

Article

Using Foucault: Genealogy, Governmentality and the Problem of Chronic Illness

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Abstract: This article explores the unique contribution that Foucault’s work on genealogy and governmentality can make to the analysis of contemporary programs of government. The article uses an Australian study of the ‘problem’ of chronic illness to argue that this perspective offers valuable insights into how ‘problems’ such as chronic illness have become linked to advanced liberal discourses and practices of self-governing and self-responsibility. These insights are particularly valuable in fields such as primary health care that have a noted shortage of critical and reflective studies that explore the links between people and changing ideas of health and disease. This article details how taking up an analytics of governmentality and political genealogy informed by Foucault, facilitated the tracing of the dominant discourses and practices, and the connections to the day-to-day lives of the clients with chronic diseases. Importantly, this approach opened up a more critical consideration of the ways in which dispersed approaches to governing through programs, such as integrated care, shape and influence the lives of individuals. These dispersed ways of governing are not linear but rather unfold through ongoing relays, connections and the (re)production of discourses.

Keywords: genealogy; governmentality; Foucault; chronic illness; translation; assemblage

1. Introduction

Research inspired by Foucault’s work on political genealogy and an analytics of governmentality (Foucault 2007a) has occurred in many disciplines and fields of study. Governmentality writers, such as Nikolas Rose (Rose 1996), Peter Miller (Miller and Rose 2008), Mitchell Dean (Dean 2006, 2007, 2010) and Thomas Lemke (Lemke 2010) to name but a few, have extended Foucault’s work, particularly in using it to analyse neo-liberal or what Miller and Rose (2008) call advanced liberal ways of governing in many different areas—the economy, welfare, organisations, bio-health and law. Foucault’s governmentality perspective is set out in the lectures he gave at the Collège de France in the Spring terms of 1977–1978 and 1978–1979 (Dean 2010). These lectures were most comprehensively published in French in 2004 (Elden 2007) to coincide with the twentieth anniversary of Foucault’s death. The translation and publication of these lectures in 2007 as *Security, territory, population* (Foucault 2007a) generated a new body of scholarship on governmentality and it has been enthusiastically taken up as an analytic approach to investigating the empirical practice of governing.

As a contribution to this *Special issue on political genealogy*, this article focuses on the utility and contribution an analytics of governmentality and genealogy make to a study of chronic illness. The article draws on data from a research study, *Governing chronic illness through integrated care* (Turnbull 2017), which used this approach to understand the ways in which the problem of chronic disease became linked to advanced liberal discourses and practices of self-governing and self-responsibility. The research

study¹ traced how a health care program in Australia—HealthOne—was translated in advanced liberal ways to the local lives of clients with chronic illnesses. The analytic perspective used offered a unique view of the contemporary ‘problem’ of chronic diseases. The broad fields of research that are concerned with chronic diseases and programs of care management tend to be dominated by evaluative and descriptive studies that focus on the need for reform and greater cost effectiveness (Braithwaite et al. 2005; Valentijn et al. 2015; Brown and McIntyre 2014). There is a shortage of critical and reflective studies that focus on “complex strategic relations” (Bacchi 2012, p. 1) that connect people and the changing ideas of health and disease. The insights presented in this article illustrate the potential offered by Foucault’s work to empirical studies in many fields, such as health studies.

Taking up an analytics of governmentality and political genealogy informed by Foucault, facilitated a unique tracing of the dominant discourses and practices circulating in the local, national and global contexts and their linkages to the day-to-day lives of the clients with chronic diseases. Importantly, this approach opened up a more critical consideration of the ways in which dispersed approaches to governing, shape and influence the lives of individuals. These dispersed ways of governing are not linear, but rather unfold through ongoing relays, connections and the (re)production of discourses. In particular, notions of translation (Rose 1996, 1998) and assemblage (Murray Li 2007) are used to illustrate how dispersed ways of governing across sites and locations come together around the lives of individuals.

This article begins by discussing an analytics of governmentality and genealogy as a ‘method’ for analysing, in this case, contemporary, dispersed ways of governing health and disease. The article then focuses on how taking up this perspective facilitated the analysis of contemporary understandings of chronic disease (re)produced within the key policies and texts associated with HealthOne, a state-run integrated, primary health care program located in a metropolitan area of Australia. Importantly, the analytic perspective and genealogical approach used in this study enabled the tracing of the translation and movement of these discourses of health and disease from policy texts and everyday practices of those involved in HealthOne. To illustrate how an analytics of governmentality and genealogy were used and the utility of such an approach, this article focuses on three aspects of the research study—first, the assembling of a crisis and emergence of a programmatic ‘solution’; second, the translations of advanced liberal notions of self-responsibility and self-care into the programmatic logic of community-based integrated care (Rose and Miller 1992); and third, the assembling of the patient as a ‘client’—the responsible and self-caring chronically ill client—through technologies of government such as education, training and advice.

2. Governmentality and Political Genealogy: Rationalities, Technologies, Translation and Assemblage

Foucault’s work on governmentality (Foucault 2007a) and genealogy have been discussed previously in this journal (Knauff 2017). As Knauff (2017, p. 6) suggests, “it is patent that Foucault’s notion of genealogy . . . has enormous power to recast, upend, and render problematic—though not to ‘transcend’—existing accounts of historical progression, influence”. As a ‘method’ for analysing contemporary problems, readings of Foucault’s work have revealed that there is no clearly stated, well-defined or prescribed methodology for investigations. There is, however, some guidance on how the perspective can be used to inform an empirical research study. This guidance takes the form of proposing an open system of maxims and injunctions that constitute an ethos of analysis for undertaking a critical and effective form of history (Dean 1994). As Rose states in his additional Foreword to the second edition of *Governing the soul*,

¹ Data reported in this article was drawn from the research study, *Governing chronic illness through integrated care* (Turnbull 2017) which was a component of a project funded by the Australian Research Council (ARC). Approval for the study was granted by the University of Technology, Sydney, Human Research Ethics Committee (HREC) on 02/07/2013 (reference code 2013000025). The names of places, programs and research participants have been changed to preserve anonymity.

I am not particularly keen on attempts to derive a formal methodology for this kind of ‘history of the present’ and it would be misleading to claim this study is the application of any such methodology. Nonetheless, speaking roughly, it is possible to identify a number of dimensions along which this analysis is conducted (Rose 1999a, p. XI).

Rose continues by identifying six dimensions—problematization, explanations, technologies, authorities, subjectivities, and strategies—which he suggests may be an appropriate analytical grid for some, but not all, problems (Rose 1999a, pp. XI–XII). However, two aspects of Rose’s quote above assist in illuminating questions of ‘method’ as posed by Foucault and critically reflected upon by others. Firstly, the notion of the ‘history of the present’; and secondly, that of genealogy, which could be considered a ‘method’ for undertaking studies framed by an analytics of governmentality perspective.

A history of the present is “concerned with that which is taken for granted, assumed to be given, or natural within contemporary social existence, a givenness or naturalness questioned in the course of contemporary” (Dean 1994, p. 35). It is not, as some more traditional historians might view it, a “writing of the past in terms of the present” (Foucault 1977a, p. 31 cited in (Dean 1994), p. 28). Foucault suggests we must avoid this approach to presentism. Rather it is about defining a problem of our time and using a genealogical method to investigate the trajectories of the problem within a history. As Dean (1994) suggests, genealogy can be used to offer unique insights into contemporary social struggles by drawing on the inherent complexity and multiple layers of these ‘problems’:

It is a way of analysing multiple, open-ended, heterogeneous trajectories of discourses, practices, and events, and of establishing their patterned relationships, without recourse to regimes of truth that claim pseudo-naturalistic laws of global necessities’ (Dean 1994, pp. 35–36).

It is important to highlight that, as has been discussed previously in this journal (Kretsedemas 2017), there are a range of styles of genealogy.² Discussion of these different styles are beyond the scope of this article. However, it is of note in the context of this article that when used within an analytics of governmentality, and following Foucault, genealogy and its methods offer a way of analysing liberalism as practices of government rather than as a philosophy or as historical time periods, and to ‘understand its plurality, capacity for reinvention and sheer longevity’ (Dean 1999, p. 48).

Further, a genealogy of power in this style has a profound (con)textualism and an intimacy with historical circumstances shaped by the specific conditions of locations and particular milieu (Foucault 2007b). It is a move “beyond the limitations of discourse analysis and . . . [to be] more attentive to that which conditions, limits and institutionalises discursive formations” (Tamboukou 1999, p. 216). As Rose (1998) describes it,

discourse analysis covers a multitude of sins . . . This is because it is not primarily an analysis of text. I’m interested in discourses as they are embedded in practices, as they lead to the emergence of regimes of truth which are connected up with systems of authority, which are operated through very, very specific techniques. This, for me, is a very—if it wasn’t a devalued term—materialist kind of analysis, and indeed a very empirical one too (Rose 1998, p. 91).

Discourse analysis in a critical theory approach differs from a Foucauldian genealogy in an analytics of governmentality perspective. The critical theory approach uses the analysis of language to focus on “unmasking the ideological content and highlight the possibility of different emancipatory truths” (Dean 1999, p. 63). In contrast, a Foucauldian genealogy from an analytics of governmentality

² See the following publications for an illuminating discussion of genealogy using two case studies of the government of welfare and poverty, highlighting the differences between the analytical method in the critical theory approach and a Foucauldian genealogy in an analytics of government perspective (Cruikshank 1993; Fraser and Gordon 1994; Dean 1999).

perspective views the language of a problem area, such as welfare dependency, as problematisation, representation and a program of reform. As [Tamboukou \(1999\)](#) suggests,

Rather than following methodological principles, Foucault's genealogies create a methodological rhythm of their own, weaving around a set of crucial questions . . . What is happening now? What is this present of ours? How have we become what we are and what are the possibilities of becoming 'other'? . . . Foucault's genealogies do not offer methodological 'certainties'. They persistently evade classification, but they do inspire the writing of new genealogies to interrogate the truths of our world. ([Tamboukou 1999](#), p. 215).

Additionally, this analytics for studies in governmentality rejects the approach to knowledge within the humanities and social sciences that defines it in terms of ideologies, that is, as "the false knowledges with a social formation of legitimation" ([Rose 1999a](#), p. 13). Rather, following Foucault and other writers on governmentality like Rose, there is a focus on the productive role of knowledges, examining the formation of knowledge practices as they have been shaped and what has made them practicable and thinkable. In particular, it is concerned with what Rose describes as 'political' knowledges—"how to govern, what to govern, who should govern and to what ends" ([Rose 1999a](#), p. XIII).

Of particular relevance in this article is an understanding of governmentality not as theory or methodology but rather a research perspective—"an angle of view, a manner of looking, a specific orientation" ([Bröckling et al. 2010](#), p. 15). Taking up this research perspective offers a way of thinking about how governing unfolds through complex linkages between "questions of government, authority and politics, and questions of identity, self and person" ([Dean 2010](#), p. 20). Considering the linkages between political problems and programmatic solutions reveals certain patterns within contemporary approaches to governing. In this article, governmentality opens up a way of thinking about how chronic disease and care are assembled through policies and practices in ways that reflect contemporary "arts of governing"—ways of "employing tactics rather than laws . . . arranging things so that this or that end may be achieved through a certain number of means" ([Foucault 2007a](#), p. 99).

In taking up an analytics of governmentality, this article draws on notions related to *how* programs of governing move from a political centre and into the homes and lives of citizens. The concept of advanced liberalism is used, following Rose, O'Malley and Valverde ([Rose et al. 2006](#))—that is, it reflects a "way of doing things" ([Rose et al. 2006](#), p. 84) that allows governing to unfold at a distance. [Rose \(1999b\)](#) described this way of operating as "government at a distance . . . distance in both constitutional and spatial senses". This form of liberal rule—at a distance—is entwined "to the activities and calculations of a proliferation of independent authorities . . . doctors, . . . , managers, planners, parents and social workers. It is dependent upon the political authorizations of authority of these authorities, upon forging of alignments between political aims and the strategies of experts, and upon establishing relays between calculations of authorities and aspirations of free citizens" ([Rose 1999b](#), p. 49).

This complex way of governing at a distance unfolds through multiple relays and connections that draw people and sites together. Key to the sense of coherence associated with such attempts to govern are the political rationalities that are (re)produced through these relays and connections. Political rationalities in this sense refer to the reasoned and accepted ways of thinking about and justifying approaches to governance ([Savage 2013](#)). Dominant political rationalities open up opportunities for the emergence of various political technologies or tools that are used to govern—the "techniques, mechanisms, instruments . . . the mechanics through which rationalities are put into practice" ([Savage 2013](#), p. 86). In this way, rationalities (or ways of thinking) are (re)produced through technologies and techniques that link ways of thinking to actions and behaviours.

The linkages between political rationalities, technologies and techniques allow attempts to govern to move from a source and to be localised within a multitude of sites. [Rose \(1999b\)](#) described these linkages as translation and explained that this connects "one place to another, shifts a way

of thinking, from a political centre—a cabinet office, a government department—to a multitude of workplaces, hospital wards classrooms, child guidance centres or homes” (Rose 1999b, p. 51). It is through the ‘fragile relays’ of translation that discourses, agencies, people and material objects come together at points in time and work to (re)produce and stabilise political rationalities. As Li (Murray Li 2007) observed:

Governmental interventions that set out to improve the world are assembled from diverse elements—discourses, institutions, forms of expertise and social groups whose deficiencies need to be corrected, among others (Murray Li 2007, p. 263).

Such interventions have no essence or singularity but are somehow made intelligible as they temporarily cohere through the practices that constitute them “only to disperse or realign . . . the shape shifts according to the terrain and the angle of vision” (Murray Li 2007, p. 265).

In this article, this way of thinking about translation and assemblage connects the study of HealthOne to broader shifts in thinking about health, disease and responsibility. The clients of HealthOne were drawn together through the (re)production of discourses that have come to dominate local, national and global ways of thinking about the problem of chronic disease and the types of programs that can address it. By taking up an analytics of governmentality and genealogy, these discourses and ways of thinking and acting are traced through global, national and local policy texts and into the daily lives of clients of HealthOne.

Drawing from data collected as part of the study—*Governing chronic illness through integrated care*, this article examines the emergence of a new program to govern chronic illness in local populations—named HealthOne. Data was collected from local, national and international policy texts, interviews with senior managers and from shadowing a Nurse at the local site on visits to four clients over six months. Observation notes and interview transcripts were analysed together with the policy texts.

Taking up an analytics of governmentality and genealogy allow this ‘site of practice’ to be traced and dominant discourses recognized. This facilitates a more critical consideration of the ways in which dispersed approaches to governing, shape and influence the lives of individuals.

The following section discusses three aspects of the study’s analysis chosen to illustrate the usefulness of analytics of governmentality and genealogy—*Illustration One*—Chronic disease: assembling a crisis and a programmatic ‘solution’; *Illustration Two*—Translations of advanced liberal notions of self-responsibility and self-care into the programmatic logic, and *Illustration Three*—Assembling of the patient as ‘client’—the responsible and self-caring chronically ill client.

3. *Illustration One*—Chronic Illness: Assembling a Crisis and a Programmatic ‘Solution’

This “illustration” focuses on the ways in which a ‘crisis’ was assembled in the policy texts and discourses of the health field, nationally and internationally, and a programmatic solution emerged. Rather than determining whether elements of these discourses were true or false, following Foucault’s (2003, p. 20) interest in problematisation as a “domain of acts, practices, and thoughts that seem to pose problems for politics” (Foucault 2003, p. 20), such analysis draws out the patterns and consistencies embedded and reproduced through texts and everyday practices.

For example, analysis of global health discourses over the past two decades suggests that the ‘crisis’ of chronic illness emerged from particular regimes of ‘truth’. Reports from international bodies such as the World Health Organization (WHO) and national government reports highlighted this crisis. For example, the World Health Organization (WHO) warned that “the global burden of chronic disease is increasing rapidly, and predicts by the year 2020 that chronic disease will account for almost three quarters of all deaths” (Department of Health and Ageing 2009, p. 9). Diseases of greatest concern included diabetes, heart disease, respiratory disease and certain types of cancers. In the USA, reports suggested that in 2010, 86% of health care expenditure was directed towards the management of chronic diseases (Gerteis et al. 2014). Similarly, reports in

low- and middle-income countries identified high rates of chronic diseases linked to approximately 80% of deaths in these nations (Slama et al. 2013, p. 83). In 2015, the Australian Government's Department of Health report highlighted the crisis of chronic diseases, which were now the leading cause of "illness, death and disability in Australia, accounting for 90% of deaths in 2011" (Department of Health Chronic Diseases 2016). Australian statistical reports released in 2016 indicated that 75% of Australians over 65 years of age now suffer from one or more of these chronic diseases (Swerissen et al. 2016).

The 'problem' of chronic disease in this crisis became intertwined with economic discourses about costs of long term, complex management, the risk of reduced economic productivity and advanced liberal discourses of self-responsibility—connecting many chronic diseases to lifestyle 'choices' made by individuals. Locating the problem of chronic disease with these economic and self-responsibility discourses, opened up spaces in which very particular programmatic solutions seemed rational and logical—a regime of truth. Importantly, patterns within these programmatic responses reflected advanced liberal ways of governing health and disease through ideas of risk and self-responsibility and dispersed programs of care and education. This way of thinking was evident in international and Australian health policy texts examined, which in recent decades have emphasized the importance of health promotion and preventative interventions for all citizens, including those with chronic diseases. The intended outcomes of these programs that promote self-management included lessening the burden and costs of hospitals on the public 'purse'. For example, in recent Australian policy texts, governments' role in relation to health was described as being to "nudge people towards health-promoting behaviour through better information, evidence-based prevention and health promotion programs" (National Health and Hospitals Reform Commission 2009, p. 62). These programs, which were initiated as a response to the 'crisis', were no longer just about hospitalization. Rather they were mobilized through advanced liberal ways of governing and making the individual 'responsible' for their care. Localized programs, new integrated care models and interventions focused on education, advice and training marked a shift away from the provision of more traditional and expensive medical care. Significantly, these ways of governing through responsibility and self-management were extended beyond general health promotion to those people with serious, long term diseases.

As seen in the following extract from a HealthOne policy text, the emphasis on prevention and community-based approaches is evident in the following program's objectives:

1. Prevent illness and reduce the risk and impact of disease and disability;
2. Improve chronic disease management in the community;
3. Reduce avoidable admissions (and unnecessary demand for hospital care);
4. Improve service access and health outcomes for disadvantaged and vulnerable groups;
5. Build a sustainable model of health care delivery (NSW Government HealthOne NSW 2016).

These objectives focused on the social, economic and political problems associated with chronic disease—prevention, disability, costs of hospital care and sustainability of services.

As seen in the illustration above, an analytics of governmentality foregrounds these dispersed approaches to governing, not in the linear ways implied in the policy texts, but rather by tracing how they unfolded through a succession of alignments, relays and affiliations. Discourses and ideas about problems and policy solutions are (re)produced as they spread from a centre of governing to local sites. This approach to analysis also illuminates the patterns in ways of thinking and talking about problems such as chronic disease, that move back and forth between policy and everyday practices. Through this movement and (re)production certain 'truths' stabilise and become accepted—ideas and ways of thinking about the problem of chronic disease move and disperse. No longer a problem of types of hospital care—what emerged was programs of self-care based in the community.

4. Illustration Two—Translations of Advanced Liberal Notions of Self-Responsibility and Self-Care into Programmatic Logic

The second illustration focuses on the ways an analytics of governmentality and genealogy foreground how advanced liberal rationalities and technologies were translated into the programmatic logic of HealthOne. Within the milieu of the global crisis in chronic disease, notions of integrated care with daily life and promoting self-care, rather than expensive hospital care, were (re)produced in HealthOne policy and organisational texts. The texts were littered with terms such as integrated, co-location, holistic and coordinated care. The emphasis was on flexibility and localisation, translating the program across sites and places as responsibility was devolved to local practitioners as the key experts.

For example, the programmatic logic of the programmatic solutions to the problem and crisis of chronic disease was about governing this population of people at a distance (Miller and Rose 2008). The program focused on integrated care—governed through policy texts from a ‘policy centre’, enacted through by local organisations and practitioners. This is can be seen in the text, *Guidelines for Developing HealthOne NSW Services*, which describes HealthOne services as having come together through the practices of professionals:

While there is no fixed model for HealthOne NSW services, they are characterised by a motivation to bring health care professionals together to reduce the increasing burden of chronic disease and to focus on those people in the community who need a greater level of coordinated care (NSW Government 2012, p. 6).

The strength of the programmatic logic embedded within HealthOne allowed for flexible configurations of local programs. Despite the variety of models, HealthOne programs were unified by the reproduction of discourses of health and care:

There is no single model of integrated care that is suited to all settings; Local Health Districts should be guided by their community needs about the configuration that is best suited to each locality. (NSW Government 2012, p. 3).

One model—the virtual model in particular highlights the dispersed nature of HealthOne:

In the virtual model, a number of separately located providers function as a team through electronic and other forms of communication. Members of a virtual HealthOne NSW may rarely meet face to face. Integration may occur through formalised networks based on explicit governance arrangements and is often underpinned by service level agreements or contracts (NSW Government 2012, p. 22).

These statements of intent, and the linking of the program’s integrated care with various models of care, set out what appears as a linear, rational process of governing through programmatic solutions to problems. These policy texts attempted to extract “from the messiness of the social world, with all the processes that run through it, a set of relations that can be formulated as a diagram in which problem (a) plus intervention (b) will produce (c), a beneficial result” (Murray Li 2007, p. 265). In the case of HealthOne, the “programmatic logic” (Rose and Miller 1992, p. 190) sought to govern at a distance through a local integrated program. This relied on the practices of local people and illustrated the translation (Rose 1999b) involved in advanced liberal ways of governing. Governing in this sense is not a rational, linear process, but rather a series of conjunctions and moments in which assemblages come together.

HealthOne was described in interviews with senior managers as suiting local needs as determined by local ‘experts’:

... that reductionist approach to describing an integrated primary healthcare model or service, we don’t fit it because we learnt and I think deliberately have allowed—it must be clinician led at the

local level. It must suit local circumstances, local needs, local conditions. Therefore, there isn't the one model. (Interview with senior policy maker, 26.10.11).

Here, the program, through a process of translation (Rose 1999b), governs chronically ill people in the local population in advanced liberal ways. The (re)configuring and localising of the programmatic response then links a multitude of workplaces and people as the program is taken up in potentially varying ways. This linking and relaying is neither smooth nor permanent. Captured within the notions of assemblage and translation are a sense of ongoing flux and movement. The neo-liberal economic concerns associated with disease and the provision of care were a recurrent theme in the data. In the heightened 'crisis' discussed above, these discourses became dominant, as indicated in the quote below

the reason all of this happened is because we've reached that kind of—is it the top or the bottom of the bell in terms of all those messages about the health budget is going to actually take the whole State budget in three years if we don't do something. (Interview with senior policy maker, 14.10.11).

The dominant discourses about impending budgetary disaster became linked in the HealthOne program to the lives and homes of its clients in particular, advanced liberal ways. The focus of the daily work of HealthOne was to be these particular practices of care enacted with these clients:

In the end it basically came down to . . . better care of people in the community who've got vulnerable, older people, people with complex health conditions particularly around the whole cost blowout of acute system and what can community-based health service delivery do to prevent that? (Interview with senior policy maker, 14.10.11).

Importantly, as this translation took place, discourses of risk and cost were (re)produced and increasingly stabilised. A sense of urgency grew around the need to find people at risk and to engage them in the program:

. . . we're focusing on the population in a primary health care sense. So we're flushing and we're looking and we're sorting. (Interview with senior policy maker, 14.10.11).

This idea of flushing, looking and sorting through the needs of local populations illustrates the way in which problematisations are localised. Programmatic interventions can thus differ yet maintain linkages to discourses of health and responsibility. This way of sorting through and monitoring populations relied on practices of communication and information sharing between local authorities and experts:

So it gives an opportunity to have a conversation . . . So communication, information sharing, understanding of each other's business; that in itself has got to do something about strengthening what we do. (Interview with senior policy maker, 14.10.11).

Here, communication and information sharing were the techniques and technologies for governing the chronic diseases in these populations—rather than the medical techniques of hospital ward rounds, etc. Although local needs differ, the connections to discourses of health and disease were (re)produced and intensified as managers and practitioners talked about what needed to be done in local areas. The localisation is illustrated in the following HealthOne policy text, which set out the problem in terms of access, communication and the need for the education of 'at risk' groups:

[Local government area] was considered an important site for the implementation of HealthOne NSW, as service partners identified [the area] to have:

- One of the highest Culturally and Linguistically Diverse (CALD) populations in the state, particularly refugees;
- Limited access to interpreter services in the area;
- Limited service access by CALD populations, particularly refugees;

- Overstretched health services with long waiting lists or closed books, particularly GPs;
- Poor communication and service coordination between existing service providers;
- Poor health status due to being a significantly disadvantaged community (2013, pers. comm., in meeting documents 8 October).

This (re)contextualisation of the problem of health and illness in local terms reinforces the linkages between risk factors such as cultural and linguistic diversity, disadvantage and the resettlement of population groups, with the *potential* to need costly health care, producing programs of care focusing on integration and community care.

Whilst such discourses are ‘depersonalised’ in policy texts, as programs translate and disperse out into local communities, problematic populations are defined and identified. In turn, individuals within these groups become a part of a local, national and global ‘problem’.

5. Illustration Three—Assembling the Patient as a ‘Client’—Responsible and Self-Caring

The third illustration focuses on the way in which the ‘patient’ subjectivity was reassembled as the responsible and self-caring chronically ill ‘client’. It utilises data collected from clients of HealthOne, as part of the research study discussed earlier. The lives of these ‘clients’ were diverse—two had quadriplegia as a result of accidents in adulthood, one suffered from a degenerative neurological disease and the other was an 83-year-old woman with a number of medical conditions affecting her heart and lungs. Whilst their medical conditions were significant, what is of most interest in this research study, was consideration of *how* these people were identified, brought together and assembled as clients of a program that promoted self-management and integrated care.

For the clients of the local program, an entry point into the assemblage was marked by a visit from the local expert at their homes and the knock on the door that announced their arrival. The process of referral and enrolment had been initiated away from the bodies of these people by other ‘experts’, who had identified their potential for reform and improved management of their health.

In analysing the brochure, the shift in subjectivities was apparent. *Patient* was used in the title and was capitalised. Using the word *patient* in this way linked HealthOne to discourses of medicine and the hierarchical relationships that structure the relations between medical authorities and patients. Within the rest of the text, however, the word *patient* is not used again. Through processes of referral, assessment and enrolment, a new and different subjectivity was emerging for the patient. The process of referral was described in the following terms, with the patient being (re)assembled as a *client*:

- Referrals . . . are generally made by GPs, Community Health workers and hospital staff.
- Once a referral is received, an assessment will be completed by a Community Health worker.
- HealthOne will be explained to you and your consent obtained to be enrolled as a . . . client.
- Your GP will be contacted and their consent obtained for their participation. At this point you become a [HealthOne] client (NSW Government n.d.).

This process of referral, assessment and access marks a transition from the subjectivity of *patient* to that of *client*. The subjectivity of the client is active in comparison to that of the patient, who is a passive recipient of care. The subjectivity of the client draws on ideas of activation, engagement and the realisation of *potential*. Networks of experts were connected to discuss and identify patients who had the need and potential to take up the subjectivity of the *client*. The use of the word ‘client’ activates discourses of choice and responsibility and opens up opportunities for experts to engage with the client in different ways (Mol 2008). Within the bounds of the institution, the doctor or nurse is associated with medical authority and expertise. However, in a program like HealthOne, which seeks to activate the responsible and self-governing client, the expert takes on a subjectivity that works through techniques that seek to engage, guide and educate, rather than through the surveillance associated with the bounded institution. As discourses of choice and responsibility became dominant in the program, a diverse range of experts and professionals came to work with clients on self-development

and improvement programs. This work was done by altering the understanding and relationships individuals had with themselves; that is, by “inculcating desires for self-development that expertise itself can guide and through claiming to be able to allay the anxieties generated when the actuality of life fails to live up to its image” (Rose 1999b, p. 88).

This shift in thinking builds an understanding of the client as intrinsically willing and able to choose to engage in projects of development and improvement. Rose (1999b) argued that the implications of rejecting such choices are embodied by the groupings of those who remain outside the “regime of civility”, such as the homeless, alcoholics, drug users and lone parents; “an amalgam of cultural pathology and personal weakness” (Rose 1999b, p. 88). The chronically ill client in this case does not, however, sit outside this regime of self-improvement. Being referred and then consenting to enrolment in the program clearly situates the client within relations and practices that help them to make the ‘right’ choices and accord them the status of the responsible, self-caring client.

6. Conclusions

This article has illustrated the usefulness of an analytics of governmentality and genealogy to the study of contemporary programs of governing. Through the three illustrations provided, this article has shown how this perspective can be used to empirically study problems such as populations of chronic illness. As noted in the introduction to this article, the field of health and care research tends to be dominated by instrumental and process-driven approaches which focus on the evaluation and description of what care is and the potential of restructures and reforms. In contrast, an analytics of governmentality and genealogy using notions of assemblage (Murray Li 2007) and translation (Rose 1999b) draws out the complexity of policy and the “fragile relays, contested locales and fissiparous affiliations” (Rose 1999b, p. 51) that connect policy to everyday practices of care. Programs like HealthOne seek ‘regimes of truth’ which appear as linear, rational programs, to solve these complex ‘problems’. Understanding these as ‘regimes of truth’ is of value as it opens up opportunities to rethink the underlying “programmatic logic” (Rose and Miller 1992, p. 192). As demonstrated in the illustrations included in this article, taking up this style of genealogy can highlight the “messiness” (Sandberg et al. 2016, p. 117) of everyday practices of care by “tracing their twists, turns, and localized effects” (Peck and Theodore 2010, p. 173). These insights emphasise the importance of critical and reflexive research that can question the close relationships between policy and governing populations at a distance. In this case, studying the translation of integrated care through empirical analysis highlights the complexity of contemporary understandings of chronic illness and the neoliberal economic rationalities that run through it. Further, an analytics of governmentality and genealogy opens up a critical stance on how advanced liberal ways of thinking about chronic disease became embedded in daily practices of a diverse group of professionals and clients in local sites in the community. In so doing it highlights the potential of these ‘intellectual tools’ for research in many different fields.

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