

Government wants healthcare staff to change patients' behaviour – but that's unlikely to work



Lorelei Jones examines government efforts encouraging healthcare professionals to get patients to change their behaviour. Drawing on her ethnographic research in England, together with analysing various educational practices and training materials used she explains why these efforts are unlikely to accomplish governmental objectives.

Government policy is increasingly focused on encouraging citizens to act responsibly and to be less reliant on public services. In the NHS, increasing 'self-care' is seen as a way of making significant cost savings, as well as improving people's health. But how is this policy being put into practice? And will it work?

I did [fieldwork](#) in four different areas of England and in each case the strategy for encouraging more self-care was the same, based on a model developed by the Kings Fund, called 'The House of Care'. The aim was to get both professionals and patients to adopt different identities and behaviours, or as one manager described it, to 'reculture'. To do this, local organisations had introduced skills workshops to train healthcare professionals in a different style of patient consultation.

I went along to some of the workshops being run by the organisations in my study. These were held in a community hall, with approximately 30 participants, mostly community nurses and therapists, arranged in small groups seated at tables. It was clear that the trainer, and the staff who attended the workshops, were concerned with improving people's health. Nonetheless, I noticed that the training materials made certain assumptions about patients.

In one workshop, participants were given handouts containing short fictional descriptions of individuals and their health-related beliefs and behaviour. These were based on the 'Healthy Foundations Lifestages Segmentation', a market segmentation model that categorises people according to their level of motivation. It is published by the Department of Health and Social Care to use with behaviour change programmes. The individuals in the handouts did things that might increase the likelihood that they would use health services in the future, such as smoking or drinking alcohol, but were otherwise well. In this respect, they were very different from the kind of patients the staff saw in their day-to-day work. Indeed on a number of occasions during fieldwork there were suggestions from staff that the acuity of their case-load had increased, as pressure on budgets resulted in rising access thresholds. One manager told me that a local programme evaluation had stalled because there were no patients who were well enough to be interviewed by researchers. These observations are borne out by a recent report on [the effect of financial pressures on access to district nursing](#).

One of the workshops was on 'motivational interviewing', an approach to communicating with patients aimed at changing behaviour. Rather like [the Christian practice of confession](#), patients are encouraged to reflect on their behaviour, and to commit to different behaviours in the future. This workshop comprised a slide presentation, interspersed with exercises on worksheets, followed by a skills rehearsal. The expectation was that when staff returned to their work they would use the techniques in clinical encounters with patients. Not all the staff who attended the workshop were convinced that the training was relevant:

– I work with people with dementia so realistically I don't think this will work (workshop participant).

– I work in elderly care and I don't like the health promotion. I think it is patronizing. I think this person has got to this age, they are probably thinking, who am I to tell them? (workshop participant).

These skills workshops are an example of the use of 'soft' power to get staff and patients to change their behaviour. [Ewan Ferlie](#) argues that soft power is becoming increasingly important in organisational settings, replacing, or used alongside of, performance management. This can be seen in the NHS in the increasing use of educational technologies – such as training, leadership development programmes, mentors, action learning sets, and coaches – to produce active change agents. These technologies encourage personal development and 'growth', but in a direction that is aligned with the national policy agenda.

There are a number of reasons why these efforts are unlikely to work. The training is provided in short sessions on an ad hoc basis, in contrast to professional training where socialisation into professional identities is accomplished through many years of education and apprenticeship. It is also provided to staff with established roles and routines, so that new professional identities must compete with self-understandings and practices that have built up over many years. [Previous research](#) on managerial efforts to introduce changes to clinical practice has found that these have struggled to become embedded as staff return to pre-existing roles and relationships.

Patients may also simply decide to ignore the advice of healthcare professionals, taking their cue instead from family and friends, as [Justin Waring and Asam Latif](#) found in their study of patient education initiatives in community pharmacy. An [evaluation](#) of a similar initiative, the Expert Patient Programme, found that it had no effect on how often patients used health services. This is because the initiative reinforced people's pre-existing self-management strategies, rather than initiating behaviour change. The evaluation found that people's patterns of using services had developed over many years and were strongly influenced by the supply side, such as entrenched forms of health service organisation relating to procedures for ordering tests, routine monitoring, and repeat prescriptions.

The self-care policy, as expressed in 'The House of Care', the 'Healthy Foundations Lifestages Segmentation' and 'motivational interviewing', assumes that we make decisions as individual rational actors, when in fact most of us are embedded in social relationships, and our behaviour is sometimes an expression of belonging to a social group or place. What all these policy tools and techniques are based on is a view of motivation, beliefs and behaviour as somehow independent or isolated from the context in which we live our lives. Low levels of motivation are seen as the cause of illness, rather than its effects. So policy interventions are targeted at increasing motivation. Yet low levels of motivation can be symptomatic of physical or mental illness, injury, the experience of violence or trauma, or ineffable social suffering, experiences which are, themselves, grounded in the economic system and its consequences for power relationships and the distribution of material resources.

The self-care policy reflects the trend for government to focus on behaviour modification, and short-term individual action, rather than 'upstream' forms of intervention, despite evidence that individual-level interventions are largely ineffective, and despite widespread academic attention to [the fundamental role played by inequalities in power and material resources in health outcomes](#). Alex Scott-Samuel and Katherine Smith call this 'utopian' policy, in the sense of 'a fantastical impossible dream which will almost certainly not come to fruition'. They argue that utopian policies result from neoliberal governments committed to free-market-orientated economic policies and to 'rolling back the state'.

Self-care may bring benefits to both patients and professionals. But as a policy it is utopian in the belief that it will significantly reduce demand on statutory services, or that organisations in local health and social care markets will respond to a reduction in demand by reducing supply and closing facilities so as to produce significant cost savings (rather than, say, lowering access thresholds). Instead of relying on healthcare professionals to encourage patients to be more independent, active, and responsible, an alternative is for policy to target the context in which people live their lives, such as by maximising the uptake of benefits; and building thriving local communities that provide opportunities for people to meet, interact, and make friends.

Note: the above draws on the author's [published work](#) in *Sociology of Health & Social Illness* (open access version available [here](#)).

About the Author



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