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What Choice Risk And Responsibilisation In CVD Policy?

Introduction

This paper aims to explore the relationship between cardiovascular disease (CVD) policy in the UK and the wider global and national socio-political landscape. Initially, we discuss the body of literature that considers the emergence of neoliberal discourses of responsabilisation in policy that are based on the principles of individualism, decentralisation of the functions of state and deregulation of markets (McGregor, 2001). Applying policy-as-discourse techniques (Shaw, 2010) we reflect on and offer an account of how policy and public health strategies have come to be predicated on principles of individualism. We aim to add depth to debates that critique the emergency of responsabilisation discourse by; examining how this trend is evident in CVD policy from 1999 to 2013; demonstrating how properties of text reflect CVD management and prevention strategies shaped by broader socio-political contexts.

Public health is an important sphere in which to explore policy-as-discourse, as the way problems are constructed, and solutions are shaped to tackle health problems, have significance for how CVD health services are organised, delivered and experienced. Our analytical framework is influenced by Norman Fairclough's (1992) Critical Discourse Analysis, that informs our analysis of how responsabilisation, discourses are developed and normalised through health policy and practice. Subsequently, we explore the tensions and conflicts evident in public health approaches based on individualism; assumptions that a market economy improves and enables consumer choice; and that individuals are self-governing responsible risk takers. We reflect on how and why messages based on individualism and lifestyle correctness come to be privileged over structural explanations for CVD that are marginalized or silenced considering what is therefore left problematic. These findings support the view that health

discourse based on individual responsibility, have consequences for individuals and contribute towards the construction of moral discourses that may exclude and marginalise those who do not share this view of how to be healthy. We therefore make suggestions about the need to rethink how responsabilisation for health is conceptualised.

Background: Neoliberalism, the Global Context and Health Policy Formation

Coronary heart disease (CHD) accounts for just over one third of all deaths globally in people over thirty-five (Benjamin, 2018). Many factors driving CVD policy development today are shaped by international agendas. Bunton et al (2005) argue the frameworks and statements used in UK health promotion literature draw on international initiatives. The World Health Organisation's Health for All objective (1978) revolutionised the focus of global and national health policy, changing the emphasis in both policy and practice from the treatment of non-communicable diseases like CVD, to prevention strategies based on behavioural change. Global health initiatives reflect a growing internationalisation of politics and policy formation in relation to health.

Intimately linked to this trend since the 1980s, has been the increasing neoliberal influence in approaches to health promotion, disease prevention and health care provision (Scott-Samuel et al., 2014). Self-management models emphasising behaviour change have been used as an approach to manage chronic illness (Lorig, 1996). Brown argues: 'There continues to be a growing trend for 'responsibilisation' often related to 'personalised healthcare' (2013:1). This trend in health policy marks a 'behavioural turn', where ways of thinking and strategising about public health are conceptualised as individual responsibility rather than the collective responsibility of communities and states (Crawford, 2013).

The self-management policy agenda in the UK has been influenced by population changes and technical advances. £6.8 billion was spent on treating CHD in the NHS in England in 2012/2013 and improvements in survival rates mean almost 2.3 million people in the UK are living with CHD (Bhatnagar et al 2014). Responsibility for choosing a healthy lifestyle is evident in a plethora of policy documents and guidelines for healthy living (Lindsay, 2010; Peterson, 2010). The policy document The Health of the Nation (DH, 1992) sets out a strategy to tackle CHD emphasising the role of the individual in making healthier life choices. Patients are increasingly expected to engage with decision making and become responsible for their own health, supported by agendas that grant them ‘expert’ status (DH 1999); provide personal health budgets and encourage partnership working between patients and health professionals (NHS England, 2013; PHE, 2018).

An expanding body of literature considers the effect of neoliberal thinking on health practices, and how neoliberal reform, has been used to govern public health care sectors (McGregor, 2001; Nordgren, 2010; Ayo, 2012; Larsen and Stone, 2015). These techniques are evident in discourses around choice that are pervasive in health promotion strategies and health policy and drawn from neoliberal principles that assume that patients are active, responsible, consumers of health care services. Nordgren’s (2010) study of Denmark, Sweden and the UK shows how neoliberal market discourses have gained ground and are reflected in new models of health care provision, establishing an emerging agenda around patient choice. Recent critiques of neoliberal discourses in health problematise the central belief that individuals have freedom to choose and are self-governing and self-regulating (Ayo, 2012; Brown, 2013; Beck-Gernsheim, 2005; O’Brien 1995; Parish 1995; Trnka and Trundle, 2014). It can be argued that choice, in relation to illness behaviour, is an illusion and socially sanctioned prescriptions of how we should behave influence our decision making (Ayo, 2012; Brown, 2013).

Contradictions inherent in neoliberal forms of governance involve the seeming retraction of the state intervention and promotion of competitive markets and consumer choice, whilst at the same time a mode of governance is maintained through incentives and competition. Those who design the incentives also exercise control and power over the choices available to citizens (Larsen and Stone, 2015). Foucault's (1997) concept of 'governmentality' draws on structural explanations of cultural theory, to account for some of the complex and subtle ways 'citizens' are encouraged to take responsibility for the decisions and choices made about health; how we come to see ourselves as 'good citizens' and engage in practices which are self-constituting. This disciplinary, or regulatory, function of medicine is a key feature of health promotion activity emerging in the last part of the 20th century and has become known as 'surveillance medicine' (Armstrong, 1995). The concept of 'responsibilisation' emerges from debates that consider practice that is involved with audit and accountability; and involve calculations that attempt to mitigate against risky behaviour and maximise health benefits to individuals.

Risk assessment and management is therefore an integral part of a neoliberal system involved in the regulation of individual behaviour. Risk discourse has formed part of a new global political vocabulary that defines risk as undesirable and holds people and governments accountable (Douglas, 1985: Chpt2 p.22). Douglas conceptualises the idea of 'risk' based on individualistic forms of social organisation. Explanations for misfortune are constructed within cultural processes and act as a mechanism for social stability. Douglas suggests that the idea of being 'at risk' plays a similar role to that of taboo or sin. 'Risk, danger, and sin are used around the world to legitimate policy or to discredit it, to protect individuals from predatory institutions or to protect institutions from predatory individuals.' (Douglas, 1994:26). Responsibilisation is a mechanism, based on neoliberal principles, that influences the relationship between state,

citizen and health providers; shaping the expectations states have of citizens and the health choices endorsed by governments and made available to individuals.

Giddens argues for understandings of risk that consider both positive and negative outcomes. Drawing from Beck's (1992) historical conceptions of risk, he argues for the need to 'rethink the welfare state' (1999; 4). Traditionally risk has been conceived of as something over which we had little control but had collective responsibility over. Illness was something that we succumbed to, and we were entitled to rely on care from the welfare state. In what Beck calls 'Risk Society', modern perceptions of risk are increasingly influenced by uncertainties and opportunities created by science and technology. People are expected to make choices, where once traditional norms were taken for granted and are considered accountable for their decisions. Giddens argues this constitutes a shift in the relationship between risk, responsibility and decision-making that gives rise to a crisis of risk management in the welfare state. New ways of understanding risk that consider the nuances inherent in decision making, including the benefits of taking 'responsible' risks, are needed (1999:10).

Decision-making processes that influence healthy lifestyle choices thus reflect a complex interplay between individual responsibility, choice and risk management. Responsibility to make the 'right' choice is often complicated and contestable. More nuanced understandings of how people understand and react to health care messages require appreciation of the competing responsibilities, dependencies, reciprocities, and obligations may support, subvert or cross-cut an individual's capacity for autonomy and decision-making (Truka and Trundle, 2014). Understandings about what is 'good' or 'bad', 'right' or 'wrong' in relation to health behaviour are defined in this complex milieu. There are tangible consequences for those who make 'bad' choices or fail to conform to health mandates, including disdain and reproach for behaviour

(Ayo, 2012). Taking responsibility involves avoiding habitual ‘bad behaviours or ‘lifestyle choices’ which contribute to chronic illness.

This ‘behavioural turn’ (Crawshaw, 2013; Mair, 2011) represents a trend in health policy development that appears less concerned with structural determinants of health and more focused on behaviour change. Strategic approaches to health have viewed individuals as both the cause and the solution to their health problems. There have been notable limitations to such behavioural approaches to health and numerous commentators, consider that the structural factors that affect peoples’ lives are more influential than change to behavioural habits (Blaxter, 1990; Newbould et al., 2006). Successive studies in the last 10 years have emphasised structural determinants of health inequality, demonstrating that more equal societies tend to exhibit better health outcomes (Marmot, 2010; Wilkinson and Pickett 2015). Reliance on behavioural strategies may obscure or limit attempts to challenge social and economic barriers to health. We go on to demonstrate how CVD health policy has been shaped by this neoliberal trend towards individualism and behaviour change and consider the impact of this ‘turn’ on CVD health strategies and service provision.

Theoretical approach

This policy-as-discourse approach (PAD) problematises commonly held views of responsabilisation in CVD policy. The intention of PAD approaches is to ‘direct attention to the ways in which the study of problematisations opens up innovative research strategies that make politics, understood as the complex strategic relations that shape lives’ (Bacchi, 2012;1). Adopting a PAD approach, we make visible the relationship between discursive, material, political and social practices from which ideas about responsabilisation emerge; positioning key CVD texts within socio-political and historic contexts; identifying both health problems

and their solutions as socially constructed. Policy-as-discourse approaches demand we recognise: ‘... the discursive (or semiotic or linguistic) character of policy, policy making and policy analysis’ (Fairclough, 2013:177) exposing the ideological frameworks that shape policy, identify and construct problems, and shape solutions.

Theorists who define policy-as -discourse recognise the limitations of rationalist approaches to policy analysis and so our approach offers more sensitive and critical methods for public health analysis (Bacchi 2012, Shaw 2010, Wedel et al. 2005). Rational approaches, that tend to assume that policy can offer logical and impartial solutions to health care provision, are problematic. They involve reasoning that considers problems or risks are easily recognisable and resolved. They assume that people are rational actors who have sufficient information and motivation to make ‘good’ lifestyle decisions; however, they do not adequately consider how actors who are engage in policy formation, are also involved in framing these problems, channelling debates and categorising target groups. We contend that what is interesting or problematic, is not the reality of dangers faced, or expectations held about individuals, but how concepts of responsabilisation are politicised and cast as moral imperatives that shape social expectations around behaviour considered to promote health.

Methodology

PAD approaches emphasise the processes concerned with constructing texts alongside the ‘reading’ of the text (Bacchi, 2000). There are many different approaches to analysing policy as discourse. Here we are influenced by the model proposed by Norman Fairclough’s multi-stage, three-dimensional framework (1992) for carrying out critical discourse analysis (CDA) which involves discussion of the object of analysis (the text), interpretation of the process by

which these texts are generated and formed and explanation of the socio-historical conditions which govern these processes (Janks, 1997).

CDA is considered both a theory of, and methodology that analyses the relations between discursive and material elements of social life. Discourse is understood as a component of, or 'moment' of political and social relations (Fairclough, 2013; 178). CDA does not provide a blue-print or fixed method for analysis, so requires researchers to explain their methods (Fairclough, 2001, Annerdale, 2010). The process of enquiry is not linear in nature but requires movement back and forth between different levels of analysis. Subsequently, it does not matter where the analysis begins; the process demonstrates the interconnected nature between texts, the processes by which they are formed and wider social discourses. (Jenks, 1997). Patterns or breaks from the language adopted, styles of text, genres and discourses can be identified.

Our approach involved close reading of each text, which formed the basis of our analysis of how responsibility, risk and choice (facets of neoliberalism) come to be threaded integrally into the language, messages and public health strategies evident in policy. In the subsequent discussions we provide a description of the aims and priorities of the four key CVD policy texts: Saving Lives: Our Healthier Nation (DH, 1999), National Service Framework for Coronary Heart Disease (DH, 2000), Mending Hearts and Brains (Boyle, 2006) and the Cardiovascular Disease Outcomes Strategy (DH, 2013); providing an overview of CVD policy development that considers their intertextual relationship and how discourses have been sustained or transformed over time.

In our analysis we clustered commonly expressed ideas together, developing broad 'umbrella' categories. Themes concerned with; CVD prevention strategies, lifestyle regimes and equality

predominated supporting and reinforcing the prevailing neoliberal discourses of responsibility, risk, and choice. Subsequently, our analysis of the linguistic choices evident in the use of language, paid attention to how words and concepts related to responsabilisation were used to represent positions and articulate public health messages. We offer explanations that consider how discourses of responsabilisation are related to the socio-political landscape from which they emerge. In this way, we use CDA to understand relations of power and the strategies of agents (Jenks, 1997; Fairclough, 2001) to demonstrate how discourses are constitutive of, and constituted by, wider political and social practices; emphasising the ideological work of texts in representing and sustaining discursive practices.

Analysis

Text and Intertextuality

Our starting point is the framework for health service provision in the UK, published as a white paper, *Saving Lives* (DH, 1999) which established the government's key priorities and targets for addressing ill-health and inequality in the National Health Service (NHS). Here CHD, stroke, cancer and mental illness are described as 'the four main killers' of people in the UK (DH, 1999: 12). These strategic plans were first presented in the documents, *The New NHS* (DH, 1997) and *A First Class Service* (DH, 1998). Building on these earlier policy initiatives, *Saving Lives* established priorities to **reduce the 'economic' and 'human cost' of 'preventable illness'**. (DH, 1999, 1.15). *Saving Lives* (DH, 1999) was one of the earliest national projects emphasising personal responsibility for health prevention. This ambition is evident in the text with an emphasis on pronouns, such as 'Our Healthier Nation' (DH, 1999) that stresses mutual responsibility and obligations for change. **Promoting equality, lifestyle change, and preventing CVD are themes evident throughout the document.**

In 2000 the National Service Framework (NSF) for CHD responded to this white paper by setting evidenced-based national standards and models for service delivery informed and legitimised by a range of ‘experts’ including academics, clinicians, managers as well as patients and carers. These standards and service models provided justification for the suggested prevention strategies, clinical interventions and rehabilitation schemes promoted and were accompanied by the setting of ‘milestones’ for the development of services. Further, this established early targets for reductions in mortality rates as a baseline against which to measure outcomes. Objectives were set ‘to contribute to the target reduction in deaths from circulatory diseases [...] of up to 200,000 lives in total’ (DH, 2000:23). The framework sets out a modernisation programme emphasising ambitions to reduce deaths from CHD through prevention, fairer allocation of resources and improvements in service provision. The NSF (DH, 2000) continues to set the national agenda for reducing mortality rates from the key identified diseases.

Mending Hearts and Brains (Boyle, 2006) explicitly acknowledged the gains made in treating CHD and, additionally, set out aspirations to improve public awareness and services in stroke treatment and prevention. Written by the National Clinical Director for Heart Disease and Stroke the document compares stroke and CHD in terms of aetiology, treatment and prevention and suggests that **a better choice of service and treatment options are necessary to improve care for people with heart disease**. Stroke and heart disease are linked to concerns for the ‘obesity time bomb’ and are described as ‘preventable’ with healthier lifestyles (Boyle, 2006: 1). **Explicit in this dialogue is a message about what are ‘good’ or ‘bad’ lifestyle choices and concerns to modify behaviour and reduce risk to health.**

The CVD Outcomes Strategy (DH, 2013), written by a cardiovascular team, develops the key principles set out in the NSF (DH, 2000). Improving CVD outcomes, quality and safety of care provision and ensuring cost effectiveness is stressed. The strategy is concerned with identifying risk factors which contribute to heart disease and poor outcome. **The language of risk management is given precedence and risk is mentioned fifteen times in the executive summary statement in relation to assessment, management and prevention of CVD. Additionally, the choice agenda is developed further and ‘more’, ‘informed’, ‘better’ and ‘real choices’ are emphasised (DH, 2013: 49-50)**

Themes

Prevention strategies: *Responsibility ‘for’ whom and ‘to’ do what?*

The term ‘responsibility’ is frequently used to identify who has or is assigned responsibility for preventing illness, and improving health, identifying and addressing health inequalities, commissioning services, assessing and managing risk, reducing the burden of CHD and ensuring the effectiveness of the strategies employed. **Broadly prevention strategies are premised on the need for accountability and responsibility and are described as something one has responsibility ‘for’ or is given responsibility ‘to’ do. The earlier NSF stresses ‘joint responsibility’ across agencies and between the government and individuals (DH, 2000: 1.18).**

In Mending Hearts and Brains (Boyle, 2006) and The CVD Outcomes Strategy (DH, 2013) people are also considered responsible for identifying early signs and symptoms and obtaining treatment rapidly in the event of emergency. It is recognised that failure to act may be down to ignorance ‘few people know the signs associate with stroke and because many people don’t realise what can be done for the victim, it is not treated as an emergency’ (Boyle, 2006: 5). Lack of knowledge and the degree of responsibility individuals have to act accordingly, are

taken into account. Delays in seeking treatment are explained by ignorance and so some individuals are considered absolved from their duty.

Conceptions of organisational and personal responsibility for illness prevention are almost always forward-looking, although the nature of that responsibility differs within and across each document. 'Individuals have the responsibility to improve their health, and the health of their families. Local agencies, led by health and local authorities, have the responsibility for delivering local services and local programmes which will enable people to claim the right of better health.' (DH, 1999: 17). The definition of responsibility, and where it lies, is not singular. Organisations are responsible 'for' intervention strategies and models of care. The language indicates the purpose or function of organisations and agencies in promoting health and management illness. Alternatively, individuals are considered as responsible citizens who need 'to' be encouraged to make appropriate 'healthy' living choices. Responsibility 'to' indicates the need for a direct action and sets normative expectations.

Lifestyle: *lifestyle change verses disease models of illness*

In the period between the publication of the NSF in 2000 and the most recent white paper CVD Outcomes Strategy (DH, 2013) there have been some fundamental changes to terminology around CHD. The adoption of the term CVD is more common and encompasses consideration of a much broader range of conditions. Mending Hearts and Brains reveals this early shift in thinking that emphasises the similarities between stroke and heart disease; referring to stroke as '*the brains equivalent to heart attack*' and CVD is described as '*an overarching term that describes a family of diseases sharing a common set of risk factors.*' (Boyle 2006:1, 5). This definition emphasises shared risk factors and the reframing of CHD to CVD accentuates the causal link to lifestyle. This represents a discursive shift away from specific disease

management towards regimes that implicate lifestyle as the cause of disease. The change from CHD to CVD reflects a change in strategy, from one concerned with single disease prevention, to one that attends to understandings of heart disease that consider complex health needs (WHO, 2002).

Equality: *Tensions between structural determinants of health and individualism*

Saving lives (DH, 1999) draws on results from the Acheson Inquiry (1998) acknowledging that countries with the greatest income disparities have greater health inequity. People from low-income groups are identified as more than twice as likely to develop CHD and stroke, than those in the highest socio-economic groups (DH, 1999:78). The document highlights inequality in relation to the prevalence of CHD across social groups and for access to health services. It considers plans to address these social, economic and environmental factors and the need for the provision of support services and for authorities to act as ‘health champions’ (DH, 1999, 30).

The CVD Outcomes Strategy charts the overall reduction of CHD, however, there is recognition of inequality in experiences of CVD. A fall in absolute gap between death rates of the least and most deprived groups (under 75) in England between 2001 and 2010 and the increase in relative gap between these groups is evident (DH, 2013:16). The discussion of inequality here, however, is limited to the high incidence of CVD and poorer outcomes for patients with mental health disorders. We suggest this concern reflects both national and international agendas for mental health service reform. The Sixty-fifth World Health Assembly called for a comprehensive, coordinated action from health and social sectors to identify risk factors for mental health disorders and called for individual countries to take responsibility for mental health services (WHO, 2013).

The CVD Outcome Strategy (DH, 2013) acknowledges that rates of heart disease continue to be higher than many other European countries and this remains the biggest cause of mortality in the UK. Further, the reduction in deaths by around 4% a year is attributed to improvements in the management and treatment of patients rather than changes in individual choices or behaviours (Boyle, 2006). **The CVD Outcomes Strategy (DH, 2013), whilst acknowledging inequalities in CVD experience, persists in emphasising health strategies based on lifestyle change despite acknowledging the limited impact of behaviour change in improving rates of CVD. Solutions to achieving targets focus on encouraging agencies to support individuals ‘to’ take action.**

We argue the nature of the discourse around responsibility, risk and choice in CVD policy is influenced by global political movements and changing ideologies of successive governments in the UK. Patients are referred to as ‘consumers’ in the earlier NSF documents (DH, 1999, 2000) but ‘stakeholders’ in the CVD Outcomes Strategy (DH, 2013). The general direction of health reform over the last 15 years reflects the global movement towards economic liberalism; we go on to consider how the discourse of responsabilisation in CVD policy, has been transformed by shifting national political landscapes.

Explanation

Co-operation

‘We want to see a new balance in which people, communities and government work together in partnership to improve health’ and further that this will achieve ‘... a new balance - a third way – linking individual and wider action is at the heart of our new approach’ (DH 1999:6, 15)

The extract above reflects the policy aim to tackle health problems in partnership. Responsibility for health appears to be equally an object -which is given- as well as an action-expected from individuals, states and health providers. Here the discourse around partnership is reinforced with the use of a 'collective' voice evident in the title 'Our Healthier Nation'. This document sets out an inclusive agenda that is reinforced throughout the text- 'many families in our country' (1999:50) assuming a community responsibility.

This rhetoric reflects the social inclusion aspirations of New Labour. Fuller and Geddes (2008) discuss how during this period, the emphasis placed on social inclusion and a rights and a responsibilities agenda based on the 'active citizen', was balanced by a managerialist approach to governing. Coates (2001) argues that, in keeping with neoliberal principles, policy reform during New Labour, reflected a philosophy which stressed 'equality of opportunity' rather than 'equality of outcome' resulting in policy reform adopting a hybrid approach to governance which incorporated principles of social democracy coupled with neoliberal approaches towards and reforming the organisation of state. **This can be seen in the Saving Lives document where expectations are for individuals to 'take action', reflecting global neoliberal influences, however, the traditional labour social democratic program is evident with the recognition that some factors that increase risk to health are 'beyond the control of any single individual' (DH, 1999; 4).**

The marketplace / Devolution revolution

'It is now generally agreed that providing benchmarked data is a very effective way of leveraging improvements in services and outcomes. It can help commissioners, providers and individual

clinicians identify where to prioritise action in the areas where they are weakest.’ (DH, 2013; 61)

We argue, the rhetoric increasingly reflects the dominance of the marketplace in health care provision and the notion of health as something that is bought and sold and meets the needs of the market. The discourse of managerialism is evident across documents **but particularly in the CVD Outcome Strategy where there is emphasis on; cost effectiveness, improving quality whilst reducing costs (DH, 2013; 3).** The message is primarily aimed at health care professionals and health service managers. It is both clinically and managerially focused and **concerned to measure performance; reflecting the Conservative and Liberal Democrat policy strategy for ‘Liberating the NHS’ (DH, 2010).**

Withdrawal of state functions in health care and increased market competition, is believed to encourage individuals and private agencies to become more active in managing risk and taking responsibility (Rose, 1999).The purchase and provision of health-related services discussed in the CVD Outcome Strategy (DH, 2013) increasingly reflects devolved state responsibilities to other agencies. Improving cardiovascular outcomes, and reducing health inequalities, has been viewed as the responsibility of a wide range of different organisations, but particularly the Department of Health, the NHS, Public Health England and local authorities’ (DH, 2013:3). Decentralisation of health services has been a widely used strategy to deliver health services across Europe for some time **(Kings Fund 2015).** **In the UK the introduction of clinical commissioning groups and foundation trusts have facilitated moves to increase the autonomy of local health providers with the intension of offering services that respond to the needs of local people. The City and Local government Devolution Bill (Sandford, 2015) saw the transfer of responsibilities and resources to local authorities and health bodies. The ‘devolution revolution’ across cities as well as health arenas, has been one of the UKs government’s flag**

ship policies in-line with the principles of neoliberalism that seeks to minimise state intervention, whilst an industry of organisations, such as the Care Quality Commission, have emerged responsible for monitoring and measuring performance.

The Big Society

‘Cardiovascular disease – heart disease, stroke and related conditions – accounts for two thirds of all premature deaths in England as well as major ill-health in terms of physical and communication disability. The overwhelming majority of this is preventable through healthier lifestyles and preventative medication such as statins for high cholesterol and drugs to control high blood pressure. (DH, 2006:1)

‘More people could live longer and with a better quality of life if they were supported to adopt healthy lifestyles – particularly quitting smoking, eating more healthily and being more physically active’ (DH, 2013:6).

The emphasis in both these segments of text shifts from notions of collective or state responsibility for information/action, towards the risks taken at the level of the individual and the duty of citizens to act in morally responsible ways. We argue responsibility discourse is utilised as an instrument to promote healthy behaviour. Political reform during the period of coalition government in the UK in 2010 has been influenced by the rhetoric of the ‘Big Society’.

Corbett and Walker (2013: 444-5) argue that the Big Society publicly draws on two main ideas: ‘red Toryism’, which suggests that social organisations of ‘intermediate institutions of the family, community groups and voluntary groups’ act as protection from the excesses of both

individualism and the state, and ‘libertarian paternalism’, in which empowerment and consumer choice are emphasised but balanced by the idea that it remains the state’s task to direct people to make ‘good’ choices. They argue, however, that these serve to disguise the main driver: neoliberalism. Critics argue that rampant individualism throughout the 1980s and 1990s destroyed much of civic tradition in Britain and discourses of a ‘big society’ appeal to a past communitarian ideal of governance, therefore, the usual checks and balances provided through the principles of red Toryism have been lost (Corbett and Walker, 2013).

The role of the state is developed to ‘steer’ individuals towards making the right choices, consistent with the rhetoric of liberal paternalism and neoliberal ideals. Whilst, on the one hand, individuals are free to make their own choices, market incentives encourage individuals to make ‘good’ choices. Government has, in effect taken on the role of ‘choice architect’ (Thaler and Sunstein, 2008:3). These intentions are evident with the establishment of the Behavioural Insights Team (BIT) in 2010 by the UK coalition government. Political aim is to apply ‘nudge theory’ to bring about changes in behaviour and ‘enable people to make better choices for themselves’ (BIT, 2013-15) to improve efficiency and effectiveness of service provision and reduce the need for state regulation (HM Government, 2010).

Neoliberal principles of minimal state intervention, devolved responsibility, the promotion of quasi markets in health and performance management are reflected in the CVD discourse. We have demonstrated how CVD policy has been framed by the ideology of consecutive governments and the discourses of responsibility reflect the philosophies and ambitions of those governments. **We have suggested there are five dimensions to responsibility evident revealing how responsibility discourse is framed and articulates the complex relationship between the individual, health service provision, and broader political movements and the**

construction of the morally responsible citizen (summarised in figure 1). We argue that language used in policy is important as changes, reflect and reinforce ideas about heart disease that have ramifications for public health messages, service provision, and treatment options available.

Figure 1.

Responsibility	
<i>As object</i>	‘For’ something you have or don’t have or can be given
<i>As action</i>	‘To’ be carried out or actions to be taken
<i>As a moral principle</i>	‘To’ make the ‘right’ or ‘good’ choices and to avoid risk
<i>As instrument</i>	‘For’ Promoting behaviour change
<i>As an ideology</i>	Reflecting the changing duties of state and individual citizen and relationship between them
Forward-looking	

Regardless of political regime change in the UK, there have been few changes recently in health policy direction. Devolution of responsibility and accountability of health services to local authorities and GP-led clinical commissioning groups continues to be part of the UK Government’s Five Years Forward strategy (Kings Fund, 2015). Theresa May’s speeches have been characterised by economic and social liberalism- “We reject the cult of selfish individualism. We see rigid dogma and ideology not just as needless but dangerous.” (Parker and Pickard, 2017) - but whilst rhetoric about tackling social injustice and inequality is evident, the main drivers to CVD policy have altered little and discourses of individualism and personal responsibility remain. CVD is described as ‘a major contributor to health inequalities’... ‘highly preventable through proven treatments for high risk conditions’ (NHS England, 2017: 44). The

emphasis continues to be placed on individual efforts to prevent disease rather than on government action to tackle the structural conditions that cause CVD prevails.

Discussion:

In the above, we have developed a discussion around three interlocking effects of neoliberalism as they relate to health policy formation: the increasing responsabilisation of individuals and communities; the development of ‘risk’ as a pervasive aspect of society; and the commoditisation of health. All of which lead to the construction of the ‘ideal citizen’ as morally responsible health conscious consumers. We have outlined how CVD health policy considers responsibility in relation to expectations of organisations and individuals. Organisational accountability is largely descriptive and forward-looking in nature, considering what responsibilities agencies have ‘for’ managing and preventing disease, whereas individuals are considered ‘to’ have responsibility. Conceptualising individuals as responsible for health-conscious behaviours enables a backward-looking narrative that reflects on positions of choice and promotes practices that hold individuals to account, assigning liability and even blame (Van de Poel and Fahlquist, 2013). Additionally, health promotion messages focusing on individualism and lifestyle appear to be privileged over structural explanations for CVD that are marginalized or silenced.

More careful consideration of this position needs to take account of the nature, impact and consequences of responsabilisation rhetoric. We go on to question the taken-for-granted conceptions of risk, responsibility and choice and the premise that policy initiatives and individual choice are based on rational autonomous decision making. By problematising how neoliberal discourses of responsabilisation are used to govern health practices, we consider how

these ways of thinking impose a system of limitations, exclusions and consequences that are hidden, therefore there is a need to rethink conceptualisations of responsabilisation.

Health practices

Rationalists tend to adopt the position that choice is freely available to all, however, this logic ignores the dual nature of forces which determine thoughts and actions where individuals are, on the one hand free agents, but on the other, are influenced by social, cultural and economic structures (Bourdieu, 1977). Bourdieu's Theory of Practice (1977) offers useful constructs to explore the limitations of the rationalist approach here. Whilst individuals are free to make healthy lifestyle choices, the degree of choice available is determined by the field and our habitus. Health care agencies operate within a shared, but tacit system of meaning and rules to identify health problems and their solutions. Walther suggests that '*fields* are places of power relations where the practices of agents are not arbitrary' (2014: 9). It is within this complex milieu that individuals realise what they can and cannot do; or should or should not do with respect to healthy lifestyles. **Simple health promotion models characterised by cause and effect arguments do not reveal the complexities, constraints, and consequences involved with decision making around health practices.**

Limitations and exclusions

Walther (2014) discusses how peoples' position in the field determines their language, lifestyle and tastes. It is this concept of 'habitus' that contributes to how and what actions and behaviours are preferred. Our past and present experiences structure our habitus that inform our schemes of perception and actions. Our social position in the field determines our social boundaries and limits to behaviour. It is in this way that our actions may be limited and consideration of this is neglected if we assume that we are rationale actors with equal capacity

to make choices. Policy formation based on neoliberal assumptions and biomedical explanations of disease marginalise accounts of disease that take account of these broader social, cultural and economic differences.

The choice agenda inevitably brings moral dilemmas and consequences for lifestyle decisions made by individuals. Making 'good choices' becomes part of the symbolic capital which agents use to situate themselves and make decisions about their own behaviour and judgements about others. We argue that behaviour change models promote a moral discourse which can have serious consequences for the patient experience. Hier offers insights into how moralising discourses operate. Suggesting, whilst they 'offer chances for self-fulfilment or the realization of safety/security through rational and prudent choice' (2008; 183), they also bring insecurity and worry about illness. Brown (2013) argues that the implications of the 'bad behaviour' argument is that those who fail to meet these obligations are less deserving of healthcare than those who do.

Blame

Knowledge paradigms based on the assertion of objectivity and neutrality obscure capacity for recognising how health discourses support a complex system of intersecting responsibilities, obligations, choices and consequences for actions. The conditions that result in blame are not confined to irrational thinking or lack of knowledge. Douglas asserts that 'knowledge always lacks. Ambiguity always lurks' (1994:9). Douglas **recognised that the way societies are organised, influences how risk is defined, and measured and blame becomes a by-product of defining danger for the public good.**

Douglas considered how taboo-thinking is associated with concerns about natural dangers; serves to uphold community values and is present in our modern approach to understanding responsibility and risk in health; asserting that ‘in all places and at all times the universe is moralised and politicised’ (1994; 4, 5). It can be argued that conceptions of responsibility in health policy discourse operate similarly to Western pollution taboos and notions of sin, in that certain behaviours and lifestyles have come to be identified as antisocial. Risk assessment has provided a modern-day divinatory space in order that we can attempt to predict our futures and negotiate hazards.

The language used in risk management policy agendas is associated with certainty of outcome and CVD is described as a ‘preventable condition’ and behaviours associated with CVD risk are ‘modifiable’ (DH, 2006:1; NHS England, 2017:44). In risk management there are no certainties, however, lifestyle has increasingly become a risk implicated with disease causation. Margret Lock (1998:9) comments that anxiety around genetic predisposition to disease has become a ‘quasi pathogen’ in that people assume that genetic factors determine disease rather than simply increase susceptibility. Conceptualising risk as irrefutable holds individuals to account for behaviours considered dangerous or hazardous. Globally, lifestyle disease has been described as a ‘pandemic’ and there have been calls for ‘norm entrepreneurs’ to direct policy and take action nationally and internationally to address behaviour change (Toebes et al, 2017).

By problematising the responsabilisation movement in health policy, numerous dimensions in the way these debates are articulated and framed, are demonstrated. Normative conceptions of decision-making assume a balanced approach demonstrating a willingness to sacrifice and commitment to change associated with virtuous character traits. In this way responsabilisation in health care, appears to be a positive force for empowering patients and their families. Whilst

organisations are considered accountable and are given authority for moderating risk, this often results in no one individual being blamed for harm caused. For example, failings in patient care at Mid-Staffordshire hospital were blamed on a culture that tolerated substandard care and leadership that was target driven (Francis, 2013). Individual responsibility for healthy lifestyle, however, supports a backward-looking system that seeks to attribute liability and blame. In this way, lifestyle correctness or the view that an unhealthy lifestyle inevitably causes disease poses a risk to vulnerable and minority groups, who may be in the least powerful positions to resist accusations and the consequences of blame.

This analysis reveals competing values in CVD health policy between individualism, neoliberalism and collectivism and demonstrates the importance of considering the context in which policy is created, enacted and received. A critical awareness of the social and cultural factors which influence policy formation illuminates the moral categories that shape our ideas about health and illness. There is further research needed to establish how responsabilisation discourse shapes patient experience; to understand how individual actions may reproduce or resist responsabilisation discourses; and to determine the significance of responsabilisation discourse in enabling, constraining or inhibiting decision-making processes that support healthy lifestyle choice.

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