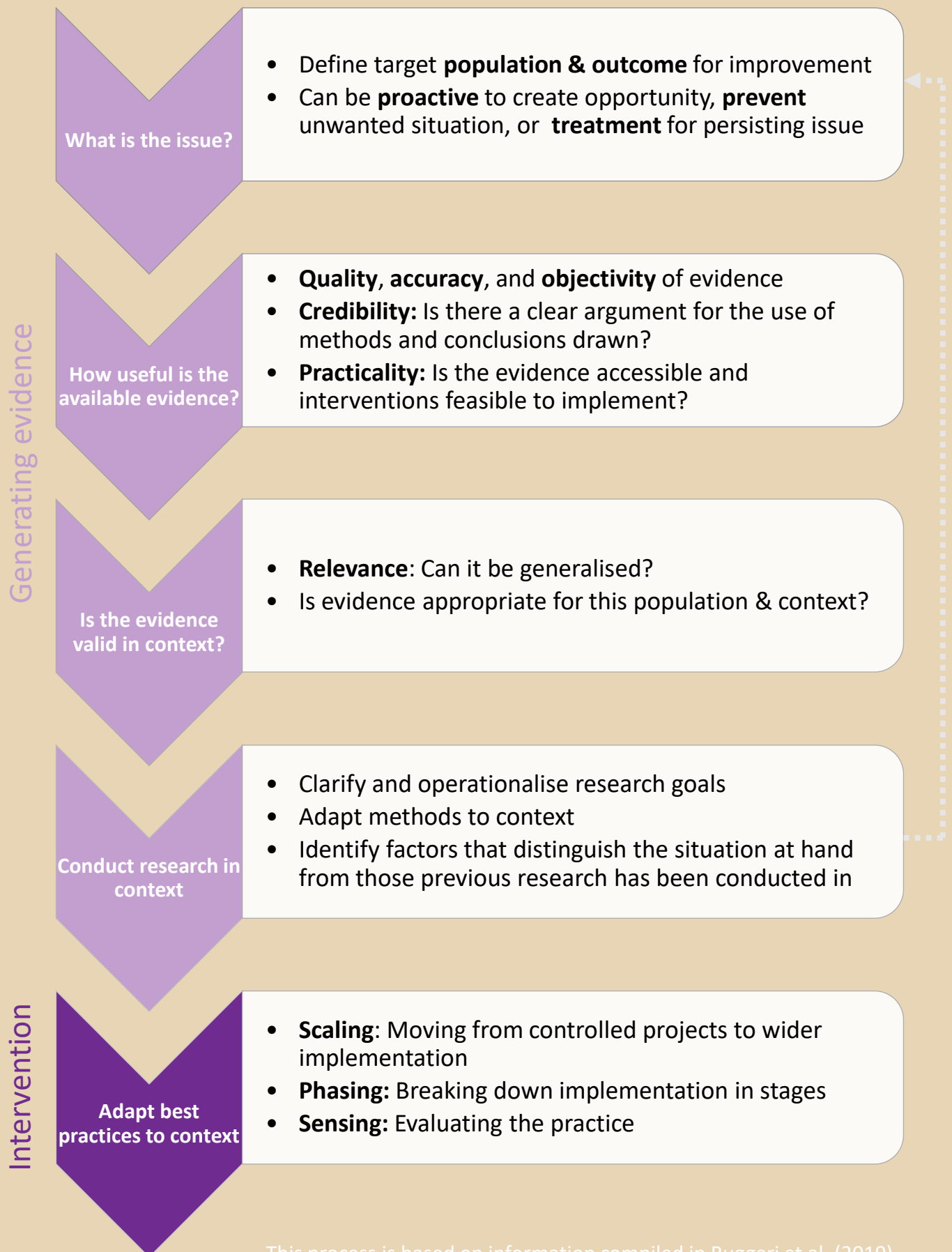
Which *other factors* need to be taken into account?

Where are risky choices beneficial or suboptimal?

When do we need *other measures of risk*?

Developing policies using scientific evidence

A process model generating and incorporating evidence into policy²⁴



This process is based on information compiled in Ruggeri et al. (2019)

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